

Submission to the Commission of Inquiry into Queensland's Child Safety System

Topic: Complaints and Incident Reporting Systems
Submitted by: Chief Executive Officer, Andrew Fa'avale, MANAWISE Care
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1. Introduction

MANAWISE Care is grateful to have the opportunity to contribute to the Commission of Inquiry into Queensland's Child Safety System (**Commission**). We commend the Commission for initiating this critical and much-needed review, as it presents an important opportunity to reflect on and improve the child protection sector. As a provider of residential care services for children and young people in out-of-home care, we are deeply invested in ensuring that the complaints system is fair, transparent, and effective in safeguarding the wellbeing of those in our care.

We make this submission in response to the Commissioner's call for submissions of 1 July 2025 on:

... the adequacy of existing complaints systems, procedures, and incident reporting guidelines for those wishing to raise serious safety concerns about children under the care of the state. This includes safety and other concerns in relation to residential care facilities, foster and kinship care placements, and services delivered by funded service providers.

We understand the 'complaints system [and] procedures]' and the 'incident reporting guidelines' to refer to distinct mechanisms as set out below:

1. The complaints system is established by Division 3A of Part 6 of the *Child Protection Act 1999* (Qld) (the **Act**). It enables a child or a member of their family who honestly and reasonably believes a permanent guardian of the child is not complying with their obligations to the children under the Act to make a complaint to the chief executive. The chief executive may refuse to deal with the complaint if they reasonably believe the complaint is trivial, unreasonable or without substance, vexatious or if the complainant refuses to give further information if requested. If the chief executive does not refuse to deal with a complaint, they must take all reasonable steps to resolve the complaint as soon as is reasonably practicable and provide a response to the complainant.
2. The Department has incident reporting guidelines in place for residential care services (**Guidelines**). These mandate reporting by providers to the Department of Families, Seniors, Disability Services and Child Safety (the **Department**) for critical incidents

such as death or life-threatening injury) and major incidents (such as serious injury or neglect). The Guidelines also recognise that there may be incidents of significant concern that do not fit into the categories of critical and major incidents but require attention from the Department.

Given MANAWISE Care is a residential care provider, our submission is focussed on the reporting mechanism established under the Guidelines. Given the complexity and often sensitive nature of the care we provide, it is essential that a transparent, accessible, and responsive reporting mechanism is available. This submission outlines:

- Key Issues with the incident reporting system;
- Structural Issues with the incident reporting system;
- Impact of issues with the incident reporting system on practice and safety; and
- Our recommendations for reform.

a. Introduction to MANAWISE Care

MANAWISE Care is a dedicated provider of residential care services for children and young people who have experienced significant trauma or disadvantage. We operate multiple residential care homes across five of Queensland's six Child Safety regions, including urban, regional, and remote communities. We are in the process of completing the formal licensing process under the *Child Protection Act 1999* (Qld) and are currently authorised to provide services under transitional arrangements. Our mission is to support our young people to thrive and live values-based and purpose-driven lives. We have offices and provide services in Brisbane, Mackay and Cairns and have provided a range of services in remote areas such as Mount Isa, Kowanyama, Doomadgee and Pormpuraaw to meet the specific needs of each child in our care.

Our Pasifika foundations align with key vulnerable groups in care including Aboriginal and Torres Strait Islander and Māori and Pasifika children through our culturally responsive practices, values, protocols and indigeneity.

We are committed to ensuring every child in our care receives trauma-informed, developmentally appropriate support. It is essential that children, carers, staff, and providers have access to transparent, accessible, and responsive complaints and incident reporting systems. This submission outlines our concerns with the current system for raising complaints and concerns about service delivery expectations and offers recommendations based on our direct experience.

2. Key Issues with the Incident Reporting System

While there are incident reporting mechanisms in place under the Guidelines, they are often inconsistently implemented and fail to deliver effective outcomes. This is particularly the case when service providers raise concerns or disagree with expectations expressed to service providers by the Department. Based on our experience, there is a concern that disagreeing with the Department may result in adverse consequences, in particular regarding placement continuity or contract security. This concern may be more pronounced for providers undergoing licensing, who are understandably mindful of maintaining a cooperative relationship with the Department.

