QUEENSLAND OMBUDSMAN

Management of child safety complaints

An investigation into the current child safety complaints management processes within the Department of Communities, Child Safety and Disability Services.

July 2016

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Standing for fairness

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July 2016

The Honourable Peter Wellington MP
Speaker
Parliament House
George Street
BRISBANE QLD 4000

Dear Mr Speaker

In accordance with s.52 of the *Ombudsman Act 2001*, I hereby furnish to you my report, *Management of child safety complaints: An investigation into the current child safety complaints management processes within the Department of Communities, Child Safety and Disability Services*.

Yours faithfully

Phil Clarke
Queensland Ombudsman

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Foreword

This report presents the findings of an investigation into the Department of Communities, Child Safety and Disability Services' (the department) management of complaints about the child safety system in Queensland.

Having regard to the significant reforms concerning the management of child safety complaints undertaken in recent years as a result of the Queensland Child Protection Commission of Inquiry, I am of the view that there is significant public interest in ensuring that the reforms put in place are delivering an effective child safety complaints management system that the public can have confidence in.

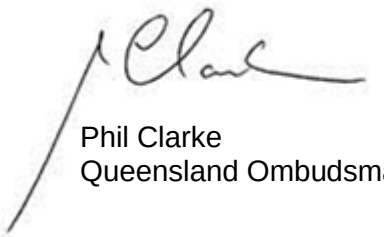
In order to gather evidence to inform the report, I examined child safety complaints data received by relevant complaint agencies, including the department, the former Commission for Children and Young People and Child Guardian and the Office of the Queensland Ombudsman between 2011-12 and 2014-15. I also conducted a more in-depth analysis of the department's handling of child safety complaints it received during 2014-15.

The report also focuses on the adequacy of collaboration and coordination between the department and the Office of the Public Guardian (OPG) regarding the resolution of issues of concern identified by OPG Community Visitors during their visits to children placed in out-of-home care.

A robust and effective complaints management system within the department is essential to ensuring an accountable and transparent child safety system, allowing individual concerns to be addressed and resolved. I am of the view that an effective child safety complaints system should be easily accessible to the public, responsive to all concerns raised and demonstrate objectivity and fairness in how complaints are managed and accountability in the recording and reporting of complaint outcomes.

Having regard to these objectives, this report presents a number of recommendations for both the department and the OPG to assist in strengthening their processes for managing child safety complaints.

I would like to thank the officers from the department and the OPG who assisted with the investigation. I would also like to thank my staff, and particularly acknowledge Senior Investigator, David McMurtrie, for their hard work and professionalism in conducting the investigation and preparing the report.



Phil Clarke
Queensland Ombudsman

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Dictionary

Term	Meaning
2014 audit	Queensland Ombudsman audit of the Department of Communities, Child Safety and Disability Services' complaints management system
Carmody Report	Taking Responsibility: A Roadmap for Queensland Child Protection
CCRU	Central Complaints and Review Unit
CCYPCG	Commission for Children and Young People and Child Guardian
CSO	Child Safety Officer
CSSC	Child Safety Service Centre
department	Department of Communities, Child Safety and Disability Services
OPG	Office of the Public Guardian
PSBA	Public Safety Business Agency
QFCC	Queensland Family and Child Commission

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Executive summary

On 1 July 2012, the Queensland Child Protection Commission of Inquiry was established, led by the Honourable Tim Carmody, QC, to review Queensland's child safety system. As a result of the recommendations made in the Commission of Inquiry's report, *Taking Responsibility: A Roadmap for Queensland Child Protection* (the Carmody Report), the child safety complaints system within the public sector has undergone significant reform.

As a result of the Carmody Report's recommendations, the Commission for Children and Young People and Child Guardian (CCYPCG) ceased operation on 30 June 2014. Relevant departments assumed responsibility for investigating child safety complaints, which had previously been investigated by the CCYPCG, through their own complaints management systems and with oversight by the Queensland Ombudsman.[1] The remaining CCYPCG functions were divided between a number of different agencies.[2]

The Carmody Report also emphasised that government departments responsible for child safety matters need to be more accountable for their performance and outcomes.[3] As part of this process, departments need to take action to improve public confidence in their complaints management systems by ensuring their processes are effective and reliable and by establishing adequate quality assurance and monitoring mechanisms.

Accordingly, the Carmody Report recommended that departments with child safety responsibilities should regularly survey complainants, publish annual complaint reports and provide child friendly complaint processes.[4] Departments should also develop a schedule of internal audit and review linked to strategic risk plans and informed by findings of investigations and complaints management systems.[5]

Having regard to these significant reforms, in September 2015 I decided to commence an investigation to determine whether the Department of Communities, Child Safety and Disability Services (the department) has a robust child safety complaints system in place that the public can have confidence in.

In commencing the investigation, I identified that a significant number of child safety complaint issues have been seemingly lost since the CCYPCG ceased operation. This is most notable by a significant decrease in total child safety complaint issues received both in the last year of the CCYPCG's operation in 2013-14 and the first year after the CCYPCG's closure in 2014-15. Part of this decrease can be explained by jurisdictional differences between the CCYPCG and the agencies currently responsible for child safety complaint management. However, there has also been a smaller than expected increase in child safety complaint issues received both by the department and the Office of the Queensland Ombudsman, warranting further investigation.

The investigation determined that the department has not been capturing all child safety complaint issues it receives due to inadequate complaint recording processes at Child Safety Service Centres (CSSC). The department has been managing many complaint issues through regular casework processes at CSSCs, meaning that potentially significant complaint issues are not being managed through the department's complaints management system and consequently not published as part of departmental complaint statistics.

Since 2014 all departments have been required by 30 September each year to publish information about complaints received and resolved in the previous financial year pursuant to s.219A(3) of the *Public Service Act 2008* (Public Service Act). The investigation determined that the department failed to comply with this requirement in 2015. However, I note that the

[1] *Taking Responsibility: A Roadmap for Queensland Child Protection*, Recommendation 12.9.
[2] These agencies included the Department of Communities, Child Safety and Disability Services, the Queensland Ombudsman, the Office of the Public Guardian, the Queensland Family and Child Commission and the Public Safety Business Agency.
[3] *Taking Responsibility: A Roadmap for Queensland Child Protection*, p.xxiii.
[4] *Taking Responsibility: A Roadmap for Queensland Child Protection*, Recommendation 12.10.
[5] *Taking Responsibility: A Roadmap for Queensland Child Protection*, Recommendation 12.5.

department has since published the data following receipt of the proposed report about this investigation.

The investigation also identified the need for greater collaboration between the department and the Office of the Public Guardian (OPG) with respect to managing which issues identified by OPG Community Visitors should be handled as a child safety complaint by the department rather than addressed through local resolution. Serious issues identified by Community Visitors were regularly managed as complaints by the CCYPCG and reported in complaints statistics. However, the OPG and the department currently do not have sufficient processes in place to distinguish between minor child safety issues and child safety complaint issues and how each should be managed.

To address these matters I have made recommendations requiring the department to enhance aspects of its complaints management system. I have also made a recommendation requiring the department and OPG to develop an agreed complexity and severity level for when a matter is considered a complaint and must be actioned under the department's complaints management system.

I hope the issues addressed in this report will help lead to a stronger system for managing child safety complaints into the future.

Opinions

Opinion 1

The publicly reported complaints data by relevant agencies between 2011-12 and 2014-15 shows a decrease in the number of child safety complaint issues received since the closure of the CCYPCG. However, it is not possible to accurately report overall on child safety complaint trends with any confidence in these years.

Opinion 2

For complaints received during 2014-15 the department is unable to fully comply with the obligations imposed by s.219A(3) of the Public Service Act, requiring the department to publicly report on its complaints data annually, as it is unable to accurately identify and record all child safety complaints it received or the number of complaints which required further action or no further action. This is unreasonable adminstrative action for the purposes of s.49(2)(b) of the Ombudsman Act.

Opinion 3

The department and the OPG have not yet established appropriate protocols to determine when child safety issues identified by the OPG should be referred to the department to be managed by way of casework, or when such child safety issues should be categorised as a complaint and managed by the department through its complaints management system. This is unreasonable adminstrative action for the purposes of s.49(2)(b) of the Ombudsman Act.

Opinion 4

There should be a coordinated approach between the department and the OPG in capturing child safety complaints data so that trends and systemic issues are easily identified.

Opinion 5

The department did not publish its complaints data for the 2014-15 financial year by 30 September 2015 in accordance with the requirements of s.219A(3) of the Public Service Act. This is administrative action taken contrary to law for the purposes of s.49(2)(a) of the Ombudsman Act.

Recommendations

Recommendation 1

The Director-General take all necessary steps to ensure that all complaints, including those managed by CSSCs, are appropriately captured, managed and reported in departmental complaints data.

Recommendation 2

The Director-General take all necessary steps to ensure:

- a full review of data fields for the department's complaints management database is conducted and relevant categories aligned to the department's core business practices and best practice complaints handling process
- appropriate training is provided to all departmental officers with complaints handling responsibilities.

Recommendation 3

The Director-General and the Public Guardian establish a protocol relating to how child safety issues raised by the OPG are to be managed by the department. At minimum, the protocol should establish:

- an agreed complexity and severity level for when a matter is considered a complaint made to the department by the OPG and must be actioned under the department's complaints management system rather than case managed as a minor issue
- an agreed process for how complaints are to be managed by the department when referred by the OPG
- communication and training of relevant officers of both agencies in this process
- the development of comparable fields by the department and the OPG in their respective electronic databases, for accurate recording and reporting on complaints received by the OPG and referred to the department.

Recommendation 4

The Director-General take appropriate steps to ensure that all entities providing child safety services on behalf of the department:

- understand the importance of complaints in ensuring the integrity and effectiveness of the child safety system in Queensland
- have adequate internal complaint handling mechanisms in place to receive, identify, record and resolve complaints in a timely way
- escalate serious or complex complaint matters to the department through its complaints management system mechanisms
- report all complaint issues and outcomes to the department on a regular basis.

Recommendation 5

The Director-General ensure that the department take steps by 30 September 2016 to establish a system where the department is able to accurately:

- evaluate and measure the performance of the child safety complaints management system
- identify trends in complaint issues
- identify potential systemic issues requiring rectification
- publicly report on complaints data as required by s.219A(3) of the Public Service Act.

Chapter 1: Introduction

Background

This report summarises the findings of an investigation into the adequacy of the current child safety complaints management processes within the department.

As part of my function to help agencies to improve their practices and procedures, in July 2014 I finalised an audit of the department's complaints management system which identified multiple issues with how the department gathered and recorded complaints data (the 2014 audit). To address these issues, the 2014 audit made 18 recommendations for action by the department, including recommendations to ensure adequate recording of complaints data and also to ensure accountability and transparency by publicly reporting on its complaints data. These recommendations were not made public at the time.

Having regard to the significant reforms resulting from the Carmody Report and the recommendations made in the 2014 audit, my purpose in conducting this investigation was to determine whether the department has a robust child safety complaints system in place that the public can have confidence in. In my view, sufficient time has passed to enable me to form views on whether the department has acted appropriately to resolve the issues previously identified.

The Australian and New Zealand Standard, *Guidelines for complaint management in organizations,* has established principles for data collection, analysis and reporting for complaint information.[6] Having regard to these principles, throughout this report I have assessed the department's complaints processes with respect to whether they are:

- reliable and consistent
- meaningful and comprehensive
- clear and unambiguous
- logical and consistent with its complaints management procedure
- quantitative (meaning measurable and definable).

I have also considered the Public Service Act which requires all departments to establish and implement a system for dealing with customer complaints.[7] Since 1 July 2014, s.219A(3) of the Public Service Act has required that by 30 September after each financial year, departments must publish the following information for the financial year on their websites:

- the number of customer complaints received by the department in the year
- the number of those complaints resulting in further action
- the number of those complaints resulting in no further action.

Issues for investigation

The principal objective of the investigation was to determine whether the department's child safety complaints system is operating effectively.

As part of this investigation, the following issues were considered:

- relevant legislation and Australian Standards regarding the establishment of an effective complaints system
- the department's current child safety complaints system
- reforms which have occurred to the child safety complaints system over the past two years
- principles for effective recording and reporting on complaint outcomes

[6] Australian and New Zealand Standard AS/NZS 10002:2014, *Guidelines for complaint management in organizations,* pp.23-25.
[7] *Public Service Act 2008*, s.219A.

