Commission of Inquiry into the Tasmanian Government's Responses to Child Sexual Abuse in Institutional Settings

Who was looking after me? Prioritising the safety of Tasmanian children

Volume 1: Summary, recommendations and findings

August 2023

Commission of Inquiry into the Tasmanian Government's Responses to Child Sexual Abuse in Institutional Settings Report

Volume 1
Summary, recommendations and findings

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Acknowledgment of Aboriginal land

We acknowledge and pay our respects to the traditional and original owners of the lands on which we conducted our Commission of Inquiry, particularly the Aboriginal peoples of lutruwita. We celebrate the rich and diverse cultures of Aboriginal and Torres Strait Islander peoples across Australia. We also acknowledge Aboriginal and Torres Strait Islander children, within whom culture lives and grows.

Content warning

Please be aware that the content in this report includes descriptions of child sexual abuse and may be distressing or raise issues of concern for some readers.

We encourage readers to exercise discretion in their engagement with this content and to seek support and care if required.

Commission of Inquiry into the Tasmanian Government's Responses to Child Sexual Abuse in Institutional Settings

Her Excellency the Honourable Barbara Baker AC
Governor of Tasmania
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7 Lower Domain Road
Hobart TAS 7000

Your Excellency

In accordance with the Order of Her Excellency Professor the Honourable Kate Warner AC issued on 15 March 2021 and amendments to that Order dated 7 February 2022 and 26 April 2023, we have the honour of presenting to you the report, findings and recommendations of the Commission of Inquiry into the Tasmanian Government's Responses to Child Sexual Abuse in Institutional Settings.

Yours sincerely

The Hon. Marcia Neave AO
President and Commissioner

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31/08/2023

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Preface

Who was looking after me?

This was a question we heard from more than one victim-survivor of child sexual abuse. Sometimes it was simply a statement, but in many instances it was a genuine question, reflecting a deep feeling of bewilderment that we came to share. How can child sexual abuse have been allowed to happen in some of Tasmania's most important institutions? How could children have continued to face known risks of sexual abuse and victim-survivors been ignored, blamed, denied justice and silenced?

On 15 March 2021, the Governor of Tasmania asked us to examine allegations and incidents of child sexual abuse in Tasmanian Government institutions. It may have appeared that our Commission of Inquiry was established in a sudden groundswell of community concern. It is true that 2020 reflected a tipping point. But it could not have been reached without persistent advocacy from victim-survivors, alongside their families and supporters, whistleblowers and journalists who have long called for greater justice, transparency and accountability in how child sexual abuse is addressed in Tasmania.

We had the privilege of hearing from extraordinary Tasmanians who placed their trust in us to drive much-needed change. This includes, most importantly, victim-survivors of child sexual abuse, who revisited their trauma and anguish to share their experiences. They told us of their pain and hopelessness when adults failed to believe or protect them as children. Victim-survivors and their families also told us of their sense of betrayal when they sought, but did not receive, support and justice for the abuse they suffered.

We respect and were deeply moved by the dedication and determination of victim-survivors, their families, whistleblowers and supporters to create change. We also

learned that there are many good people who, although working every day in broken systems, put children's interests above all else.

Several State Service witnesses gave evidence to our Inquiry. Some did so with an expectation that their actions would come under considerable scrutiny. While the public glare of our hearings was understandably uncomfortable for some, it was needed to diagnose what lies at the heart of the problems we must solve to better protect children. We are grateful to those state servants who were cooperative, reflective and sought to assist our Inquiry. While most people engaged with us in good faith, we were disappointed that this cooperation was not universal.

We hope our public hearings helped the broader Tasmanian community learn more about this complex problem, particularly with the benefit of expert and lived-experience witnesses and of other stakeholders who informed our understanding of the problems and the possible solutions. We are grateful for their time and expertise.

The symphony of people, stories, documents, reports, written submissions, oral evidence and sessions with Commissioners we heard, digested and harmonised across all our teams has informed our report. So much happens behind the scenes of an inquiry like this, including important considerations for logistics, research, writing, managing technology, safety and wellbeing, among many other matters. To this end, we were supported by a highly capable, cohesive, professional and dedicated team of people, whom we thank and acknowledge in Appendix C, including our policy and research, community engagement, operations, legal and counsel assisting teams.

Undertaking an inquiry into child sexual abuse is not easy. It involves engaging with highly confronting evidence and testimony. One aspect of our Inquiry that made it particularly challenging was the recent and continuing nature of many of the risks and systemic issues adversely affecting the safety of children and the experience of victim-survivors. The need for our Inquiry to prompt the urgent changes required weighed heavily at times, but the opportunity to create that change was also a great source of hope and motivation. All three of us emerge from this experience changed people—depleted in some ways, but greatly enriched in others.

We were pleased to see positive changes beginning to occur throughout the life of our Inquiry and trust that the Tasmanian community will call its government to account if that progress does not continue. This cannot be 'just another inquiry'. It is our strong hope that our report will increase community understanding and awareness of how child sexual abuse occurs and how deeply it harms victim-survivors and their families, sometimes irreparably. Our community needs to understand that child sexual abuse is neither rare nor isolated. Sadly, it is common and usually preventable. It is our expectation that the Tasmanian Government will implement our recommendations so that current and future generations of Tasmanian children and young people will be much better protected.

We must not look away.

Executive summary

1 Introduction

This Commission of Inquiry was prompted by a groundswell of community concern in 2019–20 over child sexual abuse in Tasmanian Government institutions. It followed media reporting of incidents of abuse and inadequacies in the Government's response to these incidents. This included the well-publicised case of a paediatric nurse, James Griffin, whose abuses at Launceston General Hospital were described in *The Nurse* podcast in late 2020, roughly a year after he died by suicide while awaiting trial. Media reports also began to expose instances of child sexual abuse by other State Service employees, including teachers, youth detention staff and health practitioners. Although the Government's initial response to these concerns characterised these matters as 'historical', others in the community and media questioned the extent to which failures to keep Tasmanian children safe were indeed in the past.[1]

Around this time, the Tasmanian Government instigated two independent reviews into child sexual abuse in the education and health systems and an investigation into the conduct of three employees at Ashley Youth Detention Centre.[2] However, as acknowledged by the then Premier, the Honourable Peter Gutwein MP, it was clear that despite establishing these reviews and other government activities, more needed to be done to protect children.[3]

On 23 November 2020, then Premier Gutwein announced that he intended to recommend to Her Excellency Professor the Honourable Kate Warner AC, then Governor

of Tasmania, that she 'establish a Commission of Inquiry under the *Commissions of Inquiry Act 1995* to investigate the responses of Tasmanian Government Agencies in relation to the management of historical allegations of child sexual abuse'.[4] In making this announcement, Premier Gutwein acknowledged that despite the Government's efforts:

> … as the number of allegations coming to light continues to grow, we must take every step necessary to ensure we identify any systemic gaps and put in place measures to fill them.
>
> This situation is nothing short of terrible and we must take further action. I believe one of our greatest responsibilities is to learn from the past, and commit to not repeating its mistakes.[5]

In the announcement, the Premier stated that 'there will be more shocking examples come to light'.[6] The Premier referred to five State Service employees who had been suspended from work at the time due to claims of child sexual abuse, one of whom was stood down pending the outcome of criminal proceedings.[7] A media report in February 2021 suggested that another 14 State Service employees had been stood down since the Premier's announcement.[8] By February 2023, the number of state servants suspended due to allegations of child sexual abuse had risen to 92.[9] These state servants came from the then Department of Communities, the then Department of Education and the Department of Health. Some 38 of those state servants were suspended following our Commission of Inquiry's establishment.[10]

The Commission of Inquiry into the Tasmanian Government's Responses to Child Sexual Abuse in Institutional Settings was established by Order of the Governor on 15 March 2021.[11]

This volume gives a high-level summary of our report, including the full list of our recommendations and findings. We start with the big picture—our overall conclusions and key reforms—before outlining how we got there, describing our approach and what we heard. We then provide short summaries of each of our volumes and chapters. We conclude with the full list of our recommendations and our findings.

2 Why this Commission of Inquiry was necessary

More than one in four Australians have experienced child sexual abuse, either within or outside institutions.[12] This represents an extraordinary number of people who are living with the devastating consequences of sexual violation. The simple reality of these numbers means that, in our lives, we will all inevitably know, love and care for victim-survivors of child sexual abuse—assuming we have not been abused ourselves. We all have a personal stake in preventing abuse from occurring and in ensuring victim-survivors receive the support, acknowledgment and justice they deserve.

The prevalence of child sexual abuse also means that many of us will, at some point, encounter abusers. While it can be hard to accept, the reality is that abusers are often our friends, family members, colleagues and neighbours. As we have learned in our Inquiry, too often they are the very people our society entrusts with the care of children—teachers, doctors, nurses, carers and youth workers, among others.

This report focuses on abuse that occurs in Tasmanian government or government funded institutions. While, overwhelmingly, people who work with children act in their best interests, some are predatory and tactical in their grooming and abuse. Not all child sex abusers are paedophiles. Some become institutional abusers because the cultural, operational or environmental context of their workplace enables or encourages such abuse to occur. Abusers need to be prevented from working in institutions, held accountable and removed from positions that give them access to children. This is generally accepted as uncontroversial but does not always translate into practice.

It is important to understand the systemic factors that can contribute to institutional child sexual abuse. This includes big-picture issues such as the effectiveness of the law, government policies (and how they are implemented) as well as community attitudes and awareness of child sexual abuse. It is also necessary to look closely at the cultural and other factors in institutions that increase the risk of child sexual abuse, allow it to go undetected, or even allow it to continue once it is suspected or known. Our consideration of these broader systemic issues has formed the basis of many of our recommendations.

But within these broader systems are individual people. Over our lifetime, many of us may find ourselves directly or indirectly contributing to the conditions that increase the risks or occurrence of child sexual abuse. Sometimes, we are directly called upon to act in the face of a disclosure, but more often it is our day-to-day actions that make us a cog in a broader machine that quietly tolerates abuse and the sexualisation of children. It is a confronting thought.

What became very clear to us is that our collective community understanding of child sexual abuse remains poor and unsophisticated. Myths and misconceptions about child sexual abuse continue to undermine the urgency and extent of the problem. These myths include that institutional child sexual abuse is rare and a problem of the past, that children are prone to misunderstand, lie or exaggerate abuse, or that abusers are obviously sinister individuals rather than ordinary and often well-respected people in the community.

The National Royal Commission into Child Sexual Abuse in Institutional Settings ('National Royal Commission'), which ran from 2013 to 2017, was instrumental in exposing the inadequacy of established systems in preventing and responding to child sexual abuse. We heard harrowing accounts not only of child sexual abuse but of unfeeling and cruel responses from institutions that sought to preserve their reputations by dodging accountability for the harm that occurred under their watch.

The recommendations of the National Royal Commission reflect the best evidence of what works to prevent and respond more effectively to child sexual abuse, and greatly informed our Commission of Inquiry. We commend the Tasmanian Government's efforts to implement many of the National Royal Commission recommendations, but other recommendations are outstanding or remain in progress. While many Tasmanians took part in the National Royal Commission, its recommendations were developed with the broader nation in mind and did not have a dedicated focus on the Tasmanian context—including its unique challenges and strengths.

As we described earlier, our Commission of Inquiry was prompted by increasing community concern in 2019–20 about the safety of children in institutions and the ability of government agencies to respond to allegations of child sexual abuse effectively. Tasmania has not had a commission of inquiry since 2000, and ours is only the second since the *Commissions of Inquiry Act 1995* ('Commissions of Inquiry Act') was passed. They are rare and reflect a unique opportunity to investigate past practices and make recommendations for future change.

We wanted our report to be a contribution to the public record—both in reflecting Tasmania's response to institutional sexual abuse at a point in time, and building broader knowledge that can help strengthen the evidence base to inform future policy development. Our report is an unprecedented account of child sexual abuse in Tasmanian institutions and, in some instances, a forensic examination of how and why abuse occurs or is enabled. For example, we have identified that, for decades, some children and young people detained at Ashley Youth Detention Centre experienced systematic harm and abuse, a horrific blight on Tasmania. This uncomfortable truth must be documented and acknowledged.

We consider the systemic harm and abuse we identified at Ashley Youth Detention Centre to reflect the end point of a longstanding organisational culture that initiates or tolerates the humiliation, belittling and devaluing of detainees, with some long-term staff continuing to apply a punitive model of youth detention. Over many years, governments had been warned of the mistreatment of children in Ashley Youth Detention Centre and yet the response appeared to remain the same—training and development. Our analysis of Ashley Youth Detention Centre is a cautionary tale for all youth justice facilities of the risks of tolerating the deterioration of respect, care and professionalism towards children and young people.

Our report adds to the understanding of the risks of child sexual abuse in health institutions, which the National Royal Commission did not specifically examine. This was an area where we found a surprising lack of research. The accounts of abuse at or connected to Launceston General Hospital challenge myths about the assumed safety of children in health services, and demonstrate that abusers can groom children gradually and be brazen risk-takers, seizing opportunities to abuse in what are often

assumed to be safe and busy settings. It is important for health services to be vigilant to the unique ways sexual abuse can occur under the guise of medical treatment and recognise the inherent power imbalance that contributes to a high degree of trust being placed in health practitioners by patients and their families.

We have also had the opportunity to understand the impact and operation of reforms from the National Royal Commission, such as the National Redress Scheme. This was recommended by the National Royal Commission to provide financial restitution and access to counselling services for victim-survivors of child sexual abuse in institutional settings, and to acknowledge the harm that has been done to them.[13] The National Redress Scheme began on 1 July 2018, with the Tasmanian Government adopting the Scheme shortly after, on 1 November 2018.[14] To date, the Tasmanian Government has received close to 700 claims.[15]

Victim-survivors told us about their mixed experiences of making claims under the National Redress Scheme and identified some areas of potential improvement. We also came to understand the challenges some government departments faced when they received information through National Redress Scheme applications that raised sexual abuse allegations about their employees. We consider this discovery requires government and non-government institutions across Australia to ensure they have systems in place for identifying whether allegations arising through the National Redress Scheme relate to current staff and to ensure any potential risks to children are addressed. It should also inform the design (or redesign) of redress schemes in the future to make it easier for institutions to use information to address potential risks to children, without compromising accessibility for applicants. As our Inquiry shows, child sexual abuse in institutions has not been relegated to the past but continues to occur. There is a clear need for redress schemes to be extended to the latest generation of victim-survivors who have been sexually abused in an institutional context.

We trust our work adds to the growing (but, in some cases, underdeveloped) research on the factors that contribute to child sexual abuse, particularly children's perspectives on safety in institutions. To assist our Inquiry, we commissioned research that asked Tasmanian children and young people how safe they felt in institutions and the steps they would take if they felt unsafe. This led to the report *Take Notice, Believe Us and Act! Exploring the Safety of Children and Young People in Government Run Organisations* by Associate Professor Tim Moore and Emeritus Professor Morag McArthur, who expertly gathered and analysed important information from young Tasmanians about what safety means to them. We are grateful to all the children and young people who participated in this research. They were candid and insightful in their opinions, which informed us greatly. We have shared their views throughout our report.

3 Overall conclusions

Through the course of our Inquiry, we have reached the following answers to four key questions about the Tasmanian Government's response to institutional child sexual abuse.

Question 1: Has the Tasmanian Government's response to allegations and incidents of child sexual abuse in institutions since 2000 to the 2020s been adequate?

Too often, no. While we saw pockets of good practice, this was often a result of the initiative and good judgment of individuals rather than something encouraged and enforced by a broader system. More commonly, institutions did not recognise child sexual abuse for what it was and failed to act decisively to manage risks and investigate complaints. Sometimes this was due to a lack of guidance and direction on how to manage incidents well but, also, due to ignorance, inertia and a desire to protect reputational interests. Too often, institutions did not effectively manage active risks to children and young people or extend adequate care when they disclosed abuse.

Question 2: Are Tasmanian Government institutions safe for children and young people?

Generally, yes. Overwhelmingly, people who work with children and young people do so with their best interests at the forefront. Most Tasmanian children are safe in government institutions, but some are not. More can and should be done to improve their safety. Despite some changes made during the life of our Inquiry, we continue to be worried about children in out of home care and youth detention, as well as Aboriginal children in institutions, and consider improving safety for them should be a priority.

Question 3: Does the Tasmanian Government have the right systems in place to effectively address risks and respond to incidents of child sexual abuse in institutions into the future?

Not often enough. We have seen improvements from changes implemented over the course of our Inquiry, but our recommendations reflect that much more needs to be done. A greater focus on child safety needs to be embedded in decision making and in the day-to-day practices of government departments. Staff need more education and training on child sexual abuse and clear guidance and support to help them identify and confidently respond to risks of child sexual abuse. We consider that requirements for organisations to comply with legislated Child and Youth Safe Standards and a Reportable Conduct Scheme (discussed in Section 6.2) will be a key way for institutions to prevent and better respond to the risks of child sexual abuse.

Question 4: Does the Tasmanian Government have a culture that encourages feedback, reporting, monitoring and reflection when responding to incidents of child sexual abuse?

Not often enough. We observed some leaders within the State Service resisted constructive criticism and lacked the curiosity and initiative required to ensure children's safety was prioritised. We also saw passivity and failures to act, particularly in response to past reviews, inquiries and internal reports highlighting problems that increased risks to children in institutions. We would like to see leaders be role models for prioritising children's rights and safety. To achieve this goal, leaders need the qualities of self-reflection, an ability to acknowledge mistakes and a drive for making improvements.

4 Key reforms for safer institutions for children and young people

We recommend several key reforms that will fundamentally change the way child sexual abuse in institutions is addressed in Tasmania. These reforms are central to protecting Tasmanian children and young people from abuse and harm in the organisations that care for them.

In developing our recommendations, we have attempted to take a strategic and practical approach by building on reforms that the Tasmanian Government has started or already implemented. We want our reform agenda to succeed and contribute to major change. We have kept at the forefront of our thinking the unique strengths and challenges to achieving good practice in Tasmania. But we have also tried to not let our emphasis on a practical approach get in the way of our aspiration for Tasmania to become a leader in child safety. We consider that Tasmania's smaller size and networked communities make it easier in some ways for it to be bold and ambitious in reform and to provide an advantage over larger jurisdictions in translating policy into changes in frontline practice. We want the Tasmanian Government and the broader community to feel pride in its child safety system rather than have a sense it is constantly catching up to an expected standard.

4.1 Creating a new, strengthened regulator and advocate for children and young people's rights and safety

It is important that children's rights and safety receives the focus and attention it deserves. For this reason, we recommend a new Commission for Children and Young People be established with appropriate independence, powers and resourcing to act as a strong and fearless advocate for children's rights and to monitor child safe practices in organisations.

We recommend that three key role-holders form the leadership of the new Commission and that all have relevant expertise in children's rights and safety:

- A Commissioner for Children and Young People with expanded powers and functions.
- A new Commissioner for Aboriginal Children and Young People to advocate broadly for Aboriginal children, particularly for those in out of home care and youth detention.
- A new independent Child Advocate to advocate on behalf of children and young people in out of home care and youth detention, with the power to make a complaint to the Ombudsman on behalf of a child or young person in out of home care or youth detention, and to apply to the Tasmanian Civil and Administrative Tribunal to review departmental decisions about children in out of home care.

We note the Tasmanian Government's creation of an Independent Regulator for Tasmania's Child and Youth Safe Framework. We consider that the functions of the Independent Regulator should sit within the new Commission for Children and Young People and that the Independent Regulator should be the Commissioner for Children and Young People. We acknowledge there may be a transition period to combine these roles.

The new Commission for Children and Young People would build on the functions and powers of Tasmania's current Commissioner for Children and Young People, particularly in advocacy, research and policy influence and in amplifying children's voices and perspectives. However, we recommend it have additional functions, including:

- acting as the Independent Regulator for Tasmania's Child and Youth Safe Framework (as noted)—this would involve monitoring and enforcing compliance with legislated requirements reflected in Child and Youth Safe Standards and the Reportable Conduct Scheme
- establishing an independent community visitor scheme for children in out of home care, youth detention and other residential youth justice facilities to increase the visibility of children and young people in these settings and make it easier for them to report any concerns to an independent person
- expanding powers to monitor and oversee the performance of the out of home care and youth justice systems and advocating for any necessary improvements and reforms
- advocating for individual children and young people in out of home care or youth detention, including by supporting them to complain to the Ombudsman about their treatment and, for children in out of home care, to apply for an independent review of a departmental decision that affects them.

The new Commission for Children and Young People should be a valued source of information, education and guidance for Tasmanian organisations and the broader community on children's rights and safety. Although we envisage it will work alongside organisations (including government departments) to promote the best interests of children and young people, we expect it to be fearlessly independent and to use its public platform and various powers to identify failings and hold government accountable when needed.

Tasmanian children and young people, particularly those who are in the day-to-day care of the Government, deserve a trusted and powerful organisation to champion their rights.

4.2 Introducing a more coordinated and statewide response to child sexual abuse and harmful sexual behaviours

We want the benefits of best practice responses to child sexual abuse in institutional settings to reach far and wide. Particularly in a small state like Tasmania, we want to avoid different organisations, departments or sectors unnecessarily 'reinventing the wheel' and failing to recognise and learn from good practices in other institutions.

While some of our recommendations are quite specific to a particular institutional setting, and the expertise required for that setting, others are intended to have a broader benefit, including to non-government institutions and the wider community. We consider child sexual abuse prevention initiatives to be of particular benefit to the broader Tasmanian community.

We consider children and young people in Tasmania should receive age-appropriate child sexual abuse education. It is not the responsibility of children and young people to prevent abuse, but we consider evidence-based education can give children and young people greater confidence to identify and report safety issues, and reduces their vulnerability to grooming and exploitation.

Child sexual abuse education can challenge myths and misconceptions and provide the opportunity for children to understand consent, respectful relationships and the important role bystanders can play. This is critical knowledge that will assist efforts to keep children and young people safe into adulthood and contribute to generational change in the incidence of child sexual abuse. We also expect parents and carers will indirectly benefit from these programs, which can help inform their own conversations about safety with their children. Given how common child sexual abuse is, we consider this education will also help people respond more sensitively to disclosures they may receive from family, friends and others in their lives. We recommend child sexual abuse curriculum be mandated from early learning programs to Year 12, across all types of state schools, drawing on evidence of best practice.

Child sexual abuse in institutions is best addressed through prevention. In our report, we explore many of the factors that reduce the risks of child sexual abuse in institutions, which include: clear, child-centred policies and practices; child safety training and professional development; strong screening practices; and an organisational culture that promotes children's rights and acts decisively in response to risks to their safety. These features are reflected in the National Principles for Child Safe Organisations, which Tasmania has legislated through its Child and Youth Safe Standards and will require a broad range of government and non-government organisations to satisfy its requirements. We recommend all organisations, whether legally bound to or not, consider adopting the National Principles for Child Safe Organisations. We consider these reforms are key to reducing risks of child sexual abuse in institutions.

While child sexual abuse can be related to other forms of harm, including family violence or adult sexual assault, child sexual abuse must be given priority by the Tasmanian Government as a standalone issue. We recommend that the Tasmanian Government develops a whole of government child sexual abuse reform strategy and action plan (which includes child sexual abuse in institutional settings) that sets out the outcomes it wants to achieve in addressing child sexual abuse and how they will be measured. This should include agreed definitions of child sexual abuse, institutional child sexual abuse and harmful sexual behaviours that can be used across government and beyond. It should describe the stakeholder landscape and consultation processes to be adopted through reform. The child sexual abuse reform strategy and action plan should be supported by strong governance arrangements and be overseen by the Secretary of the Department of Premier and Cabinet, as Chair of the Secretaries Board. This should support coordination and collaboration across government. We also recommend that the governance structures for the child sexual abuse reform strategy and action plan incorporate the voices of children and young people and adult victim-survivors of child sexual abuse, including institutional child sexual abuse.

We also see great benefit in a coordinated approach to preventing, identifying and responding to harmful sexual behaviours. The Tasmanian Government should set out a whole of government approach, with a common understanding of what constitutes harmful sexual behaviours, high-level guidance on how to respond and, in the response, a clear outline of the roles and responsibilities of different government and government funded agencies. To provide practical support and guidance, the Department for Education, Children and Young People should establish a Harmful Sexual Behaviours Support Unit. The Unit should help local areas enable a consistent, best practice, proportionate approach to responding to harmful sexual behaviours in schools, out of home care and residential youth detention that balances the needs of victim-survivors, children who have displayed harmful sexual behaviours and other affected parties. We also call for specialised and targeted responses to harmful sexual behaviours for out of home care and youth justice tailored to the heightened needs of children and young people in these settings.

We recommend the Department of Premier and Cabinet provides leadership in building a therapeutic service system for adult and child victim-survivors of child sexual abuse, as well as therapeutic interventions for children who have engaged in harmful sexual behaviours. This includes funding sexual assault services to meet demand, addressing gaps in services (including how best to meet the needs of diverse populations), evaluating the performance of services, and creating child safe accreditation standards for service providers. We also recommend the Tasmanian Government establishes a peak body for the sexual assault service system. This will bring greater cohesion and coordination and amplify the advocacy of the sector.

4.3 Increasing participation of children and young people, victim-survivors and service providers in policy design and delivery

Across our report, we highlight the importance of involving children and young people in the decisions that affect them. This not only shows children and young people that they are important, but also leads to better policies and decisions.

We consider that children and young people's perspectives should be more formally built into Tasmanian Government policy development and decision making. We consider the existing Premier's Youth Advisory Council, which has members aged between 12 and 25, to be a suitable group to offer perspectives on a broad range of issues affecting children and young people, including the whole of government approach to child sexual abuse.

We also recommend establishing advisory groups for specific institutional contexts such as out of home care, youth detention and health services. We have considered whether, for efficiency, there could be one advisory group to meet these different purposes. However, in our view, these specific institutional contexts require specialist knowledge about these systems, gained through direct experience. For example, it would be difficult for a young person to contribute meaningful opinions on youth justice without having had experience of that system. In contrast, given the lower level of vulnerability of most children and young people in schools, we consider the Premier's Youth Advisory Council and other existing broad student representative groups should be engaged on policy and reform work in schools. In constituting institution-specific advisory groups, it is important to reflect the experiences of young people with diverse backgrounds and life experiences, particularly groups that are marginalised.

We also consider that adult victim-survivors of child sexual abuse have important knowledge and expertise to offer the Tasmanian Government, particularly as it embarks on a major reform agenda. Many adult victim-survivors have recent experiences engaging with institutions and can bring important perspectives on issues such as civil litigation, access to government documents and redress. We also recommend establishing an adult victim-survivors of child sexual abuse advisory group made up of

members who have experienced institutional child sexual abuse, who are of different ages, backgrounds and geographical locations, and who can represent victim-survivors of different genders, Aboriginal victim-survivors, victim-survivors with disability and parents of victim-survivors.

4.4 Introducing stronger mechanisms for institutions to protect children in institutions from adults who pose a risk to them

Too often, our Inquiry revealed failures to take action to address risks adults posed to children and young people. While sometimes this could be blamed on the ignorance or poor judgment of individuals, it was clear to us that policies and practices for addressing risks adults posed to children in institutions tended to contribute to inaction.

We accept there is a delicate balance to be struck. We want people to feel comfortable to raise child safety concerns early and for these concerns to be well received. However, we also want to avoid organisations becoming overly paranoid and hypervigilant because this can undermine healthy and beneficial connections between staff, and the children and young people with whom they engage.

Waiting until a suspicion or concern becomes undeniable will sometimes allow abuse to continue and worsen. It may also place other children at risk. Sometimes, mistakes such as minor boundary breaches can happen due to the inexperience of individuals and can be quickly resolved through conversation and education. But, in other instances, these early warning signs point to a bigger problem that will require more serious and careful intervention. While education and guidance are important, sometimes there is no substitute for common sense and good judgment.

We make a range of recommendations for changes to State Service disciplinary processes to remove some of the real or perceived barriers to acting against staff in relation to child sexual abuse and related conduct. This includes making changes to the State Service Code of Conduct to prioritise the protection of children through clear and enforceable professional conduct policies, greater flexibility to suspend employees subject to allegations while an investigation is undertaken and increased rights in the disciplinary process for people making complaints and for affected children. We also make several recommendations to streamline processes and reduce delay. We consider that our recommendations strike the right balance in ensuring complaints are managed with fairness and transparency, but not at the expense of protecting children. Our proposed reforms require a significant shift in how the Tasmanian Government approaches disciplinary processes for state servants and may require changes to awards and agreements. We recommend the Government adopts initiatives to drive significant cultural change within the State Service. We invite unions to support our proposed reforms. We also recommend that the Government adopts appropriate measures to

ensure volunteers, contractors and temporary staff (including relief teachers) in child-facing institutions are held to the same professional expectations as staff.

We consider child sexual abuse needs a specialist response. When they arise, these matters are complicated and overwhelming for leaders. Institutions need help and guidance in how to fairly and transparently manage allegations against staff while keeping children and young people safe. We recommend creating a Child-Related Incident Management Directorate with three distinct units and functions: case managing the response; investigating the allegation; and advising the Head of Agency as to the action they should take based on the investigation.

The Child-Related Incident Management Directorate should respond to allegations about staff in schools, Child Safety Services, out of home care and youth justice. It should ensure institutions support victim-survivors, communicate appropriately with those affected, and conduct child-friendly and trauma-informed investigations that go beyond examining individual incidents to considering the broader context around an alleged abuser's interactions with children. To enable this, the unit responsible for case management should be staffed with people with knowledge and expertise of each of the organisational contexts they will support. The Child-Related Incident Management Directorate should be responsible for providing considered advice to a Head of Agency to support them to make informed disciplinary decisions.

In addition to child sexual abuse, the Child-Related Incident Management Directorate should respond to other forms of staff-perpetrated abuse in schools, out of home care and youth justice, which contribute to creating an environment in which child sexual abuse is likely to occur. This can include allegations relating to excessive use of force, inappropriate isolation or unlawful search allegations, particularly in youth detention. The Directorate could also respond to child-related critical incidents in health or family violence and homelessness services. We recommend that the Department of Health either establishes its own Health Services Child-Related Incident Management Directorate or refers matters to the broader Directorate, which should have access to appropriate specialist health expertise if this occurs.

The disciplinary reforms we recommend will only apply to state servants. However, we also hold concerns about adults who pose a risk to children in the out of home care system, including carers, or abusers in the community who target and exploit vulnerable children in care. The Department for Education, Children and Young People is responsible for children and young people in out of home care. It must respond effectively to concerns about the safety and wellbeing of children in care, including by promptly addressing any concerns or complaints about carers (including kinship, foster or residential carers). We recommend that the Office of the Chief Practitioner triages, records, monitors and coordinates all complaints about carers. We expect the Chief Practitioner to refer complaints of child sexual abuse by staff to the Child-Related

Incident Management Directorate for investigation, supported by experts in child safety and the out of home care system. The obligation to report all serious concerns to the Chief Practitioner should be embedded in contracts with out of home care providers. For other care concerns that will not require a State Service disciplinary response—such as child sexual exploitation by adults who are not state servants, alleged abuse by carers or harmful sexual behaviours—the Chief Practitioner should monitor and support the response by a child's case manager and care provider.

We also recommend stronger and more preventative approaches to child sexual exploitation, which occurs when a child is manipulated or coerced into sexual activity by adults in exchange for incentives—a circumstance too common for children in out of home care. We heard examples of children and young people being exploited in this way, with abusers taking advantage of their desperation for love, care and affection. Children and young people were exploited in return for food, shelter, drugs and an illusion of safety, care and protection. We were saddened to see this exploitation too often mistaken by child safety officers and police as a consensual 'relationship'.

We recommend that the Department for Education, Children and Young People and Tasmania Police work with non-government providers and other relevant stakeholders to develop a framework for preventing and responding to sexual exploitation of children in care that is informed by best practice and evidence from other jurisdictions. We want all agencies, particularly those working with children in the care system, to improve their ability to identify child sexual exploitation and take all steps to prevent and disrupt this behaviour.

4.5 Showing greater care, compassion and investment in protecting and healing marginalised children

All children are vulnerable to child sexual abuse and harmful sexual behaviours, but some groups of children are far more likely to be abused in institutions. This is because some children, through circumstance, spend more time in institutions—for example, children with chronic illnesses are more likely to have long stays in hospitals. Others are more likely to enter institutional care. For example, Aboriginal communities told us that the continuing impacts of colonisation, Stolen Generations and associated policy failures have caused the staggering over-representation of Aboriginal children and young people in out of home care and youth detention. These are some of the highest-risk institutions for abuse but, also, those typically associated with the poorest strategies to prevent and respond to such harms.

We were, at times, shocked at the lack of care and sometimes outright hostility extended to certain groups of children and young people, particularly those in the care system and in youth detention. Children in the out of home care system described being ignored, neglected and stigmatised by services and the broader community, despite being

in particular need of love, care and support. Children in detention were sometimes described as 'the worst of the worst' and their reports of harm and abuse commonly dismissed out of hand as lies, without any meaningful investigation.

While we are under no illusions about the challenges of supporting children and young people who often come into the care of the State exhibiting trauma and difficult behaviours, we consider that pervasive attitudes that diminish and devalue these children are compromising their care and safety. Politicisation and sensationalist media reporting can also harden community attitudes towards vulnerable young people.

The former Department of Communities held substantial information about allegations of child sexual abuse about Ashley Youth Detention Centre, which it gained through state redress schemes, the National Redress Scheme and civil claims initiated by former detainees. Some of these sources also revealed allegations of sexual abuse against staff and carers in the out of home care system, particularly information from the Abuse in State Care Program. This program was a Tasmanian redress scheme that ran from 2003 to 2013 and has, since 2015, been replaced by the Abuse in State Care Service. This information was not acted on, allowing some staff and carers to continue to be responsible for children and young people in high-risk settings despite serious allegations having been made against them.

While some of this information (as it related to current Ashley Youth Detention Centre staff) was reviewed in late 2020, there has still not been a comprehensive review of all the information relating to allegations of child sexual abuse held by what is now the Department for Education, Children and Young People. There has been no reconciliation of information received about people who may be carers in the out of home care system or working in other government institutions. As a result, we are concerned that there may still be people working with children who are the subject of child sexual abuse allegations who have not been investigated.

This highlights the need for a comprehensive historical audit of all relevant records held by the Tasmanian Government to identify all allegations of child abuse, including child sexual abuse. The audit process should examine all available sources of information and be undertaken by a senior, independent person who is given direct access to all necessary systems and information.

We recommend wide-scale reforms to the out of home care system. We consider the Tasmanian Government has moral as well as legal obligations to be the best possible parent to children and young people who cannot stay safely with their birth families. This does not just require that their basic needs are met. The out of home care system should actively nurture and support children and help them reach their aspirations and full potential in life. This level of care should flow from their legal guardian (usually the Secretary of the Department for Education, Children and Young People) through the entire system to their immediate carer, such as their kinship or foster carer. It should also

flow into the broader community, which needs to recognise how deserving of love these young people are. Children cannot be safe from sexual abuse in care if they are not more broadly safe and cared for.

We recommend increasing funding in every area of out of home care, recognising it has been starved of investment for many years, and for the Tasmanian Government to become overseer and manager of a well-resourced and closely regulated non-government sector delivering out of home care services. Aboriginal organisations should be given more funding and greater power to better support Aboriginal children and reduce their over-representation in the care system.

We want the Tasmanian Government to set an ambitious agenda in our recommendation to develop an out of home care strategic plan and to invest in monitoring, quality assurance and continuous improvement processes. We want children and young people with experience of the care system to be influential in designing reforms. We want carers to be safe, suitable and loving. We want the Department for Education, Children and Young People's performance to be monitored and scrutinised by a Quality and Risk Committee.

Children and young people in youth detention are another group of children severely overlooked by society and governments. The best way to avoid young people being abused in youth detention is to prevent them from entering detention through raising the age of criminal responsibility to 14 and improved bail and diversionary measures. An effective youth detention system is also one that provides children and young people in detention with timely access to high-quality, developmentally appropriate therapeutic supports, education and health care. Laws and custodial practices must uphold children's rights and dignity in searches, isolation and in the use of force.

Our Inquiry demonstrates that system reform is urgently needed. We acknowledge that transforming a youth detention system that has resisted change over many years is not straightforward. It requires radical cultural change, strong leadership and a long-term commitment from the Government. It may take time, but we consider it is achievable. The Tasmanian Government has acknowledged the need to move to an evidence-based, therapeutic model of care for children and young people in the youth justice system.

Key recommendations we make to improve Tasmania's youth justice system include closing Ashley Youth Detention Centre as soon as possible and initiating a change management process that includes identifying youth workers' aptitude, attitudes and capabilities, and requires all current staff to reapply for their positions. We consider such a change management process will facilitate necessary cultural change and enable staff working in youth detention to separate themselves from the stigma of the old Ashley Youth Detention Centre.

4.6 Ensuring staff and volunteers working with children have the knowledge and skills they need

We want staff and volunteers working with children and young people to feel confident and capable in their abilities. This includes having the skills and knowledge to identify risks and signs of child sexual abuse and to take appropriate steps to respond.

Too often, we saw that when people within institutions were unsure or uncertain when confronted with child sexual abuse, they tended to avoid taking action or responded poorly. We consider child safety is a core capability needed by all people engaging directly with children and young people. For all staff, in all the institutions we considered—including teachers, social workers, health workers, youth workers, police, lawyers and judicial officers—we recommend tailored minimum and continuing professional development on child sexual abuse that aligns with their specific work context.

We identified the need for baseline knowledge and skills for all frontline staff and volunteers working with children and young people. This includes foundational knowledge on grooming and child sexual abuse (including the dynamics of abuse and its impacts on children and young people), harmful sexual behaviours, child exploitation and trauma. Staff and volunteers should also be clear on their professional obligations and how to respond to complaints and concerns, including any notification and reporting obligations to other agencies.

We make a number of recommendations to ensure institutions provide training and ongoing professional development to their staff so they are equipped to respond to child sexual abuse and harmful sexual behaviours. For example, we recommend a mandatory training certification program for staff and volunteers working with children in schools, and that the Teachers Registration Board be empowered to set requirements for minimum training and professional development for teachers. We also recommend all Department of Health staff be subject to minimum professional development requirements on child sexual abuse, including grooming and professional boundary breaches. The knowledge and skills gained through such work-related skills development not only benefit children and young people in institutions but will have a broader impact as those staff and volunteers take their knowledge into their personal and recreational activities.

