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31 July 2025

Dear Commissioner, Honourable Paul Anastassiou KC,

Re: Commission of Inquiry into Queensland's Child Safety System: Complaint Systems
Submitted by: YFS LTD.

This submission is made in response to the Commission of Inquiry's invitation to examine the adequacy of existing complaints systems, procedures, and incident reporting guidelines within Queensland's child safety system. It focuses on the experiences of children and young people in residential care, foster care, and kinship care, as well as the perspectives of practitioners, carers, and legal advocates who support them.

Our organisation works with approximately 7,200 clients annually across the Logan region and surrounds. We directly assist young people in care and post-care, providing advocacy, support, and opportunities to voice their experiences and concerns. Through this work, we have witnessed firsthand the barriers they face in accessing safe, responsive, and effective complaints mechanisms which, for 17% of our clients, are compounded by further systemic obstacles existent for First Nations peoples throughout Australia. Many of these young people have experienced harm while in care, and their attempts to raise concerns have often been met with disbelief, inaction, or fear of reprisal. Their voices are central to this submission.

Drawing on recent reports, practitioner insights, and lived experiences of young people we work with, this submission identifies systemic failures and proposes reforms to ensure that children under the care of the state, and the frontline practitioners who support them, are protected, heard, and empowered when raising concerns about their safety and wellbeing.

We wish to acknowledge the personal contributions of young people in sharing their experiences through this submission in the case studies provided. These are shared in the hope they will catalyse changes for the benefit of other young people currently in the care system.

To address systemic failures affecting children and young people, our recommendations propose;

1. Establishing an independent statutory complaints body, led or partnered with First Nations organisations, to ensure culturally safe and trustworthy advocacy.
2. A revised complaints framework which is trauma-informed, child-centric, and accessible, including non-digital and culturally safe pathways.
3. Reinstatement of a body similar to the Community Visitor program for greater visibility and accountability.
4. An inclusion strategy to support children with disabilities and other barriers to ensure and amplify their voices in complaints processes.
5. A targeted complaints pathways for self-placing children.
6. The introduction of a merits review mechanism, inspired by Ryan's Rule (from Queensland Health), to provide independent oversight of child safety decisions, and provide opportunities for a second opinion.
7. All residential care providers, including unlicensed and for-profit entities, should be made accountable via transparent reporting and independent review mechanisms.

Impact on Vulnerable Groups

Aboriginal and Torres Strait Islander children

Aboriginal and Torres Strait Islander children are significantly overrepresented in the child protection system,[1] yet their exclusion from the Inquiry's terms of reference is a glaring omission. Despite the Commissioner's statement on the 7th of July that prioritised addressing the disproportionate representation of Indigenous Australians in the child protection system,[2] this absence reflects a broader pattern of systemic neglect and cultural erasure.

Specifically, the inadequacies of Queensland's child safety complaints system have a disproportionate and deeply harmful impact on the most vulnerable children in care, particularly Aboriginal and Torres Strait Islander children and children with disabilities. These groups face compounded barriers to safety, justice, and voice, and the current complaints framework fails to account for their specific needs and lived experiences. Despite legislative requirements for cultural planning, under Section 51B of the Child Protection Act 1999,[3] many children in care either lack cultural plans altogether or receive plans that are superficial and disconnected from their identity and community. The complaints system offers no culturally safe nor First Nations-led pathways for these children to raise concerns about their treatment, placement, or wellbeing. Without culturally competent mechanisms, their voices are silenced, and their rights are routinely overlooked.

The lack of First Nations oversight within the complaints process also means that systemic issues such as culturally inappropriate placements, racial bias in decision-making, and the failure to engage Aboriginal Community Controlled Organisations (ACCOs), go unchallenged.[4] The absence of a culturally safe complaints pathway not only undermines trust but also perpetuates harm. For these children, the complaints system is not just inaccessible, it is irrelevant to their lived reality.