- the quality of the department's child safety complaints data for 2014-15
- trends in child safety complaints data over the past four years.

Ombudsman's jurisdiction

The Ombudsman is an officer of the Queensland Parliament empowered to investigate complaints about the administrative actions of Queensland public sector agencies. As Queensland Government departments are 'agencies' for the purposes of the *Ombudsman Act 2001*[8] (Ombudsman Act), it follows that I may investigate the administrative actions of the department.

Under the Ombudsman Act,[9] I have authority to:

- investigate the administrative actions of agencies following a complaint or on my own initiative (without a specific complaint)
- make recommendations to an agency being investigated about ways of rectifying the effects of its maladministration and improving its practices and procedures
- consider the administrative practices of agencies generally and make recommendations, or provide information or other assistance to improve practices and procedures.

The Ombudsman Act outlines the matters about which the Ombudsman may form an opinion before making a recommendation to the principal officer of an agency.[10] These include whether the administrative actions investigated are contrary to law, unreasonable, unjust or otherwise wrong.[11]

Although the Ombudsman is not bound by the rules of evidence,[12] the question of the sufficiency of information to support an opinion by the Ombudsman requires some assessment of weight and reliability. The standard of proof applicable in civil proceedings is proof on the balance of probabilities. This essentially means that, to prove an allegation, the evidence must establish that it is more probable than not that the allegation is true. Although the civil standard of proof does not strictly apply in administrative decision-making (including the forming of opinions by the Ombudsman), it provides useful guidance.[13]

'Unreasonableness' in the context of an Ombudsman investigation

It is important to note that, in expressing an opinion under the Ombudsman Act that an agency's administrative actions or decisions are 'unreasonable', I am applying the meaning of the word in the context of the Ombudsman Act. In this context, 'unreasonable' bears its popular or dictionary meaning, not the far narrower 'Wednesbury' test of unreasonableness, which involves a consideration of whether an agency's actions or decisions were so unreasonable that no reasonable person could have taken them or made them.[14]

Adverse comment

The terms 'procedural fairness' and 'natural justice' are often used interchangeably within the context of administrative decision-making. The rules of procedural fairness have been developed to ensure that decision-making is both fair and reasonable.

[8] Section 8(1), Ombudsman Act.
[9] Section 12, Ombudsman Act.
[10] Sections 49 and 50, Ombudsman Act.
[11] Section 49(2), Ombudsman Act.
[12] Section 25(2), Ombudsman Act.
[13] See *Minister for Immigration and Ethnic Affairs v Wu Shan Liang* (1996) 185 CLR 259 at 282. See also the discussion in R. Creyke and J. McMillan, *Control of Government Action – Text, cases and commentary,* 2nd edition, LexisNexis Butterworths, Australia, 2009, at 12.2.20.
[14] See *Re Hospital Benefit Fund of Western Australia Inc* (1992) 28 ALD 25 at 42 for a discussion of statutory unreasonableness.

The Ombudsman must also comply with these rules when conducting an investigation.[15] Further, the Ombudsman Act provides that, if at any time during the course of an investigation it appears to the Ombudsman that there may be grounds for making a report that may affect or concern an agency, the principal officer of that agency must be given an opportunity to comment on the subject matter of the investigation before the final report is made.[16]

This report was completed as a proposed report in April 2016.

To satisfy my obligations I provided the proposed report to Mr Michael Hogan, Director-General of the department and Ms Julia Duffy, Acting Public Guardian. Where appropriate I have referred to the Director-General and the Acting Public Guardian's responses throughout this report. I thank the Director-General and the Acting Public Guardian for their responses.

[15] Section 25(2), Ombudsman Act.
[16] Section 26(3), Ombudsman Act.

Chapter 2: Previous review outcomes of the child safety complaints system

This chapter outlines some of the recommendations for reform which have arisen from previous reviews of the child safety complaints system and the department's responses to these recommendations.

Queensland Child Protection Commission of Inquiry

The Queensland Child Protection Commission of Inquiry was established on 1 July 2012, led by the Honourable Tim Carmody, QC, to review Queensland's child safety system. The Carmody Report was provided to the former Premier, the Honourable Campbell Newman MP, on 28 June 2013.

One aspect of the child protection system examined by the Carmody Report was the effectiveness of the monitoring, investigation and oversight of complaints. The Carmody Report identified that there was a three tiered system of accountability and review mechanisms for the child protection system:[17]

- internal oversight by the department, including complaints management, licensing of care services, performance monitoring and reporting and child death reviews
- external oversight by the CCYPCG, the Queensland Ombudsman, interagency committees and the State Coroner
- judicial oversight by the Childrens Court and the Queensland Civil and Administrative Tribunal.

The Carmody Report found that 'an overlay of external monitoring has caused duplication and complexity to the child protection system and added costs to government and non-government service providers without any discernible accountability enhancement'.[18] It proposed a new oversight structure that placed responsibility for performance and outcomes with each department with child protection responsibilities and that the CCYPCG no longer be retained in its current form.[19] External oversight of the department's actions in receiving, assessing and resolving child safety complaints would be the responsibility of the Queensland Ombudsman.[20]

In addition, the Carmody Report recommended the establishment of the Queensland Family and Child Commission (QFCC) to monitor and report on the overall performance of the child protection system, provide cross-sectoral leadership, advice and research for the protection and care of children, and build the capacity of the non-government sector and the child protection workforce.[21]

A brief overview of the former role and functions of the CCYPCG and the current role and functions of the QFCC is provided in Chapter 3.

The Carmody Report also outlined a number of criticisms regarding the department's complaints resolution processes.[22] Specifically, the report stated that:

- parents and carers drop complaints because they are worried they will be targeted as 'troublemakers' by the department and have their matter adversely affected
- complainants give up because of drawn-out processes and the department's failure to keep to agreed timelines

[17] *Taking Responsibility: A Roadmap for Queensland Child Protection*, pp.41-42.
[18] *Taking Responsibility: A Roadmap for Queensland Child Protection*, p.xxiii.
[19] *Taking Responsibility: A Roadmap for Queensland Child Protection*, p.xxiv.
[20] *Taking Responsibility: A Roadmap for Queensland Child Protection*, Recommendation 12.9.
[21] *Taking Responsibility: A Roadmap for Queensland Child Protection*, Recommendation 12.3.
[22] *Taking Responsibility: A Roadmap for Queensland Child Protection*, p.419.

- cases drag on for a number of years causing unnecessary stress to the family concerned
- the department 'moves to protect itself' in response to complaints
- non-government organisations feel closed out altogether from raising complaints as they perceive that de-funding may result if they challenge the department
- departmental processes and procedures that relate to children in care remain inaccessible outside the department, making it difficult for complainants to know what is expected.

The Carmody Report also found that the department had not conducted any client satisfaction surveys in relation to complaints since 2010 and did not report publicly on complaints received or the outcomes:[23]

> Such information would provide useful feedback to staff regarding the impact of the process on complainants and would give the public greater insight into the work of the complaints unit, building public confidence in internal-complaint mechanisms.

In response to these issues, the Carmody Report recommended:[24]

> That each department with responsibility for child protection improve public confidence in their responsiveness to complaints by:
>
> - regularly surveying complainants
> - publishing a complaints report annually
> - working with the Child Guardian to provide child-friendly complaints processes.

Ombudsman complaints management system audit

In July 2014, I finalised a routine audit examining the operation of the department's complaints management system between 1 July 2012 and 30 June 2013.

These audits are conducted by this Office to review and evaluate agency complaints processes, including:

- complaints management system policies and procedures
- external visibility and accessibility (website)
- internal communication and training
- complaints resolution
- internal reporting
- monitoring effectiveness
- external reporting.

The 2014 audit identified that the department's complaints management policy and procedure excluded certain types of complaints, identified by the department as 'issues that are minor in nature' and which were 'routinely raised and dealt with by officers during normal client interaction'. The 2014 audit found this exclusion was used by CSSCs to manage significant numbers of what would otherwise be defined as complaints under the Australian and New Zealand Standard, *Guidelines for complaint management in organizations*, but there was no explanation or examples provided in the complaints procedure to guide departmental officers about what amounted to a 'minor issue' and what was accepted as 'normal client interaction'.

The 2014 audit also identified problems with the department's recording of complaint matters. Under the complaints management procedure, the majority of complaints resolution work is carried out by CSSCs. However, the department's complaints management database is not available to CSSCs. Accordingly, to ensure the adequate recording of complaints and complaint outcomes, CSSCs must advise regional offices (that do have access to the

[23] *Taking Responsibility: A Roadmap for Queensland Child Protection*, p.420.
[24] *Taking Responsibility: A Roadmap for Queensland Child Protection*, Recommendation 12.10.

complaints management database) of complaint outcomes so they can be recorded. However, this was not occurring consistently.

Other significant issues identified with the management of complaints by CSSCs included:

- regional office staff expressed the view that CSSC officers were too busy, and as a consequence did not record everything regarding complaint work
- there was a view within CSSCs that matters were not considered a complaint for the purpose of the complaints management system until managers were involved
- CSSCs reported that almost all complaints they managed were responded to verbally
- the department's 2012-13 annual report did not report on the operation or performance of the complaints management system. The department had previously provided limited public reporting on the complaints management system in either annual reports or on its website.

Twenty-two recommendations were provided to the Director-General of the department in a report which was not made public at the time. In response, the Director-General advised that the department accepted all of the recommendations.

Department's response to recommendations

The department has commenced a 'Complaints Management Transformation Project' to finalise implementation of the Carmody Report recommendations relating to complaints management. Implementation of actions arising from the project commenced from January 2016. As part of the project, the department has also committed to:[25]

- reviewing the operations of the department's Central Complaints Review Unit (CCRU)
- implementing recommendations made previously by the 2014 audit relating to the department's complaints management system
- implementing the department's internal audit recommendations
- aligning the department's complaints management system with the Australian and New Zealand Standard, *Guidelines for complaint management in organizations.*

The Complaints Management Transformation Project includes the following key deliverables:

- review of current complaints management policy and procedures
- implementing key process improvements in how complaints are handled
- ensuring the department complies with data collection requirements and reporting requirements
- implementing a training strategy for staff responsible for managing complaints
- ensuring the complaints management database is used to manage all complaints
- implementing review and auditing processes
- improving information resources about complaints and ensuring complaints processes are child friendly
- conducting complainant surveys
- managing relationships with key stakeholders in the complaints process.

All key deliverables of the Complaints Management Transformation Project are scheduled to be finalised by the end of December 2016.[26]

[25] Department of Communities, Child Safety and Disability Services, *Lite Project Brief for DCCSDS Complaints Management Transformation Project*, January 2016, Version No. 0.1.
[26] Complaints Management Transformation Project Gantt Chart.

Chapter 3: Key agencies in the child safety complaints system

This chapter provides a brief overview of each agency involved in the child safety complaints system.

Previous role of the Commission for Children and Young People and Child Guardian

The Children's Commission was established in 1996 for the purpose of tackling organised paedophilia activities and other forms of child abuse. Following the outcome of the Commission of Inquiry into the Abuse of Children in Queensland Institutions (the Forde Inquiry) in 1998, which found significant failings in the child safety system, the Children's Commission was expanded to become an independent oversight body for the child safety and youth justice systems and called the Commission for Children and Young People. The Child Guardian was later established as part of the expanded Commission for Children and Young People in 2004 with responsibility for investigating and resolving complaints about the quality of service delivery to children in the child safety system.[27]

The Child Guardian function included a Community Visitor Program which regularly visited children in foster care, residential care, detention, authorised mental health services and 17 year olds in adult prisons. The role of Community Visitors was to independently monitor the safety and wellbeing of the children they visited, and to advocate for their interests with relevant service providers, including the department.[28] Community Visitors resolved the majority of issues raised by children during their visits with either the department or the relevant service provider. More serious matters indicating potential harm or risk of harm to a child were escalated and resolved through the CCYPCG's complaints handling function.[29]

The Carmody Report found that, from an efficiency perspective, there was no longer a need for the CCYPCG's complaint handling function.[30] It recommended that relevant departments take responsibility for investigating child safety complaints through their complaints management processes, with oversight by the Queensland Ombudsman.[31] The remaining Child Guardian functions, including the Community Visitor Program, were transferred to a newly created agency called the OPG. The establishment of the OPG was a recommendation of the Carmody Report, and was created as a result of merging the functions of the Adult Guardian and the Child Guardian.[32]

As a result of further recommendations by the Carmody Report, the CCYPCG's other legislative functions were dispersed between the department, the Queensland Ombudsman, the QFCC and the Public Safety Business Agency (PSBA).

