Dirk'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.

To the Commissioners,

My name is Dirk, and I am a [redacted] within the Queensland residential care sector. I am writing to make a formal submission to the Child Safety Commission of Inquiry and to request the opportunity to provide further evidence, documentation, and testimony regarding systemic issues I have observed.

My experience includes senior practice roles across two residential care organisations in Queensland. One of these organisations demonstrated persistent and serious failures in governance, reporting, and safeguarding. The other organisation I worked for maintained strong governance, adhered to mandatory reporting requirements, and demonstrated continuous improvement and compliance. This contrast is significant: it shows that the failures I outline are not inherent to residential care, but are the result of organisational culture, leadership, and governance practices.

The issues I raise below are based on direct professional experience and are supported by documentation and witnesses. They reflect systemic risks that I believe fall squarely within the scope of this Inquiry.

1. Mandatory Reporting Failures and Misclassification of Incidents

Senior staff routinely misclassified Category 1 incidents, discouraged reporting, and provided incorrect advice regarding statutory thresholds. Staff were directed not to report incidents that clearly met mandatory reporting criteria. These practices undermine the integrity of the reporting system and place children at risk.

2. Alteration, Deletion, and Concealment of Incident Information

Incident reports were altered, redacted, deleted, or removed from registers. Information relating to threats of harm, sexualised behaviours, environmental hazards, and restrictive practices was removed. These actions obstruct oversight and may constitute deliberate concealment of harm.

3. Misrepresentation of Staffing Models and Potential Misuse of Funds

Staffing levels reported to Child Safety did not reflect actual practice. Staff were instructed to reduce MOC levels below funded requirements while contingency funding was simultaneously requested. This raises concerns about the accuracy of reporting and the appropriate use of public funds.

4. Inadequate Training and Unsafe Practice Guidance

Training for staff and House Managers was inconsistent, inadequate, and in some cases harmful. Incorrect advice was given regarding mandatory reporting, restrictive practices, and trauma-informed care. This resulted in unsafe decision-making and inconsistent practice across homes.

5. Unlawful Instructions to Administer Chemical Restraints Without Approval

Staff were instructed to administer medication constituting a chemical restraint without the required Regional Director approval. Senior staff demonstrated limited understanding of restrictive practice legislation and dismissed concerns raised by staff. This represents a significant safeguarding breach.

6. Coercion to Manipulate Data and Conceal Non-Compliance

Multiple staff can corroborate that they were pressured to alter documentation, omit information, and present incomplete or inaccurate records to auditors. Staff were told to “make documentation appear complete” and to avoid recording information that would highlight systemic failures. These practices undermine regulatory oversight and may constitute fraud.

7. Obstruction of Practice Oversight

Practice Leads were prevented from attending homes, supporting House Managers, or addressing compliance gaps. Despite this, they were later blamed for deficiencies they were not permitted to correct. This resulted in unresolved safety risks.

8. Psychosocial Safety and Governance Failures

Internal meetings involved intimidation, coercive questioning, and public confrontation by senior leadership. Staff were required to justify their emotional state in front of executives. These practices breach WHS psychosocial safety obligations and suppress the reporting of concerns.

9. Failure to Investigate Serious Allegations Against Senior Staff

When concerns were raised regarding mandatory reporting breaches, coercion, cultural insensitivity, and unsafe advice, the organisation stated it had "no legal obligation" to conduct an external or impartial investigation. No witnesses were interviewed and no independent review occurred.

10. Comparative Experience Demonstrating That Proper Governance Is Achievable

In contrast, my experience with another residential care provider demonstrated:

- Accurate and timely mandatory reporting
- Strong governance and oversight
- Transparent documentation practices
- Continuous improvement and reflective practice
- Proper training in trauma-informed care and restrictive practices
- Ethical leadership and accountability

This comparison highlights that the failures I observed are not systemic to the entire sector, but are the result of organisational culture and governance breakdown.

I believe my experience across two contrasting organisations provides valuable insight into the conditions that enable or prevent harm within residential care settings.

I am willing to assist the Inquiry in any capacity that supports its work.