

Case Study: [REDACTED]
Support Coordinator Perspective

Executive Summary

This submission concerns the removal of [REDACTED] children [REDACTED] from their mother, [REDACTED] 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 [REDACTED] 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 [REDACTED] 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 [REDACTED] 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 [REDACTED] 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 [REDACTED] home. This process itself caused additional and avoidable trauma.
- Following the traumatic removal of [REDACTED], an isolated incident occurred in which [REDACTED] 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 [REDACTED] 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 [REDACTED] 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 concerning, [REDACTED]
[REDACTED]
- While [REDACTED] 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 [REDACTED] 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 [REDACTED] 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.

1. Background and role clarification

I make this submission based on my professional role [REDACTED] [REDACTED] supporting her to navigate child protection, disability, health, mental health, and legal systems in relation to her [REDACTED] children:

[REDACTED]

My role has been non-statutory and supportive. I hold no authority to make decisions regarding removals, contact arrangements, supervision levels, or placements. All such decisions have rested solely with Queensland Child Safety Services.

The observations below are drawn from:

- Contemporaneous case notes
- Written correspondence
- Tribunal material (including QCAT proceedings)
- Oversight complaints
- Direct interactions with [REDACTED] and other professionals

This submission focuses on systemic patterns, not individual fault.

[REDACTED] reports that her daughter was approximately four years old at the time of removal; however, Child Safety involvement began earlier, when her daughter was around two to three years of age while the family was residing on [REDACTED]. During this period, Child Safety Officers from the [REDACTED] office attended the home and

engaged in a supportive, respectful, and solution-focused manner. One officer, [REDACTED] assisted [REDACTED] with a referral into a community housing program and demonstrated a clear understanding of the environmental risks impacting the family at that time.

[REDACTED] explicitly cautioned [REDACTED] that if her daughter [REDACTED] the matter would likely be transferred to the [REDACTED] Child Safety office, and that [REDACTED] should expect a markedly different and less supportive response. This warning later proved accurate.

[REDACTED] was prioritised for housing and placed into a property that lacked basic safety features, including security screens or adequate security measures. Despite repeatedly raising concerns and urgently requesting safety modifications through [REDACTED] no action was taken. [REDACTED] reports experiencing significant distress and frustration as her requests for assistance to secure the home were consistently ignored, particularly important [REDACTED]

Following the birth of her son [REDACTED] further reducing her physical capacity to respond to her daughter's [REDACTED] behaviour.

[REDACTED] These risks were directly related to the absence of basic environmental safety supports rather than any lack of parental concern or effort.

[REDACTED] maintains that had she been placed in housing with appropriate security features, the escalation to [REDACTED] Child Safety and the subsequent removal of her children may have been avoided. This view was shared by the original [REDACTED] Child Safety Officer, whose professional assessment acknowledged the systemic failure to address environmental risk factors.

[REDACTED] continues to recall this worker as one of the very few Child Safety professionals who engaged with genuine care, integrity, and practical support. She reports that when they encounter each other in the community, the worker approaches her warmly, reinforcing [REDACTED] belief that this officer recognised both her efforts as a parent and the systemic shortcomings that followed.

2. Reunification has never been a genuine or attainable goal

From a support coordination perspective, reunification has never operated as a genuine objective in [REDACTED] case, despite being referenced in principle.

Evidence observed includes:

- [REDACTED] successfully completing a Family Intervention Program (FIP) more than a decade ago

- Repeated requests by [REDACTED] for further programs, assessments, or requirements to support reunification
- Ongoing engagement with services, advocates, tribunals, and oversight bodies

Despite this:

- [REDACTED] was explicitly advised that reunification would not occur regardless of compliance
- Required programs were delayed, unavailable, or placed on indefinite waiting lists
- No written, time-bound, or measurable reunification pathway was ever provided
- Compliance requirements were imposed without any credible link to outcomes

From a coordination standpoint, this reflects predetermined decision-making, where compliance is required but outcomes are fixed, undermining procedural fairness and discouraging engagement.

3. Systemic abuse and institutional harm

The placement of [REDACTED] [REDACTED] [REDACTED] in a residential facility represents a further escalation of systemic failure. Despite a ten-month record of successful unsupervised parental contact, the availability of family-based alternatives, and the child's [REDACTED], the Department elected the most restrictive option available. This decision appears predetermined and procedurally flawed, with evidence that school enrolment occurred prior to placement determination, documentation was withheld, and the child was moved on the same day notice was provided, effectively preventing the exercise of review rights. The refusal to implement a transition-to-overnight-care plan, obstruction of approved Family Inclusion Strategies supports, rejection of kinship alternatives, and resulting sibling separation collectively demonstrate a pattern of goalpost shifting and sabotage of reunification, rather than child-centred decision-making.