Department of Communities, Child Safety and Disability Services

The department is the lead agency for child protection in Queensland. The department's role is to protect children and young people who have been harmed or who are at risk of harm, and ensure their future safety and wellbeing.[33] The department also has a role in providing community, disability and multicultural services. However, this report focuses on the child

[27] CCYPCG Annual Report 2012-13, p.4.
[28] CCYPCG Annual Report 2012-13, p.41.
[29] CCYPCG Annual Report 2012-13, p.47.
[30] *Taking Responsibility: A Roadmap for Queensland Child Protection*, p.421.
[31] *Taking Responsibility: A Roadmap for Queensland Child Protection*, Recommendation 12.9.
[32] *Taking Responsibility: A Roadmap for Queensland Child Protection,* Recommendation 12.7.
[33] Department of Communities, Child Safety and Disability Services, Our Vision, https://www.communities.qld.gov.au/childsafety/about-us/our-department/our-vision, accessed 21 March 2016.

safety services function of the department and any reference to the department or the department's complaints management system relates solely to the department's child safety services function.

This report does not address any matters relating to the statutory child protection functions of the department. Specifically, an allegation received by the department about harm or risk of harm to a child is not a child safety complaint, as these matters are recorded and assessed by the department pursuant to the requirements of s.14 of the *Child Protection Act 1999* and relevant departmental procedures in the Child Safety Practice Manual.

The department's complaints management procedure defines the scope of a complaint as:[34]

> … where a member of the community or other stakeholder expresses dissatisfaction with a service and/or a decision of the department or a funded service or any aspect of any service or decision made by the department or funded service, including the behaviour or actions of employees, or a person otherwise engaged by a funded service.

The procedure states that issues which are minor in nature and that are routinely raised and dealt with by officers during normal client interaction are outside the scope of the procedure.

Child safety complaints can be made to the department about a range of issues, including:[35]

- actions taken or decisions made by the department
- standards of care or access to programs
- appropriateness and quality of services
- departmental and agency practices, policies and procedures.

Under the department's complaints management system, there are three options for the department to respond to a child safety complaint:

- local level resolution whereby complaints are resolved by either the CSSC, the regional level if the complainant is not satisfied with the response by the CSSC or by direct contact with a funded agency, if the complaint concerns a funded agency
- CCRU resolution, including instances where resolution at the local level has not been satisfactory, resolution at the local level may be compromised by perceived bias or conflict of interest, or there is a lack of capacity to respond at the local level or because of the complexity of the complaint
- internal review of the department's handling of a complaint.

Office of the Public Guardian

The OPG was established on 1 July 2014, combining functions previously undertaken by the Adult Guardian and the Child Guardian. The OPG is now responsible for the Community Visitor Program as well as a new child advocacy program.

There are a variety of ways the OPG may become aware of an issue that may give rise to a child safety complaint, including directly from a child, a communication box at a detention centre or an external source such as a member of the public, a service provider, carer or a family member.

The *Public Guardian Act 2014* provides that the OPG, when exercising its child advocate functions, may help a child make a complaint about a matter.[36] The Public Guardian Act also provides that the OPG may make a complaint on behalf of a child, and may make a

[34] Department of Communities, Child Safety and Disability Services, *Complaints Management Procedure*, 2014, p.1.
[35] Department of Communities, Child Safety and Disability Services, A guide to making a complaint, https://www.communities.qld.gov.au/resources/about/complaints/guide-to-making-complaint.pdf, accessed 4 March 2016.
[36] *Public Guardian Act 2014*, s.13(1)(h).

complaint to a complaints agency about services provided to a child by a service provider or other government service provider.[37]

According to the OPG's policy 'Making complaints to other agencies', when making a child safety complaint, the OPG will first raise the matter with the child's carer or site manager if the child is residing in a residential facility. If the OPG is not satisfied with the outcome or action taken, the OPG will refer the issue to the relevant CSSC. If the OPG is not satisfied with the CSSC's response, the issue may then be escalated to managerial level, meaning the relevant Team Leader or CSSC Manager.[38]

When resolution at the CSSC level is not possible, the complaint may then be escalated to a higher level within the department, including the relevant Regional Director, the CCRU or the Director-General.

In response to the proposed report, the Acting Public Guardian provided the following additional information regarding the role of the Community Visitors in resolving issues and concerns on behalf of children and young people in out-of-home care following the reforms outlined in the Carmody Report:

> Through its newly refocused community visitor program, a key role of the Office of the Public Guardian's Community Visitors (CVs) is to recognise issues or concerns impacting on a child or young person's life whilst in out-of-home care. CVs advocate on behalf of a child or young person by giving voice to, and facilitating, the timely resolution of identified issues and concerns with relevant service providers, including the Department of Communities, Child Safety and Disability Services (the department). This vital role of the CV is central to OPG's advocacy undertaken on their behalf.
>
> The main principle to be applied by a CV in carrying out their role and functions, is to act in the best interests of the child or young person. Providing the opportunity for a child or young person to build a good rapport with their Child Safety Officer (CSO) is seen to be in the best interests of a child or young person. In the experience of CVs, children and young people often prefer to have identified issues or concerns during their time in care raised informally at a local level with their CSO or local Child Safety Service Centre (CSSC) rather than raising them as part of a formal complaints management process. In other words, children do not want to be seen to be "complainants", but rather, want to have their voices heard and their views, wishes and needs addressed by service providers. They are also not "consumers" in the typical sense envisaged by complaints processes in standard service industries. Under the Child Protection Act decisions are to be made, and issues and complaints resolved, not necessarily to the satisfaction of the child or young person as a "consumer" but always in the best interests of the child or young person.
>
> One of the recognised benefits of raising issues and concerns informally at the local level, is that this provides children and young people with more opportunities to positively build on their relationship with their CSO, by experiencing the willingness of their CSO to respond to their concerns without needing to go through a formal complaints process. Additionally, where children indicate that they do not want to make a formal complaint or pursue a formal complaint process, it is important that statutory agencies recognise this and respect individual children's rights. A failure to do so is highly likely to lead to that child becoming disenfranchised and feeling less empowered by agencies set up to protect their rights and interests.
>
> Against this backdrop, the OPG does not have a dedicated legislatively based complaints function like the former Commission for Children and Young People and Child Guardian (CCYPCG). Instead, the OPG has a legislated child advocacy function. One of the functions of the child advocate is 'helping the child to resolve issues or disputes with others'. The OPG has therefore established a referral pathway from CVs to its lawyer-child advocates (who sit within OPG Legal Services) in relation to those matters that remain unresolved or unsatisfactorily resolved at the local level, or are identified as issues best dealt with under the broader child advocate jurisdiction.

[37] *Public Guardian Act 2014*, s.144.
[38] Office of the Public Guardian, Making complaints to other agencies, p.2.

All issues raised and resolved by CVs and OPG's lawyer-child advocates are recorded in OPG's case management system 'jigsaw'.[39] In this way, all issues and concerns raised on behalf of children and young people are easily tracked and monitored.

All issues raised by CVs and lawyer-child advocates are done so in writing to the relevant local CSSC. A record of all communications made in relation to the resolution of the issue are also recorded in jigsaw. The OPG is able to monitor the timely resolution of all issues with the assistance of internal monthly reporting processes, and the ability of each zone to run its own report from jigsaw.

OPG also shares information considered to be in the public interest about issues and concerns raised on behalf of children and young people in a number of ways. In its inaugural 2014-15 Annual Report, the OPG publicly reported on the number and the types of issues raised and resolved by CVs and lawyer-child advocates during its first year of operation. It also highlighted the most commonly raised issues for children and young people in the child protection system e.g. contact, placement and health issues. In addition, the OPG proactively provides a monthly report to the Queensland Family and Child Commission (QFCC), which includes information about the number and most frequent types of issues raised in the previous month by OPG's CVs. This information is provided to the QFCC to assist with its systemic oversight of the child protection system.

Queensland Family and Child Commission

The QFCC was established on 1 July 2014 in response to recommendations made in the Carmody Report. The purpose of the QFCC is to focus on system level oversight, evaluation and advocacy regarding the child protection and family support systems.[40] This differs from the previous systemic oversight functions of the CCYPCG, which is now the responsibility of the Ombudsman.

One of the roles of the QFCC is to monitor, review and report on the performance of the child protection and family support systems in line with national standards.[41]

With respect to its oversight functions, the *Family and Child Commission Act 2014* requires that the QFCC include in its annual report information on:[42]

- Queensland's performance in relation to achieving state and national goals relating to the child protection system
- Queensland's performance over time in comparison to other jurisdictions
- Queensland's progress in reducing the number of, and improving the outcomes for, Aboriginal and Torres Strait Islander children and young people in the child protection system.

While the QFCC does not have a role in monitoring or oversight of the child safety complaints system, the QFCC does have a responsibility to build the capacity of the child protection and family support sectors to deliver outcomes for children and their families.[43]

Queensland Ombudsman

External oversight of the department's complaints management system is provided by the Queensland Ombudsman.

The Ombudsman has jurisdiction and oversight with respect to the department's actions in receiving, assessing and resolving child safety complaints. When the Ombudsman receives a complaint about the actions or decisions of the department, the Ombudsman assesses the

[39] Jigsaw is the name of a complaints management database, formerly used by the CCYPCG and now managed by the OPG.
[40] Queensland Family and Child Commission, Annual Report 2014-15, p.5.
[41] *Taking Responsibility: A Roadmap for Queensland Child Protection*, Recommendation 12.3.
[42] *Family and Child Commission Act 2014*, s.40.
[43] Queensland Family and Child Commission, Our Role, http://www.qfcc.qld.gov.au/home/our-role, accessed 5 April 2016.

complaint to determine whether the complainant has made attempts to resolve the complaint with the department. If not, the complainant may be directed back to the department's complaints management system. If a complaint remains unresolved by the department, the Ombudsman may investigate the matter and may make recommendations to the department about the matter.

The Ombudsman may also conduct investigations on his own initiative.

Chapter 4: Trends in child safety complaint numbers

As a starting point to the analysis of the department's child safety complaints processes, I examined data from the relevant complaint bodies to identify trends in child safety complaint numbers over the previous four financial years. Three of these years were while the CCYPCG was still functioning and one year was after it was dissolved.

Figure 1 shows the number of child safety complaint issues received by the department, the CCYPCG and the Ombudsman between 2011-12 and 2014-15. The statistics in Figure 1 are taken from the following sources:

- departmental complaint numbers were provided by the department from an analysis of complaints data from the complaints management database
- CCYPCG complaint numbers are the publicly reported complaints numbers published in CCYPCG annual reports for the period
- Ombudsman complaint numbers were sourced from an analysis of its complaints data.

It should be noted that the CCYPCG reported its complaint numbers in terms of complaint issues rather than complaints received, and there could be a number of complaint issues making up a single complaint. For consistency and comparison purposes, the complaint numbers for the Ombudsman and the department have therefore been reported in the same manner.