Children with disabilities

Children with disabilities face similarly entrenched barriers. As a post-care support provider and legal representative of these vulnerable groups, we find that many children enter care with undiagnosed or unsupported disabilities and are mislabelled as difficult, defiant, or non-compliant. These labels often result in punitive responses from service providers, exclusion from education, and increased contact with the justice system. The complaints system does not provide accessible formats, communication supports, or advocacy pathways tailored to children with cognitive, sensory, or psychosocial disabilities. As a result, their ability to report harm, neglect, or discrimination is severely limited.

Moreover, the absence of a coordinated disability inclusion strategy within the child protection framework means that complaints related to disability-specific issues, such as lack of reasonable adjustments, denial of therapeutic services, or discriminatory treatment are not adequately captured, investigated, nor resolved. These children are left without recourse, and their experiences of harm are rendered invisible within the system.

In both cases, the failure of the complaints system to accommodate cultural and disability diversity is not a matter of oversight, it is a structural flaw and is perpetuated by the omission of these vulnerable groups from the Inquiry's terms of reference. Without targeted reforms, including the establishment of independent, culturally safe, and disability-inclusive complaints mechanisms, Queensland's child protection system will continue to fail those who need it most.

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[1] Queensland Family and Child Commission. "Over-representation of Aboriginal and Torres Strait Islander Children and Young People in Queensland's Statutory Child Protection System." In Principle Focus. 2023, https://www.qfcc.qld.gov.au/sector/monitoring-and-reviewing-systems/principle-focus.

[2] Anastassiou, Paul. "NAIDOC Week 2025 – Statement from the Commissioner of the Inquiry into Queensland's Child Safety System." Child Safety Commission of Inquiry, (2025), https://www.childsafetyinquiry.qld.gov.au/news-events.

[3] Child Protection Act 1999 (QLD). https://www.legislation.qld.gov.au/view/html/inforce/current/act-1999-010#sec.51B.

[4] Queensland Family and Child Commission. "Standard 6: Complaints Management." In Child Safe Standards. 2025, https://www.qfcc.qld.gov.au/childsafe/standards/standard-6.; Queensland Family and Child Commission. "The Universal Principle and Cultural Safety." In Child Safe Standards. 2025, https://www.qfcc.qld.gov.au/childsafe/standards/standard-6.

Systemic Failures in the Complaints System

Queensland's child safety complaints system is fundamentally failing to meet the needs of children and young people in care. At its core, the system lacks the structural integrity, accessibility, and responsiveness required to protect vulnerable children and uphold their rights. One of the most pervasive and damaging practices within the current framework is the misclassification of formal complaints as mere "issues". Highlighted and identified in the Queensland Ombudsman's 2020 investigative report,[5] this allows serious concerns, including disclosures of harm, neglect, and abuse to be diverted into informal resolution pathways. These pathways lack sufficient oversight and transparency and rarely result in meaningful action. As a result, children who courageously raise concerns often find themselves trapped in a cycle of repeated disclosures, unanswered questions, and unresolved trauma.

This failure is not just procedural; it is deeply personal. For children in care, the act of making a complaint is an exhibition of vulnerability and trust. When that trust is met with minimisation, indifference, or delay, it sends a clear message: your voice does not matter. Through this submission, we aim to highlight the voices of young people, ensuring they are heard and acknowledged. The erosion of trust in the complaints system has long-term consequences, not only for the individual child but for the integrity of the child protection system as a whole, including frontline carers. It fosters a culture of silence, discourages future disclosures, and allows harm to persist unchecked.

Compounding the erosion of trust in the complaints process is the complexity and inaccessibility of the complaints process itself. The system is designed around adult-centric procedures that fail to consider the developmental, emotional, and cognitive needs of children and young people. Navigating the complaints process requires a level of literacy, confidence, and procedural knowledge that many children, especially those who have experienced trauma, do not possess. For children placed in "technology-free" homes, the barriers are even more severe. These children are effectively cut off from online reporting tools, email access, and digital support networks. In such environments, there are no consistent alternative pathways to ensure that children can raise concerns safely, confidentially, and without fear of reprisal.