Across my involvement, the cumulative actions of the child protection system meet the threshold of systemic abuse, characterised by:

- Repeated complete suspensions of contact, including multiple periods exceeding 12 months
- Regression following demonstrated progress
- Procedural opacity and information withholding
- Reliance on historical events while disregarding current functioning and strengths
- Exclusion of support coordinators, advocates, and authorised professionals

██████████ and her children experienced:

- Extended periods of no contact
- Arbitrary restrictions imposed without evidence or explanation
- Tribunal material containing inaccuracies and vague assertions
- Decisions communicated verbally without written confirmation

The system response did not merely fail to protect, it actively compounded trauma.

4. Constant changes, case instability, and loss of continuity

██████████ children have been managed across multiple Child Safety Service Centres, including ██████████.

Each transfer resulted in:

- Loss of historical knowledge
- Failure to transfer safety, medical, and educational information
- Re-litigation of settled matters
- Restarting of assessments and “concerns”
- A judgemental approach with repeated reminders of historical events

High staff turnover contributed to:

- Inconsistent thresholds
- Shifting expectations
- Lack of continuity
- Children being required to repeatedly recount traumatic histories

A critical example occurred in ██████████ 2025, when ██████████ was not informed who ██████████ Child Safety Officer or Team Leader was, even following a serious assault on ██████████ at school, leaving her without a point of contact during a safeguarding incident.

From a coordination perspective, this instability is structural, not incidental.

5. Separation of children from siblings and from their mother

Repeated decisions resulted in children being:

- Separated from each other
- Relocated away from their mother
- Denied consistent and meaningful sibling contact

Observed examples include:

- ██████ being removed from a placement following allegations of abuse, while ██████ ██████ remained in the same environment and later disclosed further abuse years later
- ██████ being moved between placements without notification following safety concerns and ultimately being placed in residential care at ██████ years of age
- Sibling contact being restricted or denied without explanation

These decisions are inconsistent with:

- Attachment-based practice
- Best-interests principles
- Trauma-informed care

Sibling bonds were treated as disposable, despite clear evidence of harm when those bonds are disrupted.

6. Inconsistent and shifting contact arrangements

Throughout my involvement, contact arrangements were frequently changed, including:

- Alterations to times and durations
- Shifts in supervision and transport requirements
- Delays or refusals for extended or overnight contact
- Cancelled contacts that were never rescheduled, despite assurances they would be

In ██████ ██████ ██████ ██████ clearly requested overnight contact with his mother. He communicated this request directly to Child Safety, and it was acknowledged by a Child Safety Officer — yet no progress occurred.

These changes were often:

- Communicated with little notice
- Not supported by written rationale

- Revisited repeatedly without resolution

Impact:

The unpredictability undermined [REDACTED] capacity to plan supports, regulate emotionally, and prepare her children safely for contact.

7. Limited transparency and lack of procedural clarity

[REDACTED] and her support team experienced persistent difficulty obtaining:

- Clear reasons for restrictions
- Copies of incident reports
- Written confirmation of decisions

Following [REDACTED] [REDACTED] [REDACTED] was:

- Not informed promptly
- Provided minimal information
- Left without updates for over nine days
- Required to learn details while on the phone to [REDACTED] when her call was interrupted by Child Safety

Advocate enquiries regarding the assault, school response, and safeguarding outcomes were ignored or unanswered.

Impact:

This impeded informed advocacy, increased anxiety, and eroded trust in statutory processes.

8. Decisions made without collaboration

Significant decisions were frequently made:

- Without prior consultation
- Without inclusion of the support network
- Without trauma-informed planning

Monthly meetings ordered by QCAT for information-sharing were, at times, used instead to:

- Pressure [REDACTED] to drop QCAT proceedings

- Undermine her relationship with her NDIS Support Coordinator

Impact:

Opportunities for early intervention and preventative support were lost, and engagement became adversarial rather than collaborative.

9. Coercion, intimidation, and interference with legal rights

From a support coordination perspective, [REDACTED] was subjected to **coercive practices** that interfered with her legal rights.