In some areas, we have identified the need for more advanced knowledge and skills for staff in specialist roles. This may be because they are directly involved in responding to child sexual abuse or they work with high-risk groups. For example, we consider child safety officers should have access to continuing professional development, so they clearly understand their ethical and professional obligations and meet mandatory minimum knowledge requirements to investigate and respond to sexual abuse and trauma. We also recommend that Tasmania Police establish specialist child sexual

abuse units staffed by police officers who have undertaken specialised professional development on investigating and responding to child sexual abuse. We also recommend that the Tasmanian Government ensures youth workers in youth detention facilities hold a relevant Certificate IV qualification (or start or complete such a qualification within a year of enrolling) and have appropriate attributes, skills and professional experience in working with children and young people within a therapeutic framework.

4.7 Valuing and strengthening the skills and expertise of those working in the child safety and youth justice systems

Working in the child safety and youth justice systems is not easy. Staff are often forced to work under pressured and volatile conditions, carrying significant risk and responsibility. This work is distressing and emotionally taxing.

Despite this, these sectors have traditionally been comparatively undervalued and underpaid, with not enough investment in professional training and ongoing development. While this is most apparent in frontline workers, we often see senior roles in these areas viewed as 'operational' and not afforded the status and seniority required.

During our Inquiry, machinery of government changes brought together the areas of education, child protection and youth justice into a single, expanded department: the Department for Education, Children and Young People. In our report, we describe some of our reservations about this merger, mainly that it could crowd out the dedicated and specialised attention we consider child safety and youth justice need. However, we can see that, by bringing together these areas, there is also an opportunity to strengthen and align policies and practices that relate to children and to build significant expertise in the State Service.

To achieve this potential, we make several recommendations related to the executive leadership and governance of the Department for Education, Children and Young People. This includes elevating and recognising the level of risk carried by child protection and youth justice and the expertise needed to ensure Tasmania's child safety and youth justice system operates well. We were pleased to see the new Department has created the role of Deputy Secretary, Keeping Children Safe and consider it critical that this role-holder has expertise in child protection and out of home care. We recommend increased executive-level responsibility for youth justice, Child Safety Services and out of home care. In addition, we recommend a Chief Practitioner to support continuing practice improvement for out of home care, Child Safety Services and youth justice, and an Executive Director for Aboriginal Children and Young People (supported by an Office of Aboriginal Policy and Practice). Ultimately, expertise among members of the Department's executive should be evenly balanced across the areas of education, Child Safety Services, out of home care, and youth justice.

We heard from several frontline workers about the conditions under which they worked in the child protection and youth justice systems. We heard many workers experienced vicarious trauma and compassion fatigue associated with working under unsustainable and demoralising work conditions. Some staff working at Ashley Youth Detention Centre told us they had been assaulted by detainees and were frightened and hypervigilant at work. We heard that child safety staff were a traumatised workforce. If staff do not feel safe, we question how children and young people they care for can be safe.

We consider the Tasmanian Government needs to invest in these essential workforces and recognise the specialist skills needed to perform these roles well. We recommend the Department for Education, Children and Young People develops a workforce strategy for the Tasmanian child and family welfare sector to make these roles more attractive and to retain and build the skills of existing staff.

There should be enough staff at Ashley Youth Detention Centre (and any future youth detention facility) to implement a therapeutic model of care and to ensure the safety and wellbeing of children, young people and staff. We also recommend greater psychological support be given to staff following critical incidents, such as assaults or attempted self-harm or suicide incidents.

4.8 Monitoring reform

Throughout our Inquiry we reviewed many previous Tasmanian reports and inquiries into out of home care, the health system and Ashley Youth Detention Centre, which identified problems that have not been addressed over many years. We are also conscious that some key recommendations of the National Royal Commission, such as the Child and Youth Safe Standards and Reportable Conduct Scheme, are still in the early implementation stages five years after they were made.

We share the hopes we heard in evidence from victim-survivors, and their families, carers and supporters, that our Inquiry will lead to meaningful change that benefits Tasmania and its children and young people. The Tasmanian Government has said it will implement our recommendations, and we expect this. It would be a tragedy if our report were treated as the product of 'just another inquiry', to file and forget. The cost to taxpayers, the trust of the community and the toll on victim-survivors and whistleblowers that comes from sharing their experiences requires that the Tasmanian Government commits to a powerful and immediate response.

We recommend that the Tasmanian Government establishes an independent Child Sexual Abuse Reform Implementation Monitor to oversee and report on the Government's progress in implementing our recommendations and the recommendations of related inquiries, including outstanding recommendations of the National Royal Commission and the Independent Inquiry into the Department of Education's Responses to Child Sexual Abuse ('Independent Education Review').

5 How we approached our task

In broad terms, we were required to inquire into the adequacy and appropriateness of the Tasmanian Government's responses to allegations and incidents of child sexual abuse in various institutional contexts and to make recommendations to better protect children into the future.

We gathered as much information and evidence as we could across Tasmania to assist our Inquiry. We have been informed by 143 submissions, 132 sessions with Commissioners, 21 consultations with more than 150 attendees, site visits, research, hearings and roundtables, engagement of two Aboriginal engagement officers to assist with 10 consultations with Aboriginal communities, as well as reviewing more than 95,000 documents provided by the State and others. We detail each of these processes and sources of information in Chapter 1.

We have focused on responses to child sexual abuse since 2000. This is because the National Royal Commission predominantly and thoroughly examined abuses in institutions before this period (as well as some more recent cases). We also focused on responses to child sexual abuse since 2000 because we wanted to understand the effectiveness of more recent responses to child sexual abuse, including whether some of the intended changes from the recommendations of the National Royal Commission were working as intended.

We focused our Inquiry on government and government funded services. We particularly examined children's experiences in four different institutional contexts: in schools, health services, youth detention and out of home care, including non-government out of home care. We did not conduct a thorough inquiry into allegations of abuse in some state institutions such as Tasmania Police, ambulance services or in connection with councils, nor into private or community organisations (such as private businesses, recreational clubs or religious organisations). While we did not investigate these other institutional contexts in detail, many of our recommendations will apply to some or all of them.

The approach we took to each of the four types of institutions—schools, out of home care, youth detention and health services—largely depended on the evidence and information we received and how we felt we could build on what is already known and understood.

- In relation to children in schools, we were conscious that an independent review had only recently been undertaken that closely examined child sexual abuse in schools. For that reason, we looked more closely at matters that fell outside the scope of the Independent Education Review. We considered several case studies exploring the then Department of Education's responses to both child sexual abuse perpetrated by adults and children with harmful sexual behaviours to identify systemic problems. While identifying multiple shortcomings in the prevention,

identification and response to child sexual abuse, we particularly focused on the Department's disciplinary response to allegations against teachers.

- In relation to children in out of home care, we were confronted with an underdeveloped system that has not kept pace with expected policy and practice across Australia, which left us seriously concerned for the safety of some children in care. We considered that children cannot be safe from child sexual abuse in a broken care system. We heard the system was pressured to the point of crisis. This meant we had to consider how to fundamentally reform the out of home care system in a way that would suit the size and needs of Tasmania. For this reason, our recommendations relating to out of home care have a greater focus on rebuilding the system from the ground up.
- In relation to children in youth detention, we were specifically directed to inquire into the responses of the former Department of Communities to allegations of child sexual abuse at Ashley Youth Detention Centre. The problems were overwhelming and pervasive. We heard numerous accounts of child sexual abuse, harmful sexual behaviours, and other abuses such as inappropriate isolation and use of force—accounts were strikingly consistent (although sufficiently different) across many years and multiple sources. We did not want to be yet another of the many reports and reviews that have been conducted into Ashley Youth Detention Centre over the years. We took a more forensic approach to understanding how the culture and dynamics of the Centre contributed to child sexual abuse. This was a genuine inquiry, with problems and new evidence continuing to emerge up to July 2023. Our seven case studies explored a range of issues—harmful sexual behaviours, the use of force and isolation, abuse by staff and the way Ashley Youth Detention Centre and the then Department of Communities responded to complaints relating to child safety. These case studies informed our many recommendations to shift Tasmania's youth justice system from a system that compounds trauma and heightens the risk of child sexual abuse to one that offers hope and healing to children and young people.
- In relation to children in health services, we were again directed to inquire into specific institutions—the responses of the Tasmanian Health Service and the Department of Health—to allegations of child sexual abuse, particularly in relation to the now deceased paediatric nurse James Griffin. We examined three case studies into the response of health services to disclosures of child sexual abuse. Again, we took a forensic approach, particularly in relation to allegations against Mr Griffin over many years at Launceston General Hospital. We only came to understand the scale and the nature of the problems during our public hearings. We adopted a detailed approach partly to help us understand what went wrong but also to highlight the very real and often underestimated risks of child sexual abuse in health services.

In addition to our focus on these specific institutions, we also considered how effective the justice system is in holding individuals to account and responding to the needs of victim-survivors. We also looked at policy issues that cut across all government and government funded institutions, such as how the Tasmanian Government coordinates its efforts to prevent, identify and respond to child sexual abuse, disciplinary responses, and the therapeutic services available to victim-survivors. We also considered oversight mechanisms that are in place to monitor the Government and hold it to account.

Across the report, we generally focused on systemic problems to inform our recommendations for future reforms. This involved asking:

- How effectively did the relevant policies, processes and practices work to prevent and respond to child sexual abuse?
- How equipped are institutions to prevent and respond to child sexual abuse from the leadership through to the frontline workers?
- Are victim-survivors receiving the acknowledgment, empathy and support they deserve?

In considering these questions, we have also considered some important reforms to law and practice the Tasmanian Government has introduced during the period of our Inquiry. We discuss these briefly in Section 6.2.

The case studies and examples we chose illustrate issues we heard about through our early consultations, submissions and sessions with a Commissioner. Through these case studies and examples, we wanted to understand how the actions and decisions of individuals, as well as the systems in which they work, can contribute to child sexual abuse and poor responses to it. What tactics did abusers use to groom and manipulate the people around them to erode expected standards of behaviours and lower defences? What made people more likely to speak up and act rather than stay silent and passive when they suspected child sexual abuse? How do interpersonal dynamics and the culture of an institution influence people within them? Our case studies and examples shed light on the initial systemic issues we had identified and highlighted other systemic problems as we delved deeper into the evidence.

We saw examples of institutional enablers who—often driven by self-interest, misguided loyalties to abusers or reputational considerations—actively concealed or suppressed efforts to address child sexual abuse. We saw others who fell short in critical moments, through ignorance, incompetence, fear or poor judgment. People can also deliberately avoid the truth or wish their knowledge or suspicions away. Although this response can be driven by a reluctance to confront a hard truth, it was more often grounded in an inclination to give others the benefit of the doubt rather than assume the worst. Recognising that these actions contribute to the abuse of children is hard, particularly because otherwise well-meaning and caring people can find themselves in these positions.

Most often, we found that people made bad decisions or failed to respond to child sexual abuse effectively because of the flawed systems they worked in. This often made it hard to single out any one individual for an adverse finding, even when we felt their response was poor. However, we have made some findings that relate to the actions of individuals, particularly in the case study on James Griffin in Chapter 14, where we consider the conduct of those individuals could not be blamed on a systemic failure alone. We discuss some of the challenges we faced in making adverse findings in Section 5.1.

Across our entire report, we thought about how to make our recommendations work in Tasmania. While most of the problems we identify in preventing and responding to child sexual abuse are not unique to Tasmania, sometimes the needs, size and scale of Tasmania required consideration. We heard evidence about the many strengths of Tasmania—its strong personal networks and interconnectedness and how its smaller size makes it a good place to pilot new approaches to complex problems. But we also learned of some particular challenges—including in managing conflicts of interest, social dynamics that made speaking up about safety concerns more difficult, and the difficulties in consistently attracting and retaining highly skilled professionals, particularly in senior roles. We have tried to strike the right balance in challenging Tasmania to be bold and ambitious in confronting child sexual abuse while ensuring our recommendations can be properly funded and are fit for purpose for the size and scale of Tasmania.

5.1 Challenges we faced

Our Commission of Inquiry has the power to make findings or draw conclusions from evidence we gather under the Commissions of Inquiry Act. This includes:

- making adverse findings against a person under section 19, which requires us to notify the person in writing and give them at least 10 working days to respond[16]
- making a more serious finding of misconduct against a person under section 18, which requires us to follow more steps, including issuing a notice outlining the allegation and the evidence that supported it before that person gives evidence, allowing for oral or written submissions in response to the allegation and giving the opportunity for that person to call or cross-examine witnesses to defend themselves.[17]

The way these requirements were drafted enabled various parties, including the State and lawyers acting for some individuals, to adopt interpretations which had practical consequences for the way we approached our work. We heard arguments that any adverse comment about an individual's behaviour could constitute misconduct (for example, because it was a breach of the very broad State Service Code of Conduct). This interpretation made it difficult and, in some cases, impossible for us to make some of the findings we might otherwise have made. Our difficulties were caused because, sometimes:

- we received evidence or information that implicated people after our public hearings or very close to finalising our report, which meant we did not have the time or ability to follow the required statutory processes
- our proposed adverse findings may have resulted in victim-survivors and their families or whistleblowers (many of whom had already provided evidence) being recalled and cross-examined, potentially exacerbating their distress and trauma—something we considered it was appropriate to avoid given our primary focus was on making recommendations for systemic reform and not testing the veracity of individual accounts
- pursuing an adverse finding would have been time-consuming, expensive, lengthened the life of our Inquiry and diverted us away from other important activities such as designing recommendations for the future that could be implemented as quickly as possible.

As a result, we had to make some difficult decisions about how we wrote our report and framed our findings. This involved balancing the public interest in holding individuals and systems to account with the public interest in prioritising effort and funding to tangible changes to protect children. Given our grave concerns about Ashley Youth Detention Centre, we felt we could not afford to delay our findings and recommendations. As a result, we could not pursue some issues in detail. On a small number of key individual findings, we have remained firm. Most of our findings relate to systemic failures by the State. All our findings are listed later in this volume and expanded on in the relevant chapters.

We consider the Commissions of Inquiry Act should be changed to make it less onerous to make adverse findings or a finding of misconduct against an individual. We agree that procedural fairness in these processes is fundamental but consider that the requirements in the Act are out of step with other states and territories and make it too hard to do what commissions of inquiry are tasked to do—which, in some cases, involves holding individuals to account.

We also experienced challenges in the information we could publish. Section 194K of the *Evidence Act 2001* prohibits the publication of some information after sexual offence charges have been laid. Changes to this provision were advocated for by victim-survivors of child sexual abuse, and welcome reforms were introduced in April 2020. While we support the premise of this provision—to give victim-survivors control over information about the abuse they experienced—it sometimes operated in unusual ways in our Inquiry. For example, we could publish the evidence, in Chapter 14, victim-survivors gave us about the abuses perpetrated by James Griffin, but not the evidence of potential witnesses in proceedings against Mr Griffin that had commenced before his death. This was the case even when the potential witness was giving evidence with the relevant victim-survivor's knowledge and endorsement. We discuss these issues in more detail in Chapter 1 and Chapter 23. We make suggestions for reform in Chapter 23.

6 What we heard

Preventing and responding effectively to child sexual abuse is a particularly complex problem. It often involves changing laws, policies and practices. It requires education to change people's attitudes and beliefs. Across our research we learned that other parts of Australia, and indeed the world, are facing similar challenges to the Tasmanian Government in addressing sexual abuse in institutions. We heard about strengths in Tasmania that will assist it in its task. We also heard about encouraging new reforms, as well as problems and shortcomings.

6.1 Tasmania's strengths and potential for reform

We have already acknowledged the potential of Tasmania's size and social connections for effecting meaningful change. We identified a strong commitment among many leaders, state servants, service providers, the community and victim-survivors and their supporters to effect this meaningful change.

Tasmania's children are insightful and wise, as demonstrated through the research we commissioned. They know what makes them feel safe in institutions and what needs to change. They will be an incredible source of information and guidance for the Tasmanian Government in implementing the changes needed to protect and benefit them.

Victim-survivors and their supporters bring expertise and practical insights to the reform task, particularly in designing policies and practices that recognise the trauma many victim-survivors carry, and ensure they are met with respect, acknowledgement and care. Their experience and passion for effecting change for children and young people is invaluable. The Tasmanian Government should recognise the potential toll placed on victim-survivors in seeking their expertise, and recognise that investing in tangible and meaningful change is important for maintaining their participation and good will over the long term.

We were also encouraged by the many Tasmanians we met striving to do their best through their work for children and young people. We met so many people working in institutions—including teachers, nurses, youth detention staff, police, counsellors and social workers—who are driven by the best interests of children in all they do. We were impressed by the professionalism and care demonstrated by many State Service employees who live and breathe the values of children's rights in their service to the community. Ultimately, institutions are made up of people, and the more we encourage, motivate and reward people who work every day to protect and care for children, the better.

6.2 Encouraging reforms

The National Royal Commission was an important process because it drew on best evidence from around the world to develop recommendations to prevent and address child sexual abuse. We are pleased that the Tasmanian Government has completed or is working on implementing recommendations, and urge the Tasmanian Government to continue to implement them—in substance and form.

Our work has added momentum to this reform agenda, and through the life of our Inquiry, the Tasmanian Government has announced and begun to implement several reforms to improve responses to child sexual abuse. We generally welcome these efforts, and outline below some recent encouraging reforms. We also understand that some whole of government reforms can only occur after the Tasmanian Government has had an opportunity to consider our Inquiry's findings and recommendations. However, it was not always clear how new developments fit together or would integrate with what was already in place. While we agree there is little time to waste, we also consider it is important that the Tasmanian Government be strategic and coordinated about its reform agenda to make sure it leads to the transformational change needed.

Quite apart from this, the stream of announcements from the Tasmanian Government (particularly in the final months of our Inquiry) sometimes made settling some of our report and recommendations a challenge. We note this as a challenge of our report finalisation and not a criticism of the Tasmanian Government. We have done our best to account for more recent changes and announcements, wherever we could.

In this section we outline some of the key reforms we support.

6.2.1 Child and Youth Safe Organisations Act

We are particularly pleased that in 2023, the Tasmanian Parliament passed the *Child and Youth Safe Organisations Act 2023* ('Child and Youth Safe Organisations Act'), which implements important recommendations of the National Royal Commission to create child safe organisations.

Following the release of the National Royal Commission's report, the former National Children's Commissioner led the development of National Principles for Child Safe Organisations ('National Principles'), which were endorsed by members of the then Council of Australian Governments in February 2019, including the Tasmanian Government.[18] The National Principles promote child safety and wellbeing by setting out protective factors against harm to children and key actions for organisations to ensure these principles are embedded in their workplaces.[19]

The National Principles are mirrored in Tasmanian Child and Youth Safe Standards, which impose legal obligations on organisations to ensure their policies and practices promote child safety. The Child and Youth Safe Organisations Act includes an additional

enforceable Universal Principle that requires a regulated entity to 'ensure that the right to cultural safety of children who identify as Aboriginal or Torres Strait Islander is respected'.[20] Throughout our report, references to the Child and Youth Safe Standards are inclusive of the Universal Principle.

The Child and Youth Safe Organisations Act also introduces a Reportable Conduct Scheme, which requires the head of a relevant entity to notify the Independent Regulator on becoming aware of reportable conduct within their organisation. Reportable conduct includes a range of sexual offences as well as sexual misconduct, which is defined to include inappropriate behaviour, physical contact and voyeurism when performed in a sexual manner or with a sexual intention.[21] The Independent Regulator is then responsible for monitoring the organisation's handling of the conduct and can audit that organisation's policies and procedures to assist them in improving their systems and practices relevant to responding to the conduct.

A wide range of organisations must comply with the Child and Youth Safe Standards, including health, education and accommodation providers, as well as police, youth justice workers, local councils, government agencies and the Parliament of Tasmania.[22] The Reportable Conduct Scheme applies to a narrower cohort of organisations, but includes all government agencies, out of home care providers, police, youth justice, health services and schools.[23]

The Child and Youth Safe Organisations Act provides for the appointment of an Independent Regulator to monitor and enforce the requirements of the Child and Youth Safe Standards and the Reportable Conduct Scheme.[24] It also creates broad and welcome powers to share information to promote children's safety. We recommend a new Commission for Children and Young People takes responsibility for these schemes, with the Commissioner for Children and Young People acting as the Independent Regulator.

6.2.2 Decision to close Ashley Youth Detention Centre

We support the Tasmanian Government's decision to close Ashley Youth Detention Centre. We consider it is not fit for purpose as a youth detention facility and should be shut down as soon as possible. We also welcome the willingness of the Tasmanian Government to fundamentally rethink the youth justice model in Tasmania to one that is more evidence based and therapeutic. The current model is not working—for staff, detainees or the broader community.

We were disappointed that there are some indications the Tasmanian Government is reconsidering its previous announcement to close the Centre by 2024. We hold grave concerns for the safety and wellbeing of all detainees at the Centre. While we acknowledge that the process of replacing Ashley Youth Detention Centre is complex, we consider the closure of the Centre should be treated with urgency.

6.2.3 Other welcome reforms

The Tasmanian Government issued an interim response to our Commission of Inquiry, describing 30 actions to improve the prevention of and response to child sexual abuse. We welcome these initiatives, particularly:

- defined accountabilities for child safety embedded in the performance instruments of Heads of Agencies to clarify expectations and improve accountability for upholding child safety in each department
- improving approaches to responding to civil litigation, including improving skills and awareness of the nature and impact of child sexual abuse among legal practitioners defending such claims
- appointing a Safeguarding Officer (now called Safeguarding Leads) in every Tasmanian government school, with these role-holders starting at the beginning of Term 1 in 2023.[25]

Other actions taken by the Tasmanian Government that we consider will make a significant difference to the safety of children and young people, and the recovery process for victim-survivors, includes the following:

- The release of *Safe. Secure. Supported. Our Safeguarding Framework* by the Department for Education, Children and Young People in April 2023, which is a living document that describes all the actions the Department has taken to ensure children and young people are protected from abuse and harm. It has a range of guidance and reference materials, including a guide to recognising signs of abuse. It is also designed to signal the importance of child safety to staff and to give them practice support when confronted with a concern.[26]
- The commitment to multidisciplinary centres (known as 'Arch' centres), which have the potential to provide coordinated support to victim-survivors of child sexual abuse, including specialist police investigators, counsellors and other support services. Two Arch centres are planned in Launceston and Hobart, underpinned by a $15.1 million investment.[27] We discuss ways in which to protect their focus on child sexual abuse in Chapters 16 and 21.

We are also heartened by the Tasmanian Government's repeated commitment to implement and fully fund all our recommendations. It is our expectation that this occurs as part of a broader strategy to integrate the various reform initiatives that are already completed or underway, to ensure a coordinated approach that maximises the benefits of each reform. We want to be clear that implementing our recommendations—while important—should be viewed as another step Tasmania takes in its efforts to keep children and young people safe from abuse. We, at times, observed policies being allowed to date and deteriorate rather than evolve—taking systems to protect children

backwards rather than forwards. Child safety is a policy area that is always changing and gaining new evidence of what works, and it is important that Tasmania continues to adapt and evolve with these improvements.

6.3 Problems we identified in our Inquiry

Inevitably, when undertaking an inquiry like this, you tend to mostly hear about what is not working. We have tried to keep this tendency in mind throughout our Inquiry and to keep failings and criticism in perspective. While we tried to see the good alongside the bad, it was important for us to have a deep understanding of the problems so we could design effective recommendations.

Below we describe some of the key themes and problems that emerged over the course of our Inquiry.

6.3.1 Poor understanding of child sexual abuse

There is a limited understanding of child sexual abuse and harmful sexual behaviours in institutions.

Too often, we saw failures to recognise child sexual abuse for what it was. It was rare for us to receive evidence that the sexual abuse of a child was directly witnessed by staff in institutions, except for Ashley Youth Detention Centre. More often, complaints of inappropriate conduct were made later by children or their carers—sometimes many months or years later when the victim-survivor was an adult. However, we heard many examples where risks or signs of abuse were not detected when they should have been, particularly grooming behaviours or breaches of professional boundaries. These behaviours can be harder to identify, particularly where the conduct occurs under the guise of health care or when teachers could be seen to be paying particular attention to one student for good reasons. We saw too many examples of signs or reports of abuse being downplayed and denied. Sometimes, this happened because of a lack of skills and knowledge, sometimes, it was deliberate, and in other instances, it was driven by a desire to protect the reputation of a colleague, other adults or the institution. Even when reports and complaints of child sexual abuse were made directly, we saw examples of them not being recognised as such by the institution. Across the board, these actions led to inexcusable delays in managing risks to children and led to uncaring responses to victim-survivors.

Our commissioned research into the views and experiences of children and young people also saw some confused understandings around consent, particularly where there is an imbalance of power. We observed simplistic understandings of ‘consent’ in adults—including a tendency to conflate concepts of consent with compliance and an absence of physical resistance from a victim-survivor. We also saw a failure to consider age and power differences in cases of sexual exploitation of adolescents by adults, with these cases also wrongly considered consensual.

It is important that all Tasmanians (including children and young people) have a basic understanding of the nature and dynamics of child sexual abuse. Given how common child sexual abuse is, people need to assume they might receive a disclosure or witness its warning signs at some point, and it is important they know what to do if that happens. People working directly with children in organisations should have training and professional development that goes further than these basics to give them the necessary skills to identify the signs of abuse early, particularly if they work in a high-risk environment such as youth detention.

Recommendations to address this issue include:

- introducing a mandatory child sexual abuse prevention curriculum in Tasmanian schools (Recommendation 6.1)
- the Tasmanian Government continues to advocate to the Australian Government to ensure Tasmania receives the full benefit of community-wide prevention strategies under the *National Strategy to Prevent and Respond to Child Sexual Abuse 2021–2030* (Recommendation 18.1)
- changing legal terminology that reinforces problematic views around consent in child sexual abuse matters and ensuring legal professionals take greater care in describing child sexual abuse (Recommendation 16.18)
- introducing minimum mandatory education for staff and volunteers in recognising and responding to child sexual abuse (Recommendations 6.5, 9.11, 12.9 and 15.15).

6.3.2 Harmful sexual behaviours are often not properly recognised or responded to by institutions and needs greater investment

Harmful sexual behaviours need to be better understood and addressed.

We have used the term harmful sexual behaviours to describe sexual behaviours displayed by children and young people that fall outside developmental expectations, which may cause harm to themselves or others. Sexualised behaviours occur along a continuum from healthy to harmful behaviours. Not all children who have engaged in harmful sexual behaviours will benefit from the same intervention, and responses to harmful sexual behaviours need to be 'both proportionate and appropriate'.[28] For example, inappropriate sexual behaviours that are motivated by misguided curiosity about sex could be addressed through clear boundary setting and education, while more serious, coercive and persistent behaviours might need an intensive specialised therapeutic response.

We heard instances of harmful sexual behaviours in schools, out of home care and in Ashley Youth Detention Centre.

We tended to observe institutions either downplaying or overreacting to harmful sexual behaviours, which reflects the difficult balance that needs to be struck in these matters. Without guidance and experience, it can sometimes be difficult to tell the difference between age-appropriate exploration and harmful sexual behaviours. However, it is important to acknowledge that harmful sexual behaviours can be very damaging to victim-survivors and need to be taken seriously by institutions. Victim-survivors need an institution to take active steps to keep them safe after an incident and ensure they get support to recover.

However, care and sensitivity need to be extended to children and young people displaying harmful sexual behaviours. Sometimes these behaviours can be a sign that the young person is being sexually harmed. In some instances, we heard of adult abusers coercing children to engage in sexual acts. Therapeutic responses to young people engaging in harmful sexual behaviours need to be based on an individual assessment of the young person and the context of their behaviour and be carefully designed and delivered using specialised techniques for treating these behaviours.

Recommendations to address this issue include:

- a whole of government framework for preventing, identifying and responding to harmful sexual behaviours to guide responses across all Tasmanian government institutions (Recommendation 21.8)
- the Department for Education, Children and Young People establishing a Harmful Sexual Behaviours Support Unit to provide advice, support and guidance in schools, out of home care and youth detention to facilitate a consistent, best practice, proportionate approach to responding to harmful sexual behaviours (Recommendation 9.28)
- more funding for specialist therapeutic intervention and treatment services for young people displaying harmful sexual behaviours (Recommendation 21.8).

6.3.3 Children and young people are not listened to, their safety is not prioritised, and their fundamental rights are not upheld

Children and young people are too often undervalued, dismissed or disrespected.

People are generally passionate and committed to upholding the rights and safety of children. But, too often, we did not see this passion and commitment translate properly into the decisions and actions of institutions. We consider this reflects a legacy of children being undervalued in society—noting that in the recent past children were expected to be seen and not heard and were viewed as extensions of adults rather than individuals with rights.

Since Australia ratified the United Nation Convention on the Rights of the Child in 1990, there has been a shift towards recognising that children have inherent rights and

deserve special protections for their safety and wellbeing. While this is slowly influencing decision making about children, we consider there is still some way to go for children's rights to be placed at the heart of organisations that provide services to them.

We saw many examples of disclosures of abuse made by children and young people being brushed off or not believed. While we give examples across our report of children's perspectives being treated as unreliable, it was particularly pronounced for children seen as 'bad' or untrustworthy, such as those in detention, who are experiencing mental health problems, live with disability or have difficult behaviours. Children in out of home care, who often lack access to trusted and supportive adults, were often overlooked and ignored. In the case of Ashley Youth Detention Centre, we saw the extreme end point of failing to respect the rights of children, with detainees experiencing human rights violations and being harmed and abused in a systematic way.

The National Principles for Child Safe Organisations require that children and young people are informed of their rights, can participate in decisions that affect them, and are taken seriously. Similarly, through our commissioned research, Tasmanian children and young people told us they are far more likely to feel safe in institutions where they are listened to and where their worries are taken seriously by the adults around them.

We consider organisations are stronger and better at what they do when they actively involve children and young people in the design and delivery of their services. They are also much more likely to be safe.

Recommendations to address this issue include:

- establishing youth advisory groups for specific institutional contexts including out of home care, youth detention and health services (Recommendations 9.6, 12.8 and 15.7) and using existing broad student representative groups on policy and reform work in schools
- including the Premier's Youth Advisory Council as part of the governance arrangements for our recommended child sexual abuse reform strategy and action plan (Recommendation 19.5).

6.3.4 Aboriginal children and young people face unique risks of abuse and barriers to culturally appropriate support

Child sexual abuse wrongly and unequally affects Aboriginal children and young people.

Aboriginal children and young people are unacceptably over-represented in a range of high-risk settings, particularly out of home care and youth detention. This means that disproportionately more Aboriginal children are exposed to the risk of child sexual abuse in institutions and are also more likely to bear the brunt of the policy and process failures that can arise when organisations are not child safe.

We worked hard to understand and reflect in our report the views and experiences of Aboriginal communities. Through our consultations, Aboriginal people explained that the way child sexual abuse is experienced and addressed is closely linked to the trauma associated with colonisation. We heard that many Aboriginal people do not trust Child Safety Services and are worried that their parenting will be unfairly judged, and their children removed from their care. We heard many Aboriginal people were reluctant to report child sexual abuse to police because they (or their communities) had been treated poorly by police. We also heard that abuse of Aboriginal children in out of home care and youth detention was far too common and they did not receive culturally appropriate support or care.

The Tasmanian Government needs to recognise how historical mistreatment of Aboriginal people has contributed to the present-day increased risk of child sexual abuse of Aboriginal children. It needs to invest in Aboriginal-led programs that will keep children safe and work to divert them from out of home care and the youth justice system to support them to live safely in the care of their families and communities. Organisations need to work harder to build trust with Aboriginal communities by better supporting their own Aboriginal staff and by responding to what Aboriginal people say is needed to improve how they care for or provide services to children. Aboriginal victim-survivors need access to safe cultural spaces and culturally appropriate support to help them heal in a way that recognises the impact of intergenerational trauma.

Recommendations to address this issue include:

- appointing a Commissioner for Aboriginal Children and Young People to monitor the experiences of Aboriginal children in out of home care and youth detention (Recommendation 9.14)
- fully implementing all elements of the Aboriginal and Torres Strait Islander Child Placement Principle to reduce over-representation in out of home care and invest in Aboriginal-led strategies to keep children and families safe (Recommendation 9.15)
- developing an Aboriginal Youth Justice Strategy, created in partnership with Aboriginal communities, that is underpinned by self-determination and focuses on prevention, early intervention and diversion strategies for Aboriginal children and young people (Recommendation 12.27)
- Tasmania Police developing a strategy to build trust with Aboriginal communities to encourage reporting of child sexual abuse (Recommendation 16.2)
- improving healing services for Aboriginal victim-survivors and their families by resourcing and supporting Aboriginal organisations to design, develop and deliver Aboriginal-led healing approaches (Recommendation 21.7)
- creating the role of an Executive Director for Aboriginal Children and Young People in the Department for Education, Children and Young People (Recommendation 9.7).

6.3.5 Neglect and underperformance of some public institutions is tolerated and contributing to risks to children

There has been a neglect of some public institutions serving children and young people in Tasmania, leaving those institutions to flounder in key areas and putting children at increased risk.

We were confronted by how the out of home care system appeared to have been allowed to erode, impacted significantly by years of underfunding and neglect. Launceston General Hospital lacked some basic requirements for ensuring child safety and preventing child sexual abuse, and did not have strong governance arrangements and a culture of raising concerns concerning child safety. Ashley Youth Detention Centre has failed to meet the fundamental rehabilitation and developmental needs of children and young people. It has had a long history of systematic harm and abuse of children and young people, including through child sexual abuse, excessive use of force, the persistent and regular use of isolation as a form of behaviour management, punishment or cruelty, inappropriate strip searches (including searches that were sexually abusive) and not taking steps to protect children from harmful sexual behaviours. These problems, which have emerged through various reports over the years, have been tolerated by successive governments. Oversight bodies struggled to meet all their numerous obligations, with few complaints about child sexual abuse suggesting, at least at times, a lack of public confidence in their ability to effect change.

We consider these failings in the core functions of institutions to reflect the value respective governments have given to these institutions. Public-serving institutions need to be resourced and valued for their key role in society, and need to be healthy and functional to properly protect children from harm, including child sexual abuse.

Recommendations to address underperforming institutions include:

- resourcing non-government out of home care providers appropriately (Recommendation 9.3) and building a quality out of home care system, including: outsourcing care to non-government providers; strengthening leadership, governance, strategic planning, outcomes and performance monitoring; supporting Aboriginal self-determination and implementing the Aboriginal and Torres Strait Islander Child Placement Principle; supporting quality care and carers; and meeting all children's needs, including by having specific measures to address harmful sexual behaviours and child sexual exploitation (Chapter 9)
- closing Ashley Youth Detention Centre (Recommendation 12.1) and preventing children entering youth detention, creating a child-focused youth detention system (Recommendations 12.16–12.26), addressing harmful sexual behaviours in youth detention (Recommendation 12.30), and protecting against the inappropriate or unlawful use of searches, isolation and use of force (Recommendations 12.31–12.33)

- developing indicators to measure the culture and practices of health services through the Department of Health's cultural improvement program (Recommendation 15.3)
- giving the Secretary of the Department of Premier and Cabinet responsibility for overseeing, coordinating and reporting on statewide child sexual abuse reform (Recommendation 19.3)
- establishing a new statutory Commission for Children and Young People, with separate funding and reporting obligations to Parliament (Recommendations 18.6, 18.8 and 18.9).

6.3.6 Leadership efforts to mitigate the risk of child sexual abuse have not been strategic, persistent or coordinated, and there is little accountability for failings

Too often, we saw shortcomings in leadership—individually and collectively.

We were disheartened to see the way some leadership teams in government agencies responded to risks and allegations of child sexual abuse. We know that addressing an allegation of child sexual abuse is not easy, particularly once it has reached the scale of public crisis. In considering particular institutions' responses, we did not expect them to be perfect. What we did expect is that leaders would take child sexual abuse seriously, work together effectively to manage any risks, and ask for help and support from experts if they needed it. We expected them to prioritise the safety and wellbeing of children and young people.

Across all the types of institutions we examined, we rarely saw examples of child-centred leadership. Sometimes this was because of a lack of skill and good processes to guide leaders, which led to clumsy, slow and ineffective responses. But in other instances, we saw what can only be described as a callous lack of care for victim-survivors of abuse. This was more difficult for us to understand, with some leadership failings so extreme they caused enormous pain and suffering to those affected. The driving factors behind this poor leadership included an apparent disregard for children or victim-survivors, laziness or lack of interest, outdated understandings of child sexual abuse, lack of skill and capability, overwhelm and unreasonable workloads.

We consider leadership failures are more likely to occur, and be far more damaging, where there is a lack of accountability. We saw some senior leaders use terms like 'shared accountability', in some cases, to sidestep their individual accountability. Sometimes, this individual accountability comes from a person holding a legal duty, a professional duty or a moral duty. Yet we saw leaders lack curiosity or initiative, delegate their responsibilities or shift blame to others. We saw defensiveness rather than self-reflection. Some of these attitudes endured throughout our Inquiry, even when confronted with the devastating scale of what went wrong. This type of leadership can

have much broader implications, by discouraging people from speaking up about child safety or signalling that promoting child safety is not a priority for staff more broadly.

While we agree that child safety is a responsibility that should be shared among all adults working in an institution, leaders should have specific responsibilities that reflect their power and influence in decision making. They need professional development and support to make sure they are equipped to identify and respond well to risks of abuse. If leaders make mistakes, they should acknowledge them and commit to learning more, so they can do better in future. Leaders should model a culture of improvement and self-reflection, so it positively influences everyone in the organisation.

Recommendations to address this issue include ensuring:

- leaders across the multiple institutions we examined have the knowledge, skills, aptitude and core capability to effectively manage people and to lead a child safe organisation (Recommendations 9.4, 12.6, 15.3)
- expert and active leadership within the Department for Education, Children and Young People by ensuring senior executive roles reflect the risk and responsibility of respective positions and have appropriate expertise in youth justice and the child safety system (including out of home care) (Recommendations 9.4, 12.6)
- Heads of Agencies are clear about their responsibilities for implementing reforms under the child sexual abuse reform strategy (Recommendation 19.4).

