ChildProtectionPeak

Queensland Aboriginal and Torres Strait Islander
Child Protection Peak Limited

Submission to the QLD Child Protection Commission of Inquiry: Complaints Systems

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Acknowledgement of Country

QATSICPP acknowledges the Traditional Custodians across all the lands that make up the State of Queensland. We acknowledge the oldest living cultures of Aboriginal and Torres Strait Islander peoples and the continued connections to Country, language and tradition. We pay our respect to Elders past and present and acknowledge future generations of Aboriginal and Torres Strait Islander children and young people and the bright future they will have.

Introduction

The Queensland Aboriginal and Torres Strait Islander Child Protection Peak (QATSICPP) is the peak body for Aboriginal and Torres Strait Islander community-controlled organisations delivering child, youth, and family support services in Queensland. QATSICPP is also Queensland's Youth Justice Peak, collaborating with Aboriginal and Torres Strait Islander and non-Indigenous service providers to strengthen outcomes across the child protection and youth justice systems.

Our membership includes 38 Aboriginal and Torres Strait Islander community-controlled organisations (ATSICCOs), delivering vital services, guidance, and culturally grounded supports to ensure the safety and wellbeing of Aboriginal and Torres Strait Islander children, young people, and families. QATSICPP's vision is that all Aboriginal and Torres Strait Islander children and young people are physically, emotionally, and spiritually strong; live in safe, caring, and nurturing environments within their families and communities; and are afforded the same life opportunities as other children and young people to reach their full potential.

Over its 21 years, QATSICPP has worked in partnership with Aboriginal and Torres Strait Islander leaders and the Queensland Government to promote approaches that are culturally responsive and community-led. With a strong history of collaboration, QATSICPP continues to lead the development of solutions that respond to the unique strengths and needs of Aboriginal and Torres Strait Islander children, families, and communities.

QATSICPP's Opening Messages to the Inquiry

Since the announcement of the Commission of Inquiry into Child Safety ('The Inquiry'), QATSICPP has held forums and conversations with leadership from 24 of our member organisations, and has developed a summary of key messages, insights and knowledge we want to share with the Inquiry from its beginning.

In discussions to date four key themes have emerged, which are reflected in the building blocks of the Family Matters campaign. The building blocks were designed in Queensland and adopted nationally as a response to the Carmody Inquiry to guide how investment and systems should be orientated to eliminate over-representation and provide a strong framework for the knowledge and insights we want to share with this Inquiry.

Building Block 1: All families enjoy access to quality, culturally safe, universal and targeted services necessary for Aboriginal and Torres Strait Islander children to thrive.

- There is a harmful over-reliance on residential care, especially for unborn and new babies, driven by underinvestment in family support, kinship care, and culturally led alternatives.
- Investing in families reduces the trauma of separation and removal and leads to improved physical health, social, emotional and productivity outcomes over the course of a child's life.
- Culturally safe early intervention programs are not systemically embedded in government referral practices.
- The system must shift from bureaucratic risk management to child and family wellbeing, centred on lived experience.
- Inconsistent Departmental practices across regions and poor information sharing continue to undermine collaboration and delay support.

- The system continues to remove newborn babies without early, proactive support, often failing to meaningfully engage parents or refer to family support services when concerns about children are identified.
- Family Wellbeing Services and Family Participation Programs are proven to keep children safe and reunify families but are underfunded and receive referrals too late.
- There is an urgent need to reform referral pathways, improve cross-agency data sharing, and increase funding to meet demand.
- The last three Family Matters reports have highlighted a failure to sufficiently invest in early support for families so children can live safely at home, whilst over-representation of our children in out-of-home care (OOHC) remains at high levels. We need intentional investment in proven Aboriginal and Torres Strait Islander community-controlled services.

Building Block 2: Aboriginal and Torres Strait Islander people and organisations participate in and have control over decisions that affect their children.

- Participation is a key element of the Aboriginal and Torres Strait Islander Child Placement Principle, but is often a key element overlooked in child protection processes, which creates significant barriers to appropriate, early and effective interventions.
- Residential care use has increased by 44% over the past five years, raising urgent questions about the absence of Aboriginal and Torres Strait Islander voices in decision-making about where children are placed.
- There should be legislative reform to ensure Delegated Authority has the potential to continue to create positive outcomes.
- A co-designed, legislated roadmap is needed to reduce child removals, backed by independent oversight and accountability mechanisms.

Building Block 3: Law, policy and practice in child and family welfare are culturally safe and responsive.

