Child Safety
Commission of Inquiry

Zelma's story

Disclaimer: *This is the story of a person who shared their personal experience with the Commission of Inquiry through a submission or interview. The names in this story are pseudonyms and identifying details have been removed. The person who shared this experience may not have been a witness and their account is not evidence. They did not take an oath or affirmation before providing the story.*

Nothing in this story constitutes a finding of fact by the Commission of Inquiry. Instead, these stories have been published to show how people are experiencing the current child safety system in Queensland. Any views expressed are those of the person who shared their experience, not of the Commission of Inquiry.

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Executive Summary

This submission concerns the removal of seven children from their mother, and the subsequent systemic practices that prevented the maintenance of meaningful family relationships over many years.

From a support coordination perspective, this case demonstrates repeated and sustained use of statutory power that resulted in prolonged family separation, cumulative trauma, and the erosion of parent–child and sibling relationships, without a genuine, transparent, or achievable pathway to reunification.

Key observations include:

- All seven children were removed, and over time each child was subjected to periods of complete contact suspension or highly restricted contact with their mother, frequently for extended periods exceeding 12 months.
- Despite the mother's ongoing engagement, completion of therapies, educational programs, parenting programs, and repeated requests for clarity around reunification requirements, meaningful contact was routinely prevented, delayed, or reversed, even after demonstrated progress.
- It has frequently required the mother to lodge QCAT proceedings in order to prompt any movement at all in contact arrangements.
- The case also reveals coercive conduct by departmental staff, including the mother was pressured to withdraw tribunal proceedings in exchange for the prospect of increased contact with her children, reflecting an abuse of power and obstruction of independent oversight.
- Despite children repeatedly expressing a clear and consistent desire to reside with their mother, their wishes were only acted upon after they refused to return to foster care and directly communicated to police and Child Safety that they would not leave the mother's home. This process itself caused additional and avoidable trauma.

- Following the traumatic removal of the child from the mother's breast immediately after birth, an isolated incident occurred in which The mother physically assaulted a Child Safety officer; since that event, the department has repeatedly relied on this incident to justify ongoing and escalating restrictions on contact, despite the absence of continuing safety concerns.
- Decisions affecting contact and placement were frequently:
    - Changed without notice
    - Poorly explained or undocumented
    - Made without collaboration with the mother or her support network
- From the perspective of non-statutory professionals involved, relevant Child Safety offices appeared to consistently exercise power in a manner that obstructed, rather than supported, the preservation or restoration of family relationships.
- There was a pattern of punitive and adversarial engagement, where the mother's advocacy, mental health needs, and attempts to seek support were interpreted as risk factors rather than indicators of protective capacity.
- Sibling relationships were repeatedly disrupted, with children placed apart from one another and relocated hours away from their mother, despite well-established evidence regarding the importance of sibling bonds and attachment continuity.
- Most concerningly, this occurred in the context of a known domestic and family violence (DFV) offender, against whom a Domestic Violence Order was in place, and who nonetheless appeared to retain greater access, credibility, and procedural tolerance than the protective parent.
- While the mother's contact was repeatedly restricted, the DFV perpetrator was, at various times, able to maintain contact with children, raising serious concerns about inconsistent risk assessment prioritisation of safety, and gendered power imbalance.
- Despite being eligible for Queensland's Next Step program, which is designed to support young people transitioning from the child safety system, none of The mother's children were referred at the appropriate age of 16; referrals only occurred after advocacy by the NDIS Support Coordinator representing a missed early intervention opportunity that contributed to escalating behaviours and inadequate support prior to adulthood.
- From my documented case notes, interactions with departmental staff were frequently marked by unprofessional and hostile communication, including being spoken to in a demeaning manner, refusals to engage respectfully as equals, deliberate non-responses to emails and phone calls, and repeated instances of being sent on unnecessary "wild goose chases" for information or approvals that ultimately went unanswered or were later denied.

Systemic impact

The cumulative effect of these practices has been:

- Long-term psychological harm to children and parent
- Entrenchment of attachment trauma
- Normalisation of instability, surveillance, and crisis-driven intervention
- Loss of trust in statutory systems designed to protect

From a support coordination standpoint, this case reflects systemic failure rather than individual deficit. The repeated prevention of contact across all seven children, the absence of a genuine reunification pathway, and the apparent imbalance in how risk and power were applied point to structural issues in child protection practice, particularly in cases involving domestic and family violence and parental mental health.