Figure 1: Number of child safety complaint issues received by relevant agencies between 2011-12 and 2014-15

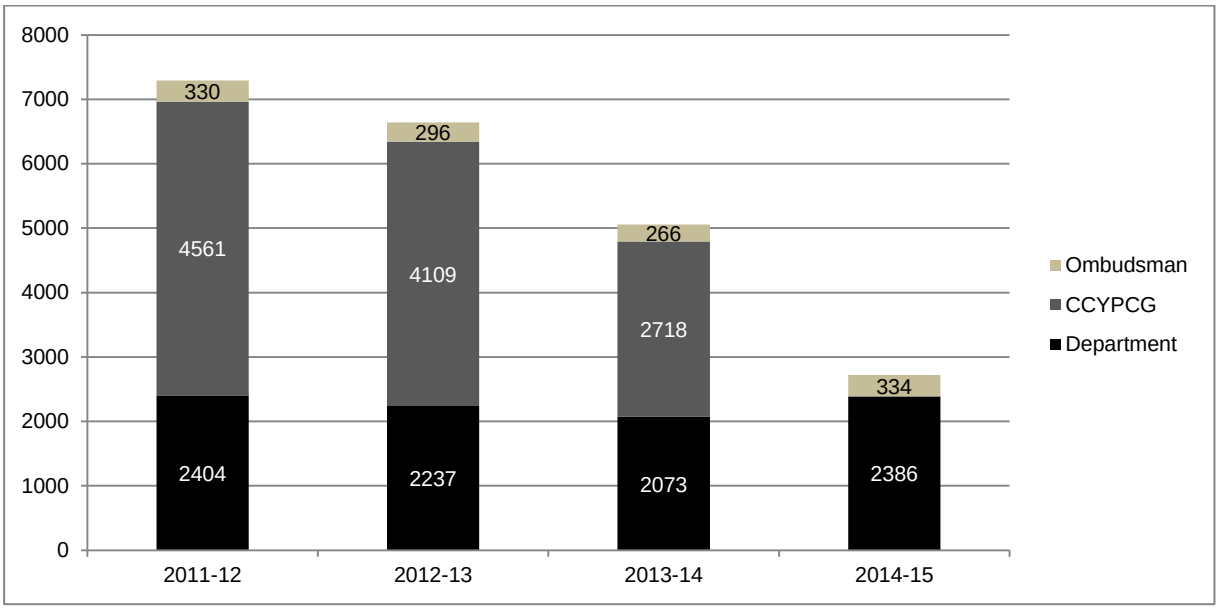


Figure 1 reveals a significant decrease in child safety complaint issues received after the closure of the CCYPCG in June 2014. In fact, there was a 46% decrease in total child safety complaint issues received between 2013-14 and 2014-15. Of note, complaint issues received by the Ombudsman increased by a small proportion in that year (26%), which equates to only 68 additional complaint issues between 2013-14 and 2014-15. Similarly, the department recorded a 15% increase in complaint issues during this same period (representing an additional 313 issues). This suggests a significant number of complaints were apparently lost to the system in one year.

Overall, 7,295 child safety complaint issues were received by three complaint handling agencies in 2011-12, compared with 2,720 complaint issues received by two complaint

handling agencies in 2014-15. This represents a 63% decrease in complaint issues received over the four years. In effect, it appears that the volume of complaint issues previously received by the CCYPCG has largely disappeared.

When asked by investigators, neither representatives from the department nor the OPG were aware of the loss of complaint issues or were able to describe what may have contributed to such a loss.[44] Both agreed that an apparently significant loss of complaint issues was concerning.

It is likely that some of the decrease in complaint issues may be attributed to changes in the jurisdiction of the relevant complaint bodies after the implementation of recommendations made in the Carmody Report. For example:

- The CCYPCG had jurisdiction to deal with complaints about any government or non-government service provided (or not being provided) to young people in the child safety and/or youth justice systems.[45] Accordingly, a small number of the complaint issues included in the CCYPCG data in Figure 1 may have solely related to young people in the youth justice system, which is outside the department's jurisdiction.
- Under s.25 of the repealed *Commission for Children and Young People and Child Guardian Act 2000* (CCYPCG Act) the Commissioner was required to refer a matter where a child may be in need of protection to the department[46] or the victim of a criminal offence to the Queensland Police Service (QPS).[47] While CCYPCG recorded these referrals as complaints, these harm or risk of harm matters are not recorded as complaints under the department's current child safety complaints processes.[48]

To accurately remove youth justice and harm complaints from the CCYPCG data, it would be necessary to determine the exact nature of each complaint to ensure there were no additional concerns regarding how the department or another agency had previously dealt with the allegations. This exercise would be lengthy and costly and would still likely not account for all of the decrease in complaint issues. I have therefore not undertaken this process.

While jurisdictional changes may account for part of the decrease, I am not convinced that this reasoning can explain all of the decrease. I am particularly concerned about this decrease as it coincides with the implementation of reforms to the child safety complaints system recommended by the Carmody Report, suggesting perhaps that the new complaints framework has resulted in a loss of complaints. Some possible explanations for this decrease are:

- that the public have not been adequately informed about how or where to make a complaint under the new framework
- that the new framework is not sufficiently transparent or accountable to ensure that complaints are being recorded and responded to appropriately.

Opinion 1

The publicly reported complaints data by relevant agencies between 2011-12 and 2014-15 shows a decrease in the number of child safety complaint issues received since the closure of the CCYPCG. However, it is not possible to accurately report overall on child safety complaint trends with any confidence in these years.

[44] Meeting between Queensland Ombudsman officers and departmental officers on 10 February 2016 and Queensland Ombudsman officers and OPG officers on 22 February 2016.
[45] CCYPCG Annual Report 2013-14, p.39.
[46] CCYPCG Act, s.25(2)(a).
[47] CCYPCG Act, s.25(2)(b).
[48] Under current processes, any allegations of harm or risk of harm to a child identified by the OPG are notified to the department where they are assessed under the provisions of the *Child Protection Act 1999*.

Department's response

In response to the proposed report the Director-General advised:

> The department does not accept this opinion. In the report the QO [Queensland Ombudsman] states that "the former CCYPCG reported its complaint numbers in terms of complaint issues rather than complaints received, and there could be a number of complaint issues making up a single complaint". The department counts complaints as a whole where there might be a number of complaint issues contained in the one complaint. Further, the QO did not include data from the Office of the Public Guardian (OPG) into the 2014-15 statistics on complaints.
> …
> The data reported for 2014-15 does not include data from the OPG, which was the agency assigned with the responsibility of the Community Visitor Program. These complaint issues that were reported through the former CCYPCG are now captured by the OPG.

I acknowledge that the department generally counts the complaints it receives as one complaint, irrespective of how many issues the complaint may contain. However, as stated above, the CCYPCG reported its complaint numbers in terms of complaint issues rather than complaints received. For consistency and comparison purposes the complaint numbers for the Ombudsman and the department were reported in this report in the same manner.

In the departmental data provided to me, the department was able to provide both its overall complaint numbers as well as the total complaint issues it received for each financial year. These are the departmental numbers I have published in Figure 1. Therefore, I do not agree that this argument negates my proposed opinion.

OPG's response

In response to the proposed report the Acting Public Guardian advised:

> It is understood that the intention of Figure 1 … is to represent the number of child safety "complaint issues" received by the Ombudsman, CCYPCG and the department.
>
> A key function of the CCYPCG was to receive and refer complaints, and report on systemic issues arising from the resolution of complaints about service delivery to children or young people in care or detention. However, with the establishment of the OPG in July 2014, the OPG was <u>not</u> empowered with the same CCYPCG function to **receive** and **refer** complaints. The OPG considers that these distinctions should be clearly reflected in the report, as well as the inherent problem of comparing data from two distinct organisations that are in reality 'no longer directly comparable' due to their obvious differences in functions.
>
> *Figure 1 – Proposed report*
>
> …
>
> The OPG has provided the Ombudsman's office with CCYPCG and OPG data for the periods 2011-12; 2012-13, 2013-14, and 2014-15 from jigsaw for the purpose of this report. However, the report has not relied on this data, but has used data regarding complaint issues drawn from CCYPCG annual reports for the years up until 2013-14.
>
> The OPG has concerns with the sole reliance upon the CCYPCG annual report data for the purpose of this report, without the express inclusion of appropriate explanations and qualifications, for the following reasons:
>
> - These figures relate to all issues "closed" by the complaints team for each financial year, rather than all issues "raised" for the financial year. Whereas the data provided by OPG was in relation to the issues raised in each financial year and OPG submits this is a more meaningful reflection, as those "closed" could relate to issues raised in

previous financial years that had not yet been resolved.
- The annual report data includes those "complaint issues" beyond the scope of the legislative functions of the CCYPCG and which were therefore immediately referred on (e.g. local authority issue). The OPG data does not include these out of scope issues and is therefore much more meaningful.
- The annual report data also includes "complaint issues" regarding service providers other than the department - e.g. Queensland Health, Education Queensland, Youth Justice and non-government organisations. The OPG has not included these "complaint issues" in the data provided to the Ombudsman, as the Ombudsman's report only relates to complaints about the department and its service delivery.
- Of the figures used for each reporting period, nearly half of the "complaint issues" relate to the reporting of "harm" under section 25 in line with the former CCYPCG's mandatory reporting of "harm" obligations. The CCYPCG complaints team referred all these issues to the department in accordance with CCYPCG's mandatory reporting obligations under the Child Protection Act 1999. These "complaints issues" included:
  - reporting of **all** types of "harm" to the department *whether it was significant or not*, or was of such a minor nature that it was able to be resolved at the local level, and
  - reporting of matters where there was **suspicion** a child may be (have been or likely to be) a victim of a criminal offence.

OPG has not included mandatory reporting data as such reports are typically not generated by way of "complaint", if consideration is given to the definition of a complaint in the Australian and New Zealand Standard (10002:2014) *Guidelines for complaint management in organisations*.

- A comment is included on p. 11 of the proposed report that the CCYPCG figures quoted on p.10 include a small number of issues that were outside the department's jurisdiction. A qualification should be included in the report noting that almost half of the "complaint issues" reported by CCYPCG for each of the reporting periods, relate to "harm" or "risk of harm", i.e. mandatory reporting obligations.

…

It is recommended that a more accurate representation of the number of issues or concerns about the department's service delivery to children and young people in the child protection system can be obtained through the use of the figures and supporting data originally provided directly to the Ombudsman's office by the OPG …

…

In the OPG data provided directly to the Ombudsman's office, all "harm" issues were removed, as the follow up actions in response to the majority of these "harm" issues indicates that these matters were considered to be minor issues, and would have been resolved by the CVs at the local level.

The OPG considers that the following matters should be clearly identified and included in the proposed report:

- In 2011-12 there were approximately 4,613 complaint issues which were ultimately received by the complaints team. Of these issues, **1,554** related to a complaint where the service provider was the Department. This means that up to **3,059** "complaint issues" were not relevant to the Department.
- In 2012-13 there were approximately 4,067 issues raised which were ultimately received by the complaints team. Of these issues, **1,040** related to a complaint where the service provider was the Department, which means that **3,027** complaint issues were not related to the Department.
- In 2013-14 there were approximately 2,525 complaint issues raised which were ultimately received by the complaints team. Of these issues, approximately **572** related to a complaint where the service provider was the Department, which means that **1,953** complaint issues were not related to the Department.

Projected trajectory of complaint issues
While the discussion at p. 10 focuses on the decrease in complaints between 2013-14 and 2014-15, it does not address the fact that all three agencies experienced a notable

decrease in complaint numbers in the two previous years as well. In particular, for each of the 2011-12, 2012-13 and 2013-14 reporting periods there had been an ongoing and considerable decrease in the number of complaint issues about the department raised by the CCYPCG's complaints team.

- 2011-12 to 2012-13 the complaint numbers dropped from **1554** to **1040** a drop of **514 complaint issues i.e. a decrease of 33%**
- 2012-13 to 2013-14 the complaint numbers dropped from **1040** to **572**, a drop of **468 complaint issues i.e. a decrease of 45%**.

…

If this trajectory continued, complaint numbers should have continued to decrease, and by a substantial rate. However, complaint numbers received by the department and the Ombudsman actually increased during 2014-15. While this number only increased by 378 complaints in total, this small increase may well be explained by taking into consideration the continuing trend in the significant decrease of complaints generally over a period of at least three years.

New function of OPG Child Advocates
In addition to this, it is critical that the impact of the creation of the new function of child advocate under the *Public Guardian Act 2014*, and the effectiveness of this function in addressing and resolving issues is not underestimated. The child advocate function is one of several factors that may have positively contributed to the decrease in complaints being made during 2014-15, particularly by the Public Guardian. Other positive elements that may have contributed to a decline in complaints include:

- an internal referral process from CVs to Lawyer-child advocates that is more pro-active in nature rather than reactive. In practice this means that matters are unlikely to escalate to a complaint level given the different powers under the *Public Guardian Act 2014* for child advocates and community visitors.
- increased opportunities for CVs under the child advocate function to engage in resolution and obtaining documentation (e.g. case plans, family group meeting's) reducing the need to escalate a proportion of formerly escalated matters.
- changes in mandatory reporting requirements, to require reporting only of "significant harm". At the CCYPCG, community visitors were required under their legislation to report all "harm" to the department *whether it was significant or not*, and report any instances where there was suspicion a child may be (have been or likely to be) a victim of a criminal offence.