The absence of a child-friendly, trauma-informed, and culturally safe complaints framework is a critical and urgent gap. Children in care are not passive recipients of services, they are rights-holders entitled to protection, participation, and redress. In our experience, the current system is neither upholding these rights in any meaningful way, nor providing for the specific ways in which vulnerable young people access support or complaints systems. It does not provide accessible formats for children with disabilities, culturally appropriate mechanisms for Aboriginal and Torres Strait Islander children, or trauma-informed supports for those who have experienced abuse. Instead, it places the burden of reporting on the child, without offering the tools, safeguards, or support necessary to navigate the process.

This systemic failure is not isolated; it is embedded in the very architecture of Queensland's child protection system. Without structural reform, including the establishment of independent oversight, the redesign of complaint pathways, and the integration of child-centred principles, the system will continue to fail those it is meant to protect. The Commission of Inquiry must recognise that the complaints system is not a peripheral issue, it is a cornerstone of accountability, safety, and justice. Reforming this system is not optional; it is essential to restoring trust, preventing harm, and ensuring that every child in care has a voice that is heard, respected, and acted upon.

Lack of Independent Oversight and Fear of Reprisal

A fundamental flaw in Queensland's child safety complaints system is the absence of independent oversight. Currently, complaints are managed internally by the Department of Child Safety, a structure that inherently compromises the integrity of the process. When the same agency responsible for service delivery is also tasked with investigating complaints against itself, it creates a clear conflict of interest. This arrangement

[5] Queensland Ombudsman. Management of Child Safety Complaints - Second Report. 2020, https://www.ombudsman.qld.gov.au/publications/ombudsman-investigative-reports/management-of-child-safety-complaints-second-report.

undermines the credibility of investigations, erodes public trust, and fails to provide the transparency and accountability that children, carers, and practitioners deserve.

This lack of impartiality has real and damaging consequences. Across the sector, carers, frontline workers, and young people report a pervasive fear of reprisal when attempting to raise concerns. Residential care workers and foster carers often feel unable to speak out due to fears of losing their jobs, placements, or vital services. Young people in care have similarly expressed fears that speaking out could result in punishment, relocation, or further isolation. These fears are not unfounded, they are supported by practitioner testimony, legal advocacy, and recent media coverage,[6] which highlight a culture of intimidation and suppression within the complaints process.

The internal handling of complaints also contributes to a broader culture of inaction. Reports are often diverted into informal resolution pathways, misclassified as “issues” rather than formal complaints,[7] and subjected to lengthy, opaque processes that rarely result in meaningful outcomes. This practice leads to underreporting, duplication of effort, and a failure to address systemic harm. Without independent scrutiny, complaints are too easily dismissed, delayed, or buried within departmental bureaucracy.

Queensland’s approach stands in stark contrast to other Australian jurisdictions. States such as New South Wales and Victoria have longstanding external oversight bodies and reportable conduct schemes that provide independent investigation of complaints, clear pathways for anonymous reporting, and robust protections for whistleblowers.[8] These models not only enhance accountability but also foster a culture of safety and transparency. Their historic absence in Queensland has left children and carers vulnerable, silenced, and without recourse. Despite plans to implement a Reportable Conduct Scheme from 1 July 2026 (which represents a positive step in addressing the above issues),[9] Queensland continues to lag behind national standards, specifically in establishing robust oversight of the intended scheme.

The lack of independent oversight is particularly concerning given the nature of complaints being raised: allegations of abuse, neglect, discrimination, and systemic failure. These are not minor grievances; they are matters that explicitly compromise the safety, dignity, and rights of children in care. A complaints system that cannot guarantee impartiality nor protection for those who speak out is not merely inadequate, it is dangerous.

To restore trust and ensure accountability, Queensland must establish a statutory, independent complaints body with the authority to investigate concerns, intervene where necessary, and advocate for children and young people. This body must be accessible, culturally safe, trauma-informed, and fully independent from the Department of Child Safety and other service providers. It must also be empowered to receive complaints from carers, practitioners, and children without fear of reprisal, and to act decisively in response to disclosures of harm.