- Support must be redirected to a full continuum of culturally safe, family-based responses, ensuring children enter care only as a last resort and remain connected to family, community, and culture.
- On-Country, kin-based residential care models led by ATSICCOs are supported.
- Cultural connection must be central, not secondary, to care and protection.
- Delegated Authority must be supported as it is showing promising outcomes for families, demonstrating the value of ATSICCO-led decision-making.
- The February 2025 commitment to transfer funding from non-Indigenous NGOs to ATSICCOs is welcomed and must be accelerated.
- Outcomes must be prioritised over compliance, to mitigate the fact that the system is perpetuated by a risk-averse, siloed culture, that leads to inconsistent practice and excessive caseloads.
- Cultural and spiritual needs must be recognised as core components of wellbeing, not optional extras.
- We warn against non-traditional adoption as a permanent solution for Aboriginal and Torres Strait Islander children as it can sever cultural and familial ties, which is particularly harmful for Indigenous children. Instead, we should look to culturally safe alternatives that prioritise connection to family, community, and culture.

Building Block 4: Governments and services are accountable to Aboriginal and Torres Strait Islander people

- The Carmody Inquiry provided clear direction for reform of the system, yet many issues remain unresolved. There is frustration that this Inquiry risks repeating known problems without enacting real change.
- There needs to be cultural and practice change, not just policy reform.
- There is a need for clear KPIs, transparent decision-making, and independent oversight, including culturally informed practice panels.
- There is a need to have Aboriginal and Torres Strait Islander representation across all Governance Groups to ensure accountability and culturally effective decisions are made for Aboriginal and Torres Strait Islander children and young people.

Overarching Messages

In our consultations with members the following overarching messages to the Inquiry have been identified:

- The Inquiry was called without community input—now communities must shape its direction. Aboriginal and Torres Strait Islander voices must be central in shaping the system.
- Success must be measured using qualitative and community-led data, not just mandated program metrics.
- Regions where community-led approaches are working must be highlighted, while calling out what needs urgent reform.
- There is a need for performance frameworks that embed accountability into practice, governance and investment decisions.
- Independent review is only meaningful if it reflects cultural values, respects lived experience and leads to real action — not more reports.

Foreword

QATSICPP welcomes the opportunity to contribute to this important review of the effectiveness of current complaints mechanisms, reporting procedures and incident management systems available to those seeking to raise serious safety concerns about children and families involved in the child protection system. As the peak body for Aboriginal and Torres Strait Islander child protection in Queensland, QATSICPP exists to promote the rights, safety and wellbeing of Aboriginal and Torres Strait Islander children impacted by the Queensland child protection system. With Aboriginal and Torres Strait Islander children comprising approximately 48 per cent of all children in care, QATSICPP has strong interest in ensuring that complaints systems specifically directed at keeping children and young people safe, can respond to the unique risks and needs experienced by our communities[i]. This includes concerns raised by children, families and workers, about residential, foster and kinship care placements and other services delivered by both government and non-government funded providers. In the absence of ongoing, disaggregated and detailed public information about the operation of Queensland's out-of-home care (OOHC) complaints system, this submission is informed by a variety of sources, including:

- QATSICPP's existing knowledge of how Queensland's OOHC system operates, developed through over 20 years' work in system reform, policy advice, program development, workforce development and service quality improvement.
- Information shared by our 38 member organisations about their experiences (and the experiences of those they work with) in navigating Queensland's child protection system.

This submission provides analysis and commentary of current complaints mechanisms in Queensland and makes a series of recommendations to ensure that complaints and incident reporting systems are culturally safe, transparent, accessible, and responsive to those most impacted.

Queensland's OOHC Complaints System

A dedicated, accessible, and culturally safe complaints process is essential to upholding the safety, protection, and wellbeing of children in OOHC, particularly when the State acts in the role of corporate parent.[ii] When functioning effectively, complaints systems should offer children, families, carers (both paid and volunteer), and service providers a trusted pathway to raise serious safety concerns — with confidence that issues will be addressed promptly, transparently, and without reprisal. An effective, child-centred complaints process not only affirms the right of children to be heard in all matters affecting them — as outlined in both international and national human rights instruments[iii] — but also strengthens accountability and practice standards across the system. These processes must serve the dual purpose of preventing further harm and embedding a care environment grounded in dignity, safety, and responsive service delivery. Research shows Aboriginal and Torres Strait Islander people in particular, face challenges in accessing fair treatment and justice through complaints processes. [iv]

The Queensland Ombudsman's 2020 report, *Management of Child Safety Complaints, Second Report* identified serious inadequacies in how the Department of Child Safety (the Department) handles complaints of children in OOHC. The report found that the complaints management system was ineffective in addressing poor decision making or directing improvements to align with best practice standards. Some key issues include the Department's failure to identify and record all complaints at child safety service centre level and inconsistent categorisation of complaints leading to inadequate responses and inaccurate reporting. It also noted there is a widespread use of alternative response methods that often resulted in no formal findings or clear documentation.