Use of CCYPCG complaints data

The Acting Public Guardian has raised concerns about the accuracy of the CCYPCG child safety complaint numbers reported in Figure 1. As stated above, the CCYPCG complaint issues reported in Figure 1 are sourced from CCYPCG annual reports between 2011-12 and 2013-14. These figures were used as they represented the number of complaint issues resolved in each financial year by the CCYPCG, as publicly reported by the former Commissioner.[49] I note the Acting Public Guardian's view that complaint issues raised with the CCYPCG in each financial year is the more "meaningful reflection" of the CCYPCG's complaints numbers. However, I consider that it is appropriate that I rely on the CCYPCG's complaint issue numbers that were approved and published by the former Commissioner.

The Acting Public Guardian also stated that the CCYPCG annual report figures include complaint issues received by the CCYPCG which were assessed as out-of-jurisdiction and complaint issues which related to service providers other than the department.

It is not clear from the Acting Public Guardian's response how many reported complaint issues were assessed as out-of-jurisdiction in each relevant financial year. However, again I am of the view that it is appropriate that I rely on the CCYPCG's

[49] The CCYPCG annual reports reported on complaint issues resolved in each relevant financial year rather than complaint issues raised.

complaint issue numbers that were approved and published by the former Commissioner. I note that without clear data I am unable to form a view that reporting differences account for the entirety of the decrease in complaints.

Reporting of complaint issues relating to other service providers

With respect to the reporting of complaint issues which related to service providers other than the department, s.54 of the former CCYPCG Act stated that a complaint could be made to the CCYPCG only so far as the complaint related to a service provided, or required to be provided, to a child while the child was in the child safety system, to a child in detention or to a child subject to certain orders or programs under the* Youth Justice Act 1992*. Accordingly, the CCYPCG had jurisdiction to deal with complaints which related to service providers other than the department, if the complaint related to a service provided, or required to be provided, to a child while the child was in the child safety system. I consider such complaints to be genuine child safety complaints as they relate to the quality of service provision to a child in the child safety system.

Mandatory reporting of harm under the CCYPCG Act

Finally, the Acting Public Guardian has stated that nearly half of the complaint issues reported by the CCYPCG related to the mandatory reporting of harm to children under s.25 of the former CCYPCG Act. I agree that this is likely accurate.

However, it is important to recognise that the reporting of harm or risk of harm was a mandatory requirement under the CCYPCG Act. Harm or risk of harm was identified by the CCYPCG through complaints made directly by the public, Community Visitors following their visits to children in out-of-home care and the CCYPCG's monitoring and investigative work. These mandatory referrals were an important aspect of the child safety complaints system prior to 1 July 2014 and it is important to account for them following the closure of the CCYPCG. As the purpose of this chapter is to represent the child safety complaint numbers both before and after the implementation of the reforms outlined in the Carmody Report, it is not appropriate to retrospectively remove complaints from the CCYPCG's reported statistics because of subsequent legislative and policy changes.

The Acting Public Guardian has suggested that the introduction of child advocates as well as changes to mandatory reporting requirements, which now require only the reporting of significant harm rather than all harm as required previously, may have contributed to an overall decrease in complaints. While this may explain some of the decrease, I am of the view that inadequate complaint recording mechanisms within the department as well as the lack of a consistently applied classification across the child safety system about what type of issues constitute a complaint can also explain much of the decrease. These issues are addressed further in Chapters 5 and 6.

Summary

The difference in views outlined in this chapter regarding the correct number of child safety complaint issues received both before and after the implementation of the Carmody Report reforms demonstrates that there has been an inadequate and inconsistent recording of complaints across all relevant agencies in the past. The number of complaints about child safety issues received in Queensland should not be a controversial topic and should not be open to debate. However, it is obvious that it is not currently possible to determine accurate trends in child safety complaint numbers over recent years.

I am of the view that information about complaints received by agencies should be recorded in a format that means it can be compared against complaints data from other agencies with ease and absolute confidence in the data. I have addressed the

issue of reliable complaints data further in this report.

Taking into consideration the responses from both the Director-General and the Acting Public Guardian, I have amended Opinion 1.

Chapter 5: Quality of the department's child safety complaints data

In order to develop a comprehensive view of the department's child safety complaints processes, I requested the department provide the following complaints data for each of the 2011-12, 2012-13, 2013-14 and 2014-15 financial years:

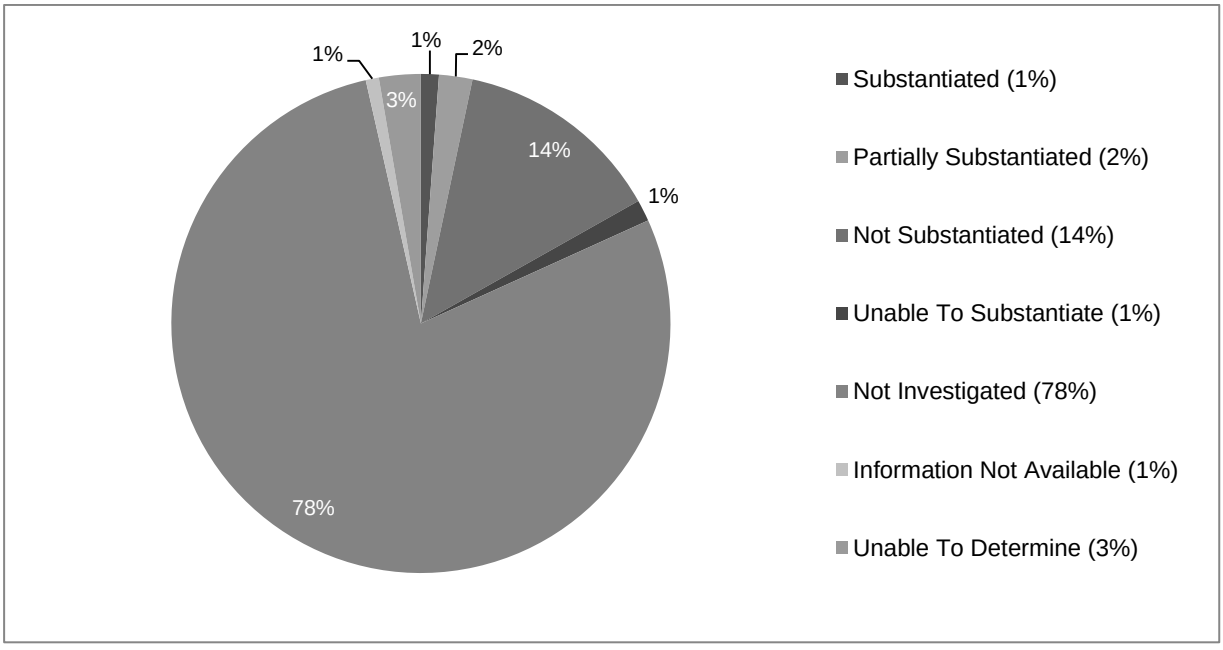
- the number of complaints received
- what each complaint was about
- where the child was residing at the time of the complaint
- how each complaint was received
- relationship of the complainant to the subject child
- which part of the department dealt with the complaint (for example, the complaints unit, regional office or CSSC)
- what action was taken with regard to each complaint
- the outcome of each complaint
- how long each complaint took to resolve.

The department provided the data as requested. However, an analysis of the data revealed significant concerns regarding its quality, including incomplete and inaccurate information about complaints received and actioned and inconsistent recording of complaint information.

Incomplete and inaccurate complaint information

The analysis of the data provided by the department highlighted inaccuracies and incompleteness of the data. This issue is best illustrated by focusing on the department's complaint outcome data for 2014-15.

Figure 2: Outcome of child safety complaints received by the department in 2014-15



What is most evident from Figure 2 is that 78% of complaints received by the department were recorded with an outcome of 'not investigated'. However, a more in-depth analysis of this data revealed that over three-quarters of complaints recorded as 'not investigated' were in fact referred internally to a CSSC for assessment and resolution. Recording these complaints as 'not investigated' may be inaccurate as in many of these cases the CSSC may

have actually conducted an investigation or taken some other resolution action after receipt of the complaint.

The department advised investigators that CSSCs do not have access to the complaints management database and are therefore unable to record the outcomes of complaints assessed, investigated and resolved by them.[50] The department explained that once each investigation is finalised, the CSSC is required to advise the regional office of the complaint outcome so it could be recorded on the complaints management database.[51] However, based on the complaint outcomes data provided by the department, as well as the findings of the 2014 audit, it is unlikely this practice is occurring. I am of the view that requiring the CSSC to contact the regional office to ensure a complaint outcome is properly recorded is inefficient, unreliable and vulnerable to multiple errors.

The Carmody Report placed responsibility with the department to accurately record, monitor and report on complaints received and complaint trends. In my view, the department is not currently in a position to gather or report on this information with any accuracy. Without the complaint outcomes from CSSCs recorded as part of the department's complaints data, the data is incomplete, making it impossible to identify trends and potential systemic issues.

The Public Service Act requires all departments to establish and implement a system for dealing with customer complaints.[52] Since 1 July 2014, s.219A(3) of the Public Service Act has required that by 30 September after each financial year, departments must publish the following information for the financial year on their websites:

- the number of customer complaints received by the department in the year
- the number of those complaints resulting in further action
- the number of those complaints resulting in no further action.

Accordingly, many of the recommendations made as a result of the 2014 audit addressed necessary improvements to the department's complaints management system, including:

- enhancing the department's systems for monitoring the effectiveness of its complaints management system
- clarifying the scope of the complaints policy and procedure with regard to what constitutes a 'minor issue'
- ensuring adequate recording of complaints data across all levels of the department
- utilising complaints data to enhance service delivery by identifying trends and systemic issues
- promoting and assisting a child friendly complaints process
- ensuring accountability by publicly reporting on its complaints data.

It appears that the department has not yet enhanced its complaints management system to facilitate compliance with the reporting requirement under the Public Service Act.

Opinion 2

For complaints received during 2014-15 the department is unable to fully comply with the obligations imposed by s.219A(3) of the Public Service Act, requiring the department to publicly report on its complaints data annually, as it is unable to accurately identify and record all child safety complaints it received or the number of complaints which required further action or no further action. This is unreasonable adminstrative action for the purposes of s.49(2)(b) of the Ombudsman Act.

[50] Meeting between Ombudsman officers and departmental officers on 9 December 2015.
[51] Meeting between Ombudsman officers and departmental officers on 9 December 2015.
[52] *Public Service Act 2008*, s.219A.

Department's response

In response to the proposed report the Director-General advised:

> The department accepts this opinion – in part.
>
> A process is in place whereby the Regional Directors have agreed that all complaints are to be managed at a regional level, by the Senior Advisor with support provided by the CSSC Manager. This will ensure [the complaints management database] is used to record all complaint data and that consistent processes are practiced across all regions and the Central Complaints Unit.
>
> A suite of [complaints management database] reports are currently being tested by the regions with public reporting of complaints data due to commence in September 2015 via the DCCSDS Annual Report and will include the information required by the Public Service Act 2008:
>
> - The number of customer complaints received by the department in the year
> - The number of those complaints resulting in further action (these will be those complaints that have recommendations attached in [the complaints management database])
> - The number of those complaints resulting in no further action (these will be those complaints that do not have recommendations attached).
>
> Given the change to the way complaints are being managed between the region and the service centre, the department is confident that complaints are being entered into [the complaints management database]. Therefore, the department is of the opinion that it can accurately count the total number of complaints received.
>
> In terms of counting the subset numbers required under the PS Act the department is not confident that it can accurately count these subset numbers for 2014-15. This is mainly due to regions not consistently entering complaint recommendations into the department's [complaints management database] system.
>
> The department is currently retraining staff on the use of the recording of recommendations that provide the information regarding action/no further action so that it can confidently count accurately the two subsets of information required under the PS Act, in 2016-17.
>
> *Departmental action to address the proposed opinion*
>
> 1. Complaint workflow diagrams are currently being developed to document processes to be used for complaint management across the department.
>
> 2. Guidelines and training instructions are also under development to support the new workflows, including the correct use of recording recommendations. SharePoint [complaints management database] reports are being tested by the regions.
>
> 3. Complaints data reporting as required by the PSA 2008, has been developed for 2014/15. Data for 2014-15 is now available on the Department's website. This data will be included in the September 2015-16 Annual Report and will appear on an annual basis – with 3 year trends shown.