Only through the creation of such a body can Queensland begin to build a complaints system that is credible, responsive, and capable of protecting those most at risk. The current model not only fails to meet the standards outlined in the Queensland Family and Child Commission’s Child Safe Standards, particularly

[6] Gillespie, Eden. "Residential Care Workers Call for Independent Complaints System Amid Fear of Reprisal for Speaking Out." ABC News. Last updated Jun 30, 2025. https://www.abc.net.au/news/2025-06-30/qld-residential-care-workers-calling-for-reform/105457576.

[7] Queensland Ombudsman. Management of Child Safety Complaints - Second Report. 2020, https://www.ombudsman.qld.gov.au/publications/ombudsman-investigative-reports/management-of-child-safety-complaints-second-report.

[8] Commission for Children and Young People. "Reportable Conduct Scheme." Victoria State Government. Last updated 2025. https://ccyp.vic.gov.au/reportable-conduct-scheme/.; Office of the Children's Public Guardian. "Reportable Conduct Scheme." NSW Government. Last updated 2025. https://ocg.nsw.gov.au/organisations/reportable-conduct-scheme.

[9] Queensland Family and Child Commission. "Reportable Conduct Scheme." Last updated 2025. https://www.qfcc.qld.gov.au/childsafe/reportable-conduct-scheme.

Standard 6,[10] and the requirements of section 219A of the Public Service Act 2008,[11] but also falls short of community expectations and the ethical obligations of a child protection system.

Inadequate Responses to Young People's Disclosures of Abuse or Complaints

In our work supporting young people aged 15 to 25 who are transitioning from, or have transitioned out of care, we have consistently encountered systemic failures in how disclosures of harm and complaints are handled. These failures, as referenced above, undermine trust, delay justice, and perpetuate harm.

Young people frequently seek access to records relating to past complaints or incidents of harm experienced in residential, foster, or kinship care settings. This is often in pursuit of Victim Assist Queensland or Redress Scheme applications. In many cases, these requests reveal that record-keeping at the time of disclosure was inadequate, incomplete, or absent altogether subsequently leaving victims unable to pursue justice and achieve closure for their traumatic experiences.

Disclosures made either while in care or shortly after exiting are often met with responses from Child Safety Officers (CSOs) that are dismissive, minimising, or lacking comprehensive outcomes. Common issues include:

- Failure to act on concerns raised;
- Minimisation of the young person's experience by CSOs or Team Leaders;
- Disbelief or denial that the incident occurred.

These responses create significant barriers to progressing complaints through formal channels. When disclosures are not taken seriously at the local level, young people and support services (specifically frontline carers) are left without a clear or safe pathway to escalate concerns.

As a provider of Next Step Plus and Extended Post Care Support programs, YFS has received disclosures of harm across all care settings identified in the Inquiry's scope. These disclosures have occurred consistently over the five years we have delivered these programs.

Key systemic issues include:

- **Delayed response times** from Child Safety following reports of harm, often requiring repeated follow-ups or escalation to receive any action;
- **Lack of trauma-informed practice**, resulting in young people feeling disbelieved, unsupported, and unclear about what actions were taken to ensure their safety;
- **Exposure to further harm** post-disclosure due to inadequate protective responses.

The overwhelming feedback from young people is that their voices were not heard, their safety was not prioritised, and their disclosures were not met with the seriousness they deserved. These failures reflect a broader culture of inaction and disbelief within the complaints system and highlight the urgent need for reform.

Audit and Contracting Review Implications

A critical and growing concern is the number of children in care who are "self-placing"—leaving their designated placements and living independently, often without support or supervision. The recent announcement of a government audit into this issue underscores the scale and urgency of the problem. These children are at heightened risk of homelessness, exploitation, and disengagement from education and health services. The complaints system must be responsive to the unique vulnerabilities of self-placing children, ensuring they have safe, accessible avenues to report harm and seek support, even when disengaged from formal care settings.