The Ombudsman reported that the internal review process for the Department did not meet the Australian/New Zealand Standard for complaint management and there was no clear framework or accountability for handling complaints about funded services. In response, the Ombudsman made several recommendations, including improving staff training, ensuring all complaints are properly recorded and addressed, and establishing a compliant internal review mechanism. These findings underscore persistent challenges in ensuring that complaints relating to the safety of children in care are taken seriously, documented properly, and resolved in a timely and appropriate manner.

The Department's Complaint Reporting Data for the period of 1 July 2023 to 30 June 2024 can be sourced from the Department's official website, which provides data on complaints received and managed within the child safety system during that period. This report outlined that the Department received a total of 2,740 complaint matters for the period as reported under the *Public Sector Act 2022*. Of these complaints, 2,274 matters resulted in further departmental action, while 399 matters required no further action. At the end of the reporting period, 67 matters remained unresolved. Most complaints (2,682 in total) related to the Department with 2,234 resulting in further action and 381 requiring no further response. Notably, this year's report includes data on First Attempt at Resolution (FAAR), a new category that accounted for 2,175 child safety matters all of which led to further action. Separate from FAAR, 429 formal complaints were received with 52 resulting in further action and 317 closed without further intervention. Additionally, 78 internal review requests were recorded, leading to further action in 7 cases. It is noteworthy that during this period no internal review matters were recorded, raising questions about whether the Department is equipped to effectively assess its own internal processes adequately.

SECTOR PERSPECTIVES AND STORIES

Aboriginal and Torres Strait Islander families, carers, and community-controlled organisations have often described the current complaints system as culturally unsafe, bureaucratic, and unresponsive. They report:

- **Exclusion from decision making about a child's care and unsupported attempts to escalate concerns.**
- **Unrecorded or unaddressed complaints, with QATSICPP forums noting cases where concerns were raised but never logged or escalated.**
- **Systemic delays at QCAT and limited investigatory power within the Office of the Public Guardian, leaving carers without meaningful external oversight.**
- **Workers feeling discouraged from raising cultural or placement-related safety issues for fear of damaging relationships with the Department of Families, Seniors, Disability Services and Child Safety ('The Department').**

Example from practice:

"We spoke up, but nothing was written down. No one ever asked us what we thought should happen next."

These lived experiences highlight the need for a different approach that restores trust, strengthens response, and elevates cultural integrity.

Issues and Recommendations

Issue: A Culturally Safe and Independent System

Further to the issues outlined in this submission thus far, the Queensland Ombudsman's 2020 report about Queensland's child safety related complaints management system also acknowledged the over-representation of Aboriginal and Torres Strait Islander children in the child protection system and the importance of culturally appropriate responses. The report found Aboriginal and Torres Strait Islander families faced barriers to lodging complaints, including:

- Lack of trust in government systems.
- Limited access to complaint mechanisms in remote communities.
- Language and literacy challenges.[v]

To meet its responsibilities under the Child Protection Act 1999 and uphold the rights of Aboriginal and Torres Strait Islander children, the Queensland Government should strengthen the OOHC complaints system to ensure adults around a child—whether they are parents, kin, carers, or community members—are empowered to raise safety concerns with confidence. Culturally safe, trauma-informed, and independently overseen complaint pathways must

be established to enable these voices to be respected and acted upon. Without such reform, the child protection system will continue to marginalise the very people best positioned to identify and respond to risk, undermining both accountability and the child's right to be cared for in safe, culturally connected environments.

SECTOR AND LIVED EXPERIENCE PERSPECTIVES AND STORIES

Aboriginal and Torres Strait Islander parents often experience **deep mistrust and distress** when engaging with the complaints system—especially if they themselves have been in care.

Parents have consistently reported being **dismissed or ignored** when making complaints and having their history with their own child protection experience being used against them.[vi]

Recommendation 1: Establish a Queensland Aboriginal and Torres Strait Islander Children's Commission

To strengthen oversight and accountability concerning service complaint responses for Aboriginal and Torres Strait Islander children and young people in Queensland, QATSICPP recommends that the Queensland Government amend the Family and Child Commission Act 2014 to establish a dedicated Aboriginal and Torres Strait Islander Children's Commission. QATSICPP proposes this new Commission have powers to receive and investigate complaints about the safety of Aboriginal and Torres Strait Islander children in out-of-home care and youth justice settings.