I note the Director-General's advice that complaints are to be managed at the regional level with support provided by CSSC managers. This appears to be in contrast with the previous process where complaints were managed at the CSSC level with actions and outcomes reported to regional offices for recording on the complaints management database. As identified in this report, I am of the view that the previous process was inefficient, unreliable and vulnerable to multiple errors. Accordingly, I welcome the new process as advised by the Director-General, and look forward to receiving information about how the process will work in practice.

The Director-General has advised that guidelines and training instructions are under

development to support the new complaints management process. As part of any guidelines and training instructions developed, the department should ensure they clearly outline:

- ***the processes for referring complaints received by CSSCs to the regional office for action***
- ***how the department will distinguish between minor issues that can be resolved through the casework process at CSSCs and more significant issues that should be addressed as a complaint through the department's complaints management system.***

Since the proposed report was provided to the department, complaints data for 2014-15 has been published on the department's website as required by s.219A(3) of the Public Service Act. The Director-General has advised that while the department is confident that the published number of complaints received is correct, it is not confident that the published number of complaints requiring no further action and complaints requiring further action are correct.

Despite this publication, I remain unable to have confidence in the accuracy of the published complaint numbers for 2014-15. Specifically, the department has reported on its website that 1,587 complaints were received during 2014-15.[53] However, during this investigation, the department advised that 1,295 complaints had been received about the department's child safety functions during 2014-15. This means that only 292 complaints were received about the department's disability services and communities' functions. These numbers appear inexplicably low.

In addition, and as discussed in this chapter, in my view the department's recorded complaints numbers for 2014-15 are not reliable as complaints received by CSSCs were not consistently or accurately recorded on the complaints management database. While the department's reforms to its complaint processes as outlined above may mean that the 2015-16 complaints data is more reliable, this was not the case during 2014-15.

To acknowledge the changes the department has made to its complaints management processes at the CSSC and regional level and how this may affect the management of complaints data going forward, I have amended Opinion 2 to focus on the department's 2014-15 complaints data.

Recommendation 1

The Director-General take all necessary steps to ensure that all complaints, including those managed by CSSCs, are appropriately captured, managed and reported in departmental complaints data.

Department's response

In response to the proposed report the Director-General advised:

> The department accepts this recommendation. All complaints data needs to be recorded in the departmental [complaints management database] and processes have been improved between regions and service centres to ensure that data is appropriately captured at the regional level in [the complaints management database] as described in the response to Opinion 2.
>
> Regional Directors have agreed that all complaints are to be managed at a regional

[53] Department of Communities, Child Safety and Disability Services, Complaints Received during 1 July 2014 to 30 June 2015, https://www.communities.qld.gov.au/resources/about/complaints/dccsds-complaints-data.pdf, accessed 25 May 2016.

level, by the Senior Advisor with support provided by the CSSC Manager. This will ensure [the complaints management database] is used to record all complaint data.

Departmental action to address the proposed recommendation

- Complaint workflow diagrams are currently being developed to document processes to be used for complaint management across the department.
- Guidelines and training instructions are also under development to support the new workflows.

I note the Director-General's acceptance of this recommendation. During implementation of this recommendation I suggest that the department have regard to my comments in response to Opinion 2 above.

Inconsistent and illogical complaint information

While the department has advised that it is moving towards ensuring that the complaints management database is installed in all CSSCs, this will only address part of the problem. There is also significant work required to address how the department currently records complaint outcomes in the complaints management database. Analysis of the department's data during this investigation revealed inconsistencies in the complaint outcome options available in the complaints management database.

There are two tiers of complaint outcomes that the department must record in the complaints management database:

1. The primary complaint outcome, which is the outcome achieved following the department's assessment of a complaint
2. The secondary complaint outcome, which is the action taken with respect to the primary complaint outcome.

The most significant concern with the data provided by the department in relation to primary and secondary complaint outcomes is the apparent inconsistent and illogical complaint outcome options. This issue is best illustrated in the following table which represents the primary and secondary complaint outcome options available in the complaints management database to departmental officers.

Primary complaint outcome recorded	Secondary complaint outcome recorded
Information not available	Ongoing Investigation
Not Investigated	Apology
	Change in Case Management
	Information provided
	Ongoing Investigation
	Out of scope of the complaints management policy
	Referred to CSCU
	Referred to CSSC
	Referred to more appropriate Agency
	Referred to Region
	Unable to contact complainant
	Use of another Intervention
Not Substantiated	Apology
	Information provided
	Referred to CSCU
	Referred to CSSC
	Referred to more appropriate Agency

Primary complaint outcome recorded	Secondary complaint outcome recorded
	Referred to Region
	Unable to contact complainant
	Use of another Intervention
Partially Substantiated	Information provided
	Referred to CSSC
	Referred to Region
Substantiated	Apology
	Information provided
	Referred to CSSC
	Referred to Region
Unable To Determine	Information provided
	Ongoing Investigation
	Referred to CSSC
	Referred to Region
	Unable to contact complainant
Unable To Substantiate	Information provided
	Referred to CSSC
	Referred to Region
	Unable to contact complainant

Specifically, I am concerned that:

- An apology is recorded as being a specific outcome for complaints which had recorded outcomes of 'not investigated' and 'not substantiated'. It is not clear why the department would provide an apology, which is essentially a rectification action, for complaint matters which were not investigated or not substantiated.
- The specific rectification outcomes of 'change in case management', 'ongoing intervention' and 'use of another intervention' have been recorded for complaints which had a primary outcome of 'not investigated'. Again these appear to be rectification actions and it is not clear how the department was able to reach such a conclusion for matters where no investigation action occurred.
- A significant number of complaints (72%) have an outcome recorded of internally referred, either to the CSSC, the regional office or the CCRU. Firstly, it is not clear why complaints that were recorded as 'not substantiated' were also referred to a CSSC or regional office. Secondly, an internal referral to another part of the department to more appropriately deal with the complaint should not be recorded as a complaint outcome. An internal referral may be an action carried out as part of an assessment, but it provides no benefit or outcome for a complainant.
- There is a lack of clarity about the difference between 'unable to determine' and 'unable to substantiate'.

In my view, complaint outcomes should reflect whether the complaint was substantiated and what rectification action was taken, or why a complaint was not substantiated (or not able to be substantiated), and the reasons for this outcome.

It is not possible for the department to gather or report on accurate and measurable complaints data if officers are not able to enter logical and meaningful results into its complaints management system. Ultimately, the quality of the department's complaints data will only ever be as good as its data recording system.

Summary

Having regard to these issues, I have significant concerns regarding the accuracy and integrity of the department's current complaints data. It is clear that the reported data captures only a proportion of the complaints received by the department given the number of complaints received by CSSCs. Further, it is clearly not a reliable record for the complaints it

does capture considering such a high proportion are referred to CSSCs with outcomes not captured.

I acknowledge that the department is reviewing the current structure of its complaints management database to identify improvements as part of its Complaints Management Transformation Project. However, as these issues were identified in the 2014 audit, it is disappointing that they still have not been addressed two years later.

In reviewing the current structure of the complaints management database, the department should conduct a full review of all data fields as part of this process, having regard to the nature of the data the department needs to gather to meet its reporting requirements. This, coupled with the rollout of the complaints management database to CSSCs and appropriate training of staff in the use of the database, will be a big step toward achieving accurate and consistent complaints data.

Recommendation 2

The Director-General take all necessary steps to ensure:

- a full review of data fields for the department's complaints management database is conducted and relevant categories aligned to the department's core business practices and best practice complaints handling process
- appropriate training is provided to all departmental officers with complaints handling responsibilities.

Department's response

In response to the proposed report, the Director-General advised:

> The department accepts this recommendation and is currently reviewing the [complaints management database] and the training that will be required to support the system.
>
> After further discussion within the department, it has been agreed that Regional Offices will be responsible for recording of ALL complaints, the CSSC's will not be responsible for entering data into [the complaints management database]. This will ensure that data integrity, complaint classification and complaint management is consistently applied across the department, and service centres will assist in the resolution of complaints, but not be considered the manager of the complaint.
>
> *Departmental action to address the proposed recommendation*
>
> - The department is looking to make significant changes to the [complaints management database] system to ensure that it is a simpler more user friendly tool to use in the management of complaints.
> - In the interim the data fields identified by the QO will be reviewed and consolidated in order to provide more meaningful data.
> - A training manual for [the complaints management database] is under development for the current system. When the new [complaints management database] is rolled out this training manual will be revised as part of the Training packages to support the use of the system.

I note the Director-General's acceptance of this recommendation.

Chapter 6: Lack of coordination between agencies

One of the most concerning issues identified during the investigation was the apparent lack of coordination between the department and the OPG regarding how each agency manages child safety complaints following the reforms implemented after the Carmody Report. One particularly relevant example of this lack of coordination is how the OPG and the department manage the significant number of issues raised by Community Visitors. This issue arose out of meetings between investigators and the nominated representatives of both the department and the OPG to discuss how child safety complaints were managed by both agencies.

In 2014-15, Community Visitors logged 11,520 issues as a result of their visits to children placed in out-of-home care.[54] Considering the high number of issues identified by Community Visitors regarding children in the child safety system, it is essential that there is significant coordination and collaboration between the OPG and the department regarding how each of these issues is dealt with and resolved to ensure that those issues that constitute complaints are appropriately captured.

Unfortunately, despite the restructure of the public sector child safety complaints system commencing in July 2014, there still appears to be a lack of coordination between the department and the OPG. During a meeting with representatives from the OPG, my officers were informed that OPG officers had last met with the department in January 2015 to discuss information exchange and complaint referral protocols for child safety matters.[55]

From discussions with agency officers it was clear that there were significant areas of confusion between the agencies and a lack of agreement over key issues. I am disappointed that following the recommendations made in the Carmody Report, there has not been closer liaison between these two key agencies, particularly given the significance of their respective roles in the reformed public sector child safety complaints system.

As a result, I am concerned that many issues identified by Community Visitors may reach the threshold to be considered a child safety complaint but are not recognised or assessed as such by either the OPG or the department.

The OPG's policy 'Making complaints to other agencies' provides that wherever possible, Community Visitors should attempt to locally resolve issues with the department or relevant service provider. If local resolution is unsuccessful, the matter can be escalated to managerial level, and finally to the executive level of the department or relevant service provider.

However, considering that Community Visitors raised 11,520 issues in 2014-15 of varying degrees of seriousness, it is not clear how the OPG distinguishes between issues which are minor in nature and can be resolved informally with the relevant caseworker at the CSSC, and issues which are more serious and properly described as a child safety complaint. The OPG has advised that it does not have a policy to determine when an issue raised by a Community Visitor is serious enough to be classified as a complaint rather than a lower level minor issue.[56] It appears that issues are simply raised informally by Community Visitors with caseworkers at CSSCs and then escalated to the CSSC Manager or regional level if the matter is unable to be resolved.

This has consequences for how the department handles issues referred by the OPG. As identified by the 2014 audit, issues raised with CSSCs that meet the threshold of a complaint under the department's procedure are often categorised as 'minor issues' by CSSCs and addressed by way of case management rather than under the department's complaints management system. As the majority of OPG matters are handled by CSSCs, it is likely that

[54] Office of the Public Guardian, Annual Report 2014-15, p.21.
[55] Meeting between officers of the Ombudsman and the OPG on 22 February 2016.
[56] Meeting between officers of the Ombudsman and the OPG on 22 February 2016.

this is how most OPG matters are addressed. There is minimal evidence in the department's complaints data to establish that any OPG matters are handled as complaints.

Accordingly, it seems likely that potential matters which would otherwise meet the threshold of a child safety complaint are not being identified or assessed as a complaint by the OPG, and following referral to CSSCs, are also not being identified or assessed as a complaint by the department. These complaint matters are also not being captured in the department's complaints data, potentially resulting in the department significantly under-reporting complaint numbers.

To address this situation, there needs to be greater coordination between the department and the OPG regarding:

- the development of an agreed complexity and severity level for when a matter is considered a complaint by the OPG and must be actioned under the department's complaints management system rather than case managed
- an agreed process for how complaints are to be managed by the department when referred by the OPG, including Community Visitors
- communication and training of relevant officers of both agencies in this process
- the development of comparable fields by the department and the OPG in their respective electronic databases, for accurate recording and reporting on complaints received by the OPG and referred to the department.

In developing an agreed complexity and severity level for when a matter is considered a complaint, both agencies should consider the following definition of a complaint in the Australian and New Zealand Standard, *Guidelines for complaint management in organizations*:[57]

> [An] Expression of dissatisfaction made to or about an organization, related to its products, services, staff or the handling of a complaint, where a response or resolution is explicitly or implicitly expected or legally required.