We believe this dynamic creates a chilling effect in the sector, where particularly incidents of significant concern may go unreported, or underreported, due to fear of reputational damage, retaliation, or strained relationships with departmental staff. This ultimately does undermine the safety and wellbeing of children in care.

3. Structural Issues

a. Lack of Independent Oversight

The absence of external oversight of the incident reporting system raises concerns about impartiality and accountability. There is a risk that issues raised by providers may be resolved in a manner that does not follow proper procedure or adequately prioritise the child's best interests. Providers and advocates are left without a meaningful avenue for seeking resolution or accountability when serious practice concerns remain unaddressed.

We strongly support the recommendation to establish an independent escalation pathway for unresolved issues. This principle should apply across all care settings, including foster and kinship care, residential care, and other state-funded placement arrangements.

b. Inherent Power Imbalance

There is an inherent power imbalance between the Department and funded service providers. This stems from factors including the funding model, lack of a partnership approach, and lack of transparency and consistency from the Department. This imbalance shapes engagement dynamics and restricts open, transparent communication.

Providers are often expected to deliver high-quality, trauma-informed services under shifting Departmental requirements, limited resources, and escalating demand. When providers raise concerns, the Department sometimes views them as resistance rather than collaboration and partnership. This fosters a repressed, risk-averse culture, where providers may withhold valid

feedback or avoid raising issues with the Department out of fear of repercussions for their service delivery or contractual standing.

c. Lack of clear, local and culturally-responsive approaches

The geographic, cultural, and workforce diversity across Queensland's child safety regions significantly dictates the demands on how services are delivered, and how complaints are raised, heard, and resolved.

In delivering services across five of Queensland's six regions—spanning over a dozen regional, remote, and Indigenous communities—we have encountered a broad spectrum of cultural, logistical, and workforce contexts that significantly shape service delivery models. Each location presents distinct dynamics requiring tailored responses. For example, in remote communities such as Mount Isa, Kowanyama, Doomadgee, and Pormpuraaw, services have been delivered exclusively through fly-in-fly-out (**FIFO**) staffing due to workforce constraints and access limitations. In Mackay, a hybrid model of FIFO and local staff has been implemented, while in Cairns and Brisbane, fully localised teams operate within markedly different environments.

Remote areas often face acute challenges such as limited housing availability, geographic isolation, and a small, stretched workforce, all within culturally diverse settings. In contrast, metropolitan centres like Brisbane present different complexities—high-volume service demand, increased bureaucratic intensity, and heightened provider competition. These regional differences must be carefully considered in the design and implementation of responsive, place-based service systems that are both effective and culturally appropriate.

This diversity means that the existing one-size-fits-all complaints framework is inherently insufficient. Providers, workers and carers in remote or culturally distinct regions often experience power imbalances, informal gatekeeping, and a lack of procedural clarity that may discourage them from speaking up. Without locally responsive and culturally competent mechanisms, these voices—many of which are closest to frontline risk—remain unheard.

d. Data transparency

A lack of transparency in complaint and incident reporting data is a significant issue, particularly regarding the types of complaints and incidents, the volume of complaints and incidents, their outcomes, and any systemic learnings that arise from them. There is insufficient public reporting on complaints and incidents across all care settings—foster care, kinship care, residential care, and other state-funded placements. This lack of transparency reduces the opportunity for systemic improvement and inhibits accountability.

e. Disproportionate Risk for Pasifika Workers

Anecdotally, Pasifika workers are significantly overrepresented within the highly casualised residential care workforce. While they contribute deep cultural knowledge, relational strength, and strong commitment to the sector, they also face specific vulnerabilities that may inhibit their ability to raise concerns. Many Pasifika workers report a reluctance to speak up to their employer or the Department due to cultural norms of deference and humility, fears of being perceived as difficult or disruptive, and concerns about the impact of raising complaints on their job security. These intersecting factors can result in underreporting of issues and missed opportunities for systemic learning and improvement.

4. Impact on Practice and Safety

We have experienced instances where provider concerns raised with departmental decision-makers were not taken seriously, were inadequately addressed, or were not escalated, even when those concerns had clear implications for child safety.

