Child Safety
Commission of Inquiry

Jewell's story

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I am a kinship carer for my nephew, who is 9 months old at the time of writing. His mother, my sister, is a long-term IV drug user (heroin). I contacted the Department when I became aware she was pregnant. The Department commenced investigations and although she was open about her active use of heroin, my nephew was sent home from the hospital with her. The police took custody of him when he was 2 weeks old and my husband and I became his carers. We have no other children.

The Department's staff were openly hostile toward my husband and I for the first 4 months of our relationship with them. The Child Safety Officer (CSO) assigned to our case was a recent immigrant from NZ, and unfamiliar with the Australian system. She appeared not to have had sufficient training and was unable to answer the many questions we had.

Perhaps consequently, her professional stance toward us was one of open hostility. She justified by saying that she "did not know us and could not trust us" until we had proven ourselves as carers.

When I escalated my concerns to her Senior Team Leader (STL), the STL was aggressive and derogatory. My husband and I quickly became stressed and overwhelmed with the constant and shifting demands from Child Safety, all whilst adapting to life with a newborn, and any demonstration of emotion prompted her to question whether I was mentally stable. I was asked repeatedly if I had the capacity to comprehend my role as carer, and whether I was mentally fit to carry this role out.

My husband and I provide excellent care for our foster son, but apart from this, he had been living in unsafe and unclean conditions with his mother who was actively using. The Department consistently defers to the biological parent's rights. If we asked questions about this, to gain a greater understanding or to query something that did not seem right, the CSO and her STL were rude about our 'ignorance' and progressed quickly to aggressive attacks.

Within the very first weeks of being carers, it was identified that my foster son had an anal fissure. This is is a common condition for many babies, especially those who were exposed to opiates in utero. I noticed this late one

evening and immediately called 13 Health and then had a phone consult with a doctor which we paid for, where he explained how to treat the fissure, and that it would heal on its own, although it would take time.

My foster son had contact the following day with his biological parent and I called the CSO to inform her of this. It took 4 attempts to reach her before she eventually answered, and when she did, she appeared not to hold the phone next to her face. It was clear she was not listening to me.

This was underscored when she later called me during contact to inform me that blood had been found in my foster son's nappy. I stated that I had called to inform her of this before and she denied that I had done so. She instructed my husband and I to take our foster son to hospital. There was no red book or Medicare card available for him. We went to the hospital and supplied the doctor's letter and notes, explaining the condition and that we were doing the right things to care for it.

The Department staff, particularly the CSO, did not have the capacity to understand the nature of this condition. When I stated "we need to acknowledge that this is the result of drug exposure in utero", I was berated for 'assuming' that he had been exposed to drugs. His mother is my sister.

My husband and I were asked to take our foster son to hospital two more times following this, because the baby continued to have an anal fissure. The staff were unable to comprehend that it was a chronic condition which would resolve on its own, and the CSO kept insisting that they "could not be sure" that we were managing it well.

While we understood that there is a duty of care to ensure the child's wellness, the CSO and her STL were empowered by the failure of the Department to use this instance to essentially bully and harrass my husband and I as carers. It is my belief that the CSO, a young woman, had somehow befriended my sister, and that this had influenced her attitude toward us. Far from a collaborative relationship, the Department made such unreasonable and stressful demands of us at a time when we were doing our absolute best to learn to care for a newborn, that I can only describe it as traumatic. Here is a brief outline of some of the other concerns we experienced, which I would be happy to discuss further if ever required:

1. On a planned contact day, the STL had given my sister and myself the wrong information and contact had to be cancelled. I attempted to go about my day, but the STL called me and told me to stay exactly where I was, that someone would be taking my foster son for contact. I said that this wasn't okay, that the contact arrangement never explained that this would happen, and the STL stated that I had "no right" to this child. She questioned my mental capacity, she informed me that I had no right to any information about the policies and procedures that govern contact, and that I just needed to do what I was told. I did facilitate the contact on this day, and this was yet another traumatic interaction.