Other jurisdictions demonstrate the value of this approach. In Victoria, the Commissioner for Aboriginal Children and Young People within the Victorian Commission for Children and Young People has successfully led systemic change through reports like Always Was, Always Will Be Koori Children (2014), which addressed the circumstances of 980 Aboriginal children in OOHC and led to reforms in delegated authority and cultural governance.

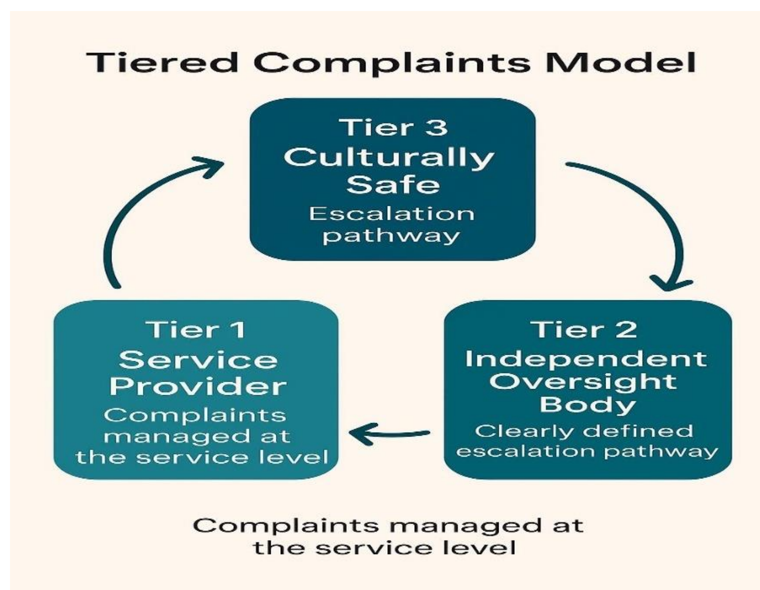
At the national level, SNAICC has called for a National Commissioner for Aboriginal and Torres Strait Islander Children and Young People. Its widely endorsed position paper highlights how independent roles grounded in cultural authority are essential for upholding children's rights and improving systemic responses to harm.

Recommendation 2: Embed Cultural Safety and Community Participation

All complaints and incident management systems relating to the safety and wellbeing of Aboriginal and Torres Strait Islander children in Queensland must be centralised into a culturally safe, trauma-informed and accessible three tiered process available to children, families, and communities. This applies across the entire child protection continuum, including government agencies, non-government organisations and ATSICCO's responsible for the care and supervision of children in OOHC. To improve the experiences of Aboriginal and Torres Strait Islander children, families and organisations engaging with child protection complaints systems, it is essential for the new process to be co-design and implement culturally safe and responsive complaints management policies, processes and practices.

Current complaints mechanisms often lack independent escalation pathways for adults concerned about children in OOHC's safety. As reported by our sector, complaints raised by children, families and carers (volunteer and paid) are managed internally by service providers or individual staff without mandatory reporting to the Department or access to an external body. To address this issue, a tiered complaints model should be introduced that includes a clearly defined, culturally safe escalation pathway. This would ensure that where complaints are not resolved at the

service level, individuals can escalate concerns to an independent oversight body, such as the Office of the Public Guardian or a dedicated Aboriginal and Torres Strait Islander Children's Commissioner with authority to investigate and intervene where necessary.



This recommendation aligns with Our Way, the generational strategy developed in partnership with Aboriginal and Torres Strait Islander leadership and the Queensland Government to address the underlying causes of child protection system involvement. A key initiative under The Breaking Cycles Action Plan 2023–2025, reinforces the importance of complaints management systems co-designed with Aboriginal and Torres Strait Islander communities to ensure that services, inclusive of complaints pathways for children and families are culturally safe, accessible, and responsive. Establishing a strengthened and independent complaints escalation mechanism is essential to supporting the broader systemic shift towards prevention, early intervention and the self-determination of Aboriginal and Torres Strait Islander peoples in child protection decision-making, further embedding child centric practices and upholding the rights of children. This action in the Breaking Cycles plan was the result of a community consultation with over 900 Aboriginal and Torres Strait Islander members about child protection where an improvement of complaints processes was identified as a priority reform issue for the system.[vii]

Issue: Barriers to Engagement with the Complaints Process

Despite the existence of formal complaints mechanisms within Queensland's child protection system, Aboriginal and Torres Strait Islander families, staff and community members continue to face significant barriers in accessing and engaging with these processes. Cultural distrust of government systems, past experiences of being ignored or marginalised, and a deep lack of confidence in departmental responses all contribute to underreporting. While the right to raise concerns may be available in theory, in practice, adults frequently report feeling dismissed, excluded from decision-making, or discouraged from pursuing complaints—especially when the complaint relates to a child in residential care[viii].