In [REDACTED] [REDACTED] was:

- Asked repeatedly to “trust” Child Safety
- Encouraged to withdraw QCAT proceedings
- Given the clear implication that increased contact would only occur if legal action ceased

Statements were also made suggesting [REDACTED] had “annoyed people behind the scenes”, reinforcing a perception of retaliation for advocacy.

This conduct raises serious concerns regarding:

- Undue influence
- Coercion
- Obstruction of independent review
- Punitive use of statutory power

9B Scapegoating of non-statutory supports

[REDACTED] was told her inability to see her son was “because of her Support Coordinator.”

This occurred despite:

- All decisions being statutory
- The Support Coordinator having no authority
- The Support Coordinator actively advocating for contact

Negative commentary was also directed toward [REDACTED] advocate.

This reflects a pattern of scapegoating used to:

- Deflect accountability

- Undermine support relationships
- Isolate [REDACTED] from advocacy

10. Poor trauma-informed practice in engagement with children

From a support coordination perspective, engagement with [REDACTED] reflected poor trauma-informed practice.

[REDACTED] was asked about spending time with his mother in the presence of his carers, placing him in a conflicted and emotionally unsafe position.

Impact:

This risked silencing [REDACTED] genuine views and failed to account for power dynamics and loyalty conflicts.

11. Inaccurate justification for refusal of contact

[REDACTED] was advised that [REDACTED] contact was refused because [REDACTED] was participating in sport. This rationale was relied upon for weeks.

It later emerged that [REDACTED] was not participating in sport during that period.

Impact:

Inaccurate reasoning delayed family connection, undermined trust, and caused unnecessary distress.

12. Barriers to respite and support approvals

Requests for respite, including respite required to allow [REDACTED] to undergo a hospital operation were refused, including:

- Carers Gateway respite
- Short-term care to attend medical appointments
- Planned respite requested months in advance

In at least one instance, refusal placed [REDACTED] at risk of missing necessary medical treatment.

Impact:

Rather than mitigating risk, refusals escalated crisis and exhaustion.

13. Delayed and reactive responses to safety disclosures

Safety concerns were reported and escalated, yet:

- Follow-up actions were unclear
- Welfare checks were delayed
- Outcomes were not communicated

The handling of [REDACTED] [REDACTED] exemplifies this pattern.

Impact:

Delays prolonged distress and reinforced perceptions of system inaction.

14. Enabling ongoing domestic violence by the perpetrator

One of the most serious systemic failures observed is the way the system enabled [REDACTED] [REDACTED] [REDACTED]

Despite:

- [REDACTED]
- Police reports and documented breaches
- High-risk behaviour [REDACTED]
- Allegations by children

The perpetrator appeared to have:

- Greater access
- Greater credibility
- Fewer restrictions

In [REDACTED] [REDACTED] [REDACTED] was advised [REDACTED] [REDACTED] without being required to complete mental health assessments imposed on [REDACTED]

From a coordination perspective, [REDACTED] consistently appeared to have more rights than the protective parent.

15. Moving the goalposts and punitive restriction of access

Child Safety repeatedly:

- Changed expectations without notice

- Withheld opportunities to demonstrate safety
- Applied inconsistent supervision thresholds

Examples include:

- [REDACTED]
- Allowing home visits in one context while requiring service-centre supervision in another
- Citing vague “parenting capability concerns” without identifying current risk

This approach is punitive, not protective.

16. Cumulative impact on children and family

Observed impacts on the children include:

- Attachment trauma
- Emotional dysregulation
- Identity confusion
- Loss of trust in adults and systems
- Exposure to unsafe placements

Observed impacts on [REDACTED] include:

- PTSD and complex trauma
- Fear of engaging with services
- System-induced incapacity rather than incapacity to parent

These harms were foreseeable, preventable, and systemic.

17. Key systemic issues for the Commission

This case illustrates:

- Removal-first responses to mental health and DFV
- Absence of enforceable reunification pathways

- Poor information sharing
- Normalisation of sibling separation
- Institutional enabling of perpetrators
- Punitive responses to advocacy
- Failure to apply trauma-informed, child-centred practice
- Placement of a five-year-old child in residential care despite the mother safely parenting two other children at home
- Failure to refer on to Next Step program for all children over 16 years preventing their support into adulthood

18. Conclusion

From a Support Coordinator perspective, this case does not reflect isolated errors. It reflects structural failure.

Reunification was never genuinely pursued.

Domestic violence was enabled.

Children were separated from each other and their mother.

The system itself became the source of harm.

I respectfully submit this case as evidence requiring system-level reform, not individual blame, to prevent other families from enduring similar outcomes.