[10] Queensland Family and Child Commission. "Standard 6: Complaints Management." In Child Safe Standards. 2025, https://www.qfcc.qld.gov.au/childsafe/standards/standard-6.

[11] Queensland Ombudsman. "Opinions." In Management of Child Safety Complaints - Second Report. 2020, https://www.ombudsman.qld.gov.au/publications/ombudsman-investigative-reports/management-of-child-safety-complaints-second-report.

Past initiatives, like the Community Visitor Program, exhibited potential for establishing a safe, accessible and responsive frameworks for reporting harm. However, this program was significantly downsized following the 2013 Queensland Child Protection Commission of Inquiry among findings of inefficiency and ineffectiveness in identifying serious problems.[12] Despite recommendations to strategically refocus the program (see Recommendation 12.8), these recommendations manifested in reductions to Community Visitor presence and accessibility, exacerbating issues surrounding insufficient complaints mechanisms.

Exposing Systemic Failures: Lived Experiences of Vulnerable Youth in Queensland's Child Protection System

The below case studies are recent, deidentified examples from the cohort of young people being supported in Next Step Plus and Extended Post Care Support programs. It is our experience in these programs that young people, either just prior to leaving care or shortly after leaving care, will discuss their care experience and at this time, may disclose having been harmed while in care upon establishing a safe and supportive relationship with a trusted adult within the service. The below case studies are examples wherein the Department was already aware of the harm that occurred to the young people involved, yet this information was not present in any referral we received regarding these clients.

Case Study 1

A young woman, currently 20 years of age, has been supported in the Next Step Plus program since she was 18 years of age. She has been supported to apply for the National Redress Scheme and has shared the below story with her Youth Development Coach.

- At 15 years of age, she was in a foster care placement with two male carers. She reports that due to her "challenging behaviours", her foster carers requested that she be moved, and she was subsequently placed within a residential care service ("YLO").
- The young person reports that it is her understanding that the foster carers were "good friends" with a senior person at YLO, and that there was "no confidentiality" about her situation as details were regularly shared with the former foster carers about her circumstances.
- While living with YLO, she met an older male through friends. On one occasion, she met with him during the day and later returned to the residential. When she returned to the residential, she reported discovering bruising and welts all over her body while in the shower. She reports she wasn't drinking when she met him but cannot remember anything about meeting with him, and therefore believes she was drugged.
- She requested for one of the youth workers at YLO to take photos of the bruising and welts which they did, but she reports that "nothing progressed" after that. The young person is not aware of what happened after she told the youth workers.
- Sometime later, when she was 15, she was diagnosed with a sexually transmitted infection, which the residential care was aware of as they supported her to attend the GP for diagnosis and treatment. At this point, the young person had not engaged in any consensual sexual activity prior.
- A few weeks later, she started experiencing heavy vaginal bleeding while she was at the residential. YLO supported her to attend a GP where she had a blood test, and it was confirmed that she was miscarrying and had been 6 – 8 weeks pregnant.
- The young person reports that she is aware there was communication between her former foster carers and YLO about this miscarriage and STI, and she was told that it would be in her best interests that she did not disclose what had occurred.
- YLO took the young woman at 15 years of age to have an Implanon bar (for contraceptive purposes) inserted, and she was told that this was "so this doesn't happen again".
- At 18 years of age, after leaving care, she was supported to attend the CSSC to pick up her identity documents (birth certificate). During this visit to the CSSC, the Child Safety Officer at the time took the young woman into a room and said that she would like to "formally apologise for the sexual abuse that she experienced while in care". This had not been arranged prior with the young person or her Youth Development Coach at YFS.

[12] Queensland Child Protection Commission of Inquiry. Taking Responsibility: A Roadmap for Queensland Child Protection. Brisbane: Queensland Government, 2013.