QATSICPP's 2023 Residential Care Review submission and subsequent community forums have highlighted the widespread view among Aboriginal and Torres Strait Islander stakeholders that the complaints system is not culturally safe. The sector and families described being left out of critical decisions affecting children's daily care and wellbeing. In many instances, their concerns were not recorded, responded to, or escalated appropriately. This and other forums also identified systemic delays within the Queensland Civil Administration Tribunal (QCAT) and highlighted the limited investigatory capacity of the Office of the Public Guardian (OPG) as major impediments to effective complaint resolution. The perception—and reality—is that adults advocating for a child's safety often encounter a closed, defensive system rather than a transparent and responsive one.

Recommendation 3: Empower Families and Carers to Speak Up

QATSICPP recommends investing in education campaigns for families, community and staff to ensure the voices of kin, unpaid carers, and family members are recognised and supported through accessible complaints mechanisms. This includes investment in culturally safe advocacy and education so that all carers and family members are aware of their rights and can raise concerns without fear of repercussions.

We know that high workforce turnover, limited cultural capability among departmental staff, and growing reliance on for-profit providers have further contributed to under-reporting. Carers have reported being discouraged from escalating concerns, fearing this may impact their relationship with the Department. Where complaints are made, there is often no observable change or feedback.

Recommendation 4: Establish an Aboriginal and Torres Strait Islander Community-Controlled Hotline for Families and Carers

QATSICPP recommends the development of a dedicated, culturally safe phone hotline designed and delivered by an ATSICCO (or collective of ATSICCOs) to support families and carers—both paid and unpaid—who are caring for or in contact with Aboriginal and Torres Strait Islander children in OOHC. This service would provide a trusted, culturally informed third party pathway for carers and family members to raise safety concerns.

Currently, carers and families report significant challenges when attempting to raise concerns through formal departmental channels, including long wait times, lack of cultural understanding, unclear escalation pathways, and a fear of being dismissed or misunderstood. These barriers are particularly acute for Aboriginal and Torres Strait Islander kinship carers and family members, who often experience systemic disadvantage, intergenerational trauma, a lack of trust of government and a lack of access to clear, culturally responsive information and support.

A dedicated, Aboriginal and Torres Strait Islander-led phone support line would provide families and carers with:
- A culturally safe space to speak openly about their concerns;
- Clear advice on complaint pathways, carer rights and responsibilities;
- Culturally appropriate guidance on navigating departmental, QCAT and OPG processes;
- Referrals to relevant ATSICCO or mainstream supports;
- The ability to escalate unresolved safety issues through an independent, community-controlled mechanism.

This initiative aligns with the principles of the Our Way strategy and responds directly to feedback from community forums, carers and ATSICCOs, who have consistently called for stronger, more culturally responsive pathways to raise concerns and receive support.

Recommendation 5: Strengthen Oversight and Partnership Mechanisms

QATSICPP recommends that the government partner with ATSICCOs to co-design consistent, culturally safe complaints escalation frameworks that can be adopted across all child protection settings, including government-managed services.

The voices of kin, unpaid carers, and family members must be recognised and supported through accessible complaints mechanisms. This includes investment in culturally safe advocacy and education so that all carers and family members are aware of their rights and can raise concerns without fear of reprisal.

The Queensland child protection system includes two critical mechanisms designed to uphold the safety of children in OOHC: harm reports and Standards of Care (SOC) reviews. When a concern is raised—whether by a parent, carer, or professional, the Department is responsible for assessing whether the threshold for a harm report is met under the *Child Protection Act 1999*. If this threshold is met, a harm report is generated to investigate the concern, alongside a SOC review to determine whether the care being provided aligns with legislated minimum standards (Section 122 of the Act). The SOC review involves engagement with the child, their carer, and their support networks

to understand the care context. Depending on the outcome, responses may range from developing an action plan to improve care arrangements, amending placement agreements or case plans, or, in more serious cases, triggering police involvement. Importantly, this framework is intended to be impartial and accessible, applying equally to concerns raised by biological parents, kin, or carers. In theory, this approach prioritises child safety and best interests, with a focus on transparency and accountability. However, concerns raised across the ATSICCO sector cast doubt on how effectively these mechanisms are working in practice.