6.3.7 Institutions' workforces have not been equipped to keep children safe and support victim-survivors

Earlier, we recognised the passion and commitment of many state servants working with children and young people. In some of the institutions we looked at, we saw some people show enormous strength and courage by calling out failures to respond to child sexual abuse, sometimes at great personal cost. Too often, we saw that good responses to risks to child safety relied on the good judgment and perseverance of individuals rather than being driven by a strong child safe system that staff fell in line with.

Some institutions did not invest enough in making sure staff were safe and suitable to work directly with children and young people, particularly in high-risk settings. Most institutions did not have clear policies that described what is (and isn't) appropriate behaviour, or that provided guidance on what to do if a staff member had concerns about the inappropriate behaviour of a colleague or the safety of a child. This led to confusion and uncertainty, which sometimes contributed to inaction. In some instances, staff told us there was a culture of fear within their institutions that stopped people from reporting concerns.

Staff in institutions often told us they did not have proper training to identify the signs of sexual abuse, particularly grooming. They also told us it was sometimes difficult to

tell whether behaviour was an honest mistake or a sign of something more serious. We understand how hard it is to report concerns when a person is not clear or confident that they are right. It becomes even harder if an institution directly or indirectly discourages staff from speaking up or does not take seriously their questions or concerns.

Staff (and, where relevant, contractors, volunteers and carers) need clear policies and processes about how they should behave with children and young people. They need to know what to do if a child reports a concern or complaint to them and be confident the right action will be taken by their managers and leaders. They also need training and professional development to help them understand the signs of abuse or harmful sexual behaviours, which will give them confidence to act when they are confronted with it.

Recommendations to address this issue include:

- increasing and mandating professional development relating to child sexual abuse for staff and leaders in schools, health services, out of home care and youth justice and people working in the justice system, which includes developing foundational knowledge and skills and specialisation, depending on the nature of the role (Recommendations 6.5, 9.11, 12.9, 12.34, 15.15, 16.3, 16.16, 17.2, 17.6)
- developing a whole of government approach to professional development for responding to trauma to equip people working in government and government funded services that have contact with child sexual abuse survivors to respond appropriately (Recommendation 19.2).

While we have made recommendations for professional development across multiple institutions, the Tasmanian Government may look for efficiencies by sharing professional development materials across agencies, particularly for foundational knowledge. Each institution will also need tailored professional development for the specific institutional context.

6.3.8 Institutional responses to child sexual abuse have not been transparent, effective and rigorous

Too often we saw poor responses when concerns, complaints or allegations of child sexual abuse were made.

It takes enormous courage for a victim-survivor to report abuse to an institution. Survivors may be fearful, experience shame or be worried they will not be believed. It can also be hard to report a concern about a colleague, particularly if you are second-guessing yourself and are worried about the fallout if your concern is unfounded. We can understand how, sometimes, it can feel easier to stay silent. But the abuse of children thrives when people don't speak up.

Institutions should do everything they can to make people feel safe about reporting concerns of abuse because this is such important information. Even where an allegation is unfounded or the behaviour was an inadvertent boundary breach, speaking up can send a message to any potential abusers in the institution and create the impetus for professional conduct expectations to be reinforced. Institutions should want to know if their staff or volunteers are a risk to children so they can take steps to address that risk and support anyone who may have been affected.

Many institutions did not have a clear complaints process, which meant that people felt discouraged from reporting. Where they did, information received (from victim-survivors, staff or others) was not treated with the importance it deserved. Complaints were sometimes downplayed or minimised and not recorded or escalated. People who made a complaint were often left in the dark about what had happened with their report. The identity of complainants was sometimes inappropriately revealed to the subject of the complaint, causing stress and hardship for the person speaking up.

Where processes to investigate were started, they often took too long and were insensitive to the needs and experiences of victim-survivors, particularly if they were still children. We saw failures to manage risks while investigations occurred (for example, by not suspending relevant staff with pay or otherwise limiting their contact with children). Sometimes investigations lacked integrity, undertaken by local managers or investigators who lacked the skills and training, or by having people involved in investigations and decisions who had (or appeared to have) a conflict of interest. In some instances, we saw allegations of abuse or misconduct managed outside formal processes outlined in the *State Service Act 2000* or legal processes weaponised to obstruct appropriate action. In other instances, legal advice that was not in the public interest or other perceived legal barriers that limited sensible action to respond to risks were passively left unchallenged, leading to poor outcomes. Often, we saw complaints and information about child safety not recorded appropriately, which meant information was not preserved and retrievable. Too often—across and within government agencies—the full picture of what the Tasmanian Government knew was not pulled together, contributing to poor assessments of risk. This often meant that abusers were not held to account or those subject to allegations were not removed from having contact with children and young people until risks could be properly determined.

Institutions need to treat information they receive about child safety as precious. Complaints processes need to be clear and accessible, including to children and young people. Investigations need to have rigour and integrity for all parties to have confidence in their outcomes.

Recommendations to address this include:

- improving complaints handling policies and practices to ensure information received through complaints is taken seriously, acted upon appropriately and recorded (Recommendations 9.31, 12.35, 12.37, 15.16)
- conducting a comprehensive audit into complaints and allegations received about Ashley Youth Detention Centre and the out of home care system (Recommendation 12.5)
- establishing a Child-Related Incident Management Directorate to provide specialised case management, investigation and advice on allegations of child sexual abuse and related conduct (Recommendation 6.6, discussed in Section 4)
- establishing a new Commission for Children and Young People to take on the functions of monitoring and enforcing the Child and Youth Safe Standards and a Reportable Conduct Scheme (Recommendation 18.6, discussed in Section 4).

6.3.9 The State Service disciplinary framework is not suited to responding to child safety concerns

Too often we heard that the State Service disciplinary framework is not well suited to responding to allegations of child sexual abuse and related conduct.

When an employee abuses or acts inappropriately with a child, their employer needs to take action to address that behaviour. Where the conduct is serious, this may mean terminating their employment. Responding quickly and fairly to allegations of child sexual abuse is an important way that government agencies can keep children and young people safe. It is important that investigations into staff are fair and transparent.

We found that policies and practices (particularly in addressing employee misconduct) were fundamentally flawed in addressing child sexual abuse and related conduct. They often relied on outdated approaches to responding to allegations that have since been changed in other contexts (such as the criminal justice process). These outdated approaches included imposing an unreasonably high standard of evidence to substantiate concerns, considering behaviour and complaints in isolation (rather than as a potential pattern of behaviour), and excluding behaviour that occurred outside the workplace. We also saw institutions (and investigators) interview children in ways that fell well short of the approach seen as best practice adopted by many police forces. These best practice approaches recognise the importance of understanding the whole history of connection between a child and an alleged abuser rather than simply focusing on individual incidents. There was also an excessive concern among some in the State Service about disciplinary decisions being challenged, which led to inertia. In some instances, we observed the interpretation and application of laws and policies to be so rigid and conservative as to entirely depart from common sense and the public interest.

At times, we considered the approach to disciplinary processes reflected outdated assumptions and requirements long since removed from the criminal justice system, which has a higher standard of proof.

We acknowledge that the disciplinary system, as it applies to child sexual abuse, is inadequate and particularly difficult to apply in certain situations (for example, if a complainant does not want to take part in an investigation or if a complaint is about conduct a long time ago and there are no good records or available witnesses). However, we saw too many examples of organisations not doing everything they could to investigate and, where appropriate, discipline or terminate employees who posed a risk to children. Although staff who are the subject of complaints need to be accorded fairness, we observed that sometimes an emphasis on their rights detracted from the safety of children and the wellbeing of victim-survivors. We consider that the rights and wellbeing of all staff are best supported by removing those staff who pose a threat to children.

Recommendations to address this include:

- clarifying the provisions of the State Service Code of Conduct in a way that prioritises protecting children (Recommendation 20.1)
- allowing for immediate suspension of staff when there is an allegation of child sexual abuse or related conduct (Recommendation 20.6)
- ensuring all child-facing departments develop a professional conduct policy that clearly describes expected standards of behaviour with children, reporting obligations and the consequences of a breach of the policy, including that it may be a breach of the Code of Conduct (Recommendations 6.4, 9.19, 12.10, 15.13, 20.2)
- increasing the rights of children and people making a complaint during disciplinary processes (Recommendation 20.8)
- funding awareness raising and culture change in the State Service approach to disciplinary processes (Recommendation 20.14).

6.3.10 Agencies with responsibilities for keeping children safe have not consistently coordinated and shared information

Too often, we saw poor coordination and information sharing across government that affected the response to victim-survivors.

A range of bodies have specific responsibilities to keep children safe from harm. This includes Tasmania Police, Child Safety Services, the Registrar of the Registration to Work with Vulnerable People Scheme and professional regulators (such as the Teachers Registration Board or the Australian Health Practitioner Regulation Agency). A range of duties may be imposed on people to report information relevant to the safety of children to these different bodies.

This means they often receive (or should receive) important information that may suggest a person is a risk to children. All these agencies have important powers that can be applied to reducing the risks from abusers.

Across our Inquiry we saw too many examples of these agencies failing to share with each other the information they received about potential abusers. We were told that privacy of alleged abusers—and, sometimes, the privacy of people providing agencies with information—was a key reason why people felt they could not share information about risks to children. We found the barriers to sharing information and coordinating a response to be primarily cultural, with legislative barriers mostly perceived rather than actual.

The practical consequence of this lack of coordination is that different agencies sometimes held pieces of information that were never put together to give a complete picture of the risk a person posed. Although individual incidents or pieces of information viewed in isolation may not be seen as serious, when put together they can sometimes reveal a far more dangerous pattern of behaviour. Putting information together also gives a better basis for agencies to use their powers to act—for example, to suspend registration, take disciplinary action, lay charges or otherwise restrict access to children and young people.

We have seen improvements through the development of information-sharing agreements and feel optimistic about broad powers given to the Independent Regulator (and other agencies) to share information relating to the Child and Youth Safe Standards and Reportable Conduct Scheme. We consider that addressing immediate risks to the safety of children should always be an overriding priority when it comes to information sharing.

Recommendations to address this include:

- developing child safety information sharing, coordination and response guidelines to use across government and government funded agencies, supported by investment in cultural change work that promotes good information-sharing practices and reinforces the need to respond appropriately to any information received (Recommendation 19.8)
- reviewing confidentiality or secrecy provisions across Tasmanian legislation to identify and remove any legislative barriers to sharing information in the interests of protecting the safety and wellbeing of children and young people (Recommendation 19.7).

6.3.11 The legal system does not consistently offer justice to victim-survivors of child sexual abuse

The legal system is one way that victim-survivors seek justice for child sexual abuse, but we found that sometimes it not only failed to deliver justice but acted to compound trauma and distress.

The criminal justice system is an important way to hold child sexual abusers accountable for their actions and a way to disrupt their behaviour (through imprisonment, sex offender registration and/or programs to address their offending). The Tasmanian Government has made many legal reforms to improve the ability of the criminal justice system to respond to child sexual abuse, including new and strengthened child sexual abuse offences and changes to make the giving of evidence more sensitive to the needs of children and adult victim-survivors.

Some victim-survivors initiate civil litigation against institutions for their failures or seek other forms of acknowledgment, such as apologies or compensation through redress schemes. Despite efforts in recent years to make these processes fairer for victim-survivors (who usually have less money and power than the institutions they are trying to hold to account), we heard these processes are sometimes gruelling for victim-survivors. We also saw situations where the Tasmanian Government relied on legal advice (including that of the Office of the Solicitor-General) that contributed to outcomes that were not trauma-informed.

Institutions have an obligation to acknowledge any harm that happens under their care and to support victim-survivors and their families to heal and recover. Sometimes this also requires institutions to rebuild trust with the community—which demands transparency, accountability and evidence of change for the better.

Recommendations to address this include:

- establishing and funding specialist units within Tasmania Police to investigate child sexual abuse (Recommendation 16.1)
- improving court processes for child sexual abuse matters to reduce delays and trauma for victim-survivors and to increase knowledge and understanding of juries and legal and other professionals working on child sexual abuse matters (Recommendations 16.10, 16.15, 16.18, 16.19)
- improving the skills and knowledge of lawyers who act for the Tasmanian Government in civil claims and developing and enforcing guidelines to uphold best practice in responding to such claims (Recommendation 17.2)

- ensuring the Tasmanian Government and relevant institutions offer apologies to victim-survivors of abuse who wish to receive them, which includes meeting with a senior representative as part of that acknowlegment and an explanation of steps taken to prevent similar abuse into the future (Recommendation 17.4)
- ensuring victim-survivors of abuse in institutional settings have access to a redress scheme to provide compensation and support for child sexual abuse (Recommendation 17.1).

6.3.12 Victim-survivors of child sexual abuse do not consistently receive the support and care they deserve to address their abuse

Victim-survivors did not always receive the support they needed.

The impacts of child sexual abuse on a person can be devastating and lifelong. Some people do not survive it. Trauma associated with abuse can spiral into a range of other problems, including drug and alcohol abuse, mental illness, problems maintaining relationships and a person's ability to work consistently. Many victim-survivors mourn the life they could have led if they had not been abused.

We learned from experts that while the impact of child sexual abuse is sometimes severe, it can be managed and treated with the help of support services and trained professionals. Survivors often told us how beneficial they found counselling and other psychological support once they found the right professional or service, but many found accessing services too hard or impossible due to cost, location or waiting lists. We also heard about survivors accessing supports that did not meet their needs, including multiple examples of therapists who hindered rather than helped survivors' recovery.

Victim-survivors of abuse deserve support and psychological help to recover from their experiences. They deserve to live a life that is not defined by their abuse. Services should reflect the diversity of victim-survivors (including those who are still children and young people, are Aboriginal, identify as LGBTQIA+, live with disability or come from culturally and linguistically different backgrounds) and be tailored to their specific needs as much as possible. They should be able to feel confident that when they access services, those services will meet minimum quality standards.

Recommendations to address this include:

- improving and increasing access to sexual assault counselling and support services for all adult and child victim-survivors of child sexual abuse and children who have experienced or displayed harmful sexual behaviours (Recommendations 21.4, 21.5, 21.6, 21.7)
- ensuring a sexual abuse service system that meets the needs of particular groups of victim-survivors, including adults and children, those with disability or a mental illness, those who identify as LGBTQIA+, are from culturally and linguistically diverse backgrounds, and male victim-survivors (Recommendation 21.6).

6.3.13 External oversight of institutions' responses to child sexual abuse could be improved

We saw room for improvement in the oversight of child sexual abuse.

It is important, particularly in an area as sensitive and complicated as child sexual abuse, that there are strong safeguards to make sure the system is working well. Oversight bodies such as the Ombudsman, Integrity Commission, Commissioner for Children and Young People, Health Complaints Commissioner and Custodial Inspector are important in making sure government agencies act ethically and in line with their statutory obligations. They need strong powers and proper funding to do this well. Bodies that regulate professions, such as the Teachers Registration Board and the Australian Health Practitioner Regulation Agency, play a critical role in ensuring people working in trusted professions are suitable to do so and meet their professional obligations.

We found that in some instances people reporting concerns about child sexual abuse (whether as a victim-survivor or a whistleblower) were let down by responses from oversight bodies. For example, we saw the Office of the Ombudsman erroneously refer some serious complaints from detainees at Ashley Youth Detention Centre back to the Centre for response without adequate oversight; inappropriate errors that have since been addressed. We also found the Integrity Commission's response to a complaint about Launceston General Hospital's management of complaints about James Griffin to be insufficient.

We also heard that understanding the role of different bodies was complicated, particularly for the broader community. Powers would begin and end at different points and intersect (or not) with other agencies. This created gaps and confusion.

External bodies need the right skills, powers and resourcing to perform their functions well. Roles and powers need to be clear to the general public and processes need to be robust and transparent to encourage trust and confidence in reporting concerns.

Recommendations to address this include:

- establishing a new Commission for Children and Young People with expertise in children's rights and safety to lead oversight of child safety practices in institutions—the Commissioner for Children and Young People should be appointed through a rigorous recruitment process, have independence over its funding and be accountable to the Tasmanian Parliament (Recommendations 18.6–18.9)
- increasing external oversight of out of home care and youth detention, including through establishing an independent community visitors program, creating an independent Child Advocate for out of home care (Recommendations 9.33, 9.34, 9.36, 9.37, 12.36 and 12.38)

- the Integrity Commission, Ombudsman, new Commission for Children and Young People and the Registrar of the Registration to Work with Vulnerable People Scheme clarifying their roles and functions as they relate to child safety and formalising information-sharing arrangements (Recommendations 18.14, 18.15)
- strengthening the powers of the Teachers Registration Board to compel information, mandate training and professional development and to suspend a teacher's registration where it receives information suggesting an unacceptable risk of harm to children and to issue infringement notices for not complying with its requirements (Recommendations 6.10, 6.12, 6.13, 6.15)
- reviewing the *Health Complaints Act 1995* so the role of the Health Complaints Commissioner can extend to administration, monitoring and oversight of the *Code of Conduct for Unregistered Health Care Workers* (Recommendation 15.21).

7 The structure of our report

Our report has eight volumes. In addition to this summary volume, Volume 2 provides details about the establishment and conduct of our Inquiry, the international, national and Tasmanian context within which this Inquiry has been conducted, and our understanding of the extent and causes of child sexual abuse in institutional contexts.

Volumes 3 through 6 of our report summarise the evidence we heard, and outline our findings and recommendations for specific institutions. In Volume 3, we discuss child sexual abuse in Tasmanian government schools. In Volume 4, we discuss child sexual abuse in out of home care. In Volume 5, we discuss child sexual abuse in youth detention. In Volume 6, we discuss child sexual abuse in health services, in particular at Launceston General Hospital. These volumes differ in their structure, style and approach, which reflects the nature and extent of the evidence we received. Where possible, we have included specific case studies, examples or summarised a particular experiences of an institution. Some of the victim-survivors who contributed their accounts were still in institutional settings at the time of writing this report.

Volume 7 outlines the gaps we have identified in the criminal and civil justice systems that may serve to undermine children's safety in institutions and create unnecessary barriers for victim-survivors seeking justice. It provides our findings and recommendations about how the justice system can be improved to better prevent and respond to child sexual abuse. Our final volume, Volume 8, outlines the need for system-wide reforms and makes recommendations for monitoring the Tasmanian Government's reforms in response to our recommendations.

Below we summarise the key contents of each volume, including an overview of our significant recommendations in each volume.

7.1 Volume 2—Establishment and context

In **Volume 2**, we provide the contextual information necessary to guide readers on the scope of our Commission of Inquiry and to help them navigate the challenging scenarios and discussions that we document over the other volumes of this report. This contextual information includes details about where our Inquiry fits in time, place and relative to broader approaches to understanding and acting on child sexual abuse, both globally and nationally. Volume 2 also includes an overview of what we know—largely from the research of the National Royal Commission—about the nature and risks of child sexual abuse in institutional settings.

In **Chapter 1 Establishment, scope and conduct**, we outline the events leading to the announcement of our Commission of Inquiry in November 2020. We go on to explain our powers as authorised by the Order of the Governor establishing our Inquiry, our terms of reference and the Commissions of Inquiry Act. This includes a discussion of relevant legislation and how it has affected our work, including our ability to make adverse findings and findings of misconduct.

Chapter 1 then provides broad details about how our Inquiry was conducted, including who informed our Inquiry and through what forums, how we managed the information they contributed, and the broad insights we gained from different individuals and groups.

In **Chapter 2 The Tasmanian, national and international contexts**, we locate our Commission of Inquiry in the broader legal and political landscape relevant to understanding, preventing and responding to child sexual abuse. We consider Australia's international obligations in relation to children and young people, outline how the National Royal Commission has informed our Commission of Inquiry, and summarise key national strategies and frameworks to address child sexual abuse in institutions.

Chapter 2 also looks at the history of Tasmania's examination of child sexual abuse and the key agencies, frameworks, programs and plans operating at the state level to respond to such abuse. These include statutory agencies, oversight bodies and justice and redress avenues for victim-survivors. We have included the most current data available to present a socio-demographic profile of Tasmania, which sheds light on the local culture within which child sexual abuse has occurred and is being called into question.

We note that the Tasmanian Government and its institutions have already begun to respond to problems revealed in the public hearings of our Commission of Inquiry. As noted, in May 2022, the Government announced the 'Keeping Children Safer' reforms, which include appointing senior staff to respond to incidents of child sexual abuse in schools, initiating a Child Safe Governance Review of Launceston General Hospital and planning for the closure of Ashley Youth Detention Centre to establish new

youth justice facilities. In December 2022, the Commissioner for Children and Young People announced an investigation into the case management of children and young people in out of home care.

The Government has committed to publicly reporting on the progress of these actions through a dedicated website, which will also include information on the implementation of the recommendations we make in this report.

In **Chapter 3 Child sexual abuse in institutions**, we describe different forms of child sexual abuse and consider the risks of such abuse occurring in institutions. We also describe the profound effects of child sexual abuse on victim-survivors, their family members and communities.

We outline two different forms of child sexual abuse most relevant to our Inquiry—non-penetrative contact abuse and penetrative abuse—and discuss harmful sexual behaviours. We pay particular attention to grooming, which is a strategy abusers commonly use to enable and conceal their sexual abuse of a child or young person. Grooming can be so effective that the child or young person (and, in some cases, the adults around them) believe they 'consented' to sexual acts or that they are in a 'relationship' with the abuser. Abusers also groom adults who work with children in institutions, including their colleagues and managers.[29]

We discuss child sexual abusers in an institutional context. Some abusers actively seek out institutional settings to sexually abuse children.[30] Other abusers may only begin abusing children once they are in an institution where the culture and environment enables them to overcome their inhibitions.[31] Professional boundary breaches of employees in institutions are a key warning sign of the risk of child sexual abuse.[32] Abusers may 'test' how resistant an institution's culture is to the perpetration of child sexual abuse by breaching boundaries incrementally and then more egregiously with each breach they get away with.[33]

In Chapter 3, we also consider the features of an institution itself—the cultural, operational and environmental features of the institution—that can increase the risk of abuse occurring, or contribute to the failure of staff to identify or respond appropriately to child sexual abuse. The leadership, management and governance structures, norms as well as the physical and online environment of an institution are all important to preventing and responding to child sexual abuse. We particularly discuss 'total' or 'closed' institutions—those that exercise full control over a child's day-to-day life. In these institutions, children are subject to strict rules and procedures, are entirely dependent on the institution, and are isolated from the outside world.[34] Because closed institutions are not common environments, they can become 'alternative moral universes'—the cultural norms and rules are established and maintained wholly within the institution and are distinct from the norms and rules of general society.[35] Such environments can enliven a culture of humiliating and degrading children, including through child sexual

abuse. Youth detention and some out of home care environments are closed institutions. We also discuss in Chapter 3 the unique risks that apply to the institutions we discuss in detail in Volumes 3, 4, 5 and 6 of this report—namely schools, out of home care, youth detention centres and health institutions. There is a greater risk of child sexual abuse in any institution that does not facilitate opportunities for children to communicate their views or that does not respect the views of the children under its care.[36] There is also a greater risk of child sexual abuse in institutions that do not have clear and appropriate child-centred policies to educate and guide staff in preventing, detecting and responding to misconduct against children.[37]

The harm caused by sexual abuse is profound and far-reaching. In Chapter 3 and throughout our report, we hear directly from victim-survivors, their families and other members of their community about the nature of this harm.

'Institutional betrayal' is a particular form of harm related to institutional child sexual abuse.[38] Institutional betrayal refers to the failure of an institution to provide a safe environment for a victim-survivor, as well as an institution's failure to act once a disclosure of abuse is made. When an institution chooses to prioritise protecting itself from public criticism or legal action by minimising, denying or concealing concerns about abuse, the risk that abuse will occur or continue to occur, and the number of children affected, is likely to increase.[39] In turn, many children and young people, their families and the broader community may lose trust in some of Tasmania's institutions.

We identified a strong—and understandable—sense of institutional betrayal from many of the victim-survivors and institutional staff who contributed to our Inquiry.

7.2 Volume 3—Children in schools

In **Volume 3**, we consider the Tasmanian Government's responses to child sexual abuse in state government schools. Although our terms of reference limit our Inquiry to government schools, much of the information and many of the recommendations in this volume will be relevant across the education system, not least because all teachers, including those working in non-government schools, must be registered with the Teachers Registration Board.

We acknowledge that, overwhelmingly, teachers and school staff are committed to ensuring the safety, wellbeing and educational achievement of students in their care and that many teachers will shape the lives of their students for the better. However, over the course of our Inquiry, we were made aware of too many instances where students were not kept safe.

In the first chapter of Volume 3, **Chapter 4 Background and context: Children in schools**, we provide an overview of the roles and functions of the Department for Education, Children and Young People (previously the Department of Education).

The Department oversees education services for more than 60,000 students in 195 government schools across Tasmania and employs about 11,000 people, including 5,700 teachers (of which more than 500 are principals and assistant principals).[40] The Department is responsible for responding to incidents of child sexual abuse in educational settings, which includes investigating complaints, supporting victim-survivors and disciplining employees who have engaged in misconduct.

We note that in August 2020, before establishing our Commission of Inquiry, the Tasmanian Government announced an Independent Education Inquiry. In late 2021, the Government publicly released findings and recommendations of the Independent Education Inquiry, although not the whole report. We discuss this report in Chapter 4. The Department accepted all 20 of the Independent Education Inquiry's recommendations.

In **Chapter 5 Case studies: Children in schools**, we consider eight cases where the Department had investigated allegations of abuse to better understand the Department's policies and disciplinary systems in response to a disclosure of child sexual abuse or harmful sexual behaviours in an education setting. Three of these cases were about abuse that occurred before 2000 but involved the ongoing response of the Department or the justice system.

These cases highlight several systemic shortcomings in the Department's responses to child sexual abuse and the impact of this on victim-survivors. They demonstrate that the initial response by school authorities to a disclosure of abuse was frequently inappropriate, showing a lack of understanding of what constitutes child sexual abuse and grooming behaviour. At times, children were simply disbelieved, with school authorities being unwilling to accept their accounts of abuse. This led to authorities supporting and protecting the alleged abusers, rather than the children involved.

In some of the cases we reviewed, we noted that responses to disclosures of child sexual abuse often did not comply with departmental policies and procedures. Further, they show that the policies and procedures available were inadequate for responding to abuse, which was particularly apparent for harmful sexual behaviours. The case studies also highlight a general lack of support, care and communication for the children and young people who disclosed abuse, and for their families, sometimes with lifelong impacts. We also heard negative experiences of victim-survivors, now adults, trying to obtain information and acknowledgment from the Department.

We identified problems with the disciplinary framework for managing allegations of child sexual abuse in schools. There were also significant gaps in information sharing within and across schools, the Department and the Teachers Registration Board, as well as in the powers and functions of the Teachers Registration Board. In one case, these gaps allowed a teacher with multiple allegations to be employed by the Department as a relief teacher in multiple schools despite past concerns about his behaviour in interstate schools.

In the final chapter of Volume 3, **Chapter 6 The way forward: Children in schools**, we review the Department for Education, Children and Young People's child safeguarding measures, recognising that these measures are a work in progress as the Department continues to respond to recommendations of the National Royal Commission and implement the recommendations of the Independent Education Inquiry. Rather than duplicate the work of the Independent Education Inquiry, we endorse its recommendations and focus our attention on issues that fall outside that inquiry's terms of reference or complement their reforms. These issues include access to education about child sexual abuse for staff and students, the Department's disciplinary framework for managing complaints of sexual misconduct in schools, and the powers and functions of the Teachers Registration Board.

Child sexual abuse prevention education programs are important for safeguarding students because of the role they play in empowering children and young people in their bodily autonomy and navigating any threats to their safety. We recommend that prevention education should be mandated across all schools and within government-run early learning preschool programs, through to Year 12. The Department should introduce and fund this education as part of the Australian curriculum.

We affirm the Department establishing the Office of Safeguarding Children and Young People in response to recommendations from the Independent Education Inquiry. A dedicated focus on child safeguarding policy and resourcing Safeguarding Leads in schools is necessary to ensure the right systems are in place to reduce the risks of child sexual abuse and respond appropriately. Although the Department has indicated that it would like to broaden the Office's remit to all child-facing service areas of the Department, our view is that it should stay focused on prevention, risk identification, policy development and related workforce development in schools.

The regular contact between teachers and students, sometimes over many years, means teachers are uniquely placed to notice concerning changes in the behaviours of their students, which may indicate they are being abused. Teachers are sometimes the most trusted adult in a child's life. For these reasons, all teachers, as well as others working and volunteering in schools, should be trained to identify abuse at the earliest opportunity and to respond with sensitivity and confidence if a student discloses abuse to them. Educators should also be confident of their professional and legal obligations, particularly in relation to maintaining boundaries with students and mandatory reporting of abuse. For these reasons, we recommend that the Department adopts mandatory child safeguarding training for all education staff and volunteers, with different levels depending on the skills and knowledge requirements of attendees.

The disciplinary process is central to the Government's response to allegations of child sexual abuse against staff. For this reason we recommend in Chapter 6 that the Tasmanian Government establishes the Child-Related Incident Management Directorate,

whose role it is to receive, assess, investigate, coordinate and oversee responses to allegations of child sexual abuse by staff, including for allegations of child sexual abuse by staff in schools.

We also make recommendations in Chapter 6 about improved departmental policies, including a professional conduct policy, responding to harmful sexual behaviours in schools, and ensuring these are regularly reviewed and publicly accessible.

The Teachers Registration Board is central to regulating the professional conduct of teachers, although it has been constrained by limited powers and a lack of information and coordination with the Department. We recommend that the Tasmanian Government enacts legislation to compel relevant entities to notify the Teachers Registration Board when the entity becomes aware of concerns about sexual misconduct by a teacher, and to involve the Board in any investigation. We also recommend that the Government amends the *Teachers Registration Act 2000* to allow the Board to immediately suspend the registration of a teacher who poses an unacceptable risk of harm to students, to better monitor where teachers are working, to take enforcement measures more easily against schools employing unregistered teachers, and to set minimum professional development requirements for teachers.

7.3 Volume 4—Children in out of home care

In **Volume 4**, we consider the risks of and responses to child sexual abuse, harmful sexual behaviours and child sexual exploitation in out of home care settings, and make extensive recommendations to significantly reform the out of home care system. Out of home care services are part of Tasmania's statutory child protection system. The Department for Education, Children and Young People is responsible for children in out of home care, which used to sit with the Department of Communities.

Under the *Children, Young Persons and Their Families Act 1997*, the Secretary of the Department can become the guardian of a child if a child is at risk of harm in their home environment. The Department is responsible for determining where a child should live, making arrangements for the child's education and medical treatment, and providing for any of the child's other needs. As part of its duty of care to children under its guardianship, the Tasmanian Government is obligated to protect children in out of home care from abuse, including sexual abuse. To help the Tasmanian Government to meet this duty, we call for an extensive rebuilding of the out of home care system.

Out of home care settings should provide for children and young people to heal from the harm that has led to the State assuming responsibility for their care. Instead, we found that such settings are, too often, causing more harm to children and young people and increasing their vulnerability to child sexual abuse. The out of home care system requires urgent attention and resourcing to turn this around.

In the first chapter of Volume 4, **Chapter 7 Background and context: Children in out of home care**, we look at how the statutory child protection system functions in Tasmania, including the Department's organisational structure for administering out of home care, how a child enters the system, and the known risks of child sexual abuse in care. We also summarise the findings of the National Royal Commission relevant to out of home care and the many Tasmanian reviews of the child protection system that have been conducted since the early 2000s. An assessment of the Department's progress in response to these previous reviews and recommendations gave us an indication of what more needs to be done to keep children in out of home care safe from sexual abuse.

While the number of children in out of home care in Tasmania has fluctuated in any given year since 2007, overall, numbers have increased. As of April 2022, there were 1,256 children in out of home care in Tasmania.[41] Approximately 90 per cent of children in care are cared for by foster or kinship carers in private homes. As of 30 June 2021, there were more than 563 Tasmanian households formally caring for at least one child in out of home care.[42] Approximately 6 per cent of children in out of home care in Tasmania are in 'residential care'; that is, they are placed with other children in a group residence supervised by rostered staff.

Children in out of home care are much more likely to experience maltreatment, including sexual abuse, than children who are not in out of home care.[43] This abuse may be perpetrated by employees and carers (within the Tasmanian Government, or in the non-government out of home care sector) or other members of a carer's family. The abuse may also be perpetrated by adults outside the out of home care system, through child sexual exploitation or by other children in care.

Some children and young people are at greater risk of sexual abuse in out of home care. Aboriginal children are more than five times more likely to be in out of home care than non-Aboriginal children.[44] More contact with out of home care institutions corresponds with a greater likelihood of being sexually abused.[45] The risk of sexual abuse is also heightened when an Aboriginal child's connection to community and culture is undermined by their out of home care placement.[46]

More than 20 per cent of children in out of home care in Tasmania have a known disability.[47] Children with disability in out of home care may need assistance with intimate care activities, may have less control over their daily lives and may have more difficulty communicating their needs to others. These factors increase their vulnerability to sexual abuse.[48]

The National Royal Commission made 22 recommendations aimed at improving the safety of children in out of home care. Since 2003, there have also been more than 20 reviews conducted into the child protection system in Tasmania, which amounted to several hundred recommendations—many of which remain unimplemented. These reviews have repeatedly highlighted that, despite attempts to reform the child

protection system in Tasmania, the safety of children in out of home care continues to be undermined by inappropriate placements, not enough support for carers, inadequate monitoring of care arrangements, poor complaints processes and a lack of accreditation, registration and licensing systems for providers.

In **Chapter 8 Case examples and our approach: Children in out of home care**, we clarify the scope of our Inquiry into the safety of children in out of home care, identifying that we have focused on out of home care specifically, and only include those aspects of the wider statutory child protection system that relate to the risk of sexual abuse for children in care.

We discuss the sources of evidence that we drew on to understand the problems and potential solutions for the out of home care sector in Tasmania—including the accounts of victim-survivors, the concerns of numerous professionals who had worked in the out of home care system, and the case files of 22 children in the care of the Department—as a sample of those who were identified as having been at risk of, or had experienced, child sexual abuse while in care since 2013.

We have identified several systemic problems with Tasmania's out of home care system, including:

- challenges in adopting measures to prevent child sexual abuse, including ensuring appropriate placements of children
- difficulties with consistently putting in place risk mitigation strategies when risks are identified, such as providing early treatment for serious and concerning harmful sexual behaviours
- not consistently addressing the trauma children have experienced before or during their out of home care experience, which increases their risk of child sexual abuse or reduces their confidence in disclosing such abuse
- not consistently addressing the cultural needs of Aboriginal children, increasing their risk of child sexual abuse or reducing their confidence in disclosing such abuse
- not enough supports for staff and carers to manage risks of child sexual abuse, or to respond appropriately when it occurs
- inconsistent and uneven responses when children disclose child sexual abuse while in care.

We consider that these problems are, at least partially, a result of a system under pressure. We heard of a system that has been chronically underfunded, a culture that resists open scrutiny, and trauma within the system itself. These problems need to be addressed through changes to the systems and processes of out of home care broadly, rather than tweaks to the system.

In **Chapter 9 The way forward: Children in out of home care**, we contemplate significant reform of the out of home care system. We outline improvements to the out of home care system to strengthen the systems and structures that can reduce the risk of sexual abuse for children in care, as well as improving how the Department responds when abuse occurs. We also make recommendations to improve the independent oversight of the out of home care system.

We consider that, fundamentally, the chronic underfunding of out of home care services and the statutory child protection system more generally must be corrected as a matter of urgency. We recommend a significant increase in ongoing funding of the out of home care system, as well as once-off funding to ensure our reforms are implemented.

We recommend that the Tasmanian Government completes its outsourcing of all out of home care services to non-government providers while the Department retains responsibility for setting the strategic framework for out of home care, for case management and for monitoring and supporting quality care. New funding guidelines should be developed for these organisations, requiring them to prove compliance with the Child and Youth Safe Standards and the National Out of Home Care Standards and to deliver trauma-informed, therapeutic services to children and young people in out of home care.

'Foundational pillars' are required within Child Safety Services and out of home care to support staff to operate with confidence and to make complex decisions about the safety of children in out of home care. We consider these foundational pillars of an out of home care system to be expert and active leadership, strong governance structures with internal accountability, a clear strategic direction for the out of home care sector, public and transparent policies, outcomes and performance reporting, and a strong and capable workforce. A central feature of these reforms is that children must be involved in designing the system that cares for them, through empowerment and participation strategies, including establishing a permanent out of home care children's advisory group.

Increased accountability for the Government will motivate it to improve out of home care. To this end, we recommend that the Government restructures the leadership of the Department to further support the Department's role and responsibilities as statutory guardian. In addition to the current roles, this involves appointing executive leadership specifically for out of home care and appointing a Chief Practitioner to lead the practice improvement activities of the Department.

Quality improvement and safety will be achieved through developing an outcomes and reporting framework and a Quality and Risk Committee that monitors the system performance of out of home care, oversees children's safety and wellbeing in out of home care, including child sexual abuse, and monitors progress on implementing the Child and Youth Safe Standards and the national out of home care standards.

The Department's workforce strategy should include measures to increase staff numbers, retention and wellbeing. It should prioritise providing mandatory professional development for all out of home care staff, including ensuring child safety officers have enough knowledge to identify and respond to child sexual abuse and trauma to perform their important role. Further, a new professional conduct policy specific to the out of home care context should be developed to assist managers, staff and carers to understand and meet standards of conduct when interacting with children in care.

The Department must have a clear line of sight to each child in care, so risks of abuse can be identified and addressed at the earliest opportunity. We recommend that an individual case manager, supervised by a more experienced practitioner, be assigned to every child in out of home care. The Department must also have a clear line of sight to every carer. All carers should be registered on a Carer Register and satisfy annual reviews as a condition of maintaining their registration.

