



Paul'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.

Content warning: *Some material may be distressing. These statements may include references to violence, abuse, neglect, exploitation, suicide, or self-harming behaviours, and may contain strong or confronting language. Some narratives may be about First Nations people who have passed away. Readers are encouraged to engage with this material in a way that supports their wellbeing.*

If you would like support, please visit the Commission's Contact & Support page or reach out to a trusted person or a relevant support service.

My partner and I commenced our foster carer journey a couple of years ago, after passing the relevant training and vetting. We were given the responsibility of caring for a baby boy. We care for this boy on a day-to-day basis as he was our own. The biological parents were no longer together.

Over the next few months, we noticed inconsistencies with decision making by Child Safety. We were not confident that some decisions made were in the best interests of the child. We expressed concerns which were either treated as not important or ignored, with some responses received that, for a lack of a better word, would be classified as 'gaslighting'. We also had a lack of communication, transparency, and the relevant home visits from the CSO.

Among the many concerns we had included the failure to let us peruse the Case Plan draft so we could provide feedback prior to its release. The CSO claimed to have consulted with us twice (which did not actually happen) regarding the addition of contact times and days.

We also had some concerns in relation to biological parent interactions, and comments made by the biological parents. We believe the CSO openly mentioned these concerns to the biological parents, affecting our previously positive relationship and causing undue tension towards us.

Additionally, we noticed what appeared to be the lack of bipartisan between the decisions affecting both biological parents. We were later made aware that one parent had made a complaint about the CSO and the Team Leader. It was around this time we noticed an increase in the lack of bipartisan towards the complaining parent.

Child Safety Commission of Inquiry



Due to our belief that the CSO and the Team Leader were unable to affectively make decisions in the child's best interests, we expressed our desire with our foster care agency to move the case to another Child Care Service Centre.

We were later informed by the agency that the Team Leader is the person that makes the decision to approve the change, and that the change would unlikely be approved. We therefore requested through the agency that instead, only the CSO be changed. We did not receive communication about the result until a few weeks later after we enquired about the change. We were told that it was unsuccessful.

A few months later, after experiencing a few more concerning decisions and inadequate behaviour involving the CSO and Team Leader, we decided to make a formal complaint through the QLD Government online complaints website, directly naming the CSO and the Team Leader. A few days later, we discovered that the complaint had actually been sent directly to the Team Leader prior to the awareness of the Child Safety Centre Manager.

In relation to the Incident Reporting process, I believe that by Child Safety failing to protect the identity of the information source, it stops carer's from voicing their concerns and sharing important information. It affects the relationship between the carer and the biological parents. Both results would surely be against the child's best interests.

For an effective complaints system towards staff and to avoid a conflict of interest, perhaps consideration towards the formation of an independent complaints department would be helpful.

To avoid negative systemic behaviour within teams, perhaps consideration to the rotation of Team Leaders within a Centre should be mandatory.