The above case highlights:

- Young people may not directly make a complaint or disclose that they have been harmed or sexually assaulted or abused in care, but there may be obvious or less obvious signs.
- If adults within the child protection system do not recognise signs of abuse or harm, they may not report it appropriately or recognise it as a complaint or concern.
- The young person in this case felt that the response provided by the adults at the time emphasised and prioritised contraception rather than safety and wellbeing.
- Even when the Child Safety Officer was aware that sexual abuse has been experienced while in care, the delivery of an "apology" was not done at an appropriate time or trauma informed way.

Case Study 2

A young woman, aged 17 years and 9 months was being supported in the Extended Post Care Support (EPCS) program in September 2024.

- The young woman met with her EPCS Coach in person on a regular basis and on a number of occasions was supported in conversations with her Child Safety Officer by phone and in person.
- She had been couch surfing and sleeping rough for a period of months, after choosing to leave a SIL placement approximately two years earlier, due to trauma she experienced there, including sexual harassment from a male residential youth worker and his threats made to her not to report it.
- She advised she did not report the incident at the time due to threats made by the male support worker.
- She further states that she had reported the incident to her CSO approximately one year later and was told by her CSO that the Police would contact her. However, she reports that she never had any follow up contact from Police about the incident.
- She stated that she did not feel comfortable to raise it again with Child Safety because she felt they did not support her and had not taken any action.
- In September 2024, during a conversation with a new CSO, she was encouraged to stay a night at emergency accommodation (One Place – no longer a provider) in Logan.
- The young woman told her CSO that she did not feel safe to return to a placement like this due to her previous experience of being sexually assaulted in the SIL accommodation.
- The Child Safety Officer responded with the following statements across two conversations (where YFS staff were present):
    - "That was a while ago now, you need to move on."
    - "That would not happen in a placement now because all carers have blue cards."
    - "Why do you keep bringing this up?"
- These statements were raised by our service with the Team Leader and CSSC Manager and Regional Practice Leader to address as a practice issue.

The above case highlights:

- Young people, when raising their concerns or complaints, often do not receive an appropriate or supportive response from Child Safety, and it is not in line with appropriate practice guidelines for responding to disclosures of abuse.
- This significantly reduces the likelihood of further disclosure or that young people will follow a formal complaint procedure, if they are not able to raise their concerns informally in a conversation with their Child Safety Officer.
- The CSOs lack of knowledge around the limits of the Blue Card system in providing a child safe environment for young people.
- The lack of care and trauma-informed practice around disclosures of abuse can cause significant psychological harm and perpetuate ongoing trauma.

Case Study 3

A young Aboriginal male, aged 16 years, was being supported by Next Step Plus and another YFS youth program. He regularly met with his Youth Development Coach in person and had been self-placing for a period of over 12 months, couch surfing with a former foster carer, and in unsafe locations with unsafe adults.

The young man raised with his Youth Development Coach that he would like to talk to Child Safety about incidents which had occurred when he was approximately 10 years of age in a residential care placement. He raised that he would like to know what Child Safety had done when they became aware of the incident, what they did to intervene and whether he is eligible for financial compensation.

Our service contacted the CSO and Team Leader to advise of the above conversation with the young person, and the CSO advised that her Team Leader had "reviewed the file" and "everything was above board".

- The details provided to the YFS program were that the young man, at 10 years of age had been involved in a sexual act with an older young person (2 – 3 years older) at the residential placement on more than one occasion.
- Our team requested a meeting to discuss how the Department would provide a supportive response to this young man at his current age now that he is seeking further information. During this meeting, the Team Leader opened the meeting by asking "Has [young person] been talking about his sexuality or whether he was exploring his sexuality at the time?". He also said that according to what he had reviewed, he believed that the young person was "the perpetrator".
    - These statements highlight a lack of understanding of harmful sexual behaviour, power dynamics and the nature of disclosures.
- The Team Leader also advised that the incident had been reported to Police and that he would follow up to provide a QPrime number so that the YFS Youth Development Coach could assist with supporting the young man to submit a Victim Assist application.
- This case was raised with the Senior Practitioner at the CSSC, due to concerns about the Team Leader's attitude and misconceptions about harmful sexual behaviour.
    - The Senior Practitioner reviewed the file and advised that, contrary to the information provided by the Team Leader, the matter had not been reported to the Police.
    - The Senior Practitioner further advised that in a discussion with the Team Leader, the Team Leader said he believed the young man was now "financially motivated" to raise this again.
    - The Senior Practitioner advised that while there is evidence on the file of an "Incident Report" there are no corresponding notes to outline:
        - What steps the Department took to ensure the young person's safety at the time of the incident.
        - What steps the Department took to offer support to the young person (medically, psychologically or emotionally).