The Aboriginal and Torres Strait Islander Child Placement Principle ('Placement Principle') is Australia's national policy framework for preventing Aboriginal children from entering the out of home care system. To date, the Tasmanian Government's implementation of the Placement Principle has been limited. An Office of Aboriginal Policy and Practice, led by an Executive Director for Aboriginal Children and Young People, should be established to oversee the implementation of the Placement Principle and to ensure the interests of Aboriginal children in out of home care are represented in all the Department's activities. This is essential to help reduce the over-representation of Aboriginal children in care and the increased vulnerability to institutional child sexual abuse this creates.

It was clear to us that children and young people with disability need tailored supports to improve their safety in out of home care. We recommend all children in care should have access to holistic assessments to meet their needs and that the Department appoints a specialised role to support children in out of home care to access the National Disability Insurance Scheme.

The Department has lacked a clear process for responding to concerns about the safety and wellbeing of children in care. We therefore recommend that the new Chief Practitioner receives and triages all complaints and concerns about the safety and wellbeing of children in care. Where concerns involve the behaviour of a staff member, the Child-Related Incident Management Unit—recommended and discussed at length in Volume 3—should respond to reports of misconduct, including conducting investigations. The Chief Practitioner should oversee the responses to all other types of concerns or complaints about the safety and wellbeing of children in care, including those relating to harmful sexual behaviours, child sexual exploitation and child sexual abuse by carers. The Chief Practitioner will then report on all concerns and complaints to the Quality and Risk Committee to inform quality improvement. We consider that the

Department should develop policy responses to harmful sexual behaviours and child sexual exploitation that collaborate with other agencies such as police and schools. Such approaches have been developed with some success in other Australian states.

In particular, in Chapter 9, we recommend that the Department establishes a Harmful Sexual Behaviours Support Unit, overseen by the Chief Practitioner, to support all child-facing areas in the Department, including out of home care services, to manage harmful sexual behaviours by providing advice, guidance and support and context-specific policies.

Given the vulnerability of children in out of home care, there is a need to strengthen individual advocacy and systemic oversight. In Chapter 18, we recommend the new Commission for Children and Young People be empowered to undertake systemic inquiries into out of home care services and recommend ongoing improvements to the structure and operation of the Tasmanian statutory child protection system. In addition, a new independent Child Advocate should sit within the Commission as a Deputy Commissioner. The Child Advocate should employ community visitors to regularly check in with children in out of home care and report back on their needs and concerns.

7.4 Volume 5—Children in youth detention

In **Volume 5**, we explore the long history of allegations of child sexual abuse in Ashley Youth Detention Centre, Tasmania's primary dedicated youth detention facility. We consider child sexual abuse is not merely a historical problem for the Centre but remains a live and current risk. We observed a closed institution with a culture that enabled the humiliation and degradation of children, rationalised because the children were seen as 'the worst of the worst'. We remain particularly concerned about the safety and welfare of detainees. The Department for Education, Children and Young People is responsible for children and young people in detention, which was previously the role of the Department of Communities.

In **Chapter 10 Background and context: Children in youth detention**, we describe the heightened risk of children in detention being sexually abused. Many children who enter youth detention have experienced some form of childhood trauma, placing them at greater risk of further abuse, including sexual victimisation and assault.[49] Internationally, about 7 per cent of girls and 6 per cent of boys in detention are exposed to sexual victimisation, either from other detainees or staff.[50]

The nature of youth detention facilities, as highly controlled environments that are largely closed off from the world, also increases risks that staff will adopt attitudes of control and punishment, which can lead to children being dehumanised.[51]

We then describe the international, national and state-based laws and standards that apply to the detention of children and young people, including for strip searches (sometimes called 'unclothed searches'), the isolation of detainees and use of force

against them, as well as rules around punishment, noting that the *Youth Justice Act 1997* prohibits punishment intended to inflict physical pain or discomfort, that intimidates or humiliates detainees or involves any abusive or discriminatory practices.[52]

We describe how youth detention works in practice in Tasmania, including the management structure, how Ashley Youth Detention Centre is staffed and run, how key decisions are made (for example, about which units detainees are placed in or how detainee behaviour is managed) and in incident reporting and oversight.

Ashley Youth Detention Centre has been the subject of multiple reviews, with 17 internal and external briefings, reports and reviews completed since 2003. Although few looked at child sexual abuse directly, all identified risks to the safety of detainees. We summarise the findings of these reports, which consistently identified systemic problems in how detainees are treated, seemingly with little improvement over time. We found there was no lack of guidance and information on how the Centre could be improved, only an absence of political will to see through such necessary reforms. This has, in our view, contributed to a crisis in Ashley Youth Detention Centre that must be addressed by its closure and significant reform of youth detention.

In **Chapter 11 Case studies: Children in youth detention**, we share seven case studies looking at different aspects of Ashley Youth Detention Centre. In Case study 1, we describe the nature and extent of abuse at the Centre, including the evidence we received from a number of current and former detainees, as well as allegations made through redress schemes and civil claims. This evidence is harrowing, describing abuses that are callous, cruel and degrading. Children and young people's powerlessness in the face of such ingrained abuse and mistreatment is palpable and devastating. The consistency of themes across all these accounts, despite coming from multiple sources, are striking and include:

- sexual, physical and psychological abuse of detainees by staff
- harmful sexual behaviours between detainees, sometimes with the knowledge of Centre staff
- staff using strip searching as a tool of control, and as an opportunity to sexually abuse children and young people
- staff humiliating, belittling and threatening detainees
- inappropriate use of isolation and use of force, including to punish and control detainees.

While we did not test the truth of individual accounts, we gave particular weight to the consistency across the accounts of victim-survivors whom we heard from directly and the accounts we read in claims under the Abuse in State Care Program and the National Redress Scheme. Despite being the accounts of different people detained at the Centre

over different periods, and the information coming from direct accounts, critical incident reports and state and Commonwealth redress schemes, we saw a striking consistency (and enough variability) in the accounts of where and how abuses occurred, the people they alleged were responsible and the patterns and consistency in specific sexually abusive behaviours.

Taken together, alongside previous reviews and the evidence we received about a longstanding corrosive culture that doubts and disbelieves reports by detainees, we find that for decades some children and young people detained at Ashley Youth Detention Centre experienced systematic harm and abuse.

In Case study 2, we examine the extent of harmful sexual behaviours at the Centre and responses to such behaviour. We include some accounts of former detainees who describe sexual harm by other detainees at the Centre and how this was often ignored by staff. We also heard allegations that staff sometimes actively used the harmful behaviours, including sexual behaviours, of some detainees to control or frighten other detainees. We make findings in this case study about the failures in responding appropriately to the risks of harmful sexual behaviours, which are listed later in this volume and explained further in the case studies. In particular, we find that Ashley Youth Detention Centre has been aware of harmful sexual behaviours at the Centre and has not taken steps to protect children and young people from these harms.

Case studies 3 and 4 examine isolation and use of force at the Centre and make a range of findings that these practices have been misused, sometimes excessively and unlawfully, to punish and degrade detainees in breach of their human rights. In particular, we find that:

- using isolation as a form of behaviour management, punishment or cruelty has been a regular and persistent practice at Ashley Youth Detention Centre since at least the early 2000s, and in July 2023, we received information to suggest that some harmful practices, such as isolation, are still occurring
- the excessive use of force has been a long standing method of abusing children and young people by some staff at Ashley Youth Detention Centre, and the Department and Tasmanian Government have not always responded appropriately.

When the isolation of young people at Ashley Youth Detention Centre is unauthorised, unregulated and unreported, or there is excessive use of force, the risk of and opportunities for the physical and sexual abuse of young people increase. Such belittling and dehumanising practices also reduce the likelihood of children and young people making disclosures of child sexual abuse because their sense of what is right and wrong, trust in adults at the Centre and self-worth have been undermined. Case studies 5 and 6 have examples of how complaints about the safety and treatment of detainees have been managed—including complaints by a staff member called Alysha (a pseudonym)

and a detainee called Max (a pseudonym).[53] We make findings about the State's, the Department's and the Centre's response to these complaints, and identify systemic problems in these responses.

Case study 7 describes how the Department has responded to alleged sexual abuse of detainees by staff at Ashley Youth Detention Centre. This traces revelations from the Abuse in State Care Program (which began in 2003) and the perceived legal barriers that the Department told us limited its ability to act against staff, despite sometimes receiving multiple allegations of serious sexual assaults by staff still working at the Centre. Over time, corporate memory of the Abuse in State Care Program (and the information it revealed about current staff) was lost within the Department. Another wave of information alleging abuses by current and former staff came with the introduction of the National Redress Scheme in 2018, which was also met with confusion and inaction because of legal advice and practices that precluded use of that information, until a belated change of practice in the second half of 2020. We make a range of findings about failures to manage risks to detainees arising from this information.

Children and young people must be safe in youth detention. In **Chapter 12 The way forward: Children in youth detention**, we look beyond the disturbing picture of youth detention in Tasmania to the future, making a raft of recommendations, all of which we consider are necessary to deliver safety.

At the beginning of Chapter 12, we acknowledge that the Tasmanian Government has committed to a reform agenda for the youth justice system in its *Draft Youth Justice Blueprint 2022–2032: Keeping Children and Young People out of the Youth Justice System*, which contains strategies designed to achieve many of the changes we agree need to occur.[54] However, we consider the Government needs to do more to keep children in detention safe.

The Tasmanian Government should close Ashley Youth Detention Centre as soon as possible. Once closed, the Government should establish a memorial to victim-survivors of abuse at the site as a tangible, public acknowledgment of their experiences, trauma, pain and suffering. For victim-survivors seeking redress, it is critical that the Government develops a process to preserve historical records relating to children and young people and staff connected with the Centre.

Cultural change is fundamental to making Ashley Youth Detention Centre and future detention facilities safer for children and young people. We make several recommendations in the areas of leadership, governance, children's participation and staffing to help create a child safe culture in youth detention where the risk of child sexual abuse is minimised. These include recommendations designed to ensure staff in detention facilities have the right qualifications, attributes and skills to work constructively and therapeutically with children in detention. They also include: continuing professional development for staff on expected standards of behaviour

in interacting with children in detention; approaches to setting fair, clear and firm boundaries for children's behaviour; and training in all custodial policies and procedures.

We have made the significant recommendation that the Department initiates a change management process that requires all staff to reapply for their positions. We consider that such a process is essential to change the culture in youth detention. It will also enable staff who are reappointed to clearly identify themselves as being a part of Tasmania's future youth detention system, rather than its past.

This recommendation, alongside others, may well add to pressure on staffing levels in the short term. The Tasmanian Government must urgently develop a staffing contingency plan for youth detention to ensure children and young people in detention are not subjected to unnecessary lockdowns and that their rights are not trumped by 'operational' considerations.

We also recommend that the Department maintains enough youth workers to implement a therapeutic model of care in youth detention, avoid lockdowns and ensure the safety and wellbeing of children, young people and staff in detention facilities.

The most effective way to protect children and young people against the risk of sexual abuse in youth detention is to prevent them entering or re-entering detention. It follows that strategies to divert children and young people from the youth justice system and from detention should be prioritised. Our recommendations include a strong focus on increasing opportunities for bail, reducing the number of children who are remanded to custody and ensuring detention is an option of last resort.

Strategies underpinned by Aboriginal self-determination are urgently needed to divert Aboriginal children and young people from the youth justice system and to reduce their over-representation in youth detention. Cultural safety for Aboriginal children and young people in detention must also be strengthened.

We consider that an effective youth detention system is one that is child-focused—that is, one that provides children and young people in detention with timely access to high-quality, developmentally appropriate therapeutic supports, education and health care, as well as support to address the underlying causes of their offending. These features are necessary to reduce reoffending and promote community safety.

Harmful sexual behaviours are a known risk in detention environments, and we heard numerous instances where children and young people were harmed by this form of sexual abuse at Ashley Youth Detention Centre. We recommend the Government develops a clear policy for preventing and responding to harmful sexual behaviours in youth detention, which considers the full range of harmful sexual behaviours that may occur in that setting, so all children and young people involved can get help. It should explore therapeutic prevention programs and ensure timely access to specialist interventions. This must be done in conjunction with our other recommended measures

to improve the Government's response to harmful sexual behaviours in institutional settings, including the Harmful Sexual Behaviours Support Unit in the Department for Education, Children and Young People to support consistent, high-quality practice in identifying and responding to harmful sexual behaviours.

It was apparent from evidence we heard that the inappropriate, and possibly unlawful, use of searches, isolation and force at Ashley Youth Detention Centre occurred as part of a broader culture that enabled abuse, including sexual abuse, of children and young people in detention. Although legislative and procedural improvements have recently been implemented for searches of children and young people in detention, we recommend that the Government introduces body scanner technology in youth detention to reduce the need for more intrusive searches and strengthen safeguards in custodial procedures for searching children in detention.

Children and young people have been, and continue to be, subjected to extensive isolation practices at Ashley Youth Detention Centre, whether because of staff shortages or as a response to difficult behaviours. Such practices interfere with children's access to education, exercise and health care, and have serious, detrimental effects on their health and wellbeing. We recommend changes to the Youth Justice Act to clarify the definition of 'isolation' and criminalise its use as a punishment.

Custodial procedures for searches, isolation and the use of force should be updated and published on the Department's website. We also recommend that Ashley Youth Detention Centre (and any future detention facility) reports regularly on the use of searches, isolation and use of force to the Secretary, the new Quality and Risk Committee and the new Commission for Children and Young People. The Department should record, report and publish separate information on lockdowns to enable further oversight of this practice.

Effective complaints processes are critical to creating a safe detention environment. If a child in detention has a concern about their safety, including a concern about child sexual abuse, they should feel confident to speak up and know they will be listened to and that their concern will be taken seriously and acted upon, without reprisal. Children in detention also need clear, developmentally appropriate processes for raising concerns and making complaints.

We recommend that all serious allegations against staff in detention that involve concerns about the safety of children and young people—including child sexual abuse, boundary breaches and inappropriate searches, isolation or use of force—be referred immediately to the new Child-Related Incident Management Directorate. This Directorate should be responsible for investigating the allegation and ensuring children and their families are informed of the progress of the investigation and the Department's response. We also recommend that staff in detention facilities have clear processes for raising safety concerns about their colleagues.

Independent external oversight is a vital part of safeguarding children in detention facilities, where contact with people outside the facility is heavily controlled, regulated and limited. To help identify and minimise the risks of child sexual abuse, children in detention need access to regular visits from the staff of an independent oversight body who have the skills and experience to build rapport and trust with detainees and to advocate on their behalf. To this end, we recommend that the Government establishes an independent community visitor program for children in detention, to be administered by the new Commission for Children and Young People and led by the new Child Advocate.

We also recommend that the new Commission for Children and Young People, as an independent body with specialist expertise in children, be given broad functions to monitor the youth detention system and the safety and wellbeing of children in detention. In addition, we recommend that the Government appoints the new Commission for Children and Young People as a child-specific National Preventive Mechanism in accordance with the Optional Protocol to the Convention Against Torture. The Government must resource the new Commission to perform these various functions.

7.5 Volume 6—Children in health services

In **Volume 6**, we focus on the safety of children and young people in Tasmanian health services.

The Department of Health is the system-wide administrator of Tasmania's public health system. The Department employs around 15,500 people who work across approximately 330 sites statewide, including in four major hospitals that each have a paediatric unit and offer outpatient services to children and young people.[55] The overwhelming evidence we received about child sexual abuse was connected to Launceston General Hospital. For these reasons, we focus primarily on Launceston General Hospital in this volume, although our recommendations are intended to benefit all Tasmanian health services.

As in other states and territories, external agencies are also responsible for overseeing aspects of Tasmania's health system. These agencies are: the Office of the Health Complaints Commissioner, which responds to systemic complaints about Tasmanian health services; the Australian Health Practitioner Regulation Agency and the National Health Practitioner Boards, which respond to complaints about individual registered health practitioners; and the Australian Commission on Safety and Quality in Health Care, which accredits Tasmanian health service organisations against the National Safety and Quality Health Service Standards.

We met many health workers across Tasmania over the course of our Commission of Inquiry, the overwhelming majority of whom do an outstanding job in providing safe and professional care to children and young people. However, revelations that paediatric nurse James Griffin perpetrated child sexual abuse, inside and outside Launceston

General Hospital, over many years—despite former patients and hospital staff repeatedly reporting his abuse and misconduct—was one of the reasons our Inquiry was established.

What we heard about child sexual abuse at Launceston General Hospital illustrates how abusers can take advantage of the trust placed in professionals in health services, including by using their health expertise to mask their abuse. We also learned the importance of strong collective leadership, with clear accountabilities for promoting children's safety, in preventing and best responding to any identified risks to children and young people.

In the first chapter of Volume 6, **Chapter 13 Background and context: Children in health services**, we describe what is known about the risks of child sexual abuse in health services, briefly describe the Tasmanian health system and outline several previous Tasmanian reviews that have examined aspects of this system, including failures to appropriately manage the misconduct of health service employees. We conclude the chapter by summarising what we heard about the organisational culture at Launceston General Hospital and how this culture contributed to abuses occurring without sanction over many years.

There is limited data globally on the nature and prevalence of child sexual abuse in health settings.[56] Child sexual abuse in health institutions was not a specific focus of the National Royal Commission.[57] In 2020, as part of an Independent Inquiry into Child Sexual Abuse in the United Kingdom, the Truth Project published a thematic report that included findings about the experiences of victim-survivors of child sexual abuse in healthcare contexts.[58] As part of our Inquiry, we commissioned research that included exploring children's and young people's perceptions of safety in Tasmanian hospitals.[59] We also heard from the Chief Protection Officer at the South Australian Department of Health about risk factors for child sexual abuse in hospitals.

Much of the qualitative data available from these different sources was similar. A key risk factor for child sexual abuse in healthcare settings is the intimate nature of medical care, which gives health practitioners unique access to children and young people in contexts that are less likely to be questioned.[60] Other risk factors include the absence of parental supervision when a child or young person is an inpatient at a hospital and children and young people recovering in hospital rooms that are not closely monitored.[61] The evidence before us also revealed that children and young people do not feel empowered to disclose concerns about how they are being treated in health services, particularly when safe complaints pathways are not actively communicated.[62]

Over the past two decades, the Tasmanian health system has been the subject of several reviews. While none of these reviews has specifically examined child sexual abuse in health services, they are relevant because they have repeatedly highlighted

that health workplaces with dysfunctional cultures—particularly those that allow poor conduct to go unaddressed—may contribute to, or at least hinder, the identification of child sexual abuse.[63]

At consultations over the course of our Inquiry, several former and current staff members of Launceston General Hospital independently raised concerns about the hospital's culture. While we have not established that each of these concerns are true, considered as a whole, they suggest a culture that discourages complaints of misconduct and therefore allowed such conduct to go unaddressed.

In **Chapter 14 Case studies: Children in health services**, we focus on case studies relating to former employees of Launceston General Hospital. Our terms of reference specifically required us to have regard to allegations of child sexual abuse against James Griffin.[64] We received evidence about other incidents at Launceston General Hospital and decided to examine some of these more closely as well. We did this to acknowledge the efforts of the victim-survivors involved and their families to improve the safety of other children and young people, and to bring to light that Mr Griffin's abuse and the hospital's failures to respond to it appropriately were not an anomaly.

Case study 1 examines a complaint made about a health practitioner in the context of receiving a health service. This case study is subject to a restricted publication order, which means it will not be made available to the public or media. We are committed to being open and transparent. During our Inquiry, we heard evidence that, too often, people, including victim-survivors, have felt silenced or have felt unable to come forward and be heard. At the same time, we have sought to avoid prejudicing any current investigation or proceedings. Not only was this required by our terms of reference, but we are acutely aware of ensuring we did not prejudice the ability of victim-survivors to seek justice and ongoing attempts to keep children safe. It is in this context that we made a restricted publication order in relation to Case study 1. We made this order because we were satisfied that the public interest in the publishing of evidence contained in the case study is outweighed by relevant legal and privacy considerations, including avoiding prejudicing current investigations and proceedings.

Case study 2 examines a complaint by 11-year-old Zoe Duncan (now deceased) and her parents in 2001 alleging sexual abuse by Dr Tim (a pseudonym), a former doctor at Launceston General Hospital. It outlines a series of wrongful assumptions and inadequate investigations, each infecting the next. We make several findings in relation to this case study, which are listed later in this volume and explained further in Case study 2.

Case study 3 examines complaints regarding paediatric nurse James Griffin, who died shortly after his abuses against children began to be reported and exposed. We were overwhelmed by the extent of evidence about Mr Griffin's abuse over his tenure at Launceston General Hospital. The length of the case study about Mr Griffin in this chapter reflects the volume of material we received and evidence we heard, much of

which was available to the hospital and other agencies and had been for some time. Over the course of Mr Griffin's offending, there were numerous and consequential missed opportunities—by Launceston General Hospital, Tasmania Police and Child Safety Services—to intervene earlier. The number and scale of findings we make in Chapter 14 reflects the magnitude of the failures to keep children and young people safe from Mr Griffin for almost 20 years, until he was finally suspended from his employment in mid-2019 after losing his registration to work with vulnerable people following a police report.

We describe a range of systemic failings that contributed to managers and human resources staff at Launceston General Hospital not acting appropriately in response to concerns raised about Mr Griffin over the years and to an inadequate response once the scale of Mr Griffin's abuses became more broadly known. The hospital did not have clear executive accountabilities for child safety, nor a transparent system for managing complaints relevant to child safety. At times, the response to reports of professional boundary breaches in the paediatric ward where Mr Griffin worked appear to have discouraged other concerns being raised or pursued by staff. Records of complaints and concerns, when they did exist, were incomplete, inaccessible and not escalated consistently. This reduced the ability of all concerned to view each complaint in the context of cumulative complaints about Mr Griffin, which revealed a disturbing and longstanding pattern of misconduct.

Further, there was no clear process in place at the hospital for reporting complaints about staff conduct to external agencies such as Child Safety Services, the Australian Health Practitioner Regulation Agency (or its predecessor boards) or the Registrar of the Registration to Work with Vulnerable People Scheme. Consequently, ward staff, nurse unit managers, senior management and members of the executive were not aware of their distinct roles and responsibilities for reporting. We also observed a highly conservative approach to initiating disciplinary proceedings against an employee, to the significant detriment of several children who were patients of the hospital.

It was apparent to us that the leadership at Launceston General Hospital was dysfunctional, which contributed to its overall failure to keep children and young people safe from Mr Griffin and respond appropriately once his offending became broadly known. We also found problems with the decisions and actions of human resources staff in responding to an important disclosure about Mr Griffin in 2011 or 2012 and in contributing to various processes within the hospital following his suspension (and ultimate resignation and death). We carefully considered the responsibilities of individuals at the hospital relative to their roles in addressing Mr Griffin's behaviour and in the context of the dysfunctional environment within which they were operating. In some cases, the conduct and omissions of individuals in response to known risks and incidents of abuse by Mr Griffin were not justified and we make findings accordingly. We make several findings, including that human resources staff at Launceston General Hospital failed to act on a serious disclosure of child sexual abuse in 2011 or 2012 and,

later, failed to properly and accurately review Mr Griffin's complaints history, including in response to a complaint to the Integrity Commission. We also found a range of collective leadership failures in preventing and addressing the risks Mr Griffin posed but also the broader response once the extent of his offending became known. We also make a number of findings against Tasmania Police and Child Safety Services for their failures to share and act on important information each held that suggested Mr Griffin was a risk to children. We make a finding of misconduct against a former executive, who was closely involved in Launceston General Hospital's management of revelations about Mr Griffin from mid-2019 onwards, for misleading our Commission of Inquiry.

In **Chapter 15 The way forward: Children in health services**, we overview the suite of reforms that the Department of Health has begun in response to the evidence about Mr Griffin that was before our Commission of Inquiry. Some of these reforms complement the Child Safe Governance Review of the Launceston General Hospital and Human Resources, and the Launceston General Hospital Community Recovery Initiative, both of which were established, and reported their findings, during our Inquiry.[65] The Department has also implemented some reforms under its Child Safe Organisation Project, which aims to implement the National Principles for Child Safe Organisations and improve child safety in health services.[66]

We have concluded that while these recent reforms represent progress in improving child safety, it is still unclear exactly what reforms will be implemented, when and by whom. To this end, we recommend that the Department develops and publicly communicates a policy framework and an implementation plan for the reforms. This policy and plan should explain: the purpose and need for the reforms; the role, responsibilities and interactions of bodies established by the Department as part of the reforms; how the reforms will work together to provide a system-wide response to child sexual abuse in health services; how the reforms are being prioritised for implementation; who is responsible for their implementation; and the expected timeframes for implementation.

We also propose additional reforms in this report, with the objectives of ensuring child sexual abuse in the Tasmanian health system is identified and responded to appropriately when it occurs in the future, and that community trust in Launceston General Hospital and Tasmanian health services more broadly is restored.

Of national significance, recognising the risks we have identified of child sexual abuse in health settings, we recommend that the National Principles for Child Safe Organisations are a mandatory requirement for accrediting health services against the National Safety and Quality Health Service Standards under the Australian Health Service Safety and Quality Accreditation Scheme. The Tasmanian Government should advocate for this reform at the national level.

We recommend that the Department of Health's cultural improvement strategy ensures clear organisational values, has strong governance and ensures accountability of senior

managers and executives. We recommend that the Department of Health establishes processes and forums to facilitate the participation of children and young people in decisions affecting health service delivery, including a health services young people's advisory group. The advisory group should be composed of young people of different ages and from diverse backgrounds, with significant lived experience of health services. Through the advisory group, young people should have a say in departmental strategies, policies, procedures and protocols that affect them.

We recommend that the Department develops and implements a professional conduct policy for health services staff, which also applies to volunteers and contractors who have contact with children and young people. The policy should provide examples of behaviours that are relevant to the health services context. It should also reference existing professional and ethical obligations held by registered health practitioners.

The development and implementation of a clear complaints management, escalation and investigation process is critical. Noting the specialised context in which health workers operate, the Department may choose to establish a standalone Health Services Child-Related Incident Management Directorate or work to ensure the Child-Related Incident Management Directorate we recommend in Chapter 6 has access to appropriate health-related expertise to accept referrals.

The Department, Launceston General Hospital and Tasmania Police must ensure ongoing assistance to all victim-survivors of child sexual abuse by Mr Griffin, including any victim-survivors who are yet to come forward. The Department should also develop and implement a critical incident response plan to ensure measures are in place to communicate clearly and consistently, and to support the affected members of the community, in the event of a future critical incident such as a serious breach to children's safety in the public health system. The plan should identify who is in charge of leading the response to the critical incident, facilitate debriefing for community members and provide for a comprehensive review of how the incident has been handled.

Further, the Tasmanian Government should undertake a review of the *Health Complaints Act 1995* to ensure the role of the Health Complaints Commission extends to addressing systemic issues in health services related to children's safety.

7.6 Volume 7—The justice system and victim-survivors

Volume 7 looks specifically at the role that the criminal and civil justice systems, including redress schemes, play in responding to child sexual abuse, and how these systems might better serve victim-survivors of child sexual abuse in government institutions. In this volume, we discuss the criminal and civil systems, noting that while the former focuses on holding individual perpetrators to account and the latter has a broader focus on institutional accountability, they are not mutually exclusive options for victim-survivors seeking recourse for child sexual abuse.

In **Chapter 16 Criminal justice responses**, we consider recent reforms to criminal justice responses to child sexual abuse in institutional settings and what further reforms are needed. While the criminal justice system is an important mechanism for holding perpetrators of child sexual abuse to account, as an adversarial system, it is not always equipped to respond to the complex and sensitive issues that arise for victim-survivors of child sexual abuse. However, there are many ways that the system's limitations can be alleviated. We heard about the importance to victim-survivors of having a voice and of not having damaging myths and language around sexual abuse—particularly misplaced notions of consent—wielded against them throughout the criminal justice process.

The criminal justice system only works if victim-survivors feel comfortable in coming forward and making a complaint to police. How police respond to an initial report of child sexual abuse will influence a victim-survivor's willingness to continue to engage with the criminal justice system.[67] Some victim-survivors with recent engagement with police told us that police officers responded professionally and sensitively to their accounts of child sexual abuse, but others told us that their complaint was not taken seriously or that the police failed to follow up an initial complaint.

We note that in late 2020, Tasmania Police initiated an internal management review to examine the response to allegations against James Griffin, which we discuss in detail in Chapter 16.[68] This review identified multiple investigative shortcomings.[69] In response to the review, Tasmania Police developed *Initial Investigation and Notification of Child Sexual Abuse Guidelines*, and committed to establishing a specialist investigative and policy team to focus on improving police procedures relating to child sexual abuse.[70] We further note that in March 2022, the Tasmanian Government announced that it would establish three multidisciplinary centres to bring together in one location family and sexual violence support services and specialist police investigators.[71]

Investigating allegations of child sexual abuse is a highly complex task that requires specialised knowledge and skills, particularly to elicit detailed, reliable and relevant accounts from children.

We have serious reservations about the Government's intention to incorporate family and sexual violence responses with child sexual abuse responses.[72] When child sexual abuse investigations are absorbed into other units, particularly those that are busy with a high number of family violence reports, there is a risk that responding to child sexual abuse allegations (particularly when they are historical) will be overwhelmed by the immediate pressures of managing family violence offenders.

We consider that the best approach for Tasmania is to establish specialist police child sexual abuse units, separate to family violence, in Hobart, Launceston and the North West. These specialist units should work closely with other agencies. They may but do not necessarily have to be co-located. Specialist child sexual abuse units constituted by appropriately trained officers should be resourced to ensure they can build trust with

priority communities, that timely investigations of child abuse allegations are conducted and that the emotional wellbeing of officers in these units is supported. Officers in these units should only be drawn into other policing areas when there are exceptional circumstances such as natural disasters or public health emergencies.

Once an investigation of a child abuse allegation has been conducted, Tasmania Police may refer the case to the Office of the Director of Public Prosecutions, which is responsible for prosecuting an alleged perpetrator through the court system. As was the case with police, victim-survivors told us of mixed experiences with prosecuting authorities.

The Director of Public Prosecutions advised us that his office has implemented relevant recommendations of the National Royal Commission.[73] We further recommend that the Office of the Director of Public Prosecutions provides ongoing professional development to its staff relevant to managing child sexual abuse cases, including for adopting more trauma-informed processes, addressing common myths about the nature of child sexual abuse and how to talk about consent, and keeping up to date on the laws of evidence and procedure that apply in child sexual abuse cases.

We note that the Tasmanian Parliament recently passed the *Justice Miscellaneous (Royal Commission Amendments) Act 2023*. This Act removes the limitation period for child sexual abuse offences, allowing historical offences to be pursued through the courts.[74] It also introduces model provisions to address barriers to the admissibility of evidence that may show a pattern of offending behaviour by a person accused of child sexual abuse offences.[75] It also introduced the offence of penetrative sexual abuse of a child or young person by a person in a position of authority in Tasmania. While we welcome these changes to the law, we recommend the new position of authority offence covers all forms of sexual contact (not just sexual penetration).

We would like to see further amendments to criminal legislation, rules of evidence and court procedures so the full range of offending behaviour in child sexual abuse cases can be prosecuted, adult victim-survivors of child sexual offences are extended the same protective measures that are in place for children to minimise the traumatic impacts of giving evidence in court, and juries understand the dynamics of child sexual abuse so they can effectively assess evidence in trials.

It was apparent to us that there is a lack of comprehensive data about how many child sexual abuse allegations result in prosecution and conviction in Tasmania. This data would provide a means of assessing the performance of the Tasmanian criminal justice system in responding to child sexual abuse. The Tasmanian Government should prioritise collecting and publishing data about institutional child sexual abuse such as the number of reports made to police, the prosecution outcomes relative to reports, and any trends in reports and prosecutions relevant to victim-survivor cohorts, including Aboriginal people.

In **Chapter 17 Redress, civil litigation and support**, we assess the effectiveness of the three main pathways available in Tasmania to victim-survivors seeking recompense from the State for the sexual abuse they suffered as children. These pathways are the National Redress Scheme, civil litigation and victims of crime compensation. Relevant to our assessment of these pathways is a consideration of the accessibility of information and records held by the Government and its institutions. In this chapter, we also consider the importance to victim-survivors of a personal apology for the sexual abuse perpetrated against them in government institutions.

Of national significance, we discuss the National Redress Scheme that is only available to victim-survivors who were abused before 1 July 2018 and expires on 30 June 2028.[76] Noting that it can take some victim-survivors more than 20 years to disclose child sexual abuse and recognising that child sexual abuse continues to occur in government institutions, we recommend that the Tasmanian Government ensures victim-survivors of child sexual abuse in Tasmanian government institutions continue to have access to a redress scheme that applies to child sexual abuse experienced after 1 July 2018 either by advocating for the Australian Government to extend the National Redress Scheme to abuse experienced on or after 1 July 2018 or by establishing a Tasmanian redress scheme with no specified closing date for applications.

The Tasmanian Government has made several amendments to legislation that regulates civil actions in response to recommendations of the National Royal Commission. These include removing the time limitation on commencing a civil action and providing that an institution can be held vicariously liable for an employee perpetrating child abuse, in some circumstances.[77] Recent guidelines for the Conduct of Civil Claims, drafted by the Child Abuse Royal Commission Response Unit in the Department of Justice, also provide that the Tasmanian Government and its agencies must act as model litigants in response to child sexual abuse civil claims, including avoiding unnecessarily adversarial conduct.[78] In March 2023, the Tasmanian Attorney-General, the Honourable Elise Archer MP, announced that she would 'establish a new separate State Litigation Office to take over the management of the Tasmanian Government's civil litigation'.[79] We welcome this reform and recommend that the new State Litigation Office trains staff in and ensures compliance with guidelines for managing settlement processes in child sexual abuse cases in trauma-informed ways.

Despite these improvements, there are still significant challenges for victim-survivors when bringing civil claims for child sexual abuse. One of these challenges is accessing information and records relevant to a claim. According to the Tasmanian Government, an Information and Records Management Standard introduced in 2020 aligns with the National Royal Commission's records and record keeping principles.[80] However, we heard evidence of child sexual abuse allegations, complaints and investigations not being recorded, and the loss of relevant records by government institutions and departments.

There was also evidence before us that a victim-survivor's right to access information has been undermined by inordinate delays in responding to requests for information and inadequate review processes when the release of information is refused. We recommend that the Tasmanian Government reviews legislation governing access to information to ensure victim-survivors of child sexual abuse in institutional contexts can access their records and consider reforms such as an explicit presumption in favour of disclosing information related to child sexual abuse. We further recommend that the Tasmanian Government considers centralising the management of access to information requests relevant to child sexual abuse within a specialist unit or department.

Applications for compensation by victim-survivors of child sexual abuse under the *Victims of Crime Assistance Act 1976* should also be administered using trauma-informed principles. Victim-survivors should have a right of review before the Tasmanian Civil and Administrative Tribunal for decisions about the amount of compensation payable or decisions to refuse compensation.

We note that the Tasmanian Parliament recently delivered an apology to all victim-survivors of child sexual abuse in Tasmanian Government institutions.[81] Some victim-survivors who gave evidence to our Commission of Inquiry emphasised that a personal apology was also important to their healing. The Tasmanian Government should ensure individual victim-survivors of child sexual abuse who request an apology receive one. The apology should acknowledge what happened to the victim-survivors, answer any questions they might have about their time in the institution and the institution's response, and be prepared to answer questions about what steps have been taken to prevent child sexual abuse happening again.

7.7 Volume 8—Oversight, coordination and therapeutic support

In the final volume of our report, **Volume 8**, we consider how the Tasmanian Government can better coordinate and strengthen its approach to addressing child sexual abuse. The recommendations that we make in the chapters of this volume are relevant to all the institutions we consider in detail in other volumes of this report, as well as those that were outside our terms of reference.

In **Chapter 18 Overseeing child safe organisations**, we consider community-wide child sexual abuse prevention strategies recommended by the National Royal Commission and the Tasmanian Government's interest in ensuring staff and volunteers who work in child-facing organisations have a good baseline knowledge of child sexual abuse and how to respond to it.

Over the course of our Inquiry we heard evidence of, or otherwise observed, a limited understanding about child sexual abuse across the Tasmanian community and workforce. Considerable misconception about 'grooming' was apparent, as were

simplistic understandings of 'consent', including a lack of appreciation of the many ways in which consent is usually irrelevant in the context of child sexual abuse.[82] We also heard that there is a limited understanding in organisations of the spectrum of conduct that constitutes harmful sexual behaviours and how to appropriately respond, and incorrect assumptions about who is likely (or unlikely) to perpetrate abuse.

We recommend a new Commission for Children and Young People. The new Commission should subsume the functions of the current Commissioner for Children and Young People, which include advocating for, and promoting the wellbeing of, all children in Tasmania. The new Commission should also be responsible for educating relevant organisations on the Child and Youth Safe Standards and overseeing and enforcing compliance with those standards, and administering, overseeing and monitoring the Reportable Conduct Scheme. The Commissioner for Children and Young People should assume the role of the Independent Regulator. We make a range of recommendations to support the independence of the Commissioner for Children and Young People.

We consider the Child and Youth Safe Standards and Reportable Conduct Scheme operating in tandem and overseen by a well-resourced and empowered Independent Regulator, will go a long way to reducing the need for recourse to other oversight bodies, such as the Integrity Commission and the Ombudsman. However, these bodies may still play a role, particularly in addressing specific complaints and targeting the broader systemic risk factors in organisations that can increase risks of child sexual abuse.

We recommend that the Ombudsman, the Integrity Commission, the Registrar of the Registration to Work with Vulnerable People Scheme and the new Commission for Children and Young People clarify and formalise their respective functions and information-sharing arrangements and ensure these are clear to the community. We consider that the new Commission for Children and Young People will lead most oversight issues relating to child safety in institutions. However, we consider that the Ombudsman should manage formal individual complaints about the administrative actions of a public authority that do not constitute reportable conduct and that the Integrity Commission should lead the response to complaints about misconduct by public officers in agencies that are not legislatively required to comply with Child and Youth Safe Standards or the Reportable Conduct Scheme. We emphasise the importance of the Registrar of the Registration to Work with Vulnerable People Scheme in screening the suitability of individuals to engage with children and young people. We recommend legislative changes to ensure the Registrar considers potential risk to children and young people when undertaking an assessment of a person's suitability for holding registration.