2. My foster son repeatedly contracted head lice from his biological parent, but the CSO informed me that they had no idea where it came from and heavily implied that I was not taking good care of him. As he was under 8 weeks old, he had not been exposed to anyone in our home who could possibly have given it to him.

3. When I referred to my foster son in a phone call by the shortened version of his name, the STL informed me that I was disrespecting the identity his parent assigned him and neglecting my role as carer. This then prompted another round of questioning as to whether I had mental capacity to care for the child, if I was unable to respect this.

4. Consistent preference is shown to the child's mother, to the point of the absurd. His vaccinations are significantly behind schedule because the Department offers multiple opportunities for his mother to attend with him which she does not take.

5. When our case moved to another office, we were assigned a competent CSO. However, when she was unavailable one day, and I needed clarification of contact arrangements, I spoke with the STL. Not only was he not informed of the very basic elements of the situation, he was unable to comprehend the policy of his own department when I quoted it to him. He had met with my sister the day before and was unable to recall her. He then referred to me multiple times by her name. It was very clear that he had no contextual information for this case, and he is the ultimate decision maker.

6. I received a phone call from the After Hours team informing me that a threat had been made against my foster son and that the Child Protection Unit of the Police had been informed. When I asked for more information the following Monday, I was told that the Department was unable to determine whether the child in danger was my foster son, or another child with a similar name. I asked if this meant that the other child and his carer did not know they were in danger, and I was informed that yes, this was possible.

7. The CSO pressured me into opening a line of communication with my sister. It is my choice not to have contact with her due to her pattern of abusive behaviours, but this stance was not respected. I ultimately ended the communication and was then told that I never 'had' to do it.

8. Derogatory comments were made constantly by the CSOs whenever they entered our home.

9. A 3hr meeting was held at our home to establish a placement agreement. The document did not arrive for 8 weeks afterwards, and when it did, it contained none of the things that had been discussed. The staff members who attended had then moved on to other offices and could not be contacted for their notes. There was no governing document to safeguard us when it came to the terms of the placement agreement.

10. We did not receive a Medicare card for our foster son for 7 months. I followed this up avidly and just kept being told that it was in the works. However, when the second office interrogated this further, they found that the application had never been lodged.

11. Queensland Health's Child Health Nurse made contact with me, frantic, stating that they had been trying to get in contact with my foster son's carers for months to ensure he was okay, but they could not get any information from the Department of Child Safety.

12. Errors were made in almost every single document received. Our Authority to Care forms had our names spelled wrong, my foster son's name spelled wrong. His date of birth had been entered incorrectly in all governmental systems, meaning he was unable to be found by Child Health or any other Department until the issue was identified. His name is misspelled on his Medicare card as of today, and I still await the corrected one.

13. Payments from the Department vary for no discernible reason, and the remittances offer no explanation. When queried, the officers appear to forward the question on to another department with which they have minimal affiliation.

Email communications are rarely responded to, phone calls are almost never returned. The team leaders are at best ignorant of the cases their staff manage, and at worst, partially aware and unwelcoming of any requests for information.

Decision making follows no apparent logic and there is no clear link to governing legislation. The system is so heavily understaffed that it appears that the officers are hostile and aggressive, likely as a result of the stress placed on them, and potentially as a tactic to reduce inbound communication.

Child Safety Officers make decisions about medical requirements without clinical training or even awareness, and do not appear to have the capacity to comprehend the basic clinical requirements of the children they are responsible for.

There appears to be no oversight for the Senior Team Leaders, and this means that they are free to speak rudely, offensively and with heightened aggression, as there is nobody above them who would return the call of a carer with concerns.

There is a general awkwardness to the management of kinship carers which seems to indicate either that our circumstances are unusual or that there is no provision for it.

Caring for a newborn is an extreme endeavour for anyone, let alone when you had no time to prepare. We were called at 4:20pm on a Thursday and asked if we could become carers and pick up our foster child by 5pm, because the office closed then.

We know we are doing a wonderful job as carers because our foster son is thriving. I never want another carer to experience what my husband and I did.