In my view, this lack of coordination is having a significant impact on the data integrity of the department's child safety complaints management system. Better coordination between the department and the OPG should result in improved consistency in how child safety complaints are managed between the agencies and ultimately ensure the publicly available complaints data provides a more accurate reflection of the functioning of the child safety system.

Improved consistency between agencies and improved data integrity should also result in more accurate trends in complaints received across the child safety system.

Opinion 3

The department and the OPG have not yet established appropriate protocols to determine when child safety issues identified by the OPG should be referred to the department to be managed by way of casework, or when such child safety issues should be categorised as a complaint and managed by the department through its complaints management system. This is unreasonable adminstrative action for the purposes of s.49(2)(b) of the Ombudsman Act.

Department's response

In response to the proposed report, the Director-General advised:

> The department does not accept this opinion. During 2015 there was considerable consultation with the OPG due to the QCPCOI [Queensland Child Protection

[57] Australian and New Zealand Standard AS/NZS 10002:2014, *Guidelines for complaint management in organizations, p.6.*

Commission of Inquiry] recommendations, and the OPG was represented on the Child Friendly Complaints working party up until October 2015. In December an email was sent to all participants in the working party, closing the work of the group and thanking them for their input.

After confirmation with several of our regions, OPG matters, in particular the Community Visitor matters are dealt with according to the DCCSDS complaints management policy and procedure. The regions confirmed that most matters are issues dealt with through regular case work and are not classified as complaints by the department. Issues that can be managed through case management is the preferred option, however if this is unable to occur the matter is treated as a complaint and recorded in [the complaints management database].

Consideration will be given to adding in a referral field to ICMS [Integrated Client Management System] and [the complaints management database] to capture that the issues or complaint has been referred by OPG.

To date there have been 8 meetings with the Child Friendly Complaints Working Party from September 2014 through to July 2015 to work through ways in which the department could make it easier for children and young people to make complaints easier. There were three OPG officers who were nominated to attend. Two Officers regularly attended the meetings with three exceptions.

Departmental action to address the proposed recommendation

The department will continue with the relationship established with the OPG and ensure they are aware of how matters are dealt with according to the DCCSDS complaints management policy and procedure.

OPG's response

In response to the proposed report, the Acting Public Guardian advised:

Since commencing operation on 1 July 2014, the OPG has focused on a number of fundamental priorities in response to implementing recommendations arising from the Queensland Child Protection Commission of Inquiry. These included:

Stage 1: 1 July 2014 to 30 Jun, 2015

- merging the community visitor (child) program of the former CCYPCG with the former Office of the Adult Guardian to form the OPG
- refocusing its community visitor program to prioritise visits to the most 'vulnerable' groups of children and young people in out-of-home care and taking on an enhanced advocacy role
- the rollout of the OPG's refocused visiting and advocacy service delivery model which includes delivery through a mix of four physical OPG offices and a centrally based state-wide virtual access point (for example, via telephone and email).
- recruiting a suitable workforce to respond to OPG's refocused child visiting and newly established child advocacy functions, including a professional team of lawyer-child advocates dedicated to protecting the rights and interests of children in the child protection system, and providing them with a 'voice' in key decisions making forums such as in case planning and family group meetings, QCAT and Childrens court matters, and
- developing OPG's Strategic Plan and key performance indicators.

Stage 2: 1 July 2015 – present

- amalgamation of the adult and child visiting programs to achieve greater efficiencies
- developing and refining OPG's practice frameworks for both its CVS and lawyer-child advocates (OPG's legal services) in adherence to its statutory functions
- commencing work on developing a risk management framework
- establishing Memorandums of Understanding (MOU)/Protocols with key stakeholders including the department
- commencing the development of a suite of policies, procedures and best practice guidelines to support delivery of its visiting and child advocacy functions and good decision making.

> Initial work commenced in 2015 in relation to OPG developing its process for identifying and referring issues to the department under its complaints management system. Further, it has also been identified that there is a need for a dedicated officer within the community visitor program to develop key policies and procedures for CV staff. The OPG is in the process of recruiting a dedicated Senior Policy and Practice Officer to the [Community] Visiting program to assist with development of practice and procedures specifically for the CV program, and to work with other practice areas to ensure coordination of practice within the OPG. In light of this, OPG's visiting and child advocacy programs are well placed to progress the work identified under proposed opinion 3.

The Director-General appears to have misunderstood the intent of my proposed Opinion 3.

Proposed Opinion 3 relates specifically to the lack of appropriate protocols regarding how child safety complaints raised by the OPG are referred to and managed by the department. With regard to this specific issue, I note that the Director-General advised in his response that 'OPG matters, in particular the Community Visitor matters … are issues dealt with through regular casework and are not classified as complaints by the department. Issues that can be managed through case management is the preferred option, however if this is unable to occur the matter is treated as a complaint and recorded in [the complaints management database].' I do not agree with this statement.

As discussed in this chapter, while it may be appropriate for many lower level issues referred by Community Visitors to be managed by the department through regular casework, there needs to be an agreed process to determine at what threshold an issue identified by a Community Visitor should be considered a complaint and recorded as such, regardless of how it is resolved. There was no evidence of such a process during the investigation and it is to address this issue that greater collaboration and coordination is needed between the department and the OPG. I have addressed this issue in Opinion 3 and Recommendation 3 below.

For the sake of clarity, I note that whether an issue is properly considered a complaint should not depend on how quickly it is resolved, or the structured level at which resolution occurs.

It is also important to consider, as identified in Chapter 4, that the lack of an agreed process to determine when an issue identified by a Community Visitor should be recorded as a complaint likely explains a large proportion of the decrease in child safety complaint numbers following the closure of the CCYPCG. While a significant proportion of the CCYPCG's complaint numbers were issues internally referred by Community Visitors for complaints resolution, this process is no longer possible as the OPG has no complaint resolution powers. The process now relies on the OPG identifying that an issue raised by a Community Visitor is of sufficient seriousness that it should be recorded as a complaint and then referring it to the department (or other relevant agency) to be managed and resolved.

However, it is also necessary that the department record these issues referred by the OPG as a complaint and manage them through the complaints management system, with all actions being recorded on the complaints management database. I note that neither the department nor the OPG was able to identify a single issue raised by the Community Visitors that was considered to be a complaint. Should the department and the OPG manage to address this issue, a more accurate reflection of child safety complaint numbers should be available in future years.

Finally I note the response provided by the Acting Public Guardian, particularly the work that is ongoing to improve referral processes regarding issues identified by Community Visitors. I agree that such work is necessary.

I have amended Opinion 3 to further clarify my intention with regard to this issue.

Recommendation 3

The Director-General and the Public Guardian establish a protocol relating to how child safety issues raised by the OPG are to be managed by the department. At minimum, the protocol should establish:

- an agreed complexity and severity level for when a matter is considered a complaint made to the department by the OPG and must be actioned under the department's complaints management system rather than case managed as a minor issue
- an agreed process for how complaints are to be managed by the department when referred by the OPG
- communication and training of relevant officers of both agencies in this process
- the development of comparable fields by the department and the OPG in their respective electronic databases, for accurate recording and reporting on complaints received by the OPG and referred to the department.

Department's response

In response to the proposed report, the Director-General advised:

> The department accepts this recommendation – in part.
>
> The protocol used to deal with OPG complaints is already established within the DCCSDS complaints management policy and procedure, and will be applied consistently as in all other complaints.
>
> The department's process for all matters is to manage this as close to the first point of contact as possible, which means that anything referred by a client including OPG, will try to be resolved through case management in the first instance.
>
> If the department is unable to manage the matter referred by the OPG as an issue, via case management, the OPG will be advised that it will be managed as a complaint, using the DCCSDS complaints management classification, regarding complexity and severity and the OPG will be kept informed of progression of the complaint, as per our current process.
>
> DCCSDS will ensure that the OPG is aware of the process used to manage complaints, and provide support to the OPG in the training of their staff.
>
> As advised above, consideration will be given to adding in a referral field to ICMS and [the complaints management database] to capture that the issues or complaint has been referred by OPG. DCCSDS will discuss with OPG possible changes to their database to include a field for any referrals made to DCCSDS.
>
> *Departmental action to address the proposed recommendation*
>
> DCCSDS will liaise with OPG to ensure that their staff are aware of the DCCSDS complaints management process and how it is applied.
>
> Further the department will ensure that complaints which are referred from the OPG are appropriately captured in the department's [complaints management database] and ICMS systems.

OPG's response

In response to the proposed report, the Acting Public Guardian advised:

Supported.

It is proposed that OPG will progress this work as a priority.

It is noted that this MOU could include the development of an agreed complexity and severity level for when a matter is considered a complaint by the OPG, and actioned under the department's complaints management system.

As with any change in practice, appropriate training of all relevant staff would need to be undertaken. This training could be developed by the Visiting Practice team with assistance, and support from OPG's Professional Development Officer. Delivery of the training would be dependent on the type of package developed.

I note the responses provided by the Director-General and the Acting Public Guardian.

With respect to the Director-General's response, the purpose of this recommendation is for the department and the OPG to establish protocols relating to how child safety issues identified by the OPG are to be managed by the department, with a number of minimum requirements.

The Director-General has advised that the department's process is that 'anything referred by a client including OPG, will try to be resolved through case management in the first instance. If the department is unable to manage the matter referred by the OPG as an issue, via case management, the OPG will be advised that it will be managed as a complaint.' I do not agree with this blanket approach in dealing with OPG matters. It may not be appropriate for all issues identified by Community Visitors to be addressed by way of casework in the first instance as some will have already reached the threshold to be dealt with under the complaints management system.

As specified in the recommendation, there needs to be an agreed complexity and severity level for when a matter is considered a complaint by the OPG and must be recorded under the department's complaints management system rather than case managed. This will ensure that the complaint is addressed appropriately under established systems as well as recorded and measured as a complaint by the department.

It is necessary for the department and the OPG to establish a protocol relating specifically to how matters referred by the OPG are managed by the department in order to address this issue.

Chapter 7: Outsourcing of child safety functions

I note that the department has taken the approach of outsourcing some of its functions in relation to child safety services. These functions include the provision of out-of-home care, family and other support services.

It is not within the scope of this investigation to comment on whether such an approach is appropriate or desirable. However, I do note that s.10(c) of the Ombudsman Act extends the definition of 'administrative actions' over which I have jurisdiction to include administrative actions 'taken for, or in the performance of functions conferred on, an agency, by an entity that is not an agency'.

This provision effectively ensures that the Ombudsman's jurisdiction is not excised through the conferral of agency functions on other, non-public entities. Therefore, where the department is conferring its child safety functions on other entities through contracts for service delivery, this Office's oversight extends to how these statutory child safety functions are being exercised by these other entities even if these entities are private businesses or charity organisations.

This is particularly relevant in relation to complaints management. As mentioned in Chapter 2, the Carmody Report noted that:[58]

- parents and carers drop complaints because they are worried they will be targeted as 'troublemakers' by the department and have their matter adversely affected
- the department 'moves to protect itself' in response to complaints
- non-government organisations feel closed out altogether from raising complaints as they perceive that de-funding may result if they challenge the department
- departmental processes and procedures that relate to children in care remain inaccessible outside the department, making it difficult for complainants to know what is expected.

During the investigation, the nature of the existing departmental complaints data meant that I was not able to conduct an in-depth examination of complaint issues. Therefore, the integration between the department's outsourcing of child safety functions and its complaints management processes was not examined in any detail.

However, as a general principle, I consider it the department's responsibility to ensure that any service delivery providers who are performing child safety functions on behalf of the department also comply with reasonable expectations of complaint handling. These will include:

- adequately identifying complaints
- appropriate complaint handling mechanisms
- escalation of complaints through the department's CMS as appropriate
- reporting of complaint numbers, issues and outcomes to the department.

The department must also ensure that service delivery providers are not under-reporting complaints or attempting to prevent their staff from complaining about the department in order to protect their funding from the department. This will include the department embedding the approach that complaints are a valuable mechanism for ensuring the effective operation of the child safety system in Queensland, and ensuring that adverse action is not taken against any individual or service provider for raising complaints with the department.

[58] *Taking Responsibility: A Roadmap for Queensland Child Protection*, p.419.