In **Chapter 19 A coordinated approach**, we describe what is required to ensure there is a united approach to child safety issues across the Tasmanian Government. We recommend developing a child sexual abuse reform strategy and action plan to bring

together an extensive reform agenda, hold government and government funded agencies and statutory bodies to account for their responsibilities in implementing child sexual abuse reforms, and provide information to victim-survivors and their families, the community and government and non-government agencies about what is being done to address child sexual abuse in Tasmania.

The strategy and action plan should, among other things, describe the system for preventing, identifying and responding to child sexual abuse that Tasmania is seeking to achieve and be informed by the voices of children and young people and adult victim-survivors of child sexual abuse. It should identify agencies and role-holders involved in responses to child sexual abuse and describe their respective responsibilities in implementing reforms. People working in government and government funded agencies, statutory bodies and the broader Tasmanian community should be able to access the child sexual abuse reform strategy and action plan on a dedicated website.

It is our view that successfully implementing reforms also requires strong and sustainable leadership, accountability and governance mechanisms. We recommend that the Secretary of the Department of Premier and Cabinet, as Chair of the Secretaries Board, is responsible for overseeing the child sexual abuse reform strategy and action plan. We also recommend that children and young people and adult victim-survivors of child sexual abuse form part of the Tasmanian Government's governance structure for the child sexual abuse reform strategy and action plan through the Premier's Youth Advisory Group and establishing an adult victim-survivors of child sexual abuse advisory group.

To assist government and government funded agencies and statutory bodies to work effectively with one another and share information about child safety, the Tasmanian Government should review confidentiality and privacy provisions in legislation such as the *Children, Young Persons and Their Families Act 1997*, the *Registration to Work with Vulnerable People Act 2013* and the *Personal Information Protection Act 2004* to identify legislative barriers to sharing information across agencies for the purpose of protecting the safety and wellbeing of children and young people. Where barriers are identified, the Government should consider ways to remove them.

However, we consider the primary barrier to cross-government coordination and information sharing in the response to child sexual abuse is cultural—a deeply held view across many parts of the Government that prioritises privacy over child safety. We acknowledge that work is already underway across Tasmanian Government departments to better coordinate responses to child safety issues and information sharing. We consider that a key element missing from this work is publicly available guidance about the Government's framework for managing and exchanging information on child safety matters. To remedy this gap, we recommend that the Department of Premier and Cabinet leads development of child safety information-sharing, coordination and response guidelines to support government and government funded agencies and

statutory bodies to respond to child safety issues, including institutional child sexual abuse. The Tasmanian Government should also invest in cultural change work to achieve good information-sharing practices and to foster a culture in which information sharing leads to action to protect children.

In **Chapter 20 State Service disciplinary processes**, we consider the disciplinary processes that apply when an employee of a government institution is the subject of an allegation of child sexual abuse or related conduct. The *State Service Act 2000*, the State Service Code of Conduct and Employment Directions form the central components of Tasmania's State Service disciplinary system.[83] This system has remained largely unchanged for more than 20 years.

An increasing number of employment suspensions in the State Service due to child sexual abuse contributed to establishing our Commission of Inquiry. Despite the recent increase in suspensions, a 2021 *Independent Review of the Tasmanian State Service* reported that terminations for Code of Conduct violations in the Tasmanian State Service were much lower than in the Australian Public Service.[84]

Over the course of our Inquiry, we heard from many sources that the disciplinary system is not fit for the purpose of keeping children and young people safe from abusers employed in government institutions. There is a delicate, difficult balance incumbent on the State between exercising a duty of care to ensure the safety of children and complying with obligations to an employee in matters of alleged child sexual abuse and related conduct. We consider that, in this balance, the duty of care to children has been compromised due to both barriers in the existing disciplinary framework and its practical application.

We heard of instances where there was a reluctance to initiate disciplinary processes against an employee despite multiple complaints of child sexual abuse or related conduct being made and employees only being suspended once a formal investigation had begun or the employee had been charged by police. We heard of lengthy periods to undertake preliminary assessments of an allegation, resulting in employees subject to allegations of child sexual abuse continuing to have contact with children and young people for an extended period before any action was taken.[85] We also heard that investigations of allegations of child sexual abuse were not triaged, leading to delays in investigating serious misconduct. Also, prior unsubstantiated complaints, potentially revealing patterns of concerns about behaviour, were not considered when assessing whether an employee had breached the Code of Conduct.

Affording procedural fairness to employees who are being investigated under State Service disciplinary processes is necessary. However, it should not act as a hindrance to pursuing investigations or considerations of child safety. Immediately removing an employee from the workplace when there has been an allegation or incident of child sexual abuse is critical. Suspension should not be contingent on the commencement of an investigation. Prior complaints, allegations and disciplinary action, even if they do not

culminate in a sanction, should also be considered when making a determination about an employee's conduct when concerns about child sexual abuse and related conduct have been raised.

In Chapter 20, we recommend that child-facing departments develop professional conduct policies specific to child sexual abuse and related conduct. To ensure disciplinary action can be taken for misconduct of a sexual nature involving children, it is important to ensure a breach of a professional conduct policy may be taken to be a breach of the State Service Code of Conduct.

Heads of Agencies should ensure obligations under the State Service Code of Conduct and professional conduct policies apply to volunteers, contractors, sub-contractors, temporary staff and other relevant adults, including carers.

In conjunction with proposed legislative and policy reforms, we recommend funding initiatives aimed at education and cultural change in interpreting and applying disciplinary processes across the State Service to ensure the protection of children is truly embedded within the norms and practices of the State Service.

We note in Chapter 19 that unions have an important and influential role to play in effecting child safety in government workplaces, through advocacy on behalf of members who are subject to State Service disciplinary processes and by fostering a child safe culture in their union. We invite unions to support the significant reforms to the State Service disciplinary processes that we are recommending by issuing a statement of support.

In **Chapter 21 Therapeutic services**, we review the support services available to children, young people and adults who have experienced child sexual abuse in an institutional setting. We also consider the support needs of children and young people who have engaged in harmful sexual behaviours and need an extra level of specialised intervention to address those behaviours.

Without appropriate support and intervention, victim-survivors can be left to cope with their trauma in ways that are harmful to themselves and others, such as self-harming, using drugs and alcohol, or engaging in violent or criminal behaviour. It can affect their life opportunities, including their ability to engage in education and employment. They can also become vulnerable to further victimisation. There are not enough therapeutic services available to ensure victim-survivors of child sexual abuse have timely access to the supports they need. There is an urgent need for more culturally appropriate Aboriginal healing services, as well as support services that accommodate diversity and disability. The long waiting lists to access therapeutic services for children and young people who have engaged in harmful sexual behaviours is of particular concern.

We make several recommendations aimed at ensuring both victim-survivors of child sexual abuse and children and young people engaging in harmful sexual behaviours can access timely and appropriate supports. These recommendations include that the Tasmanian Government provides leadership and funds development of a therapeutic

service system with set maximum waiting periods. The Government should ensure funding agreements with non-government specialist services have appropriate governance requirements, sexual abuse service standards, service evaluation and child safe accreditation built into them. They should require that services meet the needs of children who are victim-survivors or who have displayed harmful sexual behaviours, victim-survivors with disability or mental illness, victim-survivors who identify with the LGBTQIA+ community, male victim-survivors, and victim-survivors who are from culturally and linguistically diverse backgrounds.

We also make recommendations in Chapter 21 that the Tasmanian Government establishes and funds a peak body for the sexual assault service support system, distinct from and working collaboratively with the family violence peak body, and that the Government develops a statewide framework and plan for preventing, identifying and responding to harmful sexual behaviours. Among other things, this framework should ensure the Government provides ongoing and increased funding to specialist therapeutic interventions for abusive and violent harmful sexual behaviours.

In **Chapter 22 Monitoring reforms**, we note that the Tasmanian Government has committed to implementing our recommendations. We propose that the Government establishes an independent Child Sexual Abuse Reform Implementation Monitor to ensure the recommendations of our Commission of Inquiry result in sustained systemic improvements towards preventing child sexual abuse in institutions, improving institutional responses to such abuse and providing the necessary supports for those who have been abused. Ongoing monitoring is essential to maintaining momentum for reform, adapting reform efforts to changing circumstances as required and ensuring progress is transparent.

In that chapter, we also lay out a six-year reform agenda to guide implementation of our recommendations, noting that the Government may need to negotiate some timeframes with the implementation monitor. We consider that many of our recommendations can be implemented by mid-2024, while others should be implemented by mid-2026. Implementing some of our recommendations will take careful planning and require long-term investment. We propose that these recommendations are implemented by mid-2029.

In the final chapter of Volume 8 and of our report, **Chapter 23 Afterword**, we outline barriers we have faced due to legislative provisions that affect the way in which a commission of inquiry can be conducted. We suggest legislative reform to address these barriers for the benefit of future commissions of inquiry.

We understand that the reforms we propose across our report will require significant effort and investment. However, these changes are necessary and will ultimately make Tasmanian institutional settings safer for all children and young people. We share the hopes of the victim-survivors, their families, carers and supporters who shared their stories with us that this report will result in meaningful change.

Recommendations

Chapter 6 – The way forward: Children in the education system

Child sexual abuse prevention education in schools

Recommendation 6.1

1. The Department for Education, Children and Young People should introduce and fund a mandatory child sexual abuse prevention curriculum as part of the mandatory respectful behaviours curriculum from early learning programs to Year 12, across all types of government schools (including specialist schools).
2. This mandatory prevention curriculum should draw on expert evidence of best practice and successful approaches adopted in other states and territories, including South Australia's mandatory curriculum.
3. The Department should develop a plan for sustained implementation of the mandatory prevention curriculum. The plan should:
    a. set out the goals and objectives of implementing the mandatory prevention curriculum

b. define the roles and responsibilities of key participants

c. include criteria for evaluating the curriculum.

4. The Department should evaluate the effectiveness of the mandatory prevention curriculum five years after its implementation.

Office of Safeguarding

Recommendation 6.2

1. The Office of Safeguarding within the Department for Education, Children and Young People should focus primarily on safeguarding children in the education context, with a particular focus on prevention, risk identification, policy development and related workforce development.
2. The Office of Safeguarding should not be involved in critical incident management beyond learning from systemic reviews and trend data.

Policies, procedures and guidance in education

Recommendation 6.3

1. The Department for Education, Children and Young People should make its child safeguarding policies publicly available, including policies on mandatory reporting, professional conduct, and responses to allegations and concerns about child sexual abuse.
2. The Department should establish a regular review process for its child safeguarding policies.

Recommendation 6.4

The Department for Education, Children and Young People, in developing a professional conduct policy (Recommendation 20.2), should ensure:

a. there is a separate professional conduct policy for staff who have contact with children and young people in schools

b. the professional conduct policy for schools, in addition to the matters set out in Recommendation 20.2, specifies expectations outlined in other relevant school policies and procedures, including those covering online technology and a duty of care owed by staff members

c. the professional conduct policy for schools spells out expected standards of behaviour for volunteers, relief teachers, contractors and sub-contractors

d. the Department uses appropriate mechanisms to ensure compliance by volunteers, relief teachers, contractors and sub-contractors with the professional conduct policy for schools.

Professional development

Recommendation 6.5

1. The Department for Education, Children and Young People should adopt and implement a training certification program that is mandatory for all education staff and volunteers. This training should be structured to provide basic and advanced levels of training for different role holders and targeted most directly at staff and volunteers operating in higher-risk settings.
2. Training should cover:
    a. key safeguarding policies of the Department, including appropriate standards of behaviour between adults and students and what to do if child sexual abuse or harmful sexual behaviours are witnessed or disclosed
    b. relevant legal obligations, including requirements for reporting to Tasmania Police, Child Safety Services, the Registrar of the Registration to Work with Vulnerable People Scheme, the Independent Regulator under the *Child and Youth Safe Organisations Act 2023*, and the Teachers Registration Board.
3. Training should be refreshed periodically and delivered at a time and in a format that will maximise engagement. It should be centrally recorded to monitor participation.
4. The Department should work with the Teachers Registration Board to establish the minimum training requirements for teachers (Recommendation 6.15).

Responding to and investigating complaints and concerns

Recommendation 6.6

1. The Tasmanian Government should establish a Child-Related Incident Management Directorate to respond to:
    a. allegations of child sexual abuse and related conduct by staff, breaches of the State Service Code of Conduct and professional conduct policies, and reportable conduct (as defined by the *Child and Youth Safe Organisations Act 2023*) in schools, Child Safety Services, out of home care and youth justice
    b. other forms of staff-perpetrated abuse in schools, Child Safety Services, out of home care and youth justice, including other serious care concerns and allegations of excessive use of force, inappropriate isolation or inappropriate searches of children and young people in detention.
2. The directorate should comprise three units tasked as follows:
    a. **Incident Report Management Unit.** This unit should be responsible for case management—that is, assisting child-facing services within the Department for Education, Children and Young People with the management of incidents or allegations of child sexual abuse and related conduct, including being the point of contact for these services.
    b. **Investigations Unit.** This unit should undertake preliminary assessments and investigations. It should comprise appropriately trained and skilled investigators or use external investigators with the requisite qualifications and training.
    c. **Adjudication Unit.** This unit should examine the investigation reports prepared by investigators and make recommendations to the Head of Agency about what disciplinary decisions are available and the appropriate response. The unit should be staffed by personnel with relevant experience, including a background in law.
3. The directorate should appoint staff with knowledge of schools, Child Safety Services, out of home care, and youth justice.
4. Within 12 months of appointment, all staff in the Investigations Unit should:
    a. undertake specialist training in interviewing vulnerable witnesses

b. undertake training in child development, child sexual abuse and trauma-related behaviours.

5. The directorate should maintain a case management platform and oversee a 'single file' for all child sexual abuse allegations and concerns about staff, including recording matters that do not result in disciplinary action.
6. The Tasmanian Government should decide where in the State Service this directorate should be established. Wherever it is established, it should be separated from traditional human resources functions.

Recommendation 6.7

1. The Department for Education, Children and Young People should develop guidelines that outline the ongoing supports that should be provided for victim-survivors, families, staff and the school community when there are allegations or incidents of child sexual abuse by staff or harmful sexual behaviours.
2. The guidelines should include policies, procedures, and templates for:
    a. Counselling and support—a counselling and support plan should be developed for victim-survivors and their parents and carers, other children or young people at the school, staff at the school, and the alleged perpetrator and their family.
    b. Risk assessment—a risk assessment should be conducted to determine whether there is any concern for the ongoing safety of other children and whether there may be other victim-survivors.
    c. Informing responsibly—the Department should develop specific policies that outline what communications should be made by the Department, and to whom they should be made, at particular stages of a child sexual abuse matter. These policies should take account of all legal obligations and the importance of informing victim-survivors, parents and the community. Communication may be needed with children and young people, staff, School Association Committees, parents, previous students and other schools.
3. Any policy outlining the communications that should be made by the Department should extend to matters where conduct does not amount to a criminal offence or where police do not proceed with charges but the matter is investigated as a possible breach of the State Service Code of Conduct, a professional conduct policy or reportable conduct under the Reportable Conduct Scheme.
4. Guidelines should also be developed for Child Safety Services, out of home care and youth justice contexts.

Recommendation 6.8

The Department for Education, Children and Young People should work with the Catholic and independent school sectors to adopt a statewide approach to responding to child sexual abuse in schools.

Harmful sexual behaviours

Recommendation 6.9

The Department for Education, Children and Young People should develop detailed education-specific policies, protocols and guidelines for preventing, identifying and responding to harmful sexual behaviours in schools. The development of these policies, protocols and guidelines should be:

a. led and informed by the Harmful Sexual Behaviours Support Unit (Recommendation 9.28)

b. informed by the Tasmanian Government's statewide framework and plan to address harmful sexual behaviours (Recommendation 21.8).

Teacher registration

Recommendation 6.10

The Tasmanian Government should introduce legislation to:

a. allow the Teachers Registration Board to compel relevant entities—including the Department for Education, Children and Young People, other employers of teachers, the Registrar of the Registration to Work with Vulnerable People Scheme, police, and Child Safety Services—to give the Board information or documentation that is relevant to child sexual abuse matters involving a registered teacher or a holder of a Limited Authority to Teach

b. compel these relevant entities to notify the Teachers Registration Board when they become aware of allegations or suspicions of child sexual abuse by a teacher. Such entities should also be required to notify the Board if they begin any formal investigation that involves allegations or suspicions of child sexual abuse by a teacher or a holder of a Limited Authority to Teach, and the outcome of any investigation

c. allow entities, when investigating matters involving child sexual abuse by a registered teacher or holder of a Limited Authority to Teach, to jointly appoint investigators to investigate the matter, taking into account the different criteria required for investigations by the Department and the Board.

Recommendation 6.11

The Tasmanian Government should:

a. introduce legislation to amend the *Teachers Registration Act 2000* (or regulations) to require details of the prospective or current place of employment of a teacher (or a holder of Limited Authority to Teach) to be included on the Register of Teachers

b. develop an electronic means of updating the Register of Teachers with details of the place of employment of a teacher (or a holder of Limited Authority to Teach)

c. require employers to make updates to a teacher's place of employment—including when a teacher (or a holder of Limited Authority to Teach) begins working at the school or is no longer working at the school

d. fund the Teachers Registration Board to develop an upgraded, fit-for-purpose Customer Records Management System to enable the Board to maintain a Register of Teachers which can support information exchange in real time with other bodies working with children, and other jurisdictions.

Recommendation 6.12

The Tasmanian Government should introduce legislation to amend the *Teachers Registration Act 2000* to allow administrative infringement notices to be issued for noncompliance with the provisions of the Act that currently carry penalties in the form of fines.

Recommendation 6.13

The Tasmanian Government should introduce legislation to amend section 24B of the *Teachers Registration Act 2000* to:

a. allow for the immediate rather than emergency suspension of registration or a Limited Authority to Teach when the Teachers Registration Board considers there is an unacceptable risk of harm to children

b. allow the Board to suspend a person's registration or a Limited Authority to Teach where that person has been charged with a serious offence.

Recommendation 6.14

The Tasmanian Government, Department for Education, Children and Young People and the Teachers Registration Board should continue to advocate at the national level for an automatic mutual recognition scheme that takes into account risks to child safety and imposes measures to address these risks.

Recommendation 6.15

1. The Tasmanian Government should introduce legislation to amend the *Teachers Registration Act 2000* to allow the Teachers Registration Board to set requirements for minimum training and ongoing professional development.
2. The Teachers Registration Board should make child safeguarding training (Recommendation 6.5) a mandatory requirement for the granting of teacher registration and as part of ongoing registration requirements.

Recommendation 6.16

The Tasmanian Government should ensure the Teachers Registration Board is funded to perform its core function of regulating the professional conduct of teachers.

Chapter 9 – The way forward: Children in out of home care

Funding

Recommendation 9.1

The Tasmanian Government should provide one-off funding to help implement the Commission of Inquiry's recommended out of home care reforms and significantly increase ongoing funding of out of home care, including out of home care services provided by Child Safety Services (such as out of home care governance and case management).

The role of the Department

Recommendation 9.2

1. The Department for Education, Children and Young People should outsource the provision of all forms of out of home care to the non-government sector.
2. The Department should maintain and improve its role in:
    a. the budgeting and purchasing of out of home care services from the non-government sector
    b. establishing and leading the strategic plan and policy framework for out of home care
    c. monitoring the quality of out of home care
    d. providing case management and leadership in out of home care
    e. ensuring carers and staff receive adequate education and skill development
    f. responding to complaints and safety and wellbeing concerns about children in out of home care
    g. cross-sector (government and non-government) data collection, ICT infrastructure and public reporting
    h. carer registration and monitoring.
3. The outsourcing of the provision of out of home care should be achieved through an orderly, staged and trauma-informed transition process and commissioning strategy.

4. The Department should establish a minimum out of home care dataset and a plan for two-way data sharing between the Department and non-government out of home care providers.

Contract management and auditing

Recommendation 9.3

1. The Department for Education, Children and Young People should develop new funding agreements with non-government out of home care providers that set quality and accountability requirements, including:
    a. compliance with the National Standards for Out-of-Home Care
    b. compliance with the Child and Youth Safe Standards
    c. provision of trauma-informed, therapeutic models of care (Recommendation 9.18)
    d. adoption of preventive measures for harmful sexual behaviours and child sexual exploitation
    e. only using carers who are registered on the Carer Register (Recommendation 9.20)
    f. governance and organisational structures to support monitoring and responding to child sexual abuse including grooming, harmful sexual behaviours and child sexual exploitation
    g. sharing relevant information about carers and children in their care
    h. quarterly reporting to the Department on these requirements
    i. periodic reporting of data against the outcomes framework (Recommendation 9.9).
2. All funding agreements between the Department and non-government out of home care providers should require the Department to give providers:
    a. relevant information about carers and children in their care
    b. information about the provider's performance against the data outcomes framework and compliance with standards.
3. The Department should monitor and audit non-government out of home care providers' compliance with contracts.
4. The Tasmanian Government should resource non-government out of home care providers appropriately.

Expert and active leadership

Recommendation 9.4

1. The Tasmanian Government should fund and restructure the Department for Education, Children and Young People to ensure (in addition to the current roles of Deputy Secretary for Keeping Children Safe, and the Executive Director for Youth Justice):

    a. there is separate executive-level responsibility for out of home care services

    b. there is separate executive-level responsibility for the combined areas of Child Safety Services, the Strong Families, Safe Kids Advice and Referral Line and family support services

    c. the classification level of these executive roles reflects the level of risk and responsibility carried by the positions

    d. the holders of these executive roles have knowledge and understanding in the area of child protection or out of home care and experience in providing strategic direction and leadership

    e. executive responsibility for child safeguarding in the education context is not combined with responsibility for child safeguarding in the children and family services context

    f. the role of Executive Director for Aboriginal Children and Young People is established and supported by an Office of Aboriginal Policy and Practice (Recommendation 9.7)

    g. the role of the Chief Practitioner is established and supported by an Office of the Chief Practitioner (Recommendation 9.17)

    h. expertise among members of the Department's executive is evenly balanced across the areas of education, Child Safety Services, out of home care, and youth justice

    i. the relevant specialist for out of home care and youth justice in the executive leads policy and practice development for those areas

    j. relevant centralised functions within the Department, such as human resources, procurement, and staff learning and development, address the distinct needs of schools, Child Safety Services, out of home care and youth detention.

2. The Tasmanian Government should ensure that:
    a. the Secretary of the Department demonstrates active efforts to inform themselves about child protection and out of home care through individual professional development
    b. the Deputy Secretary for Keeping Children Safe has knowledge and understanding of the area of child protection or out of home care and experience in providing strategic direction and leadership
    c. the Secretary and Deputy Secretary, and the holders of the new executive roles, have key performance measures that include culture change in Child Safety Services and out of home care
    d. the Secretary and Deputy Secretary, and the holder of the new executive role responsible for out of home care, have key performance measures that include preventing sexual abuse in out of home care
    e. the Department has appropriate processes in place to ensure leaders have the knowledge, skills, aptitude and core capability requirements to effectively manage people and to lead a child safe organisation.

Governance

Recommendation 9.5

1. The Department for Education, Children and Young People should establish a Quality and Risk Committee for Child Safety Services, out of home care, and youth justice.
2. The Secretary of the Department should chair the committee.
3. The functions of the committee should include monitoring:
    a. the system performance of the out of home care sector
    b. the performance against the outcomes and reporting framework (Recommendation 9.9)
    c. children's safety and wellbeing in out of home care, including from child sexual abuse
    d. progress on implementing the Child and Youth Safe Standards and the National Standards for Out-of-Home care

e. practices in youth detention, including in relation to searches, isolation and the use of force (Recommendations 12.31, 12.32 and 12.33).

4. The committee should report routinely to the Commission for Children and Young People.

Recommendation 9.6

1. The Department for Education, Children and Young People should, in consultation with the Commission for Children and Young People (Recommendation 18.6), develop an empowerment and participation strategy for children and young people in out of home care. This strategy should have regard to best practice principles for children's participation in organisations at the individual and systemic levels.
2. The empowerment and participation strategy should include:
    a. establishing a permanent out of home care advisory group to be involved in developing the out of home care strategic plan (Recommendation 9.8) and have ongoing input into the out of home care system
    b. building engagement with children into the Department's quality assurance and continuous improvement activities under the strategic plan (Recommendation 9.8)
    c. implementing the Viewpoint online questionnaire without delay
    d. regular monitoring and evaluation of the effectiveness of the empowerment and participation strategy.
3. The out of home care permanent advisory group should:
    a. include children, young people and young adults up to the age of 25 years with current or previous experience of out of home care in Tasmania, including Aboriginal people and people with disability
    b. have clear terms of reference developed in consultation with children, young people and young adults with experience of out of home care
    c. enable its members to participate in a safe and meaningful way and express their views on measures to empower children and young people in out of home care
    d. meet regularly, be chaired by a person independent of the Department and be attended by a senior departmental leader
    e. be adequately funded and resourced.

Recommendation 9.7

The Department for Education, Children and Young People should appoint an Executive Director for Aboriginal Children and Young People for the whole of the Department. The office holder should:

a. report directly to the Secretary

b. be supported by a sufficiently resourced Office of Aboriginal Policy and Practice

c. oversee and report on the implementation of the Aboriginal and Torres Strait Islander Child Placement Principle (Recommendation 9.15)

d. facilitate departmental engagement and build partnerships with Aboriginal communities

e. promote and help establish recognised Aboriginal organisations (Recommendation 9.15)

f. ensure Aboriginal culture, views and interests are represented in all departmental activities

g. promote cultural safety for Aboriginal staff and Aboriginal children and families who come into contact with the Department

h. increase recruitment of Aboriginal staff in the Department

i. participate in the Quality and Risk Committee at least every six months in discussions about the number of Aboriginal children in out of home care, the proportion of Aboriginal children placed with Aboriginal carers, the proportion of Aboriginal children in out of home care with a cultural support plan, reunification rates for Aboriginal children and other key performance indicators to be agreed with the Quality and Risk Committee.

Strategic planning for out of home care

Recommendation 9.8

1. The Department for Education, Children and Young People should develop a strategic plan for the out of home care system. The plan should include:
    a. a vision for future models of out of home care in Tasmania
    b. the transition plan and commissioning strategy for outsourcing the provision of out of home care to the non-government sector (Recommendation 9.2)
    c. the empowerment and participation strategy for children and young people in out of home care (Recommendation 9.6)
    d. implementation of the Aboriginal and Torres Strait Islander Child Placement Principle (Recommendation 9.15)
    e. a commitment to trauma-informed, therapeutic models of care (Recommendation 9.18)
    f. a commitment to the National Standards for Out-of-Home Care and the Child and Youth Safe Standards
    g. a workforce capacity building strategy (Recommendation 9.10)
    h. developing a carer recruitment, support and retention strategy, in consultation with the non-government sector
    i. a process for ongoing carer accreditation, registration and monitoring (Recommendation 9.20)
    j. establishing the outcomes and performance reporting framework (Recommendation 9.9)
    k. building quality assurance and improvement into all activities
    l. an updated framework of policies for the safety and wellbeing of children in care, including updating key policies relating to
        i. complaints handling
        ii. harmful sexual behaviours
        iii. mandatory education for staff in child sexual abuse
        iv. care concern and critical incident reporting and management
        v. child sexual exploitation

vi. how decisions can be appealed and reviewed

vii. professional conduct

viii. implementing the Child and Youth Safe Standards.

2. All policy documents should be published on the Department's website.
3. Each element of the strategic plan for the out of home care system should have a timeframe attached, with staggered implementation, and the plan should be fully implemented within five years.
4. The Secretary's key performance indicators should require the implementation of the strategic plan for the out of home care system within allocated timeframes.

Outcomes and performance reporting

Recommendation 9.9

The Department for Education, Children and Young People should:

a. establish an outcomes and performance reporting framework against which it can measure the performance of the out of home care sector, including in relation to child safety

b. develop the data capability to enable reporting against the framework

c. routinely report against the framework.

Workforce strategy

Recommendation 9.10

The Department for Education, Children and Young People should develop a workforce strategy for the child and family welfare sector to pursue the following objectives:

a. an increase in staff numbers and retention

b. workplace conditions that make the sector a more attractive employer, particularly in the Department

c. a reduction in unplanned staff vacancies, particularly in the Department

d. promoting staff wellbeing, at the individual and system levels, including by addressing the causes and effects of trauma and vicarious trauma

e. a workforce equipped with the knowledge and skills to respond effectively to the needs of children and families.

Recommendation 9.11

1. The Department for Education, Children and Young People should establish mandatory core knowledge requirements for Child Safety Officers, which include an understanding of:
    a. child sexual abuse, including grooming, harmful sexual behaviours and child sexual exploitation
    b. the effects of trauma, trauma-informed care and therapeutic responses to trauma
    c. ethical and professional conduct.
2. The Department should ensure Child Safety Officers attain this knowledge during their induction period.
3. The Department should provide regular refresher training and continuous professional development opportunities to enable Child Safety Officers to continue to advance their knowledge and skills (advanced professional development).
4. In its role of overseeing the out of home care system, the Department should:
    a. determine the core knowledge and skills required for staff in non-government organisations providing carer assessment and support, and for residential, foster and kinship carers
    b. ensure non-government out of home care staff and carers have access to professional development in core knowledge and skills, recognising existing high-quality training available in Tasmania and developing or funding new training where required.

Recommendation 9.12

1. The Department for Education, Children and Young People should ensure the *Foster and Kinship Carers Handbook* is updated to include:
    a. information applicable to all carer types
    b. more information on child sexual abuse, including harmful sexual behaviours and child sexual exploitation
    c. mandatory reporting requirements for carers
    d. the professional conduct policy for foster and kinship carers.
2. The Department should:
    a. make the Handbook available publicly on its website
    b. ensure the Handbook is regularly updated in line with any relevant changes to policy.

Recommendation 9.13

The Department for Education, Children and Young People should ensure staff have access to the latest out of home care practice knowledge by becoming a learning organisation, including by:

a. implementing purposeful means for critical reflection and internal review
b. establishing strategic partnerships with specialist out of home care, child maltreatment and child protection researchers
c. engaging in cross-jurisdictional partnerships where there are opportunities for shared learning
d. developing opportunities for formal recognition of ongoing learning for staff through these partnerships, such as via micro-credentialling pathways.

Keeping Aboriginal children safe

Recommendation 9.14

The Tasmanian Government should appoint a Commissioner for Aboriginal Children and Young People with statutory powers and functions to monitor the experiences of Aboriginal children in out of home care and youth detention.

Recommendation 9.15

The Tasmanian Government should fully implement all elements of the Aboriginal and Torres Strait Islander Child Placement Principle by:

a. increasing investment in Aboriginal-led targeted early intervention and prevention services for Aboriginal families, including family support and reunification services, to a rate equivalent to the representation of Aboriginal children in the Tasmanian child safety system

b. adopting and reporting on measures to reduce institutional racism and supporting decolonising practices in the Department for Education, Children and Young People to reduce the over-representation of Aboriginal children in out of home care

c. ensuring that the Aboriginal status of all Aboriginal children in contact with Child Safety Services is accurately identified and recorded at the earliest opportunity, and appropriately shared with non-government out of home care providers and carers

d. introducing legislation to amend the *Children, Young Persons and Their Families Act 1997* to

    i. require decision makers to consult with a relevant recognised Aboriginal organisation in relation to any decision likely to have a significant impact on an Aboriginal child—in particular, decisions about whether to remove a child from their family and where a child should live

    ii. require the involvement of a relevant recognised Aboriginal organisation nominated by an Aboriginal child, or their advocate, in family group conferences, case planning and cultural support planning in respect of the child

    iii. create a statutory framework and plan co-designed with Aboriginal communities for transferring child safety decision-making authority for Aboriginal children to recognised Aboriginal organisations

e. partnering with Aboriginal communities to

    i. promote and support establishing recognised Aboriginal organisations with local knowledge of Aboriginal children, families and communities, to facilitate the participation of Aboriginal children and families in child safety and out of home care decision-making processes

    ii. develop a model or models for the transfer of child safety decision-making authority to recognised Aboriginal organisations

iii. invest in recognised Aboriginal organisations' capacity to ensure they are fully resourced, and their workforces fully equipped and supported, to participate in child safety and out of home care decision-making processes for Aboriginal children, including involvement in cultural support planning, and to manage any transfer of decision-making authority for Aboriginal children

f. designing and establishing, in partnership with Aboriginal communities, fully resourced, Aboriginal-led, therapeutic residential programs for Aboriginal children who have been removed from their families and for whom an appropriate placement with an Aboriginal carer cannot be found

g. implementing systems to ensure every Aboriginal child in out of home care has a meaningful cultural support plan prepared by or with the involvement of a recognised Aboriginal organisation or an Aboriginal person with relevant cultural knowledge, and regularly reviewing cultural support plans to ensure cultural connections for Aboriginal children are being maintained

h. ensuring non-government out of home care providers comply with the 'placement' and 'connection' elements of the Placement Principle

i. ensuring the Aboriginal status of carers is identified and accurately recorded

j. providing mandatory professional development to Child Safety Services staff to ensure all interactions with and responses to Aboriginal children, families and organisations are culturally safe.

Supporting quality care

Recommendation 9.16

1. The Department for Education, Children and Young People should:
   a. ensure all children in care, including those on guardianship orders until age 18, have a case manager
   b. set a maximum case load for Child Safety Officers.
2. The Department should report quarterly to the Quality and Risk Committee on the:
   a. number of children without an individual case manager
   b. average case load for Child Safety Officers

c. average frequency of case manager visits children received, and the longest and shortest time periods between visits

d. the number of children with a care team and Aboriginal representatives on the care team (where appropriate)

e. average frequency of care team meetings

f. percentage of children with a current care plan.

3. The Department should ensure these figures are published quarterly on its website.

Recommendation 9.17

1. The Department for Education, Children and Young People should appoint a Chief Practitioner to lead clinical practice and quality assurance across Child Safety Services, the Strong Families, Safe Kids Advice and Referral Line, and out of home care.
2. The Chief Practitioner should lead an Office of the Chief Practitioner, manage a team of clinical practice experts across Child Safety Services and report to the Secretary.
3. The Chief Practitioner should be responsible for:

    a. developing the clinical capacity of practitioners through professional development and supervision

    b. informing clinical policies, procedures and practice directions to ensure they reflect best practice in child protection and trauma-informed care

    c. receiving, triaging, recording, monitoring and coordinating responses to complaints about Child Safety Services and out of home care (Recommendation 9.31) and concerns about the safety and wellbeing of children in care (Recommendation 9.32)

    d. supporting best practice responses to children in out of home care experiencing or at risk of child sexual exploitation

    e. conducting file reviews and audits to inform an understanding of current clinical practice and identify areas for reform.

4. The Chief Practitioner should:
    a. work closely with the Quality and Risk Committee to monitor data to identify systemic strengths and weaknesses within practice across Child Safety Services and out of home care
    b. have a close working relationship with the Department's Learning and Development team, ensuring that workforce development of Child Safety Services and out of home care is designed and delivered to support best practice service provision
    c. support the Department's strategic partnerships and collaboration where appropriate, including with research and teaching institutions and non-government service delivery partners to enhance knowledge and practice across the sector (Recommendation 9.13).
5. The Department should ensure clinical practice experts are located in all regional offices of Child Safety Services across the state.
6. The Chief Practitioner should lead the Harmful Sexual Behaviours Support Unit (Recommendation 9.28).

Recommendation 9.18

1. The Department for Education, Children and Young People should require out of home care to be trauma-informed and therapeutic and identify the key components of trauma-informed, therapeutic models of care.
2. The Department should require non-government out of home care providers to deliver services that align with these key components of trauma-informed, therapeutic models of care, noting some providers have already adopted such models of care.
3. The Department should ensure children are assessed for trauma symptoms when entering care through the holistic assessment (Recommendation 9.23) and, where needed, receive appropriate therapy and intervention for their trauma.

Recommendation 9.19

1. The Department for Education, Children and Young People, in developing a professional conduct policy (Recommendation 20.2), should ensure:
    a. there is a separate professional conduct policy for staff who have contact with children and young people in Child Safety Services and out of home care
    b. the professional conduct policy for Child Safety Services and out of home care, in addition to the matters set out in Recommendation 20.2, specifies expectations outlined in other relevant policies and procedures, including the policy on concerns about child safety and wellbeing and the duty of care owed by staff members
    c. the professional conduct policy for Child Safety Services and out of home care articulates expected standards of behaviour for volunteers, contractors and sub-contractors, and carers
    d. the Department uses appropriate mechanisms to ensure compliance by volunteers, contractors and sub-contractors, and carers with the professional conduct policy for Child Safety Services and out of home care.
2. The Department should develop guidance material and information sessions for children in care about the expected behaviour of carers, staff, volunteers and adults in their lives.

Ensuring quality carers

Recommendation 9.20

1. The Department for Education, Children and Young People should establish and maintain a Carer Register of all types of carers in the out of home care setting to ensure all third-party guardians, and foster, respite, kinship, and salaried residential carers can provide quality care to children and act protectively.
2. The Department should:
    a. set minimum requirements for registration as a carer
    b. record allegations of concern about a carer or members of their household
    c. set out a process for de-registering carers
    d. enable easy information sharing between the Carer Register, the Registration to Work with Vulnerable People Scheme and the Reportable Conduct Scheme.

3. The minimum requirements for carer registration should include:
    a. current Registration to Work with Vulnerable People and satisfactory National Police Checks
    b. best practice and tailored approaches to foster, kinship and residential carer screening and assessment
    c. mandatory knowledge and skill requirements for carers, including
        i. understanding child sexual abuse, including grooming, harmful sexual behaviours and child sexual exploitation
        ii. understanding the effects of trauma, trauma-informed care and therapeutic responses to trauma
        iii. understanding the professional conduct policy and ethical behaviour
    d. requiring other relevant adults who routinely spend time in the carer household to hold Registration to Work with Vulnerable People and to have been subject to carer assessment
    e. satisfactory annual carer reviews conducted by non-government providers and reported to the Carer Register.
4. The Department should provide for kinship carers to be provisionally registered for 12 months after assuming care of a child. During this time kinship carers should be required to complete their mandatory training requirements or apply for an exemption in exceptional circumstances.
5. Non-government out of home care providers should support kinship carers to access and complete the mandatory training required for full registration as a carer. The mandatory training should contain measures to overcome literacy difficulties, cultural difference or geographical remoteness.
6. The Department should only place children with a carer who is registered or provisionally registered on the Carer Register.
7. The Department should establish a mechanism for reviewing decisions about the registration or deregistration of carers.
8. The Tasmanian Government should adequately resource the Department to establish and maintain the Carer Register.