The above case highlights:

- Despite obvious harm that occurred to this young person while in care, the response provided by the CSSC both at the time (2019) and when first raised by the young person again in 2025 was less than adequate and reflected the culture of apathy and inaction surrounding reports of harm.
- Concerns or complaints may be raised informally by young people or external parties (such as service providers) and if the initial response minimises the concerns (the statement "everything was above board"), it may never progress to a formal complaints system.

Recommendations

To address these systemic failures, we propose the following reforms:

1. **Establishment of an Independent Statutory Complaints Body**
   A new body should be created with the authority to investigate, intervene, and advocate on behalf of children and young people. It must operate independently of government departments and service providers and be led by, or in partnership with, First Nations organisations to ensure cultural safety and community trust.

2. **Implementation of a Trauma-Informed, Child-Centric Complaints Framework**
   The complaints system must be redesigned to align with Standard 6 of the Queensland Child Safe Standards. This includes ensuring accessibility, cultural safety, and trauma-informed practices.

Children must be informed of their rights and provided with multiple avenues to raise concerns, including non-digital options.

3. **Reinstatement and Reform of Community Visitor Programs**
   Community Visitors should be reintroduced and reformed to provide regular, trusted, and culturally appropriate contact with children in care. These figures must be visible, accountable, and responsive to the needs of children and young people.

4. **Development of a Disability Inclusion Strategy**
   A coordinated policy framework is needed to identify and support children with disabilities in care. This should include access to therapeutic, educational, and behavioural supports and mechanisms to ensure their voices are heard in the complaints process.

5. **Introduction of a Merits Review Mechanism**
   Similar to Ryan's Rule in health settings,[13] a merits review process should be established to allow for second opinions and independent review of child safety decisions (a recommendation also made in the Ombudsman's 2020 investigative report).[14] This would provide an essential safeguard for children and families navigating the system.

6. **Complaints Pathways for Self-Placing Children**
   Develop targeted complaints pathways for self-placing children, including outreach mechanisms and anonymous reporting options to ensure their safety and access to support.

7. **Oversight of Unlicensed Residential Care Providers**
   Mandate complaints accountability for all residential care providers, including unlicensed and for-profit entities, with transparent reporting and independent review mechanisms.

Conclusion

The current complaints and incident reporting system in Queensland's child safety framework is inadequate and failing to protect the most vulnerable. Without independent oversight, accessible pathways, and culturally safe practices, children remain at risk of harm, neglect, and systemic failure. This Inquiry presents a critical opportunity to implement long-overdue reforms and ensure that Queensland's child protection system is safe, responsive, and accountable to the children it serves.

We urge the Commission to consider these recommendations and to centre the voices of children, carers, and practitioners in its deliberations.

YFS is happy to provide further information to support our submission and recommendations

Yours Sincerely,

[redacted]
Christopher John
Chief Executive Officer, YFS Ltd
[redacted]

[redacted]
Ash Simpson
Advocacy and Development Director
[redacted]

[13] Queensland Government. "Ryan's Rule." 2025. https://www.qld.gov.au/health/support/shared-decision-making/ryans-rule. https://www.health.qld.gov.au/clinical-practice/guidelines-procedures/patient-safety/duty-of-care/ryans-rule

[14] Queensland Ombudsman. "Recommendations." In Management of Child Safety Complaints - Second Report. 2020, https://www.ombudsman.qld.gov.au/publications/ombudsman-investigative-reports/management-of-child-safety-complaints-second-report.