Despite clear legislative provisions, QATSICPP member organisations have reported widespread inconsistencies in how complaints are triaged and escalated, especially in residential care settings. There are troubling instances where reports that appear to meet the legislative threshold for significant harm are not formally recorded or responded to as harm reports. This inconsistent application undermines the Department's obligations as the 'corporate parent' and reflects a broader issue of under-reporting, especially among Aboriginal and Torres Strait Islander communities. For the 12-month period ending March 2024, there were 238 substantiated harm reports involving children in OOHC, representing a 20.8% increase from the previous year. However, this figure likely underrepresents the true scope of harm, given the sector's longstanding concern that Aboriginal and Torres Strait Islander children and families do not feel safe or supported in raising complaints with the system. Systemic distrust, intergenerational trauma, and fear of reprisal continue to act as significant barriers to reporting, as does the lack of independent oversight of the harm review process.

Birth parents and kinship carers, many of whom have personal histories within the child protection system have described feeling dismissed, ignored, or treated with suspicion when raising concerns. The Department has implemented a three-stage complaints process and produced a Charter of Rights for Parents to improve pathways for resolution. In practice, however, many parents report that raising concerns with child safety service centres (CSSCs) often leads to little or no response, particularly when the complaint relates to a CSSC or staff member involved in their own care. Escalation to regional or central complaints units, or even ministerial complaints, often results in matters being referred back to the same departmental staff. This not only erodes trust but perpetuates the perception that the system is closed, inaccessible, and unlikely to drive change.

Feedback from our members indicated that in relation to any urgent concerns, the Child Safety After Hours Service Centre provides limited support, operating as a call centre with no capacity for in-person response. This service is heavily reliant on Queensland Police, Health and Youth Justice to intervene under the delegations of authority, making it an unreliable avenue for serious after-hours complaints, given departmental staff servicing the central office often lack case knowledge and can only rely on Unify if the system is up to date. Collectively, these system limitations reinforce the need for a culturally safe, transparent, and independent complaints model that is genuinely responsive to the needs and rights of Aboriginal and Torres Strait Islander children (and adults in their lives) wanting to raise concerns about safety and wellbeing.

SECTOR PERSPECTIVES AND STORIES

Despite clear legal duty, QATSICPP members have repeatedly reported that not all safety concerns raised are recorded or escalated—particularly in residential care settings—raising questions about the data completeness and accountability of the system.

In the 12 months ending March 2024, 238 substantiated harm reports were recorded among children in OOHC—a 20.8 % increase from the previous year. Yet ATSICCO leaders fear this underrepresents the true scale of harm, given that distrust in the system may discourage reporting.

Standard of Care (SOC) reviews, while structured, often result in non-binding action plans and lack independent oversight—calling into question the robustness of the care review mechanism.

Recommendation 6: All Safety Concerns to be Assessed Through Regional Child Safety Teams

QATSICPP recommends that any report raising concerns about the safety and wellbeing of a child in care should go to one of the Department's regionally based teams for immediate triage and assessment.

By having a highly experienced team of CSO's based outside the CSSC, this process will ensure a high level response to children and young people's complaints. Across Queensland, the Department operates regionally based C-Teams, which are designed to assist with backlogs in Investigations and Assessments or be deployed at the region's discretion. These teams are made up of more senior CSOs with strong investigative capability. QATSICPP proposes that C-Teams throughout Queensland be consistently utilised to investigate all serious concerns relating to children in the care or under the supervision of the Department. This approach would support timely and appropriate responses, reduce delays in decision-making and ensure that workers under investigation are not left waiting for extended periods to recommence work. Importantly, it would also ensure that children receive an immediate and coordinated response, aligned with the core purpose of these teams.

Furthermore, introducing independent auditing of SOC reviews and establishing a culturally safe, third-party support mechanism—such as a dedicated toll-free hotline for Aboriginal and Torres Strait Islander parents and carers—would significantly strengthen safeguards. These reforms must be underpinned by transparency, with publicly reported, disaggregated data on harm reports, outcomes, and departmental responses. As a system designed to protect, restore and support children in care, Queensland's complaints and harm reporting structures must be trusted, independently reviewed, and genuinely accessible to the very people they are intended to serve.