Recommendation 9.21

To improve placement stability and the oversight of the care of children by third-party guardians, the Department for Education, Children and Young People should:

a. make publicly available the criteria and process for a carer to become a third-party guardian

b. sufficiently resource the team responsible for third-party guardianship applications to ensure appropriate assessments and timely processing

c. require third-party guardians to be registered on the Carer Register to maintain their guardianship

d. ensure third-party guardians receive the same level of support in their caring role as received by foster or kinship carers

e. ensure children in third-party guardianship arrangements continue to have their safety and wellbeing supported and monitored (for example, through independent community visitors (Recommendation 9.34)).

Meeting children's needs

Recommendation 9.22

1. The Department for Education, Children and Young People's out of home care processes, including assessments, placements and care planning, should be tailored to address the specific needs of individual children.
2. These processes should address the specific needs of all children, including Aboriginal children, children from other culturally diverse backgrounds, children with disability, children with mental illness and children who identify as LGBTQIA+.
3. The Department's empowerment and participation strategy for children and young people in out of home care (Recommendation 9.6) should include processes that enable children's views to inform all elements of their individual care, including their assessments, placements and care planning.

Recommendation 9.23

1. The Tasmanian Government should ensure all children in care have access to:
    a. a timely holistic assessment when entering care across all domains of physical health, trauma and mental health, disability and educational need
    b. health and wellbeing assessments conducted annually, or more often where there is an identified need.
2. Multidisciplinary health teams should provide expert consultation to the care team around a child about the child's needs, and input into the child's care plan.
3. The Department for Education, Children and Young People should create a specialised role to support children in out of home care to access the National Disability Insurance Scheme.

Recommendation 9.24

1. The Tasmanian Government should increase funding for specialist trauma therapy services for children in care to ensure their needs are met.
2. The Tasmanian Government should ensure the Child and Adolescent Mental Health Service's new specialist mental health service for children in out of home care is resourced to meet demand.

Recommendation 9.25

The Department for Education, Children and Young People should improve placement stability and reduce the risk of sexual abuse of children in care by:

a. considering the views of the child or children about their out of home care placement
b. using placement matching guidelines to aid placement decisions and support planning
c. placing siblings together or maintaining sibling connection where safe to do so
d. ensuring carers are aware of any history of abuse in relation to the child and the child's specific needs relevant to this
e. introducing an intensive salaried or professional foster care model to allow children with challenging behaviours to remain in family-based care

f. funding all placements (including kinship, foster, respite and residential care) to fully meet all the child's assessed needs to the extent these are not covered by other schemes (such as the National Disability Insurance Scheme and public health or education services).

Recommendation 9.26

The Department for Education, Children and Young People should ensure:

a. each child is involved in developing their care plan

b. each child's care plan is informed by the holistic assessment (Recommendation 9.23) and the interests and aspirations of the child

c. care plans include strategies to address identified risks of child sexual abuse, including the risk of harmful sexual behaviours and child sexual exploitation

d. the care team reviews any risk assessments and management plans for child sexual abuse at least every six months, or more frequently if incidents occur or circumstances change such as when a new child joins the household.

Children on out of home care orders involved in youth justice

Recommendation 9.27

In its role as statutory guardian of a child in care, the Department for Education, Children and Young People should:

a. ensure a representative of the Department with knowledge of the child appears for a child in out of home care in the Magistrates Court (Youth Justice Division) and in the new specialist children's division of the Magistrates Court (Recommendation 12.15), in order to

   i. support the child in court

   ii. inform the court of all relevant considerations to the court, including the child's child protection history

   iii. make submissions to the court on behalf of the child

   with arrangements in place for this to occur in out-of-hours bail hearings as well as those that occur during normal business hours

b. take actions that may address any causes contributing to child offending, including changes to care plans

c. ensure, when a child in care is admitted to youth detention or another residential youth justice facility, that the child's Child Safety Officer

   i. arranges an immediate review of the child's care plan with their care team, which includes developing a transition plan for when the child leaves detention

   ii. visits the child as soon as practicable and regularly thereafter, with a minimum of one visit during their admission in line with the child's revised care plan

   iii. notifies the Commission for Children and Young People of the child's admission to youth detention

d. report to the Quality and Risk Committee on the number of children in care in detention and on the activities listed above.

Harmful sexual behaviour

Recommendation 9.28

1. The Department for Education, Children and Young People should establish a Harmful Sexual Behaviours Support Unit to support best practice responses to harmful sexual behaviours across the Department, including in schools, Child Safety Services, out of home care and youth detention. The unit should:

   a. provide advice, guidance, and support across the Department

   b. develop context-specific policies for all settings informed by the Tasmanian Government's statewide framework and plan to address harmful sexual behaviours (Recommendation 21.8)

   c. work closely with the Quality and Risk Committee (Recommendation 9.5) to ensure systemic risks, practice issues and opportunities for improvement are identified.

2. The Tasmanian Government should allocate additional funding to support responses to harmful sexual behaviours in out of home care and youth justice.

3. The Harmful Sexual Behaviours Support Unit should develop detailed out of home care-specific policies, protocols and practice guidance to support best practice responses to harmful sexual behaviours in out of home care.

4. The Department should ensure the advanced professional development for departmental staff in understanding and responding to harmful sexual behaviours (Recommendation 9.11) includes tailored professional development for both Child Safety Officers and carers, and is available to staff in relevant roles in schools and youth justice.
5. The Department should ensure staff working in the Harmful Sexual Behaviours Support Unit are suitably experienced or undertake additional professional development to advance their knowledge in responding to harmful sexual behaviours.
6. The Department should ensure Power to Kids or another program or approach with comparable components is implemented in government funded residential care homes as a supplementary strategy to address the heightened risk of harmful sexual behaviours (including child sexual exploitation and dating violence) in out of home care.

Child sexual exploitation

Recommendation 9.29

1. The Department for Education, Children and Young People and Tasmania Police should work with non-government providers and other relevant stakeholders to develop a framework for preventing and responding to sexual exploitation of children in care that is informed by best practice and evidence from other jurisdictions. The framework should:
    a. acknowledge the responsibility of the Department to lead the protection of children in care from child sexual exploitation
    b. outline the prevention strategies to be used and each agency's role in delivering those strategies
    c. outline the detection, disruption and intervention strategies to be used and each agency's role in delivering those strategies
    d. outline how children in care who have been exploited will be supported to heal and recover
    e. describe how agencies will work together
    f. implement a reporting framework about the incidence of sexual exploitation of children in care, which is reported to the Quality and Risk Committee.

2. The Chief Practitioner should lead the development of the framework.
3. The *Keeping Children Safe Handbook* and Tasmania Police operating guidelines should be updated to reflect the role of police in responding to child sexual exploitation in the new framework.

Recommendation 9.30

Tasmania Police should more fully utilise the offences in sections 95 and 96 of the *Children, Young People and Their Families Act 1997* (the offences of harbouring or concealing a child and of inducing a child to be absent without lawful authority) to deter behaviour by adults that puts children in out of home care at risk of sexual abuse.

Responding to complaints and concerns about child sexual abuse

Recommendation 9.31

1. The Department for Education, Children and Young People should develop and maintain a complaints policy and procedures for Child Safety Services and out of home care. The policy and procedures should:
    a. explain how to make a complaint and who to complain to using a 'no wrong door' approach
    b. direct who should be informed when a person receives a complaint
    c. direct who is responsible for responding and within what timeframes
    d. ensure a child-friendly complaints procedure is made available to all children in care
    e. apply to all types of complaints or incidents
    f. cross-refer to the new concerns about the safety and wellbeing of children in care policy (Recommendation 9.32)
    g. explain how to seek an internal review of a decision made by the Department
    h. outline how to provide feedback and support for a complainant.

2. The Department should implement a centralised complaints and incident recording system.
3. The Chief Practitioner should receive all complaints about Child Safety Services and out of home care and be adequately resourced to receive, triage, record, monitor and coordinate responses.
4. The Chief Practitioner should report regularly on complaints handling to the Quality and Risk Committee and the Commission for Children and Young People.
5. The complaints policy and procedure should be published on the Department's website.

Recommendation 9.32

1. The Department for Education, Children and Young People should develop a new policy to guide responses to concerns about the safety and wellbeing of children in care. The policy should:
    a. identify all forms of sexual abuse—including grooming, child sexual exploitation, harmful sexual behaviours, abuse by adults within and outside the out of home care system—as serious and requiring a higher-level response
    b. describe response pathways for concerns about the sexual abuse of children in care depending on the context. Specifically
        i. concerns or complaints about the sexual abuse of a child in care, or related conduct, by departmental staff should be referred to the Child-Related Incident Management Directorate (Recommendation 6.6)
        ii. responses to concerns about the sexual abuse of children in care, or related conduct, by adults who are not departmental staff should be led or overseen by the Chief Practitioner
        iii. responses to concerns about sexual exploitation of children in care should be led or overseen by the Chief Practitioner (Recommendation 9.17)
        iv. responses to concerns about harmful sexual behaviours involving children in care should be led or overseen by the Harmful Sexual Behaviours Support Unit (Recommendation 9.28).

2. The Chief Practitioner should receive all concerns about the safety and wellbeing of children in care and be adequately resourced to receive, triage, record, monitor and coordinate responses. Where the Chief Practitioner has referred a matter to another entity, the Office of the Chief Practitioner should support the localised response to the child's safety and ongoing welfare.
3. The Office of the Chief Practitioner should include staff with skills in investigation and child interviewing to conduct investigations.
4. The outcomes of all concerns about the sexual abuse of children in care should be reported to the Quality and Risk Committee.

Independent advocacy and oversight

Recommendation 9.33

1. The Tasmanian Government should establish an independent Child Advocate, to be included in the Commission for Children and Young People (Recommendation 18.6).
2. The Child Advocate should have responsibility for:
    a. the independent community visitor scheme (Recommendation 9.34)
    b. individual advocacy for children, including making complaints to the Ombudsman on behalf of a child in care (Recommendation 9.35)
    c. the permanent out of home care advisory group (Recommendation 9.6).

Recommendation 9.34

1. The Tasmanian Government should introduce legislation to establish an independent community visitor scheme for children in out of home care, youth detention and other residential youth justice facilities.
2. The scheme should be administered by the Commission for Children and Young People (Recommendation 18.6) and led by the Child Advocate (Recommendation 9.33).
3. The scheme should be funded to enable every child in care, youth detention or another residential youth justice facility to receive regular and frequent visits, and children in family-based care to be visited regularly or when they request a visit. Resourcing should also enable community visitors to undertake advocacy on behalf of the children they visit.

4. Community visitors should be appointed by the Child Advocate based on their skills, knowledge and expertise, and remuneration should be comparable to similar paid roles in other jurisdictions.
5. Aboriginal children should have access to Aboriginal community visitors under the scheme.
6. Community visitors should be responsible, among other matters, for:
    a. developing trusting and supportive relationships with children in out of home care, youth detention or other residential youth justice facilities
    b. advocating on behalf of children by listening to, giving voice to and helping to resolve their concerns and grievances
    c. facilitating children's access to support services
    d. inquiring about and reporting on children's physical and emotional wellbeing
    e. inquiring about whether children's needs are being met.
7. The program should include funding for a small number of legally trained child advocacy officers, also appointed by the Child Advocate (Recommendation 9.33), to assist children with more complex concerns and to support them in seeking independent review of departmental decision making.

Recommendation 9.35

Legislation establishing an independent Child Advocate in the Commission for Children and Young People should provide the Child Advocate with power to make a complaint to the Ombudsman on behalf of a child who is in out of home care, youth detention or another residential youth justice facility, seeking the child's permission to do so first.

Recommendation 9.36

1. The Tasmanian Government should introduce legislation to:
    a. expand the jurisdiction of the Tasmanian Civil and Administrative Tribunal to include review of decisions of the Department for Education, Children and Young People in exercising its custody or guardianship powers—including decisions about where a child should live and arrangements for the child's care

b. ensure children whose cases are subject to review have the right to express their views and participate in Tribunal proceedings

c. give the Child Advocate the power to apply for a Tribunal review of a decision about the care arrangements for a child on behalf of the child, or on the Child Advocate's own initiative

d. grant parties, such as parents or carers, the right to apply for a Tribunal review depending on the nature of the decision.

2. To support their understanding of the experiences of children in out of home care, Tribunal members should be specifically trained in the nature and effects of trauma and child sexual abuse.

Recommendation 9.37

1. The Secretary of the Department for Education, Children and Young People should notify the Commission for Children and Young People of sexual abuse allegations involving children in out of home care that fall outside the Reportable Conduct Scheme, including incidents of child abuse by non-carers, and of the outcomes of investigations into those allegations.
2. The Commission for Children and Young People should have the power to require the Department to provide it with information about its responses to such allegations.

Recommendation 9.38

1. The Commission for Children and Young People should have the following functions in relation to out of home care:

   a. monitoring the operation of the out of home care system and the provision of out of home care services to children, by regularly monitoring data and conducting own motion systemic inquiries into aspects of the system

   b. conducting own motion inquiries into the services received by an individual child or group of children in out of home care

   c. making recommendations to the Government for out of home care system improvements

   d. advocating for individual children in out of home care, including supporting children to make complaints to the Ombudsman and to apply for independent reviews of departmental decision making

e. administering the independent community visitor scheme

f. upholding and promoting the rights of children in out of home care.

2. The Commission should be fully resourced on an ongoing basis to perform these functions.

Chapter 12 – The way forward: Children in youth detention

Addressing the legacy of abuse

Recommendation 12.1

The Tasmanian Government should close Ashley Youth Detention Centre as soon as possible.

Recommendation 12.2

Once Ashley Youth Detention Centre is closed, the Tasmanian Government should establish a memorial to victim-survivors who experienced abuse at the Centre. The form and location of the memorial should be decided in consultation with victim-survivors of abuse at Ashley Youth Detention Centre.

Recommendation 12.3

The Tasmanian Government should ensure no person who has been detained at Ashley Youth Detention Centre is detained or imprisoned in any redeveloped facility at the same site unless the person expresses a preference for this to occur.

Recommendation 12.4

The Department for Education, Children and Young People should work with the Office of the State Archivist to:

a. establish a process to identify, recover, restore, collate, digitise, index and catalogue all historical records relating to children and young people and

staff at Ashley Youth Detention Centre, and all other children in, or staff or carers connected with, state care

b. ensure digitised records are searchable, retrievable, secure and protected against corruption or loss

c. determine which physical records should be retained following digitisation, and maintain these physical records in line with the National Royal Commission's record-keeping principles

d. determine protocols and guidance on how people who have been detained at Ashley Youth Detention Centre can access their records.

Recommendation 12.5

The Tasmanian Government should:

a. conduct an audit of allegations arising from

   i. claims made under the Abuse in State Care Program, the Abuse in State Care Support Service and the National Redress Scheme

   ii. civil claims in relation to Ashley Youth Detention Centre or the out of home care system

   iii. complaints regarding Ashley Youth Detention Centre or the out of home care system

   to identify any current or former staff in government institutions or carers in the out of home care system who are the subject of child abuse allegations, including child sexual abuse

b. ensure the names and details of any staff or carers identified by the audit are added to the cross-government register of misconduct (including unsubstantiated allegations) concerning child sexual abuse (Recommendation 20.9)

c. ensure all relevant information derived from the audit is provided to Tasmania Police, Child Safety Services, the Registrar of the Registration to Work with Vulnerable People Scheme and the Independent Regulator under the *Child and Youth Safe Organisations Act 2023*, disciplinary action is considered, and the current safety of children in institutions prioritised

d. require the Department of Justice to

    i. pass on to the Department for Education, Children and Young People and other relevant departments as a matter of urgency the full details (rather than a summary) of any relevant National Redress Scheme application or claim under any future state redress scheme that the Department of Justice administers

    ii. make appropriate notifications to Tasmania Police, Child Safety Services, the Registrar of the Registration to Work with Vulnerable People Scheme and the Independent Regulator under the *Child and Youth Safe Organisations Act 2023* in relation to allegations in National Redress Scheme applications or claims under a future state redress scheme

e. advocate at a national level to review the information-sharing framework in the *National Redress Scheme for Institutional Child Sexual Abuse Act 2018* (Cth) and the National Redress Scheme's *Operational Manual for Participating Institutions* to

    i. ensure information about current risks to children is reported to police, child protection authorities, authorities responsible for registration to work with children and administrators of reportable conduct schemes in the timeliest manner and by the most appropriate entity

    ii. identify the most appropriate point in the process for the National Redress Scheme Operator to seek consent from applicants to share information with relevant authorities

f. implement systems to enable future monitoring of National Redress Scheme applications, claims under any future state redress scheme and civil claims to identify current staff in government institutions or carers in the out of home care system who are the subject of child abuse allegations, including by adding relevant information to the recommended register of misconduct concerning child sexual abuse (Recommendation 20.9)

g. make appropriate supports available to victim-survivors who disclose abuse at Ashley Youth Detention Centre, including warm referrals, with permission, to sexual assault counsellors who have training and experience in working with victim-survivors of child sexual abuse

h. remove any barriers to information sharing that would prevent the implementation of this recommendation.

Cultural change

Recommendation 12.6

The Department for Education, Children and Young People should:

a. have appropriate processes in place to ensure leaders in youth detention have the knowledge, skills, aptitude and core capability requirements to effectively manage people and to lead a child safe organisation

b. ensure the person who holds the position of Executive Director, Services for Youth Justice, has knowledge and understanding of youth justice and therapeutic models of care in youth justice, and experience in providing strategic direction and leadership

c. ensure cultural change in youth detention is included in the key performance indicators of the Secretary, Associate Secretary and Executive Director, Services for Youth Justice

d. reclassify the position of Manager, Custodial Youth Justice from Band 8 in the Tasmanian State Service Award to at least a Senior Executive Service Level 1

e. ensure the position description and performance measures for the role of Manager, Custodial Youth Justice include implementing cultural change in youth detention.

Recommendation 12.7

The Tasmanian Government should:

a. develop measures to monitor and evaluate progress towards cultural change in youth detention and include these in the Outcomes Framework under the Youth Justice Blueprint and associated action plans

b. include monitoring and evaluation of progress towards cultural change in youth detention in the Youth Justice Reform Governance Framework

c. urgently begin data collection and monitoring of progress towards cultural change

d. ensure there is an ongoing governance structure to oversee and monitor the functioning of the youth justice system, including the performance and culture of youth detention, beyond the implementation of the youth justice reforms

e. fund the Department for Education, Children and Young People to immediately appoint a culture change manager at Ashley Youth Detention Centre reporting to the Centre Manager and whose role is to work with and support the Centre Manager to

   i. drive cultural change in youth detention

   ii. create a child safe organisation

   iii. establish a positive, collaborative and supportive working environment

f. maintain the culture change manager position or function beyond the closure of Ashley Youth Detention Centre for as long as monitoring indicates there is a need for it.

Recommendation 12.8

The Department for Education, Children and Young People should, in consultation with the new Commission for Children and Young People (Recommendation 18.6), develop an empowerment and participation strategy for children and young people in detention, having regard to best practice principles for children's participation in organisations. The strategy should include:

a. the establishment of a permanent advisory group that

   i. includes children, young people and young adults up to the age of 25 years with previous experience of youth detention in Tasmania, including Aboriginal people and people with disability

   ii. has clear terms of reference developed in consultation with young people with experience of detention

   iii. enables its members to participate in a safe and meaningful way and express their views on measures to empower children and young people in detention (including the role and purpose of the Resident Advisory Group) and achieve cultural change in detention

   iv. meets regularly and is chaired by a person independent of the Department and attended by a senior departmental leader

   v. is adequately funded and resourced

b. a review of the Ashley Youth Detention Centre Resident Advisory Group to ensure it conforms with best practice principles for children's participation and provides a safe forum for children and young people in detention to express their views, including on measures to achieve cultural change in detention, without fear of reprisal

c. a consultation forum for children and young people in any youth detention facility that replaces Ashley Youth Detention Centre

d. mechanisms to ensure children and young people in detention are aware of their rights

e. regular monitoring and evaluation of the effectiveness of the empowerment and participation strategy.

Recommendation 12.9

The Department for Education, Children and Young People should:

a. initiate a change management process that includes identifying the aptitudes, attitudes and capabilities expected of youth workers, and requires all current youth workers to reapply for their positions

b. ensure individuals recruited to the youth worker role hold a relevant Certificate IV qualification before starting or complete such a qualification within a year of starting, and have appropriate attributes, attitudes and skills to build positive relationships and work therapeutically with children and young people in youth detention

c. create incentives for ongoing professional development by supporting youth workers to complete higher qualifications and providing for operational career progression to a senior youth worker role

d. maintain a sufficient level of youth workers to implement a therapeutic model of care in youth detention and to ensure the safety and wellbeing of children, young people and staff

e. establish an ongoing biannual recruitment process for youth workers

f. ensure the induction program and continuing professional development for youth workers are based on best practice principles and include

    i. expected standards of behaviour in interacting with children and young people

    ii. a focus on children and young people's human rights, particularly in relation to isolation, force, restraints and personal searches

    iii. approaches to setting fair, clear and firm boundaries for children and young people's behaviour within a therapeutic, trauma-informed framework

    iv. training in all custodial policies and procedures

g. ensure newly recruited youth workers are not eligible to start work until they have satisfactorily completed the induction program, followed by two weeks of 'buddy shifts'

h. develop a clear policy on the appropriateness of providing training, counselling or direction to detention centre staff members who have repeatedly demonstrated resistance to change

i. urgently develop a staffing contingency plan to ensure children and young people in detention are not subjected to lockdowns caused by staff shortages

j. consider introducing mechanisms to attract more youth workers, such as an allowance or loading that reflects the regional location of Ashley Youth Detention Centre and the current high-risk environment of youth detention

k. implement other supports for Ashley Youth Detention Centre staff in relation to allegations of child sexual abuse against their colleagues and strengthen support for youth workers and other detention centre staff following critical incidents in detention, such as riots, assaults, attempted suicide and self-harm, by providing psychological first aid, additional support from skilled psychologists on an 'as needs' basis and, where appropriate, critical incident debriefing facilitated by a neutral and trained expert.

Recommendation 12.10

The Department for Education, Children and Young People, in developing a professional conduct policy (Recommendation 20.2), should ensure:

a. there is a separate professional conduct policy for staff who have contact with children and young people in detention facilities and other residential youth justice facilities

b. the professional conduct policy for detention facilities and other residential youth justice facilities, in addition to the matters set out in Recommendation 20.2, specifies expectations outlined in other relevant custodial policies and procedures, including those on the use of force, isolation and personal searches of children and young people in detention

c. the professional conduct policy for youth detention and other residential youth justice facilities spells out expected standards of behaviour for volunteers, contractors and sub-contractors

d. the Department uses appropriate mechanisms to ensure compliance by volunteers, contractors and sub-contractors with the professional conduct policy.

Reducing the number of children in youth detention

Recommendation 12.11

The Tasmanian Government should:

a. introduce legislation to increase the minimum age of criminal responsibility to 14 years, without exception

b. develop and provide a range of community-based health, welfare and disability programs and services that are tailored to meet the needs of children and young people under the age of 14 years who are engaging in antisocial behaviour, and to address the factors contributing to that behaviour

c. work towards increasing the minimum age of detention (including remand) to 16 years by developing alternatives to detention for children aged 14 and 15 years who are found guilty of serious violent offences and who may be a danger to themselves or the community.

Recommendation 12.12

The Tasmanian Government should ensure legislation to replace or amend the *Youth Justice Act 1997* contains updated general principles of youth justice that reflect contemporary understandings of child development, children's antisocial behaviour and children's needs.

Recommendation 12.13

1. The Tasmanian Government, in reviewing current diversion processes and developing a Diversionary Services Framework, should:

   a. examine the exercise of police discretion to determine whether opportunities for cautioning and community conferencing are being maximised, particularly for Aboriginal children and young people, and children and young people without a strong family support network

   b. commission research to examine the effectiveness of formal cautions imposed with undertakings and the sanctions imposed by community conferences, to ensure they are proportionate to the alleged offending and not unnecessarily onerous

c. introduce legislation to widen the range of alleged offences in respect of which diversion may be pursued and create a presumption in favour of pre-court diversion for children and young people.

2. The Tasmanian Government should begin statewide delivery of new diversion programs under the Diversionary Services Framework by 2025.

Recommendation 12.14

The Tasmanian Government, to maximise opportunities for children and young people to be admitted to bail and minimise the number of children and young people on remand, should:

a. introduce legislation to

   i. require bail decision makers to consider the matters specified in section 3B of the *Bail Act 1977* (Vic) when determining bail for a child, as well as the child's age (including their developmental age at the time of the alleged offence), Aboriginal status and any previous experience of trauma or out of home care

   ii. prohibit the refusal of bail to a child on the sole ground that the child does not have any, or any adequate, accommodation

b. examine the effectiveness of the existing bail support program with a view to expanding its capacity and funding additional bail support programs

c. establish and fully resource a statewide 24-hour bail system for children and young people with

   i. specialised and trained decision makers who have knowledge of children and young people, Aboriginal children and young people, and the impact of trauma

   ii. access to corresponding bail support services

   iii. access to legal representation for children and young people

d. ensure its proposed assisted bail facilities

   i. are small, homelike and, subject to bail conditions, do not place restrictions on the movements of children and young people

   ii. have the capacity to deal with children and young people with complex needs

iii. are designed to include wraparound services, such as health, education and employment

iv. are culturally safe for Aboriginal children and young people

v. include specialist, therapeutically trained bail support workers to help children and young people attend programs and services, and to comply with their conditions of bail.

Recommendation 12.15

The Tasmanian Government should:

a. ensure any legislation designed to amend or replace the *Youth Justice Act 1997* provides that

i. rehabilitation is the primary purpose of sentencing a child

ii. the list of sentencing options is a hierarchy and a sentencer can only impose a sentence at a particular level of the hierarchy if satisfied that it is not appropriate to impose a sentence that is 'lower' in the hierarchy

iii. a sentence imposed on a child should be the minimum intervention required in the circumstances

iv. a custodial sentence must only be imposed as a last resort and for the minimum period necessary

v. in sentencing a child the court must consider the child's experience of trauma, any child protection involvement or experience of out of home care, disruptions to the child's living situation or education, any mental illness, neurological difficulties or developmental issues experienced by the child, and the child's chronological age and developmental age at the time of sentencing

vi. in sentencing an Aboriginal child, the court must consider additional factors including the consequences of intergenerational trauma, historical discriminatory policies, general and systemic racism, and any previous culturally inappropriate responses that may have worsened the effects of trauma on the child

vii. there is a presumption against imposing restrictive conditions (such as curfews and non-association conditions) with community-based sentencing orders, which may increase a child's likelihood of breaching a sentencing order and being sentenced to detention

b. ensure children who are sentenced to a supervised community-based order receive adequate support to comply with the conditions of the order from therapeutically trained, culturally competent staff

c. assist and support the Magistrates Court to establish a new division of the Court to hear and determine both child protection matters and criminal charges against children and young people, which should be constituted by at least three dedicated full-time magistrates with specialist knowledge and skills relating to children and young people

d. support the Magistrates Court to arrange for the implementation and operation of the Court's new specialist division to be independently evaluated after three years

e. fund the Magistrates and Supreme Courts to provide professional development for judicial officers hearing matters involving children and young people in the adult jurisdiction, in areas including child and adolescent development, trauma, child and adolescent mental health, cognitive and communication deficits, and Aboriginal cultural safety.

Creating a child-focused youth detention system

Recommendation 12.16

The Tasmanian Government should ensure its proposed new detention facility (and any future detention facilities) are small and homelike and incorporate design features that reflect best practice international youth detention facilities. This includes features that:

a. promote the development of trusting and therapeutic relationships between staff and children and young people

b. facilitate and enhance trauma-informed, therapeutic interventions for children and young people

c. minimise stigma to children and young people

d. facilitate and promote connections between children and young people, and their families and communities

e. protect children and young people against the risks of child sexual abuse (including harmful sexual behaviours)—for example, by enabling line-of-sight supervision as far as possible, without infringing on children and young people's privacy.

Recommendation 12.17

1. The Tasmanian Government, to enhance the safety of children and young people in Ashley Youth Detention Centre and any new detention facility, should:
    a. ensure all public areas of the facility are subject to electronic surveillance
    b. introduce viewing panel swipe readers
    c. introduce body-worn cameras, supported by comprehensive policies and procedures for their use by staff
    d. develop and implement a policy for managing and retaining surveillance footage that
        i. takes account of the record-keeping principles identified by the National Royal Commission and the disposal freeze on records relating to children issued by the Office of the State Archivist
        ii. promotes transparency of staff conduct and enables regular audits of staff performance to be undertaken
        iii. requires footage to be made available on a timely basis on the lawful request of a government department or oversight body.
2. The Commission for Children and Young People (Recommendation 18.6) should annually review the use of electronic surveillance in detention to determine whether it increases children and young people's feelings of safety in detention and should continue to be used. The initial review should seek the views of children and young people at Ashley Youth Detention Centre on whether electronic surveillance should be deployed in the proposed new detention facility.

Recommendation 12.18

1. The Tasmanian Government should ensure:
    a. use of the Behaviour Development Program is discontinued in Ashley Youth Detention Centre and not adopted in any new detention facility
    b. the Youth Justice Model of Care planned to be developed by 2025 includes a specific operating philosophy, service objectives and service standards for detention facilities that are based on non-punitive, child-centred, trauma-informed, culturally safe practice and reflect international best practice in youth justice

c. staff in youth detention facilities have the skills needed to undertake evidence-based, trauma-informed, child-centred interventions with children and young people, including the skills to anticipate, de-escalate and respond effectively to challenging behaviours without resorting to force or restrictive practices

d. implementation of the Youth Justice Model of Care and updated Practice Framework for youth detention is monitored by the governance structure outlined in Recommendation 12.7.

2. The Custodial Inspector, or the body responsible for inspection standards for youth detention centres in Tasmania, should review standards and guidelines on the appropriate use in youth detention of behaviour management programs that incorporate incentives and rewards, having regard to international best practice and research on effective responses to children and young people with trauma backgrounds and emotional regulation challenges.

Recommendation 12.19

The Tasmanian Government should:

a. establish clear processes and guidelines for assessment, case planning and case management for children and young people in detention, to enable the delivery of tailored, multidisciplinary, therapeutic responses to each child and young person as part of their daily routine, which meet their health and wellbeing needs and address the factors contributing to their offending behaviour

b. implement a collaborative, multidisciplinary approach to responding to each child and young person in detention that includes all relevant service providers and, to the greatest extent possible, the child or young person's family

c. develop a memorandum of understanding between agencies involved in delivering services to children and young people in detention, including child protection, health, disability support and education that

   i. describes the roles and responsibilities of each agency in case planning and case management

   ii. commits to agencies adopting a collaborative, child-centred approach

   iii. contains clear protocols for record keeping, information sharing, incident reporting and dispute resolution

d. ensure each child or young person in detention (and/or their representative) is given the opportunity to participate in case planning and case management processes, express their views and have those views given due weight

e. ensure each child and young person on remand has access to therapeutic services and supports, with statutory protections that prohibit using disclosures made during interventions and programs on remand as evidence of guilt.

Recommendation 12.20

The Tasmanian Government should ensure:

a. there are appropriate mechanisms and pathways for children in contact with the criminal justice system to be diverted to the mental health system for assessment and treatment

b. the proposed Youth Forensic Mental Health Service provides timely referral and access to mental health treatment, care and support for children and young people when appropriate, whether they are under community-based supervision, in detention or not yet sentenced (including on remand)

c. children and young people in detention have daily access to an onsite child and adolescent psychologist and fortnightly access to an onsite child and adolescent psychiatrist

d. the proposed mental health inpatient unit for children and adolescents in Hobart provides for children and young people in detention.

Recommendation 12.21

The Tasmanian Government should ensure children and young people in detention (including on remand):

a. receive a mental and physical health assessment on admission to the detention facility, and when needed while in detention

b. have access to 24/7 medical care

c. have a say in their mental and physical health care.

Recommendation 12.22

The Department for Education, Children and Young People should:

a. ensure the Youth Justice Model of Care emphasises the central importance for children and young people in detention of access to high-quality education and vocational training that is tailored to their individual learning needs and that includes learning life skills

b. make education programs and other structured activities accessible to all children and young people in detention (including on remand)

c. ensure a child or young person's access to educational programs or physical exercise in detention is not linked to, or limited by, their ranking in behaviour management programs

d. develop and establish partnerships with community organisations to create employment and training opportunities for children and young people leaving detention.

Recommendation 12.23

The Department for Education, Children and Young People should:

a. develop and implement a policy that recognises the importance to children and young people in detention of maintaining or building connections with their family and community and

    i. specifies ways to promote such connections, including through visits, temporary leave and phone or video calls

    ii. clearly states that entitlements to visits, temporary leave and phone or video calls cannot be denied on the basis of a child or young person's behaviour

b. provide reasonable assistance (including financial help) to members of a child or young person's family or Aboriginal community to enable them to visit the child or young person frequently, where families or Aboriginal community members have barriers to accessing the youth detention facility.

Recommendation 12.24

The Tasmanian Government should:

a. establish an integrated throughcare service for children and young people in detention that

   i. begins exit planning as soon as possible after a child or young person enters detention for the provision of safe and stable accommodation, access to physical and mental health support, and assistance with education or employment after release to facilitate their reintegration into the community

   ii. provides increased access to the detention facility for staff of community-based providers of post-release services

   iii. adopts a collaborative, child-centred, cross-organisation approach involving child protection, housing, health, disability support and education services, supported by a memorandum of understanding and clear policies and procedures

   iv. involves the child or young person and, to the greatest extent possible, their parent, guardian or other significant adult in exit planning

   v. includes post-release wraparound support services for children and young people

   vi. is culturally safe for Aboriginal children and young people

b. deliver community-based schooling options for children and young people with complex behavioural challenges, including those who are or have been involved in the youth justice system, to provide appropriate learning environments for children to transition to when they leave detention.

Recommendation 12.25

The Tasmanian Government should introduce a new process for approving transfers of young people from youth detention to an adult prison facility that:

a. limits transfers to young people aged 16 years or older

b. requires the Department for Education, Children and Young People to notify the Commission for Children and Young People (Recommendation 18.6) of any proposed transfer

c. requires the Department to apply to the Magistrates Court (Youth Justice Division) or the new specialist children's division of the Magistrates Court (Recommendation 12.15) for approval to transfer

d. requires the Magistrates Court, in determining whether to approve the transfer, to consider, among other matters, the steps the Department has taken to avoid the need for the transfer, whether the transfer is in the young person's best interests and the views of the Commission for Children and Young People on the appropriateness of the transfer.

Recommendation 12.26

The Auditor-General should undertake an audit of the length of custodial stays at Ashley Youth Detention Centre to determine whether they align with sentencing orders.

Aboriginal children in youth detention

Recommendation 12.27

1. The Tasmanian Government, to protect Aboriginal children and young people against the risk of sexual abuse in youth detention, should urgently develop, in partnership with Aboriginal communities, an Aboriginal youth justice strategy that is underpinned by self-determination and that focuses on prevention, early intervention and diversion strategies for Aboriginal children and young people. Aboriginal communities should be funded to participate in developing the strategy.
2. The strategy should consider and address, among other matters:
    a. legislative reform to enable recognised Aboriginal organisations to design, administer and supervise elements of the youth justice system for Aboriginal children and young people
    b. capacity building and funding for recognised Aboriginal organisations to participate in youth justice decision making in relation to Aboriginal children and young people, and to deliver youth justice services to Aboriginal children and young people
    c. the use of police discretion in the investigation and processing of Aboriginal children and young people, including cautioning, arrest, custody, charging and bail

d. alternative pre-court diversionary options for Aboriginal children and young people

e. mechanisms to increase the likelihood of Aboriginal children and young people receiving bail and minimise the number of Aboriginal children and young people on remand, including culturally responsive supported bail accommodation and other bail assistance programs, and legislative reform to require bail decision makers to consider a child's Aboriginal status

f. mechanisms to support Aboriginal children and young people to comply with the conditions of community-based youth justice orders, to minimise their likelihood of breaching conditions and entering detention.

Recommendation 12.28

The Tasmanian Government should ensure:

a. any new facilities intended to replace Ashley Youth Detention Centre are co-designed with Aboriginal communities and include culturally enriching environments for Aboriginal children and young people that promote connection to family, community and Country

b. the Aboriginal youth justice strategy (Recommendation 12.27) considers whether a small, homelike facility that has Aboriginal staff, provides trauma-informed care and enables Aboriginal children and young people to connect with culture through the involvement of local Aboriginal communities, should be established specifically for Aboriginal children and young people who are remanded or serving a custodial sentence. Careful consideration should be given to the most appropriate management model for such a facility.

Recommendation 12.29

The Tasmanian Government should take steps to ensure Ashley Youth Detention Centre and any replacement facilities are culturally safe for Aboriginal children and young people. These steps should include:

a. updating admission procedures and case management guidelines to require staff to

    i. ask children and young people who identify as Aboriginal whether they would like the support of an Aboriginal organisation or an Aboriginal community member while they are detained

ii. notify the nominated organisation or individual within 12 hours of the child or young person's admission

iii. facilitate the involvement of the child or young person's nominated representative in case planning, case management and exit planning in respect of the child or young person

b. updating relevant guidelines and procedures to require staff to consult with an Aboriginal child or young person's community to determine how best to provide individual cultural support to the child or young person while they are in detention

c. working with Aboriginal communities to establish ongoing cultural programs for Aboriginal children and young people in detention, such as visiting Elders programs, on-Country programs and cultural mentoring programs

d. ensuring the new policy on supporting children and young people in detention to maintain connections to their families and communities (Recommendation 12.23) emphasises the central importance of connection to family, community and culture for the wellbeing of Aboriginal children and young people in detention

e. establishing the role of Aboriginal liaison officer in youth detention to support Aboriginal children and young people, including by facilitating cultural support and becoming involved in case planning, case management and exit planning

f. ensuring the updated Ashley Youth Detention Centre Learning and Development Framework is designed to equip staff with the knowledge and skills to provide a culturally safe environment for Aboriginal children and young people, including providing trauma-informed and culturally safe responses to children and young people engaging in self-harm or other challenging behaviours.