The absence of a transparent, independent review process for Departmental decisions in relation to reporting by providers undermines provider confidence and, most importantly, the safety and wellbeing of the children in care.

Examples of systemic challenges include:

- Reluctance by the Department to approve placements under section 82(1)(f) of the Act, even when suitable housing is available, with a preference for higher-cost or emergency models rather than more stable, cost-effective solutions.
- Ongoing refusal by the Department in multiple regions to approve new residential placements, despite a high volume of referrals, illustrating a systemic misalignment between placement demand and available services.
- Increasing reliance on unlicensed or transitioning providers to accept high, very high, and extreme-needs Individual Placement and Support (IPS) referrals when licensed Outsourced Service Delivery (OSD) providers decline them.

5. Recommendations

To address these challenges and ensure complaints systems are fair, safe, and effective, we recommend the following reforms:

1. **Incorporate providers' incident reporting guidelines into the Act:** Elevate the current Guidelines to a statutory footing, similar to the complaints mechanism in Division 3A of the Act. This would ensure a clearer, legally supported process for providers to escalate

concerns, mandate departmental responses to significant incidents, and enable independent review pathways.

2. Establish an Independent Child Protection Complaints and Escalation Body:

Create a legislated, independent body with the authority to review and investigate unresolved safety matters and complaints across all care settings. This body should be separate from the Department, with statutory powers to address serious concerns raised by children, carers, staff, or community members. It should also have the mandate to escalate unresolved issues for independent review, ensuring impartiality and accountability. This body should have jurisdiction across all state-funded placement types—including foster care, kinship care, and residential care—to ensure a consistent, impartial, and transparent complaints system for all stakeholders.

3. Implement Whistleblower Protections and Safeguards:

Ensure that individuals who raise concerns are protected from retaliation. This includes providing contractual and placement security for service providers and reinforcing whistleblower protections for staff and carers.

4. Embedding Local Context in Complaints Escalation Mechanisms:

Any complaints escalation mechanism must incorporate consideration of the unique context and nuances of the community and service delivery environment in which it operates. This includes embedding sensitivity to local service delivery models, staffing structures—such as FIFO, local, or hybrid workforces—and the cultural and social dynamics of each region. The design and implementation of the mechanism should be informed by meaningful consultation with key stakeholders, including residential care providers and frontline workers from each region and town, to ensure it reflects operational realities and community needs. To ensure accountability, complaints data and trends should be disaggregated by region and made publicly available to help identify emerging systemic issues.

5. Improve Transparency and Feedback Processes:

Introduce transparent mechanisms to ensure that individuals who lodge complaints or raise concerns receive timely updates and clear reasons for decisions. This should include ongoing communication regarding the progress towards resolution of the complaint or concern, and clear notification of its outcome. Transparency should also extend to the public reporting of complaints, including clear disclosure of complaint volumes, types, and outcomes across all care settings. This ensures that children, carers, service providers, and the wider community are informed of systemic issues and the responses to those issues. Public reporting of complaints data will enable trend identification, accountability, and quality improvement.

6. Enhance Data Reporting and Public Transparency:

There is currently insufficient public reporting on complaints across foster care, kinship care, residential care, and other placements. The lack of transparency inhibits systemic learning, weakens accountability, and impedes public confidence.

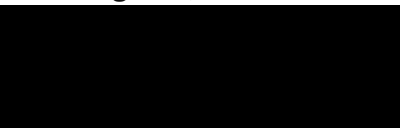
We recommend that a standardised, comprehensive public reporting framework be established to require regular disclosure of complaints data in a way that is accessible to all stakeholders. This should include disaggregated data on complaints by care setting, region, demographics, and types of issues raised. Furthermore, outcomes and resolutions should be clearly communicated, including any systemic improvements that have been made as a result. Such transparency will support continuous improvement, inform better policy and practice, and build trust across the sector.

6. Conclusion

The safety and wellbeing of children in care must be the paramount consideration in every decision and system design. A robust, transparent, and independent complaints system is a foundational element of an accountable child protection system. We encourage the Commission to use this opportunity to drive meaningful reform in how serious safety concerns are heard, investigated, and resolved.

We welcome further engagement with the Commission to provide additional detail, or case examples should that be helpful to its inquiry.

Best Regards,



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