Issue: System Design and Oversight Gaps

The existing departmental processes, while procedurally defined[ix], are often experienced as overly bureaucratic, difficult to navigate, and lacking transparency and independence. The central complaints system is rarely transparent about outcomes and many frontline workers appear under-trained or unaware of the formal rights of families to escalate issues. Carers and frontline staff from ATSICCOs have also raised concerns about being excluded from complaint pathways or discouraged from raising cultural or placement-related risks for fear of damaging their relationship with departmental offices. Where complaints are made, there is little feedback, and rarely any observable change in practice or placement outcomes for the child involved.

Concerns raised by Aboriginal and Torres Strait Islander leaders and service providers indicate that systemic under-resourcing, high staff turnover, and the growing reliance on for-profit residential care providers have further reduced the responsiveness of the current system. These providers are not always held to consistent standards, and concerns raised by parents or community members are often filtered through multiple layers of departmental interpretation before any action is taken. This creates additional barriers and reinforces the perception that only certain voices are legitimised within the complaint's framework.

Recommendation 7: Improve Transparency, Reporting and Data Collection

QATSICPP recommends the introduction of mandatory reporting metrics on the number, nature and outcomes of complaints made by or involving Aboriginal and Torres Strait Islander children and families. Data should be disaggregated and publicly reported to improve transparency and accountability.

External bodies such as the OPG, the Community Visitor (CV) Program, and avenues like QCAT are important safeguards but have limited reach and impact due to declining visitations, procedural delays, and limited community and cultural awareness. OPG and Community Visitors have limited resources and avenues for concerned adults as the OPG focuses on complaints from children themselves.

Recommendation 8: Strengthen the Community Visitor Program

To improve independent oversight, QATSICPP recommends assigning a dedicated, Aboriginal and Torres Strait Islander-identified Community Visitor to every Aboriginal and Torres Strait Islander child in OOHC. This ensures that cultural considerations are embedded in oversight and that children receive regular, independent advocacy.

In addition to concerns raised by adults, the Royal Commission of Institutional Responses to Child Sexual Abuse found that children's voices are central to the network of care that helps to prevent them from harm.

The CV program provides a vital avenue for children in OOHC to raise concerns about their care. However, recent changes to the program have limited its effectiveness in preventing harm and advocating for children. To strengthen oversight and accountability concerning service complaint responses for Aboriginal and Torres Strait Islander children and young people in Queensland, QATSICPP recommends that the Queensland Government amend the Family and Child Commission Act 2014 to establish a dedicated Aboriginal and Torres Strait Islander Children's Commission (for more detail please see Recommendation 1 above).

The Voices of Aboriginal and Torres Strait Islander Children and Young People

Aboriginal and Torres Strait Islander children in Queensland often face significant structural and cultural barriers in raising complaints. As highlighted in the Queensland Family and Child Commission's Anti-Discrimination Act submission[x], and echoed by QATSICPP's Solid Voices of Tomorrow Project Group, these barriers are deeply rooted in systemic distrust, fear of repercussions, and limited confidence in departmental responses.[xi] Although many young people report awareness of how to lodge a complaint, they are often unsure whether the system will protect or act on their concerns. Cultural stigma, fear of being disbelieved, or even facing retaliation have been cited — especially by children in residential care settings — as deterrents to speaking up. These concerns are compounded by a broader narrative in some settings that discourages children from expressing dissatisfaction, particularly when they have experienced prior harm or instability.

Evidence noted by both Aboriginal and Torres Strait Islander and non-Indigenous young people involved in Queensland child protection in CREATE Foundation's position paper, highlights that many children and young people in OOHC face significant barriers when attempting to engage with the complaints process to self-advocate their needs[xii]. Although most young people are aware that they can raise a complaint, typically through their Child Safety Officer or case manager, many report that their concerns are not taken seriously and fail to result in any meaningful action. Other related challenges raised by children and young people demonstrates a consistent lack of privacy for the child when disclosing concerns which further drives the child's feelings of not being heard on issues that are important to them. As further stated in the position paper, some young people described experiences where complaints were ignored or "swept under the rug" while others reported facing retaliation or further trauma after making a complaint.