Harmful sexual behaviours in youth detention

Recommendation 12.30

1. The Harmful Sexual Behaviours Support Unit (Recommendation 9.28) should develop detailed youth justice-specific policies, protocols and practice guidelines to support best practice responses to harmful sexual behaviours in youth detention and other residential youth justice facilities.

2. All incidents of harmful sexual behaviours in youth detention or other residential youth justice facilities should be reported to:
    a. the Harmful Sexual Behaviours Support Unit to enable data on harmful sexual behaviours in youth detention and other residential youth justice facilities to be included in the Department for Education, Children and Young People's monitoring and oversight of harmful sexual behaviours through the new Quality and Risk Committee (Recommendation 9.5)
    b. the Commission for Children and Young People (Recommendation 18.6).
3. The Department should explore the potential to implement Power to Kids (or another program or approach with comparable components) in youth detention and other residential youth justice facilities as a supplementary strategy to address the heightened risk of harmful sexual behaviours in those settings and take a proactive approach to prevention.
4. The Tasmanian Government should ensure measures are in place to facilitate timely access to specialist therapeutic interventions for children in youth detention displaying or harmed by harmful sexual behaviours. Where treatment is likely to extend beyond their custodial sentence this should be provided by a clinician external to the detention centre who can continue the treatment after the child is released from detention.

Searches, isolation and use of force

Recommendation 12.31

1. The Tasmanian Government should introduce legislation to amend the *Youth Justice Act 1997* to ensure the Act expressly prohibits fully unclothed searches of children and young people in detention.
2. The Department for Education, Children and Young People should:
    a. introduce body scanner technology at Ashley Youth Detention Centre and include such technology in any facility designed to replace the Centre
    b. update the Department's *Personal Searches of Young People Detained at AYDC* procedure to
        i. define a fully unclothed search as a form of child sexual abuse
        ii. explicitly outline the hierarchy of search options, from the least to the most intrusive

iii. align gender requirements for staff who conduct or observe searches with requirements in the *Youth Justice Act 1997*

iv. specify internal and external reporting requirements in relation to searches

c. publish the personal searches procedure on the Department's website

d. consider what search policies and procedures, if any, should apply in the proposed new assisted bail and supported residential facilities

e. ensure Ashley Youth Detention Centre (and any future detention facility) provides

i. monthly reports on searches of children and young people in detention to the Secretary

ii. quarterly reports on searches of children and young people in detention to the Quality and Risk Committee (Recommendation 9.5) to enable it to monitor trends and identify any areas of concern

iii. the search register and all relevant supporting documentation to the Commission for Children and Young People (Recommendation 18.6) on a monthly basis or more frequently, as agreed with the Commission for Children and Young People.

Recommendation 12.32

1. The Tasmanian Government should introduce legislation to amend the *Youth Justice Act 1997* to ensure the Act:

a. makes clear that confining a detainee in their room or unit and preventing them from having contact with other detainees (other than overnight) constitutes isolation, regardless of the label used to refer to the practice

b. clarifies that the use of isolation as a punishment is a prohibited action and makes it a criminal offence for a person to punish a detainee by isolating them or causing them to be isolated

c. refers expressly to the principle that isolation should only be used as a measure of last resort and for the minimum time necessary.

2. The Department for Education, Children and Young People should:
    a. update the Department's *Use of Isolation* procedure to
        i. make clear that confining a detainee in their room or unit and preventing them from having contact with other detainees (other than overnight) constitutes isolation, regardless of the label used to refer to the practice
        ii. specify clearly who is a delegate of the Secretary or the detention centre manager for the purpose of authorising isolation and extensions of isolation
        iii. require isolation beyond three hours to be authorised by a senior departmental official such as a Director
        iv. specify internal and external reporting requirements in relation to isolation
    b. publish the updated *Use of Isolation* procedure on the Department's website
    c. ensure Ashley Youth Detention Centre (and any future detention facility) records information on lockdowns, including the reason for the lockdown, details of authorisation processes, the duration of the lockdown, the number of children and young people isolated during the lockdown, measures adopted during the lockdown to meet the needs of children and young people and support their health and wellbeing, and steps taken after the lockdown to address its effects on children and young people
    d. ensure Ashley Youth Detention Centre (and any future detention facility) provides
        i. monthly reports on isolation and lockdowns in detention to the Secretary
        ii. quarterly reports on the isolation of children and young people in detention and lockdowns to the Quality and Risk Committee (Recommendation 9.5) to enable it to monitor trends and identify any areas of concern
        iii. the isolation register (with all relevant supporting documentation) and separate data on lockdowns to the Commission for Children and Young People (Recommendation 18.6) on a monthly basis or more frequently, as agreed with the Commission for Children and Young People
    e. publish quarterly data on isolation and lockdowns in youth detention.

Recommendation 12.33

1. The Tasmanian Government should introduce legislation to amend the *Youth Justice Act 1997* to provide that:
    a. subject to sections 25E and 133, force may only be used when reasonable and necessary to prevent an imminent and serious threat of harm to a person or to prevent an imminent escape, and when all other means of control have been exhausted
    b. force must be used for the minimum time necessary
    c. force must never be used to punish a child or young person, or solely to secure their compliance with an instruction or direction
    d. using force in contravention of the Act is a criminal offence.
2. The Department for Education, Children and Young People should:
    a. update the Department's *Use of Force* procedure to
        i. require all uses of force to be immediately reported to a senior departmental official, such as a Director, in addition to identifying the use of force as part of an incident report
        ii. require every child or young person who has been subjected to the use of force to be provided with health care and offered the opportunity to discuss the incident with a staff member who was not involved
        iii. require parents and carers of a child or young person who has been subjected to the use of force to be notified
        iv. specify internal and external reporting requirements in relation to the use of force
    b. publish the updated *Use of Force* procedure on the Department's website
    c. ensure Ashley Youth Detention Centre (and any future detention facility) provides
        i. monthly reports on the use of force in detention to the Secretary
        ii. quarterly reports on the use of force in detention to the Quality and Risk Committee (Recommendation 9.5) to enable it to monitor trends and identify any areas of concern
        iii. the use of force register and all relevant supporting documentation to the Commission for Children and Young People (Recommendation 18.6) on a monthly basis or more frequently, as agreed with the Commission for Children and Young People.

Recommendation 12.34

1. The Department for Education, Children and Young People should provide regular joint training and professional development for staff who have contact with children and young people in youth detention facilities and relevant staff of the Youth Justice Services directorate on laws, standards, policies and procedures regarding the use of isolation, the use of force and searches of children and young people in detention to ensure consistency in understanding and application. This training should be mandatory.
2. Tasmania Police should ensure its members receive regular training and guidance on laws and procedures on the use of isolation, the use of force and searches of children and young people in detention to enable police to readily identify conduct that falls outside the parameters of acceptable professional conduct among staff and may constitute a criminal offence.

Responding to concerns, complaints and critical incidents in detention

Recommendation 12.35

The Department for Education, Children and Young People should:

a. update its complaints procedure and practice advice for youth detention to
    i. address structural barriers to making complaints in detention and include developmentally appropriate communication methods at all stages
    ii. require concerns, regardless of the form in which they are raised, to be recognised, recorded and actioned as a complaint where the person raising the concern wants to make a complaint
    iii. define child sexual abuse (including sexual misconduct, grooming and harmful sexual behaviours) and boundary breaches
    iv. require all complaints and concerns involving allegations of child sexual abuse and related conduct or other harms to children (including the inappropriate use of force, isolation or searches) by staff, breaches of the State Service Code of Conduct or the professional conduct policy for youth detention (Recommendation 12.10) and reportable conduct as defined by the *Child and Youth Safe Organisations Act 2023* to be referred immediately to the new Child-Related Incident Management Directorate for response (Recommendation 6.6)

v. require all incidents involving harmful sexual behaviours to be reported to the Harmful Sexual Behaviours Support Unit (Recommendation 9.28)

vi. clearly specify mandatory and voluntary reporting obligations for staff in relation to Tasmania Police, Child Safety Services, the Registrar of the Registration to Work with Vulnerable People Scheme and the Independent Regulator under the *Child and Youth Safe Organisations Act 2023*

vii. set timeframes for responding to complaints

viii. specify requirements for communicating with and providing support to complainants and other affected parties, including parents or carers of affected children and young people

ix. clarify the requirements for recording complaints and outcomes of complaint investigations to enable the monitoring of trends for quality, safety and governance purposes

x. include procedures for making and responding to complaints in relation to other residential youth justice facilities, including the proposed assisted bail and supported residential facilities

b. ensure staff in detention and other residential youth justice facilities understand and comply with their role in responding to complaints, including complaints about child sexual abuse, and have a clear process for raising safety concerns about other staff

c. use a range of child-friendly tools to ensure children and young people in detention and other residential youth justice facilities are aware of complaints processes and understand the steps facility staff and the Department will take in response to a complaint, including a complaint about child sexual abuse

d. ensure a child-friendly guide to making a complaint and explaining complaints procedures, including the circumstances under which complaints made to oversight bodies may be referred to the Department, is readily accessible on the Department's website, as well as a guide for adults wishing to make a complaint on behalf of a child in detention or another residential youth justice facility

e. ensure there are staff in the Child-Related Incident Management Directorate with expertise in youth justice, including an understanding of the risks of child sexual abuse in detention and the characteristics of mistreatment and abuse in detention environments.

Independent oversight of youth detention

Recommendation 12.36

The Tasmanian Government, in establishing and resourcing the new independent community visitor scheme (Recommendation 9.34), should ensure:

a. independent community visitors visit children and young people in detention facilities weekly, at a minimum

b. Aboriginal children and young people in detention or other residential youth justice facilities have access, wherever possible, to visits from an Aboriginal independent community visitor or from the Commissioner for Aboriginal Children and Young People, depending on the child's preference

c. independent community visitors have the necessary statutory powers to perform their functions, including the power to enter the facility, have access to children and young people in the facility and inspect the facility

d. each facility where children and young people are detained or reside has a safe, dedicated space where independent community visitors can meet with children and young people and discuss concerns without being observed or overheard by staff or other children and young people.

Recommendation 12.37

The Ombudsman should develop written guidelines for its staff on managing complaints it receives containing allegations of child sexual abuse involving children in youth detention, other residential youth justice facilities or out of home care. Among other matters, these guidelines should include:

a. the definition of child sexual abuse and related conduct, including sexual misconduct, grooming, harmful sexual behaviours and boundary breaches

b. the process for reporting relevant allegations to Tasmania Police, Child Safety Services, the Registrar of the Registration to Work with Vulnerable People Scheme and the Independent Regulator under the *Child and Youth Safe Organisations Act 2023*

c. guidance on referring an allegation or complaint to an agency named in the complaint

d. guidance on communicating with child complainants on the referral of their complaints to other entities and the progress of investigations into their complaints

e. processes for sharing information with other oversight bodies regarding the management of complaints (Recommendation 18.15).

Recommendation 12.38

The Tasmanian Government should ensure the Commission for Children and Young People (Recommendation 18.6):

a. has functions and powers to monitor the operation of youth detention centres and other residential youth justice facilities, and the safety and wellbeing of, and the provision of services to, children and young people in detention, and in the youth justice system more broadly, by

   i. regularly monitoring and reviewing custodial population data and information on serious or adverse incidents (such as child sexual abuse, assaults, attempted suicide, self-harm, riots, escapes and property damage) and the use of isolation, force, restraints and searches

   ii. conducting regular onsite inspections of youth detention and other residential youth justice facilities

   iii. conducting own-motion systemic inquiries into issues that are identified through monitoring

   iv. conducting own-motion inquiries into the youth justice services received by an individual child or group of children

b. has the power to enter adult prison facilities to visit children and young people in those facilities to monitor their safety and wellbeing

c. is adequately resourced on an ongoing basis to fulfil its systemic monitoring functions.

Recommendation 12.39

The Tasmanian Government should:

a. appoint the Commission for Children and Young People (Recommendation 18.6) as an additional National Preventive Mechanism under the United Nations Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT), with expertise in child rights, child trauma, the prevention and identification of child abuse, the needs of Aboriginal children and young people and the needs of children and young people with disability, and with power to inspect places where children and young people are detained

b. resource Tasmanian National Preventive Mechanisms sufficiently to allow them to effectively fulfil their functions under OPCAT.

Chapter 15 – The way forward: Children in health services

A policy framework and implementation plan

Recommendation 15.1

The Department of Health should develop and communicate a policy framework and implementation plan for reforms to improve responses to child sexual abuse in health services. The policy and implementation plan should:

a. set out the purpose and need for the reforms

b. set out the role, responsibilities and interactions of bodies the Department has set up as part of the reforms

c. explain how reforms, including departmental reforms and those recommended by the Child Safe Governance Review, Community Recovery Initiative and this Commission of Inquiry, will work together to respond to child sexual abuse in health services

d. outline how the reforms are being prioritised for implementation and who is responsible for their implementation

e. set out the expected timeframes for implementation

f. be published on the Department's website.

Implementing the National Principles for Child Safe Organisations

Recommendation 15.2

1. The Tasmanian Government and Department of Health should continue to implement the National Principles for Child Safe Organisations across all health services.
2. The Tasmanian Government should advocate at a national level for compliance with the National Principles for Child Safe Organisations to be a mandatory requirement for accrediting health services against the National Safety and Quality Health Service Standards under the Australian Health Service Safety and Quality Accreditation Scheme.

Protecting children through a safety culture

Recommendation 15.3

The Department of Health should ensure its cultural improvement program embeds a safety culture in health services by:

a. requiring clear organisational values be observed across all levels of health services, including in relation to staff conduct

b. establishing strong governance arrangements to address staff practices that place children at risk of abuse, and complementing established patient safety governance structures

c. ensuring all levels of management demonstrate a commitment to a safety culture, including by addressing poor staff conduct

d. clarifying roles and responsibilities among staff when there is a suspicion that child sexual abuse has occurred or that safety policies are not observed

e. ensuring there are processes that hold senior managers and executives accountable to respond appropriately to the conduct of their staff, including through performance agreements and role descriptions

f. establishing measures of a strong organisational culture that indicate an organisation

i. welcomes concerns about staff and sees them as an opportunity to improve safety for staff and patients

ii. empowers staff to feel safe and supported to raise concerns about colleagues with their leaders and gives them confidence in the ability of leaders to respond to concerns and take disciplinary actions (including termination) where appropriate

iii. ensures staff are clear about the process for raising concerns, how these concerns will be addressed and what feedback they can expect to receive

g. providing progress reports to the Child Sexual Abuse Reform Implementation Monitor to demonstrate how these principles have been translated into policy and practice (Recommendation 22.1).

Recommendation 15.4

1. The Department of Health should consider integrating features of the St Vincent's Health Australia's Ethos Program into its cultural improvement program.
2. The Department of Health should ensure, in adopting its cultural improvement program, professional boundary breaches by staff towards a child are always formally reported, responded to and recorded in centralised records for future reference.

Embedding child safety as a priority for leadership

Recommendation 15.5

The Department of Health should make health leadership accountable for embedding child safety as a priority, including by:

a. ensuring that all relevant health leaders have an obligation to act consistently with the National Principles for Child Safe Organisations (reflected in Tasmania's Child and Youth Safe Standards) in their role descriptions and performance agreements, with compliance with this obligation to be reviewed annually

b. ensuring that the role descriptions and performance agreements of all staff providing services to children require them to protect child safety, with compliance with this obligation to be considered as part of annual performance reviews.

Recommendation 15.6

The Department of Health, to support health services become child safe organisations, should ensure:

a. child safety, including safety from abuse in health services, is overseen by the governance and leadership structures established through the cultural improvement program

b. child safety is built into the safety and quality systems of health services

c. staff responsible for providing care to children have the knowledge and skills to respond to child safety concerns in line with the expectations of a child safe organisation and relevant health service policies, including being equipped to identify and respond to indicators of child sexual abuse

d. staff act consistently with the National Principles for Child Safe Organisations (reflected in Tasmania's Child and Youth Safe Standards) when performing their work, including in discussions between health practitioners, health workers and children about care planning and treatment.

Empowering children, families and carers

Recommendation 15.7

1. The Department of Health should establish a health services young people's advisory group. The advisory group should:

   a. have a clear purpose and objectives

   b. be guided by clear terms of reference developed in consultation with children and young people

   c. comprise young people with significant lived experience of health services, including young people of different ages, from diverse backgrounds and with different care needs

   d. enable young people to contribute to decision making in a safe and meaningful way about issues that affect them

   e. allow young people to have a say in departmental strategies, policies, procedures and protocols that affect them

   f. be adequately funded and resourced.

2. Summaries of the health services young people's advisory group meetings should be prepared and distributed to all senior executive teams in the Department.
3. The Department should report on the activities of the health services young people's advisory group and on other engagement with children and young people through its annual report.
4. The Department should undertake other age-appropriate engagement with children to ensure as many children and young people as possible can take part in shaping health services.

Recommendation 15.8

1. The Department of Health should ensure consistent information is provided to patients, including suitable age-appropriate resources for children and young people and their families and carers, across its health services. These resources should include information on:
    a. requirements and expectations of a child safe organisation
    b. patient rights when receiving health care, including the rights of children and young people
    c. expected standards of behaviour for health service staff
    d. processes for raising concerns and making complaints internally and externally
    e. roles of health regulatory bodies in receiving complaints.
2. This information should be provided in formats that meet community needs, especially for those with less capacity to comprehend complex written text.

Recommendation 15.9

The Department of Health should require its health services to undertake regular and ongoing monitoring of children and young people's sense of safety in health services to inform continuous improvements to child safety, including in the safety of the physical environment.

Recommendation 15.10

The Department of Health should work with relevant stakeholders to consider the needs and backgrounds of children and young people using health services, including Aboriginal children, children from culturally diverse backgrounds, children with disability, children with mental illness and children who identify as LGBTQIA+. The Department should consult with Aboriginal communities on how it can provide culturally safe spaces for Aboriginal children across its health services.

Policies, procedures and protocols on child safety

Recommendation 15.11

1. The Department of Health should review and consolidate its policies, procedures and protocols. This review should prioritise identifying gaps in relation to safeguarding children and should inform the development and implementation of consistent statewide policies, procedures and protocols on child safety.
2. The Department's safeguarding policies should include implementing the National Principles for Child Safe Organisations and other recommended policy changes (namely, policies on reporting obligations, professional conduct and providing a chaperone (Recommendations 15.12, 15.13 and 15.14)).
3. The Department should undertake regular scheduled reviews of its policies, procedures and protocols for child safety to ensure they continue to reflect best practice and organisational changes.
4. The Department should publish its policies, procedures and protocols for child safety on its website to promote transparency and ensure accessibility to staff, patients and their families.

Recommendation 15.12

1. The Department of Health should ensure there are up-to-date policies on mandatory and voluntary reporting obligations, including for concerns about staff conduct, and that these are effectively communicated to staff. These policies must not require that reporting be formally authorised.
2. The Department's review of the *Tasmanian Health Service Protocol – Complaint or Concern about Health Professional Conduct* and associated documents should include:

a. a description of external reporting requirements in relation to child safety, including voluntary reporting pathways, and reporting to Tasmania Police, Child Safety Services, the Registrar of the Registration to Work with Vulnerable People Scheme, the Independent Regulator under the *Child and Youth Safe Organisations Act 2023* and the Australian Health Practitioner Regulation Agency

b. guidance on when it is appropriate to acquit mandatory reporting obligations by reporting concerns to a superior (for example, to avoid multiple notifications). This should make clear that a person is always entitled to make a notification to an external agency if they wish to do so

c. a list of internal contacts for staff who have questions about child safety concerns and their reporting obligations.

Recommendation 15.13

1. The Department of Health, in developing a professional conduct policy (Recommendation 20.2), should ensure:

   a. there is a separate professional conduct policy for staff who have contact with children and young people in health services

   b. the professional conduct policy for health services, in addition to the matters set out in Recommendation 20.2

      i. specifies expectations outlined in other relevant Department of Health policies and procedures

      ii. refers to other professional obligations of registered health practitioners, including those developed by the Australian Health Practitioner Regulation Agency and the National Boards

      iii. reflects the specific risks that arise in health services, particularly the sometimes intimate and invasive nature of health services, and the significant trust and power afforded by patients and the broader community to those providing health services

   c. the professional conduct policy for health services spells out expected standards of behaviour for volunteers, contractors and sub-contractors

   d. the Department uses appropriate mechanisms to ensure compliance by volunteers, contractors and sub-contractors with the professional conduct policy for health services.

2. The professional conduct policy for health services should be reinforced through professional development requirements (Recommendation 15.15).

Recommendation 15.14

The Department of Health's chaperone (or Accompanying Person/Observer) policy should be updated to require the presence of an extra staff member during examinations or episodes of care where no family member or carer can be present.

Professional development for health service staff

Recommendation 15.15

1. The Department of Health should identify minimum requirements for professional development on child safety for different levels of staff, including staff, volunteers and contractors, as well as leadership. Professional development should cover, at a minimum:
    a. understanding child sexual abuse (including grooming and boundary breaches)
    b. the requirements and expectations of a child safe organisation
    c. mandatory and voluntary reporting obligations, including the role and function of Tasmania Police, Child Safety Services, the Registrar of the Registration to Work with Vulnerable People Scheme, the Independent Regulator under the *Child and Youth Safe Organisations Act 2023* and the Australian Health Practitioner Regulation Agency
    d. relevant child safeguarding policies and procedures.
2. The Department should have appropriate processes in place to ensure leaders have the knowledge, skills, aptitude and core capability requirements to effectively manage people and to lead a child safe organisation.
3. The Department should develop outcomes-based measures of the effectiveness of child safety professional development initiatives for all categories of staff, volunteers, and contractors, including management, leadership, human resources, and professional and non-professional staff.
4. These outcomes-based measures should be reviewed annually and the results used to inform further professional development initiatives and leadership selection.

Recommendation 15.16

1. The Department of Health should have a specific policy on responding to complaints and concerns about staff conduct. The policy should establish a complaints escalation, management and investigation process that is informed by the following principles:

    a. Complaints processes should be well-understood, trusted and accessible to staff, patients and others.

    b. Complaints processes should have clear escalation processes, internal and external reporting requirements within specific timeframes, and address immediate risks to children's safety.

    c. There should be appropriate scrutiny and oversight of how complaints about child safety are escalated to senior staff, managed and recorded.

    d. Complaints about child safety should be recorded comprehensively and stored securely in incident management (such as the Safety Reporting and Learning System) and human resources systems.

    e. Complaints about unprofessional conduct and boundary breaches with child patients should be recognised as indicating a patient safety issue and treated as serious.

    f. Complaints data should support decision making and inform system improvements.

    g. There should be appropriate communication and supports provided to those making complaints or affected by the alleged conduct, including through open disclosure processes (Recommendation 15.18).

2. The policy should include a diagram showing the complaints escalation, management and investigation pathways for child safety concerns and associated governance and review arrangements. It should also outline the roles and responsibilities of the various bodies involved in responding to child safety concerns.

3. This policy and diagram should be available to health service users and the public.

Recommendation 15.17

1. The Department of Health should establish a separate Health Services Child-Related Incident Management Directorate or partner with the Child-Related Incident Management Directorate (Recommendation 6.6) to respond to allegations of child sexual abuse and related conduct by staff, breaches of the State Service Code of Conduct and professional conduct policies, and reportable conduct (as defined by the *Child and Youth Safe Organisations Act 2023*) in health services.
2. If the Department partners with the Child-Related Incident Management Directorate, it should ensure the directorate has access to specialised advice to inform investigations against health services staff, particularly where allegations have arisen in the context of provision of health care.
3. If the Department establishes a new Health Services Child-Related Incident Management Directorate, it should mirror the functions and manner of operation reflected in the Child-Related Incident Management Directorate, including having three distinct roles and skill sets covering incident response management, investigations, and misconduct and disciplinary advice.

Recommendation 15.18

The Department of Health should ensure open disclosure processes for patients who experience child sexual abuse in health services and their families and carers that:

a. create a safe, trauma-informed pathway for victim-survivors, or others affected by an event, to receive clear and personalised information in response to their questions or concerns

b. facilitate appropriate notifications including to Tasmania Police, Child Safety Services, the Registrar of the Registration to Work with Vulnerable People Scheme, the Independent Regulator under the *Child and Youth Safe Organisations Act 2023* and the Australian Health Practitioner Regulation Agency

c. make appropriate supports available to affected people, including victim-survivors, their immediate family and carers, where abuse is connected to the Department's health services, including warm referrals, with the person's consent, to trained and experienced child sexual abuse counsellors.

Recommendation 15.19

The Department of Health should develop and implement a critical incident response plan for human-caused traumatic events where numerous staff and patients are affected, including serious child-related incidents. The response plan should:

a. identify who is responsible for leading the response to a critical incident and set out the applicable reporting arrangements

b. identify the steps to responding to a human-caused traumatic event (including incidents relating to child safety)

c. provide for external assistance from experts with training and expertise in crisis management

d. be based on best practice responses to traumatic events

e. provide for early communication of information about the event

f. provide psychological first aid to affected people

g. provide extra support from skilled psychologists on an 'as needed' basis to affected people

h. provide for information about other support services that can assist affected people

i. facilitate communication and support among affected people as a means of social support

j. provide for critical incident debriefing run by a neutral and trained expert where appropriate

k. provide for a review of the Department's response to the critical incident

l. provide for an evaluation of any actions to be implemented as part of the Department's response to the critical incident

m. provide for any lessons from a review or an evaluation of the Department's response to the critical incident, to be shared with the Secretaries Board to further inform responses to critical incidents across the whole of government.

Restoring trust

Recommendation 15.20

1. The Department of Health, Launceston General Hospital and Tasmania Police should make clear that they will continue to assist, on an ongoing basis, known and as yet unknown victim-survivors of child sexual abuse by James Griffin related to the hospital and should nominate a contact person for people who have enquiries.
2. Assistance should include:
    a. outlining what is known about Mr Griffin's offending at the hospital
    b. taking steps to ascertain whether a person is or may be a victim-survivor of Mr Griffin's offending or clearly explaining why this cannot be done.
3. The Department and Launceston General Hospital's communications with known and as yet unknown victim-survivors of Mr Griffin and their families and carers and the broader community should be informed by the principles of open disclosure.
4. Launceston General Hospital should ensure victim-survivors and their families and carers who do not receive individual open disclosure (Recommendation 15.18) still receive a warm referral to trained child sexual abuse counsellors if desired.

Oversight

Recommendation 15.21

The Tasmanian Government should ensure a review of the *Health Complaints Act 1995* is completed and considers the role of the Health Complaints Commissioner in relation to:

a. addressing systemic issues within health services related to child safety
b. incorporating the administration, monitoring and oversight of the Code of Conduct for Unregistered Health Care Workers
c. coordinating with the role of the new Commission for Children and Young People (Recommendation 18.6), and the Independent Regulator under the *Child and Youth Safe Organisations Act 2023*.

Chapter 16 – Criminal justice responses

Police responses

Recommendation 16.1

1. The Tasmanian Government should fund and establish specialist units in Tasmania Police, based on the Victorian Sexual Offences and Child Abuse Investigation Teams model, to investigate child sexual abuse and to be based in three locations (Hobart, Launceston and the North West).
2. The specialist police units should:
    a. specialise in the investigation of child sexual abuse, including historical child sexual abuse (and potentially adult sexual assault) but not undertake domestic and family violence work unless it is directly connected to child sexual abuse (or adult sexual assault)
    b. be staffed by police officers who have undertaken specialised professional development (Recommendation 16.3) and members who have trauma-informed training (Recommendation 19.2)
    c. partner with other agencies and support services involved in responding to child sexual abuse to create multidisciplinary teams. These teams do not have to be co-located, although this may be appropriate in some areas
    d. have access to a 'soft' interview room, ideally offsite from police stations and potentially in multidisciplinary centres
    e. be directed to perform other policing duties only in exceptional circumstances and not as part of a unit's usual roster
    f. support the wellbeing of police officers and members working in the specialist unit
    g. develop and implement strategies to engage and build trust with marginalised communities, particularly Aboriginal people and people with criminal histories (Recommendation 16.2).
3. Tasmania Police should measure and report on victim-survivor satisfaction with the operation of the specialist units within two years of establishment and regularly thereafter.

Recommendation 16.2

1. Tasmania Police should establish ways for people to report child sexual abuse online.
2. The Department of Justice and the Department for Education, Children and Young People should review their internal processes to make it easier for people in prison and youth detention to report abuse to the police or other bodies, including online or by phone hotline, and ensure appropriate confidentiality of reports.
3. Specialist police units (Recommendation 16.1) should develop a strategy to engage with 'priority communities', by implementing measures to develop relationships, build trust and encourage reporting of child sexual abuse, and to assist prevention and 'disruptive' policing (Recommendations 9.29 and 9.30).
4. Priority communities include:
    a. Aboriginal communities
    b. people who are or were in prison or youth detention
    c. people who are or were in out of home care (or youth support services).

Recommendation 16.3

Tasmania Police should review its professional development on child sexual abuse to ensure:

a. all police are trained in
    i. the dynamics of sexual abuse and the concept of grooming, and perpetrators' use of these to facilitate a crime
    ii. myths and misconceptions about child sexual abuse and disclosure
    iii. responding to child and adult victim-survivors sensitively and with an understanding of trauma
b. child sexual abuse specialist detectives are trained in
    i. approaches to interviewing child and adult victim-survivors and vulnerable witnesses, including the Whole Story framework (or similar specialist interviewer training)

ii. understanding the vulnerability of specific groups of children (such as those in out of home care and youth detention) and common myths about these children

c. all police receive scheduled and regular refresher training and ongoing professional development.

Recommendation 16.4

1. Tasmania Police should develop and implement quality audit and assurance processes for investigating child sexual abuse offences, including random file sampling.
2. File sampling should:
   a. capture data on how well police are complying with procedures for investigating child sexual abuse offences, including the requirements set out in the Initial Investigation and Notification of Child Sexual Abuse Guidelines
   b. assess whether
      i. contact was made with the person reporting child sexual abuse
      ii. every effort was made to establish the victim's identity and to assess and investigate the report, where appropriate
      iii. a thorough examination of intelligence on Tasmania Police databases was conducted
      iv. cross-agency and interstate requests for information checks were made to determine whether any intelligence held outside Tasmania might assist the investigation
      v. contact details of the investigating officer were provided to the victim, parent, guardian or other support person
      vi. a supervisor confirmed whether the above actions were taken
   c. capture data on the timeliness of investigations
   d. go beyond technical adherence to requirements and assess the overall quality of police investigative responses and outcomes for victim-survivors, including identifying any opportunities for improvement.

Recommendation 16.5

Tasmania Police should:

a. review the adequacy and availability of equipment used to record evidence by video or audio, and ensure this equipment is available in all police facilities where victim statements relating to child sexual abuse are taken

b. ensure specialist child sexual abuse police officers receive training on the use of recording equipment and refresher training if they have not used the equipment for six months or more.

Recommendation 16.6

1. The Department of Health should increase the availability of forensic medical examination services for child victim-survivors of sexual abuse to ensure all child victim-survivors can access an examination with minimal delay. To achieve this, the Department should:

   a. train existing adult sexual assault forensic medical examination services to examine child victim-survivors

   b. ensure, in areas of Tasmania where no sexual assault forensic medical examination services exist, suitably qualified local health professionals are trained and supported to conduct forensic medical examinations for child sexual abuse.

2. At a minimum, the training should include:

   a. an external, recognised qualification in forensic medical examinations

   b. external recognised training in sexual abuse care for children.

Recommendation 16.7

Tasmania Police should:

a. establish a clear, publicly accessible process for reporting and responding to allegations of child sexual abuse against a member of Tasmania Police, including the ability to report to an entity independent of police such as the Integrity Commission

b. expand the domestic violence review panel to cover child sexual abuse and ensure independence in investigations when a member is alleged to have been involved in child sexual abuse.

Prosecutions

Recommendation 16.8

1. The Office of the Director of Public Prosecutions should provide ongoing professional development to staff on child sexual abuse, including:
    a. specialist training on trauma-informed practice
    b. training on issues that children and adult victim-survivors may face in giving evidence and approaches that can be taken to make the process trauma-informed, including the role of witness intermediaries
    c. training on the laws of evidence and procedure that apply in child sexual abuse cases
    d. training on the nature, causes and methods of child sexual abuse and grooming, including addressing common myths about child sexual abuse.
2. The Office of the Director of Public Prosecutions should also explore opportunities with Tasmania Legal Aid and the Law Society of Tasmania for joint training on the dynamics of child sexual abuse and trauma-informed practice.

Offences, evidence and procedure

Recommendation 16.9

The Tasmanian Government should introduce legislation to amend the following provisions in the *Criminal Code Act 1924*:

a. section 125A to remove all language referring to 'maintaining a sexual relationship with a young person' and replace it with words referring to the 'persistent sexual abuse of a child or young person'
b. section 124A (the position of authority offence) to cover indecent acts with or directed at a child or young person under the age of 18 by a person in a position of authority in relation to that child or young person. The offence should
    i. not apply where the person accused of the offending is under the age of 18 at the time of the offence
    ii. qualify as an unlawful sexual act for the purposes of the offence of 'persistent sexual abuse of a child or young person' under section 125A of the *Criminal Code Act 1924*

c. section 125E (the offence of failure by a person in authority to protect a child from a sexual offence) to ensure the offence does not apply to a person who was under the age of 18 at the time of the offence.

Recommendation 16.10

1. The Tasmanian Government should extend the Witness Intermediary Scheme to include children who are under investigation for, or who have been charged with, sexual offences, and fund it to do so.
2. The Tasmanian Government should consider whether legislation should be enacted requiring police to use witness intermediaries in police interviews of children and young people and adults with communication needs (including defendants), relating to sexual offences.

Recommendation 16.11

1. The Tasmanian Government should introduce legislation to amend the *Evidence (Children and Special Witnesses) Act 2001* to simplify the legislation to clarify when special measures are available to adults who are complainants in trials relating to child sexual abuse and allow them to:
   a. have a support person present when they give evidence in court
   b. give their evidence at a special hearing before the trial unless the judge considers that this would be contrary to the interests of justice, regardless of whether the accused consents
   c. be shielded from the view of the accused person by a screen or partition if they choose to give evidence in court.
2. The Tasmanian Government should ensure courts, public defence counsel (such as Tasmania Legal Aid) and the Office of the Director of Public Prosecutions are appropriately funded to carry out this recommendation.

Recommendation 16.12

The Tasmanian Government should:

a. update the audiovisual equipment available to the Supreme and Magistrates Courts

b. discuss with the Supreme and Magistrates Courts ongoing training for relevant staff on using audiovisual equipment.

Recommendation 16.13

The Tasmanian Government should introduce legislation to extend the principles of section 13B of the *Family Violence Act 2004* to sexual assault matters, including child sexual abuse. This will ensure that where a person is acquitted in the Magistrates Court because the prosecution has informed the Court it will not be offering any evidence in support of the charge, the acquittal does not prevent admitting evidence of relationship, tendency or coincidence evidence in a later related matter.

Recommendation 16.14

The Tasmanian Government should, in similar terms to sections 199, 204 and 205 of the *Criminal Procedure Act 2009* (Vic), amend the *Criminal Code Act 1924* (including section 361A) to:

a. allow pre-trial rulings or orders to be made before the accused person has entered a plea

b. provide that such pre-trial rulings or orders are binding on a trial judge, even where a different judge made the order, unless the trial judge considers that would not be in the interests of justice

c. provide that such pre-trial rulings or orders apply at a new trial unless this would be inconsistent with any order or decision made on an appeal or would not be in the interests of justice.

Recommendation 16.15

The Tasmanian Government should introduce legislation to:

a. require trial judges to explain to juries the difficulties child witnesses often face in giving evidence in court, and the distinctive ways in which they give evidence, in cases where the reliability or credibility of a child witness is likely to be in issue, in similar terms to section 44N of the *Jury Directions Act 2015* (Vic)

b. provide that in jury trials of a person accused of a child sexual abuse offence, if a party so requests, the judge must, unless the judge considers there are good reasons for not doing so, direct the jury that

    i. children who have been subjected to child sexual abuse respond in a variety of ways and some children who have been abused do not avoid the alleged perpetrator

    ii. disclosure of abuse may occur over time and not all on one occasion

c. prohibit, in similar terms to section 294AA of the *Criminal Procedure Act 1986* (NSW), a judge in a trial of a person indicted for sexual offences against a child from

    i. warning a jury against convicting the accused person solely because the only evidence is the evidence of the complainant

    ii. directing the jury about the danger of conviction in the absence of corroboration

d. amend the *Evidence Act 2001*, in similar terms to section 52 of the *Jury Directions Act 2015* (Vic), to require a trial judge who considers that delay in complaining is likely to be raised in a trial for a child sexual abuse offence to inform the jury that

    i. people react differently to sexual abuse and there is no typical, proper or normal response to a sexual offence

    ii. some people may complain immediately to the first person they see, while others may not complain for some time, and others may never make a complaint

    iii. it is common for a person to delay making a complaint of sexual abuse, particularly if it occurred when they were a child

    iv. there may be good reasons why a person may not complain, or may delay complaining about sexual abuse

e. amend the *Evidence Act 2001* to provide that the warnings and directions can be

   i. given by a judge to the jury at the earliest opportunity, such as before the evidence is called or as soon as practicable after it is presented in the trial

   ii. repeated by the judge at any time during the trial

   iii. given by the judge's own motion, or if requested by either party before the trial or at any time during the trial.

Recommendation 16.16

The Tasmanian Government should:

a. fund the Supreme Court to support the professional development of judicial officers on the dynamics of child sexual abuse and trauma-informed practice

b. consider introducing legislation dealing with the responsibility of the Chief Justice to direct the professional development and continuing education and training of judicial officers, in similar terms to section 28A of the *Supreme Court Act 1986* (Vic).

After a conviction

Recommendation 16.17

The Tasmanian Government should ensure preventive programs for adults who are at risk of abusing, or have abused, children are available beyond the custodial setting. These programs should be:

a. properly funded

b. align with the practice guidelines issued by the Association for the Treatment and Prevention of Sexual Abusers

c. include a monitoring and evaluation process.