Recommendation 4

The Director-General take appropriate steps to ensure that all entities providing child safety services on behalf of the department:

- understand the importance of complaints in ensuring the integrity and effectiveness of the child safety system in Queensland
- have adequate internal complaint handling mechanisms in place to receive, identify, record and resolve complaints in a timely way
- escalate serious or complex complaint matters to the department through its complaints management system mechanisms
- report all complaint issues and outcomes to the department on a regular basis.

Department's response

In response to the proposed report, the Director-General advised:

> The department accepts this recommendation – in part.
>
> In regard to final dot point regarding the reporting of complaints to DCCSDS - suggest that NGO's provide evidence that they have a CMS, and monitor this. However, the reporting of complaint issues back to DCCSDS, and how DCCSDS manage this information will need further consideration and possible discussion with the Human Services Quality Framework (HSQF) audit team.
>
> *Departmental action to address the proposed recommendation*
>
> The department will discuss this recommendation with Financial Services Contract management for possible implementation. Further discussion to also occur with HSQF regarding how reporting of complaint issues could be used to assist with audits.

I note the Director-General's response and that further consideration and discussion will occur with the Human Services Quality Framework audit team with regard to the reporting of all complaint issues and outcomes to the department of a regular basis.

However, I consider that the department has the responsibility to gather and report on all child safety complaints in Queensland that relate to publicly delivered child safety services. Outsourcing of child safety functions does not remove any complaint issues from oversight or reporting obligations.

Chapter 8: Conclusion

The purpose of commencing this investigation was to determine whether the department's child safety complaints processes are operating effectively, having regard to the significant reforms following implementation of the recommendations made in the Carmody Report. To this end, I gathered data from the key agencies in the former and current child safety system, including the department, the OPG, the former CCYPCG and the Ombudsman.

As part of this report, I had intended to comment on the characteristics of child safety complaints dealt with by the department, including the type of complaints received, how they were actioned and what outcomes were achieved. However, based on the quality and coding of the data provided by the department it has not been possible to comment on these issues with any confidence.

Overall, I have significant concerns with the accuracy of the complaints data provided by the department. This investigation made it clear that the majority of complaints resolution work occurs within CSSCs, without CSSCs having access to the department's complaints management database. As a consequence the department is not able to accurately report on:

- the number or type of complaints dealt with by CSSCs
- the outcome of complaints dealt with by CSSCs
- timeframes for resolving complaints dealt with by CSSCs.

It was also clear that CSSCs do not consider many of the issues they deal with as a 'complaint' as commonly understood and defined by the Australian and New Zealand Standard. Rather, they are categorised and actioned as minor issues and then dealt with by officers through their regular client interaction. These issues are unlikely to be included as part of the department's complaints data.

Accordingly, in my view, the department's complaint records are not reliable, do not reflect the broad nature of complaints received and are not able to be used to effectively report on complaint outcomes. As a consequence, I have doubts that the department is able to adequately comply with s.219A(3) of the Public Service Act requiring the public reporting of complaints data following the end of each financial year.

Many of the issues regarding the integrity and accuracy of the department's complaints data were highlighted to the department following the 2014 audit. I am disappointed that nearly two years after the department was provided with recommendations to address these issues, little progress is apparent.

There may also be questions about whether the public can have confidence in the public sector child safety complaints system given the data shows a significant decrease in child safety complaint issues received across all relevant agencies following the closure of the CCYPCG. The Carmody Report recommended that the department take responsibility for investigating child safety complaints which were previously assessed by the CCYPCG, through its complaints management process.[59] I would therefore have expected to see the department's complaint numbers rise significantly after July 2014.

While the decrease in complaint numbers can partly be explained by jurisdictional changes, this investigation also identified significant concerns regarding the adequacy of recording processes within and across agencies. Issues raised by OPG Community Visitors, which were previously recorded as complaints by the CCYPCG, appear to be largely raised at the CSSC level without being recorded as a child safety complaint by either the department or the OPG. The OPG has advised that it does not have a policy about the classification of

[59] *Taking Responsibility: A Roadmap for Queensland Child Protection*, Recommendation 12.9.

complaints or the escalation of minor issues to complaint status when these issues cannot be locally resolved.[60]

In my view, the department is not adequately and effectively capturing and coding complaints about child safety issues so that trends can be monitored and proactively addressed. In addition, differences in how the department and the OPG define and record child safety complaints mean that the resulting data is of limited use for cross-agency analysis or to produce an overall picture of the child safety system. Such analysis is necessary to inform both the effective functioning of the QFCC and my oversight of the child safety complaints system going forward.

In my view, there should be a coordinated approach between the department and the OPG in capturing child safety complaints data so that trends and systemic issues are easily identified. This information should be made available to the QFCC as it will inform its reporting requirements regarding the performance of the child safety system in Queensland.

Opinion 4

There should be a coordinated approach between the department and the OPG in capturing child safety complaints data so that trends and systemic issues are easily identified.

Department's response

In response to the proposed report, the Director-General advised:

> The department accepts this opinion and will work with the OPG to develop a coordinated approach to ensure trends and systemic issues are easily identified.
>
> *Departmental action to address the proposed recommendation*
>
> DCCSDS will liaise with relevant OPG staff to establish a coordinated approach to the capture of child safety complaints.

OPG's response

In response to the proposed report, the Acting Public Guardian advised:

> Supported in principle. However, it is noted that the ability to fully coordinate the capturing of relevant data may be limited by inherent differences between the data collecting systems operated by the OPG and the department.
>
> The OPG is agreeable to working collaboratively with the department to coordinate the capturing of child safety complaints data, so that trends and systemic issues are easily identified. As noted above, the OPG proactively shares its issues data with QFCC which has systemic oversight responsibility in relation to service delivery to children and young people in the child safety system to assist it in the identification of trends and systemic issues.

I note the responses from the Director-General and Acting Public Guardian. I also note that the need for a coordinated approach does not inherently require the use of the same data collecting system, but that the collection of similar data is necessary to give the public confidence in the effective operation of the child safety complaints system in Queensland.

[60] Meeting between officers of the Ombudsman and the OPG on 22 February 2016.

Data collection and public reporting requirements

In 2014, s.219A(3) was added to the Public Service Act requiring that each department publish the following information for the previous financial year on its website by 30 September each year:[61]

- the number of complaints received by the department
- the number of those complaints resulting in further action
- the number of those complaints resulting in no further action.

It was clear during this investigation that the department had failed to comply with the requirement to publish its 2014-15 complaints data on its website. Following receipt of my proposed report in April 2016 the department did publish its 2014-15 complaints data and it is currently available on the department's website.[62]

Opinion 5

The department did not publish its complaints data for the 2014-15 financial year by 30 September 2015 in accordance with the requirements of s.219A(3) of the Public Service Act. This is administrative action taken contrary to law for the purposes of s.49(2)(a) of the Ombudsman Act.

Department's response

In response to the proposed report, the Director-General advised:

> The department accepts this opinion and has published the 2014-15 results via the department's website.
>
> *Departmental action to address the proposed recommendation*
>
> The 2014-15 data has been published via the department's website and processes have been put in place to ensure that this information will be available in future years by 30th September.

I note that the department's 2014-15 complaints data has now been published on the department's website. I have concerns regarding the accuracy of this data as outlined in Chapter 5 of this report.

Therefore, I have amended my opinion to focus on the department's non-compliance with the requirement under s.219A(3) of the Public Service Act to publish its complaints data by 30 September 2015.

To ensure that the department is able to meet its obligations under the Public Service Act, as well as meet the Australian and New Zealand Standard, *Guidelines for complaint management in organizations* regarding issues such as data collection, analysis and reporting of complaint information, the department needs to consider:

- establishing who is responsible within CSSCs for receiving, actioning and recording complaints
- providing appropriate training for all officers within CSSCs with complaint handling responsibilities
- ensuring fields on the complaints management database are logical, consistent and provide an accurate method for recording complaints data that the department needs to report on

[61] *Public Service Act 2008*, s.219A(3).
[62] See https://www.communities.qld.gov.au/resources/about/complaints/dccsds-complaints-data.pdf.

- determining when a matter is a complaint, and must be managed under the complaints management process, rather than a minor issue that can be managed as part of normal casework processes
- greater collaboration and coordination with the OPG regarding reaching consensus on when a matter referred from OPG constitutes a complaint, and when a matter can be managed as part of normal casework processes.

In this report, I have noted the importance of the department analysing the child safety complaints it receives in order to:

- evaluate and measure the performance of the child safety system
- identify trends in complaint issues
- identify potential systemic issues requiring rectification
- publicly report on complaints data as required by s.219A(3) of the Public Service Act.

In my view, based on the quality and reliability of complaints data which is currently available, the department is unable to effectively achieve any of these objectives. This is a significant concern which requires urgent action.

I acknowledge that the department has indicated it is addressing many of these issues through its ongoing Complaints Management Transformation Project. However, it has been almost two years since both the Carmody Report and the 2014 audit were provided to the department and little progress appears to have been made to ensure there is a robust public sector child safety complaints system in place.

Recommendation 5

The Director-General ensure that the department take steps by 30 September 2016 to establish a system where the department is able to accurately:

- evaluate and measure the performance of the child safety complaints management system
- identify trends in complaint issues
- identify potential systemic issues requiring rectification
- publicly report on complaints data as required by s.219A(3) of the Public Service Act.

Department's response

In response to the proposed report, the Director-General advised:

> The department accepts this recommendation – in part and provides the following timeframes:
>
> **Evaluate and measure the performance of the child safety complaints management system**
> **Identify trends in complaint issues**
> **Identify potential systemic issues requiring rectification**
> - The revised complaints management policy, procedure, workflows and guidelines for the accurate recording of complaints by regions will come into effect from 1st July 2016. This will include training to all staff, involved in the management of complaints.
> - The evaluation and measurement of child safety complaints to determine the performance of the child safety complaints management system will not adequately reflect trends or systemic issues until at least 30 June 2017 i.e. until 12 months of accurate and reliable data has been recorded
>
> **Publicly report on complaints data as required by s219A(3) of the *Public Service Act 2008***
> - The 2014-15 data has been published via the department's website and will be available in future years by 30th September via the department's Annual Report and

the department's website.

Departmental action to address the proposed recommendation

1. Evaluate and measure the performance of the child safety complaints management system

- Release the DCCSDS Complaints Management Policy, Procedure, workflows and guidelines by 1st July 2016
- Provide training to all staff management [sic] complaints as per the new policy, procedure, workflows and guidelines
- All complaints referred to CSSC's, including referrals from OPG, will be recorded and managed at the Regional level to ensure that performance of the child safety complaints management system can be effectively evaluated and measured.
- Discussion with IT to occur regarding recording of issues in ICMS
  - To determine if referrals from OPG, that are assessed as issues and require case management can be recorded for reporting purposes in ICMS
  - To determine if there can be any linkage between ICMS and [the complaints management database] for reporting purposes.

2. Identify trends in complaint issues

- A comprehensive suite of reports and information is being developed that will provide trend analysis of the performance of the department's Complaints Management System.
  - Effective from July 2016 Monthly SharePoint reporting will commence from [the complaints management database] and provided to Senior Advisors to share with Regional Directors and Regional Executive Directors.
  - Effective from October 2016 Quarterly reports will be produced by the Central Complaints Unit, with consolidated analysis from regions and provided to the Service Delivery Leadership Forum.
  - Quarterly focus reports will be produced where reports identify areas of concern and will be discussed with Regions to identify opportunities for improvement.

3. Identify potential systemic issues requiring rectification

- The revised procedure states clearly that RD's [Regional Director] or equivalent are to review all operational or systemic recommendations and if accepted to provide timeframes for implementation.
- The recommendations tab in the [complaints management database] system is being reviewed to ensure follow up and closure, with evidence of all open recommendations.

4. Publicly report on complaints data as required by s.219A(3) of the *Public Service Act 2008*

- Complaints data will be reported through the department's Annual Report in September each year and via the department's website.

I note the Director-General's response. I acknowledge that the department's ability to identify trends in complaint issues will take some time to rectify due to the absence of accurate and reliable complaints data in preceding years. Consistent with the Director-General's comments on timeframes, I have slightly amended the recommendation.

I anticipate that, as part of my obligations to oversee the proper functioning of the child safety complaints system, I will conduct a further review of the department's complaints processes once sufficient time has passed to determine whether these changes have occurred.