Case Story

A 13-year-old Aboriginal girl was placed with her paternal grandmother after being removed from her mother's care. She now resides with her paternal grandparents in the catchment supported by an Aboriginal and Torres Strait Islander Foster and Kinship Care Service known to QATSICPP. Prior to her removal, the child had an ongoing relationship with her biological father until the age of eight, when her mother ceased all contact and withdrew her from his life. At the time of investigation and assessment, the Department did not explore the paternal side of the family including her father, despite the ATSICCO having assessed him as safe, willing and able to care for his daughter. While there had been some years of no contact, the young girl expressed a strong desire to live with her father. Following her removal, the child was initially placed in residential care for 4–6 weeks before being moved to her paternal grandparents. Since then, she has become withdrawn, isolated and emotionally distressed. School has become her only safe space, where she attends consistently and engages meaningfully. The child recently disclosed to a foster care support worker that her grandparents provide little emotional support, leaving her feeling helpless, anxious about her future and uncertain about her place in their home. Consequently, the service raised these concerns with the child's CSO and Team Leader, noting that a Standard of Care (SOC) review was already underway for the placement and that this new information could have been incorporated into the existing investigation. The ATSICCO is currently working with the Department to have the young person reunified to her biological father as he has been assessed by the ATSICCO as both willing and able to meet his daughters care and protective needs. If proper assessment had been done by the department at the time of the removal she could have been placed with her father at the beginning of the intervention as opposed to being placed in residential care.

Conclusion

The current child protection complaints systems remain overly complex, inconsistent and largely inaccessible to the very children, families, and communities they are intended to support. This is particularly true for Aboriginal and Torres Strait Islander children and young people, who continue to be significantly overrepresented in the child protection and youth justice systems. While multiple mechanisms exist to hear the voices and experiences of children subject to departmental intervention or living in OOHC. Serious concerns persist regarding the lack of cultural safety, transparency and accountability in how complaints are recorded, investigated, and resolved, specifically by non-Indigenous-led entities. For many Aboriginal and Torres Strait Islander children and young people who have or are experiencing significant trauma and harm while in care, the complaints process is too often marked by a fear of punishment, limited awareness of their own rights.

QATSICPP firmly believes that meaningful reform must go beyond administrative adjustments and drive a cultural shift that centres the rights, voices and self-determination of Aboriginal and Torres Strait Islander children and young people. This includes the establishment of an independent complaints body, co-design of child friendly and culturally responsive complaint pathways and greater accountability for both government and non-government service providers who supervise the care of vulnerable Aboriginal and Torres Strait Islander children. If we are to truly meet the intent of the Child Protection Act 1999 and uphold the rights of every child, inclusive of the rights of Aboriginal and Torres Strait Islander children, the Department must commit to a complaints system that is delivered in a safe, transparent, culturally safe way. As such QATSICPP is eager to partner with the Department and the sector

to ensure a better, fairer future for our jarjums, one that provides children and young people an elevated voice in relation to matters that impact their safety and wellbeing.

Contact

For questions about this submission, please contact Ms Helena Wright, DCEO Policy and Strategy on [redacted] or [redacted]

Appendix A

[i] https://performance.dcssds.qld.gov.au/__media/documents/2024-children-in-care-census-full-report-for-publication.pdf
[ii] https://www.childabuseroyalcommission.gov.au/final-report.
[iii] https://humanrights.gov.au/our-work/child-safe-organisations; https://humanrights.gov.au/our-work/childrens-rights; https://www.legislation.qld.gov.au/view/html/inforce/current/act-1999-010; https://www.ohchr.org/en/instruments-mechanisms/instruments/convention-rights-child.

[iv] https://www.pc.gov.au/ongoing/overcoming-indigenous-disadvantage/2020/report-documents/oid-2020-chapter1-introduction.pdf#:~:text=research%20on%20structural%20and%20systemic%20barriers%20that,at%20the%20national%2C%20state%20and%20territory%20level.
[v] https://www.ombudsman.qld.gov.au/publications/ombudsman-investigative-reports/management-of-child-safety-complaints-second-report.
[vi] https://finseq.org.au/assets/docs/FIN-Resources/Notes-Parent-Forums-v12.pdf.
[vii] https://www.families.qld.gov.au/__media/documents/aboriginal-torres-strait-islander-families/supporting-families/breaking-cycles-flagship-forum-findings-report.pdf.
[viii] https://www.abc.net.au/news/2025-06-30/qld-residential-care-workers-calling-for-reform/105457576. https://www.abc.net.au/news/2025-07-03/queensland-residential-care-complaints-system-workers/105489950.
[ix] Standards of care | Community support | Queensland Government
[x] https://www.qhrc.qld.gov.au/law-reform/anti-discrimination-act-review.
[xi] https://coe.qatsicpp.com.au/solid-voices-of-tomorrow.
[xii] https://create.org.au/wp-content/uploads/2022/09/Complaints-Processes-in-Out-of-Home-Care.pdf

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