The language of consent

Recommendation 16.18

1. The Tasmanian Government should introduce legislation to amend section 11A of the *Sentencing Act 1997* to provide that, in determining the appropriate sentence for an offender convicted of a child sexual abuse offence, the acquiescence or apparent consent of the victim is not a mitigating circumstance.
2. The Director of Public Prosecutions should amend its *Prosecution Policy and Guidelines* to make it clear that in child sexual abuse matters where consent is not an element of the offence, then the language of consent should not be used by prosecutors.
3. Professional education for judicial officers (Recommendation 16.16) and prosecutors (Recommendation 16.8) should include challenging the myths and misconceptions about consent in relation to child sexual abuse.

Responses to children and young people displaying harmful sexual behaviours

Recommendation 16.19

We encourage the courts to consider using their powers to direct young people engaging in harmful sexual behaviours who are charged with a criminal offence to specialist therapeutic services.

Monitoring and evaluation

Recommendation 16.20

1. The Department of Justice should:
    a. prioritise collecting and publishing key data about institutional child sexual abuse, including
        i. the number of reports of child sexual abuse made to police
        ii. police, prosecution and court outcomes of reports, and reasons for outcomes, including the reasons why cases did not proceed

iii. the time between reporting, charging or a decision not to progress, and prosecution

iv. whether the abuse took place in an institutional setting

v. basic demographics of victim-survivors and alleged perpetrators (for example, age, gender and Aboriginal status)

vi. trends in relation to particular groups, including Aboriginal people

b. support the Office of the Director of Public Prosecutions to improve its data collection for child sexual abuse cases so it can effectively monitor

i. the cases on which police seek advice, that proceed to court and that are discontinued, including the reasons for discontinuance

ii. the number, type and success rate of appeals in child sexual abuse matters

c. cause periodic surveys to be conducted and published with victim-survivors of child sexual abuse on their experience and satisfaction with the criminal justice system, including on whether the victim-survivor

i. felt listened to

ii. felt believed

iii. understood the process

iv. was kept informed of the progress of the case.

2. The Sentencing Advisory Council should periodically review trends in sentencing for child sexual abuse offences in Tasmania and compare them with sentencing outcomes for equivalent offences in other Australian jurisdictions.

Chapter 17 – Redress, civil litigation and support

The National Redress Scheme

Recommendation 17.1

1. The Tasmanian Government should ensure victim-survivors of child sexual abuse in Tasmanian Government institutions have access to a redress scheme irrespective of when the abuse occurred, when they were born or whether they have committed a serious offence.
2. To achieve this outcome, the Tasmanian Government should advocate at a national level for:
    a. the National Redress Scheme to apply to child sexual abuse in institutions experienced on or after 1 July 2018, with no specified closing date for applications
    b. changes to the National Redress Scheme that will allow access to redress for people sentenced to imprisonment for five years or longer for a state, territory, federal or foreign country offence.
3. If the National Redress Scheme is not extended, the Tasmanian Government should itself establish a redress scheme for victim-survivors of child sexual abuse in Tasmanian Government institutions, with no specified closing date for applications to be made.
4. The design and operation of any Tasmanian redress scheme should:
    a. ensure delays are minimised and that applications for redress are handled in a sensitive and trauma-informed manner
    b. incorporate relevant recommendations made in the *Second Year Review of the National Redress Scheme*
    c. make it available to people sentenced to imprisonment for five years or longer for a state, territory, federal or foreign country offence
    d. allow information to be shared to reduce current risk to children wherever possible, and to facilitate disciplinary action and reporting to Tasmania Police, Child Safety Services, the Registrar of the Registration to Work with Vulnerable People Scheme and the Independent Regulator under the *Child and Youth Safe Organisations Act 2023* (Recommendation 12.5).

Civil litigation

Recommendation 17.2

1. The Tasmanian Government should ensure all lawyers who act for the Tasmanian Government in civil claims relating to child sexual abuse receive regular professional development on:
    a. the nature and effects of child sexual abuse, including institutional child sexual abuse, perpetrator tactics and impacts on victim-survivors
    b. how to consider these effects when victim-survivors are involved in civil litigation processes.
2. The Solicitor-General or the new State Litigation Office should issue and ensure compliance with guidelines relating to:
    a. trauma-informed management of settlement processes and conferences in child sexual abuse cases
    b. whether and when legal professional privilege should be claimed by the Tasmanian Government in relation to medical reports or expert evidence, adopting the principle that generally legal professional privilege should be waived
    c. making apologies before reaching a final settlement.

Recommendation 17.3

1. The Attorney-General should issue guidelines to clarify the respective roles of the Solicitor-General and the new State Litigation Office, departmental secretaries and other agency heads where Tasmanian government agencies are engaged in the conduct and settlement of civil litigation arising from allegations of child sexual abuse.
2. The Treasurer's Instruction relating to obtaining external legal advice should be amended to:
    a. make it consistent with the Attorney-General's guidelines on civil litigation arising from allegations of child sexual abuse
    b. specify the circumstances in which departmental secretaries and other agency heads should be able to seek external legal advice on matters related to child sexual abuse.

Apologies

Recommendation 17.4

The Tasmanian Government should ensure individual victim-survivors of child sexual abuse who request an apology receive one. Proactive steps should also be taken to offer an apology to victim-survivors who make contact in relation to their abuse. The apology should include:

a. the opportunity to meet with a senior institutional representative (preferably the Secretary) and receive an acknowledgment of the abuse and its impact

b. information about the victim-survivor's time in the institution

c. information about what steps the institution has taken or will take to protect against further sexual abuse of children, if asked.

Recommendation 17.5

The Tasmanian Government should introduce legislation to amend the *Civil Liability Act 2002* to ensure that an apology in relation to child sexual abuse can be made without amounting to an admission of liability.

Support for victims of crime

Recommendation 17.6

The Department of Justice should ensure that:

a. in relation to claims for financial assistance under the Victims of Crime Assistance Scheme, delays are minimised and applications for compensation are handled in a sensitive and trauma-informed manner

b. staff in Victims Support Services receive regular professional development on the effects of child sexual abuse and how to respond to victim-survivors in a trauma-informed manner

c. people being considered for appointment as Criminal Injuries Compensation Commissioners are required to take part in professional development on the effects of child sexual abuse and how to respond to victim-survivors in a trauma-informed manner before their appointment and regularly thereafter.

Recommendation 17.7

The Tasmanian Government should introduce legislation to amend the *Victims of Crime Assistance Act 1976* to create a right of review on the merits by the Tasmanian Civil and Administrative Tribunal in relation to a decision of the Criminal Injuries Compensation Commissioners:

a. to refuse financial assistance to a victim-survivor of child sexual abuse

b. about the amount of financial assistance to which a victim-survivor of child sexual abuse is entitled.

Access to information and records

Recommendation 17.8

1. The Tasmanian Government should review and reform the operation of the *Right to Information Act 2009* and the *Personal Information Protection Act 2004* to ensure victim-survivors of child sexual abuse in institutional contexts can obtain information relating to that abuse. This review should focus on what needs to change to ensure:

   a. people's rights to obtain information are observed in practice

   b. this access is as simple, efficient, transparent and trauma-informed as possible.

2. The review should consider reforms to the *Right to Information Act 2009* and the *Personal Information Protection Act 2004* to:

   a. include an explicit presumption in favour of disclosure in the *Right to Information Act 2009* and *Personal Information Protection Act 2004*

   b. embed the public interest test in specific exemptions in the *Right to Information Act 2009*, tailored to those exemptions

   c. streamline the interface between the *Right to Information Act 2009* and *Personal Information Protection Act 2004* to overcome what has, by default, become a two-step process to obtain personal information

   d. require that a personal information custodian under the *Personal Information Protection Act 2004* 'must provide' rather than 'may provide' personal information upon request from an individual who is the subject of that information, subject to any appropriate exemptions to that requirement

e. include a 'reasonableness' test in the *Right to Information Act 2009* as part of the assessment of whether to withhold personal information relating to a person or third party other than the person making the request for information

f. strengthen and streamline internal and external review processes in the *Right to Information Act 2009* and *Personal Information Protection Act 2004*, with a focus on options to enforce decisions of the Ombudsman and to apply for review by the Tasmanian Civil and Administrative Tribunal

g. provide an automatic fee waiver for right to information applications relating to child sexual abuse made under the *Right to Information Act 2009* by victim-survivors or a person acting on their behalf.

3. The Tasmanian Government should consider centralising management of access to information processes in a specialist unit or department, supported by access to information liaison officers located in government departments and agencies.

4. The Tasmanian Government should provide funding to government departments, agencies and the Ombudsman, as the case may be, to:

   a. ensure access to information requests are processed within statutory timeframes

   b. speed up external review of right to information decisions

   c. provide trauma-informed training to the Tasmanian State Service in relation to victim-survivor access to information (Recommendation 19.2).

Chapter 18 – Overseeing child safe organisations

Community-wide prevention strategies

Recommendation 18.1

The Tasmanian Government should continue to advocate for Tasmania to receive the full benefit of Australian Government prevention strategies, including under the *National Strategy to Prevent and Respond to Child Sexual Abuse 2021–2030*.

Creating child safe organisations

Recommendation 18.2

All organisations engaging in child-related activities should voluntarily comply with the National Principles for Child Safe Organisations (as reflected in Tasmania's Child and Youth Safe Standards) to the greatest extent possible, regardless of whether they are legislatively bound to do so or when their legislative obligations commence.

Recommendation 18.3

The Tasmanian Government should ensure the Ombudsman is prescribed as an entity for the purposes of disclosure of information under section 40 of the *Child and Youth Safe Organisations Act 2023*.

Child and Youth Safe Organisations Act 2023

Recommendation 18.4

The Tasmanian Government, in implementing the *Child and Youth Safe Organisations Act 2023*, should ensure:

a. the functions of the Independent Regulator and Deputy Independent Regulator under the Act are embedded within the new Commission for Children and Young People (Recommendation 18.6)

b. the Commission is sufficiently resourced to enable it to effectively perform these regulatory functions

c. the Commission has access to government data systems such as those held by Tasmania Police, Child Safety Services and the Registrar of the Registration to Work with Vulnerable People Scheme to enable systematic and proactive monitoring and that those agencies have access to the Commission's data, where appropriate.

Recommendation 18.5

The Tasmanian Government should ensure its independent three-year review of the *Child and Youth Safe Organisations Act 2023* has a particular focus on:

a. whether the Independent Regulator is sufficiently resourced and empowered to perform its functions effectively, and new or additional resourcing, functions and powers are necessary to support compliance

b. how effectively the Independent Regulator is working with other agencies, including the Ombudsman or other oversight bodies, Registrar of the Registration to Work with Vulnerable People Scheme, Tasmania Police, professional regulatory bodies and other peak bodies, to support compliance, share information and manage active risks to children and young people

c. how organisations captured by the Child and Youth Safe Standards and the Reportable Conduct Scheme have experienced the new regulatory requirements, and in particular whether they have felt sufficiently supported to comply

d. analysing data emerging from the operation of the schemes, particularly as they relate to complaints and notifications and trends within and across sectors

e. whether the Universal Principle requiring organisations to uphold cultural safety is achieving its intended objective, and whether it should become an additional Child and Youth Safe Standard, mirroring the approach in Victoria

f. whether any further legislative changes are required to ensure appropriate information sharing between the Independent Regulator and other agencies.

Oversight and safeguards supporting a child safe system

Recommendation 18.6

1. The Tasmanian Government should establish a statutory Commission for Children and Young People, which includes the following roles, each appointed for a term of five years:

   a. a Commissioner for Children and Young People

   b. a Commissioner for Aboriginal Children and Young People

   c. a Child Advocate (Deputy Commissioner).

2. The Commission for Children and Young People should, in addition to the functions of the current Commissioner for Children and Young People under the *Commissioner for Children and Young People Act 2016*, have the following functions:

    a. educating relevant entities on the Child and Youth Safe Standards and overseeing and enforcing compliance with those standards as Independent Regulator under the *Child and Youth Safe Organisations Act 2023*

    b. administering the Reportable Conduct Scheme as Independent Regulator under the *Child and Youth Safe Organisations Act 2023*

    c. administering the independent community visitor scheme for children in out of home care, youth detention and other residential youth justice facilities (Recommendations 9.34 and 12.36)

    d. advocating for individual children in out of home care, youth detention and other residential youth justice facilities

    e. monitoring the operation of the out of home care and youth justice systems and the provision of out of home care and youth justice services to children (Recommendations 9.38 and 12.38)

    f. conducting inquiries into the out of home care and youth justice systems and the services provided to individual children in those systems, including own-motion inquiries (Recommendations 9.38 and 12.38)

    g. making recommendations to government for out of home care and youth justice system improvements

    h. promoting the participation of children in out of home care and youth justice in decision making that affects their lives

    i. upholding and promoting the rights of children in the out of home care and youth justice systems.

3. The Commission for Children and Young People should have all necessary powers to perform its functions.

Recommendation 18.7

The Tasmanian Government should ensure the process for appointing future Commissioners and Deputy Commissioners for Children and Young People adopts the following:

a. future Commissioners and Deputy Commissioners be appointed following an externally advertised merit-based selection process to ensure they have relevant professional qualifications and substantive experience in matters affecting vulnerable children

b. the recruitment process for these roles include a non-partisan adult selection panel with at least one member external to the Tasmanian State Service, and a separate children's selection panel

c. the adult and children's selection panels for the role of Commissioner for Aboriginal Children and Young People have a majority of Aboriginal members

d. before making a recommendation to the Governor for an appointment to the Commission for Children and Young People, the Minister be required to consult with the leader of any political party with at least two members in Parliament.

Recommendation 18.8

The Tasmanian Government should ensure the Commission for Children and Young People is separately and directly funded, rather than through the Department for Education, Children and Young People. Any funding arrangements or conditions should be structured to ensure the Commission has power to control its budget and staffing.

Recommendation 18.9

A joint standing committee of the Tasmanian Parliament should oversee the performance and proper execution of functions of the Commission for Children and Young People.

Other oversight and regulatory bodies

Recommendation 18.10

1. The Integrity Commission and Ombudsman should develop a publicly available policy for complaints related to child sexual abuse which explains the circumstances in which complaints may be referred back to the agency that is the subject of the complaint for investigation.
2. The Integrity Commission and Ombudsman should consult the complainant on the intended approach to handling the complaint, including referring the complaint back to the relevant agency.

Recommendation 18.11

The Tasmanian Government should implement Recommendation 11 of the Independent Reviewer's 2016 Report *Independent Review of the Integrity Commission Act 2009*, which would oblige public authorities to notify the Integrity Commission of any allegations of serious misconduct.

Recommendation 18.12

1. The Tasmanian Government should introduce legislation or regulations to provide statutory guidance to the Registrar of the Registration to Work with Vulnerable People Scheme on the factors to be considered when conducting risk assessments in respect of applications for registration, suspension or cancellation pursuant to the *Registration to Work with Vulnerable People Act 2013*.
2. The statutory guidance should provide that (among other things):
    a. the assessment of unacceptable risk is a predictive exercise that is not necessarily capable of empirical proof nor subject to a particular standard of proof such as 'the balance of probabilities'
    b. the assessment of unacceptable risk of harm to a child or children requires determination of two separate questions, without conflation, namely
        i. whether or not an allegation or allegations of previous harm to vulnerable people are proven on the balance of probabilities, and

ii. whether or not an unacceptable risk of harm is demonstrated regardless of whether there is a finding, on the balance of probabilities, that previous harm occurred

c. the Registrar is not limited in the factors they can consider in assessing unacceptable risk, including information that suggests a person's tendency to cause harm, as the ultimate determination of unacceptable risk is a predictive exercise

d. when the Registrar is considering suspending a person's registration, the focus on the prospective risk that a person may pose to children should have a lower evidentiary threshold, noting further assessment will likely occur prior to a decision to cancel registration or otherwise

e. once the Registrar makes a determination that a person poses an unacceptable risk to a child or young person, irrespective of other factors (such as employment or mental health), that person's registration must be refused, suspended or cancelled (as the case may be).

Recommendation 18.13

1. The Tasmanian Government should introduce legislation to amend the *Registration to Work with Vulnerable People Act 2013* and related statutory instruments to replace the Administrative Appeals Division of the Magistrates Court with the Tasmanian Civil and Administrative Tribunal as the forum for administrative reviews of decisions under the Act.
2. The Tasmanian Government should:

   a. introduce legislation or regulations to require the Tasmanian Civil and Administrative Tribunal to support Tribunal members who hear administrative reviews of decisions under the *Registration to Work with Vulnerable People Act 2013* to have the knowledge, skills, experience and aptitude to deal with each matter, including in relation to child sexual abuse, neglect and family violence

   b. provide sufficient funding to the Tribunal to support members to gain this knowledge, skills, experience and aptitude.

Recommendation 18.14

1. The Commission for Children and Young People, the Registrar of the Registration to Work with Vulnerable People Scheme, the Integrity Commission and the Ombudsman should work jointly to develop a user-friendly guide for the general public, which describes:
    a. how each of these agencies can assist with complaints and concerns about how organisations respond to child sexual abuse
    b. the process these agencies will adopt in responding to reports, complaints and concerns, including what outcomes these agencies are empowered to achieve
    c. how information provided by a person lodging a report, complaint or concern will be shared and managed
    d. that agencies are committed to a 'no wrong door' approach to complaints, so people are reassured that all reports, complaints and concerns will receive a response from an agency
    e. pathways for raising concerns about the way any of these agencies respond to reports, complaints or concerns.
2. A child and youth-friendly version of the guide should also be developed and should be publicised and distributed widely in schools, out of home care, youth justice and health settings.
3. Both guides should be available on each of the agencies' websites and form part of their child safety community education and engagement activities.
4. While the Commission for Children and Young People should be promoted as the key agency for receiving reports, complaints or concerns relating to conduct towards children, people should be able to raise reports, complaints or concerns with any of these agencies and these agencies should ensure the matter is appropriately referred (the 'no wrong door' approach).

Recommendation 18.15

The Commission for Children and Young People, the Integrity Commission, the Ombudsman and the Registrar of the Registration to Work with Vulnerable People Scheme should develop a formal memorandum of understanding relating to the management and oversight of reports, complaints and concerns relating to child sexual abuse and information sharing. The memorandum of understanding should:

a. define the roles, responsibilities, functions and limitations of each agency and describe where these overlap or intersect

b. require consultation prior to the initiation of systemic reviews or inquiries where the subject of that inquiry relates to areas of common interest or intersecting functions

c. provide for permissive and enabling information-sharing practices that prioritise the safety and welfare of children for individual matters and ensure each party receives from others de-identified trend data necessary to perform its functions.

Chapter 19 – A coordinated approach

Developing a child sexual abuse reform strategy

Recommendation 19.1

1. The Tasmanian Government should develop a whole of government child sexual abuse reform strategy for preventing, identifying and responding to child sexual abuse, including child sexual abuse in institutions and harmful sexual behaviours. The strategy should:

   a. describe the system that Tasmania seeks to achieve, including the component parts of that system, how Tasmanians will know it is working, and the role of key initiatives, reforms and recommendations in achieving the intended outcomes

   b. be separate from, but complement, the Government's Family and Sexual Violence Action Plan

   c. be informed by the voices of children and young people and adult victim-survivors of child sexual abuse (Recommendation 19.5)

d. include agreed definitions of child sexual abuse, institutional child sexual abuse and harmful sexual behaviours

e. set out guiding principles and objectives to inform preventing, identifying and responding to child sexual abuse

f. identify the agencies, including statutory bodies and non-government organisations, involved in preventing, identifying and responding to child sexual abuse

g. set out processes through which government agencies, statutory bodies and non-government organisations can consult on child sexual abuse reform

h. set out considerations relevant to particular cohorts of children and young people, including Aboriginal children, children with disability, children with mental illness, children who identify as LGBTQIA+ and children from culturally and linguistically diverse communities

i. outline the sources of funding for key initiatives and reforms set out in the strategy

j. outline the governance, monitoring, review and evaluation arrangements for child sexual abuse reform, including that the Secretary of the Department of Premier and Cabinet, as Chair of the Secretaries Board, is responsible for endorsing, overseeing, coordinating and reporting on the strategy and action plan (Recommendation 19.3).

2. The Tasmanian Government should develop an action plan for the implementation of the child sexual abuse reform strategy. The action plan should:

   a. prioritise all recommendations and reforms for implementation over the short, medium and long term and include expected timeframes for implementing each recommendation

   b. identify the role holders and agencies that have responsibility for implementation of each recommendation and reform

   c. describe the actions to be taken to implement the recommendations and reforms, including any milestones, sequencing and dependencies

   d. identify the status of each recommendation and reform (that is, complete, under way or not commenced) and whether it is progressing on time

   e. be endorsed and overseen by the governance structure identified in the strategy.

3. The child sexual abuse reform strategy and action plan should be:
    a. tabled in each House of Parliament
    b. published on a dedicated website
    c. supported by a communication plan that seeks to inform and provide visibility of reform work to stakeholders and the community
    d. periodically reviewed and updated by the Secretaries Board through the Department of Premier and Cabinet.

Trauma-informed government services

Recommendation 19.2

The Tasmanian Government should develop a whole of government approach to professional development on responding to trauma within government and government funded services, as well as statutory bodies, that provide services to children and young people or adult victim-survivors of child sexual abuse.

Establishing a strong governance structure for child safety

Recommendation 19.3

The Secretary of the Department of Premier and Cabinet, as Chair of the Secretaries Board, should be responsible for endorsing, overseeing, coordinating and reporting on the child sexual abuse reform strategy and action plan.

Recommendation 19.4

1. The Premier should, through their performance agreements, ensure Heads of Agencies are responsible for reforms under the child sexual abuse reform strategy and action plan within their portfolio responsibilities.
2. Heads of Agencies should ensure relevant State Service executives are also responsible for implementing the strategy and action plan.
3. The statements of duties for relevant departmental staff should refer to their responsibilities in relation to the strategy and action plan.

Recommendation 19.5

1. The Tasmanian Government should ensure, in setting out the governance structure for the child sexual abuse reform strategy and action plan, that children and young people and adult victim-survivors of child sexual abuse are part of this governance structure through:
    a. the Premier's Youth Advisory Council
    b. the establishment of an advisory group comprising adult victim-survivors of child sexual abuse, including child sexual abuse in institutions, of different ages, backgrounds, cultures, gender identities and geographical locations and parents of child victim-survivors.
2. The Department of Premier and Cabinet should report on the activities of these advisory groups in its annual report.
3. These advisory groups should:
    a. be guided by clear terms of reference that have been developed in consultation with the advisory groups
    b. have a clear purpose and objectives in terms of how they can contribute across the whole of government
    c. receive secretarial support and be adequately funded and resourced
    d. ensure trauma-informed processes apply in their interactions
    e. support and enable members' attendance by covering the costs of travel and expenses, and providing honorariums where appropriate.

Improving information sharing and cross-agency coordination for child safety

Recommendation 19.6

The Tasmanian Government should introduce legislation to amend the *Registration to Work with Vulnerable People Act 2013* to clarify that, in addition to the duty to report in certain circumstances, any person can notify reportable behaviour to the Registrar of the Registration to Work with Vulnerable People Scheme.

Recommendation 19.7

The Tasmanian Government should review confidentiality and secrecy provisions in Tasmanian legislation, including the *Personal Information Protection Act 2004*, to identify any specific legislative barriers that hinder the sharing of information necessary to protect the safety and wellbeing of children and young people and remove these barriers.

Recommendation 19.8

1. The Department of Premier and Cabinet should lead the development of child safety information sharing, coordination and response guidelines to support government and government funded agencies and statutory bodies to respond to child safety issues. The guidelines should:
    a. set out the principles which guide information sharing, cross-agency coordination and the roles of different services and entities in responding to child safety issues, and require that staff are trained on these issues
    b. identify a process for nominating a lead agency for cross-agency responses to individual child safety issues and set out the lead agency's role and responsibilities
    c. identify a process for setting out the roles and responsibilities of collaborating agencies in responding to child safety issues
    d. explain child safety information-sharing obligations and responsibilities and how staff can fulfil them
    e. set out an escalation and dispute resolution process to resolve disagreements that may arise across agencies
    f. identify resources and professional development opportunities for staff in relation to responding to child safety issues
    g. be subject to periodic review to ensure they remain up to date and accurately reflect best practice cross-agency information sharing and coordination arrangements.
2. The Tasmanian Government should fund the culture change work required to achieve good information-sharing practices.

Chapter 20 – State Service disciplinary processes

The State Service Code of Conduct

Recommendation 20.1

1. The Tasmanian Government should, by introducing legislation or through other means, ensure that the State Service Code of Conduct includes the following binding obligations:

    a. if a state servant's conduct creates an unacceptable risk to the safety and wellbeing of children or young people accessing government and government funded services, the State Service disciplinary framework should apply, and termination, suspension or sanction should be available (including being able to terminate employment based on a loss of confidence)

    b. in relation to child sexual abuse and related conduct, the requirement that state servants must comply with all applicable Australian law is determined on the basis of a balance of probabilities test and does not require a breach of the law to be determined by a court

    c. where a state servant has contact with a child or young person through their work, and an allegation is made of child sexual abuse or related conduct in relation to that child, this contact is sufficient to establish the conduct occurred 'in the course of employment' or, in the case of section 9(14), has a nexus to employment regardless of whether the conduct complained of occurred outside the workplace or outside working hours.

2. The Tasmanian Government should develop policy documents or guidance on the interpretation of the State Service Code of Conduct explaining (among other things):

    a. how the required connection between a state servant's employment and a child and young person should be interpreted in matters that involve child sexual abuse or related conduct

    b. explain that all provisions of the Code of Conduct should be interpreted to prioritise the protection of children.

Recommendation 20.2

1. All Heads of Agencies whose agencies provide services to children should develop a professional conduct policy for the agency's employees that:
    a. explains what behaviours are unacceptable, including concerning conduct, misconduct or criminal conduct
    b. defines and prohibits child sexual abuse, grooming and boundary violations, in language consistent with the *Child and Youth Safe Organisations Act 2023*.
2. The professional conduct policy should:
    a. acknowledge the challenge of maintaining professional boundaries in small communities and provide clear identification of, instructions about and examples of how to manage conflicts of interest and professional boundaries in small communities
    b. provide guidance on identifying behaviours indicative of child sexual abuse, grooming and boundary violations relevant to the particular organisation
    c. outline behaviours that must be reported to authorities, including what behaviours should be reported to Tasmania Police, Child Safety Services, the Registrar of the Registration to Work with Vulnerable People Scheme and the Independent Regulator under the *Child and Youth Safe Organisations Act 2023*, or other relevant agencies
    d. provide that not following reasonable directions is a breach of professional standards
    e. provide that a failure to report a breach or suspected breach of the policy may be taken to be a breach of the policy
    f. outline the protections available to individuals who make complaints or reports in good faith
    g. provide and clearly outline response mechanisms for alleged breaches of the policy
    h. specify the penalties for a breach, including that a breach of the policy may be taken to be a breach of the State Service Code of Conduct without needing to assess whether a separate provision of the Code has been breached, and may result in disciplinary action
    i. cross-reference any other policies, procedures and guidelines that support, inform or otherwise relate to the professional conduct policy, for example, complaints handling or child protection policies or other codes of conduct relevant to particular professions.

3. The professional conduct policies should be:
    a. easily accessible to everyone in the agency and communicated by a range of mechanisms
    b. explained to and acknowledged and signed by all employees
    c. accompanied by a mandatory initial training session and regular refresher training, including as part of professional development training
    d. communicated to children and young people and their families through a range of mechanisms, including publication on the agency's public-facing website.
4. The professional conduct policies should include a specific prohibition on romantic or sexual relationships between an employee and a young person where that employee has been in a position of authority, care or protection with the young person for two years after the young person turns 18 or the employee's position of authority, care or protection has ended, whichever is later. This requirement should operate in addition to any other professional and ethical obligations.
5. Heads of Agencies should ensure the professional conduct policy spells out expected standards of behaviour for volunteers, contractors and sub-contractors, and other adults where relevant to the specific organisation and use appropriate mechanisms to ensure their compliance with the policy.
6. The Tasmanian Government should introduce legislation, or other binding mechanisms, to ensure:
    a. a breach of a departmental professional conduct policy may be taken to be a breach of the State Service Code of Conduct, without needing to assess whether a separate provision of the Code has been breached
    b. such a breach does not have to be accompanied by a lawful and reasonable direction for there to be a breach of the Code of Conduct.

Recommendation 20.3

The Tasmanian Government should introduce legislation to ensure that where a finding is made that a State Service employee has committed reportable conduct under the Reportable Conduct Scheme, this also constitutes a breach of the State Service Code of Conduct under section 9 of the *State Service Act 2000*.

Recommendation 20.4

The Tasmanian Government should introduce legislation to ensure the provisions in the professional conduct policies apply to contractors, sub-contractors, volunteers and other adults who have contact with children.

Employment Directions

Recommendation 20.5

1. The State Service should develop guidance material for conducting preliminary assessments to ensure:
    a. they are conducted quickly (within three to five business days after an allegation is received)
    b. the reasons for any delay are documented, a new timeframe set, and the reasons for the delay and the new timeframe are communicated to the parties if applicable in the circumstances
    c. they are confined to a basic gathering of information and do not require evidence of wrongdoing
    d. they do not assess whether the alleged conduct occurred in the course of the employee's State Service employment.
2. Victim-survivors and child witnesses should not normally be interviewed at the preliminary assessment stage to avoid them being interviewed more than once or being interviewed by a person without special skills. If it is necessary to interview a child or young person at this stage, then this should be done in line with clause 7.3 of Employment Direction No. 5—Breach of Code of Conduct. Any such interview should be conducted by individuals who have been trained in child development, child sexual abuse (including taking a Whole Story approach), and trauma-related behaviours.
3. Any engagement with a child or young person during the preliminary assessment stage should be child-centred and trauma-informed.
4. The Child-Related Incident Management Directorate should conduct preliminary assessments in child sexual abuse or related conduct matters.

Recommendation 20.6

The Tasmanian Government should amend Employment Direction No. 4—Suspension to:

a. specify that in matters involving complaints or concerns about child sexual abuse or related conduct of an employee, they may be suspended immediately

b. clarify, to avoid any doubt, that suspension can occur before the start of any disciplinary processes, including preliminary assessments

c. exclude, in matters involving complaints or concerns of child sexual abuse or related conduct, the requirement that the Head of Agency must have a reasonable belief that it is in the public interest to suspend the employee

d. include the safety of children and young people among the matters a Head of Agency must take into account when deciding whether to suspend an employee.

Recommendation 20.7

The Tasmanian Government should ensure investigations into misconduct in relation to child sexual abuse or related conduct by State Service employees of the Department for Education, Children and Young People and the Department of Health under Employment Direction No. 5—Breach of Code of Conduct are conducted by the Child-Related Incident Management Directorate.

Recommendation 20.8

The Tasmanian Government should amend Employment Direction No. 5—Breach of Code of Conduct, as it relates to child sexual abuse or related conduct, to:

a. ensure people making a complaint and children or young people who have been abused have the right to

    i. reply to any factual matters put forward by the alleged abuser

    ii. know the outcome of an investigation

    iii. seek a review of decisions in an appropriate forum

b. clarify timeframes for carrying out investigations, set out the process for seeking an extension of time for an investigation and the considerations involved, and require the granting of, and reasons for, an extension of time be communicated to the parties affected

c. provide that all matters of concern relevant to an employee's conduct with a child or young person pertaining to child sexual abuse or related conduct be treated as potential serious misconduct

d. note the importance, in circumstances where it is appropriate to summarily dismiss an employee for misconduct, of conducting an investigation to identify children who have been harmed and any systemic problems that need to be addressed

e. ensure investigations are conducted by people who have been trained in child development, child sexual abuse (including taking a Whole Story approach) and trauma-related behaviours.

Recommendation 20.9

The Tasmanian Government should maintain a central cross-government register of misconduct concerning complaints and concerns about child sexual abuse and related conduct. This register should contain records of substantiated and unsubstantiated matters, including those that did not proceed to investigation.

Recommendation 20.10

1. The Tasmanian Government should take measures to ensure that misconduct investigations under Employment Direction No. 5—Breach of Code of Conduct in relation to complaints and concerns of child sexual abuse are able to take into account prior substantiated, untested and unsubstantiated complaints, allegations and disciplinary action, in addition to the immediately alleged misconduct.

2. The Tasmanian Government should take measures to ensure that prior allegations (including unsubstantiated allegations) should be considered at various stages of the disciplinary process, including in determining:

a. the process to be used to deal with new allegations

b. whether the conduct occurred on the balance of probabilities, with previous substantiated allegations being given more weight than unsubstantiated allegations

c. if misconduct has occurred

d. the sanction to be applied.

Recommendation 20.11

1. The Head of the State Service should monitor and publicly report annually on the management of misconduct matters related to child sexual abuse or related conduct.

2. Heads of Agencies should report quarterly to the Head of the State Service on all misconduct matters related to child sexual abuse or related conduct, substantiated and unsubstantiated.

Recommendation 20.12

The Tasmanian Government should introduce legislation to amend Employment Direction No. 6—Inability to provide for:

a. a simplified process that applies to matters where the employee no longer has an essential employment requirement (for example, no registration under the *Registration to Work with Vulnerable People Act 2013*)

b. powers to immediately terminate a person's employment if the employee no longer meets an employment requirement for working with children or young people

c. any interview with a child or young person in line with Employment Direction No. 6—Inability to be subject to the same considerations as should apply under clause 7.3 of Employment Direction No. 5—Breach of Code of Conduct (Recommendation 20.8).

Recommendation 20.13

1. The Head of the State Service should issue guidance on State Service disciplinary processes that contains key principles and procedures to be followed. This guidance should include information on:
    a. the steps involved in the process of dealing with disciplinary matters
    b. maintaining confidentiality
    c. setting timeframes for investigations and communicating timeframes to the parties
    d. preliminary assessments
    e. employee suspensions, in particular where matters are alleged to involve child sexual abuse
    f. considerations when interviewing children
    g. an employee's inability to perform a role due to the loss of employment requirements
    h. the rights of an employee and any complainant.
2. This guidance should be developed in line with relevant child safety considerations, relevant recommendations of this Commission of Inquiry and the Integrity Commission's *Guide to Managing Misconduct in the Tasmanian Public Sector*.

Cultural change

Recommendation 20.14

The Tasmanian Government should allocate funding for initiatives aimed at cultural change and awareness raising to promote a shared understanding and application of disciplinary processes across the State Service in a manner that ensures the safety and wellbeing of children at risk of child sexual abuse or related conduct.

Role of the Tasmanian Industrial Commission

Recommendation 20.15

The Government should fund the Tasmanian Industrial Commission to enable its members to attend training on child sexual abuse either locally or through any relevant interstate program or training, such as the programs offered by the Judicial College of Victoria.

Chapter 21 – Therapeutic services

Improving the therapeutic service system

Recommendation 21.1

1. The Department of Premier and Cabinet should lead, coordinate and fund a therapeutic service system for child and adult victim-survivors of child sexual abuse and children who have experienced or displayed harmful sexual behaviours.
2. The Department should ensure the therapeutic service system:
    a. addresses service gaps and provides coordination of services, appropriate coverage and equitable access to quality services
    b. is easily understood and accessible to the public, state servants and other mainstream service providers.
3. The Department, in leading this work, should consult with:
    a. any relevant government departments, including the Department for Education, Children and Young People, the Department of Health and Tasmania Police
    b. sexual assault and abuse counselling services
    c. the Premier's Youth Advisory Council and the adult victim-survivors of child sexual abuse advisory group (Recommendation 19.5)
    d. the peak body for the sexual assault service system (Recommendation 21.3).
4. The Tasmanian Government should ensure funding agreements with non-government specialist services include appropriate governance requirements, sexual abuse service standards, service evaluation and child safe accreditation.

Recommendation 21.2

1. The Tasmanian Government should conduct an independent process and outcomes evaluation for the pilot multidisciplinary Arch centres and any future centres after three years of operation to inform the Government of any systems improvements that could be made to the centres and whether they have resulted in improvements in client outcomes. The evaluation should incorporate:
    a. an evaluation and data outcomes framework established during the first year that includes required baseline and outcomes data for clients receiving services through the Arch centres, and considers how Arch centre outcomes can be compared with the outcomes of cases that have not received an Arch centre response
    b. the collection of data in line with the data outcomes framework in the first year
    c. the storing and retention of data in a format that can be provided to the independent evaluators.
2. The evaluation and data outcomes framework should include outcome measures for adult and child victim-survivors of child sexual abuse and children who have experienced or displayed harmful sexual behaviours.
3. The Tasmanian Government should ensure multidisciplinary centres are not the sole response to the therapeutic needs of adult and child victim-survivors of child sexual abuse.

Recommendation 21.3

1. The Tasmanian Government should establish a peak body for the sexual assault service system, including therapeutic interventions for children who have engaged in harmful sexual behaviours, to:
    a. ensure the needs of adult and child victim-survivors of child sexual abuse and children who have experienced or displayed harmful sexual behaviours are met by the sexual assault service system
    b. represent sexual assault service providers in a coordinated way
    c. share evidence and experience
    d. develop or identify practice standards for sexual assault services and interventions for child sexual abuse and harmful sexual behaviours

e. coordinate service delivery for victim-survivors

f. advocate for improvements in the sexual assault service system.

2. This peak body for the sexual assault service system should be distinct from, but work in cooperation with, a family violence peak body.

Recommendation 21.4

1. The Tasmanian Government should increase the funding for free or low-cost sexual assault counselling services to:

   a. reduce waiting times to no longer than four weeks for victim-survivors, regardless of where they live in Tasmania

   b. enable fortnightly access to sexual assault counselling in Ashley Youth Detention Centre

   c. assist peer support groups.

2. The Department of Premier and Cabinet should adopt strategies to increase the number of professionals with skills to provide therapeutic responses to abuse-related trauma to address the challenge in attracting and retaining sufficient suitably qualified staff to fill vacancies and meet the need for therapeutic responses to child sexual abuse.

Recommendation 21.5

The Tasmanian Government should increase the capacity of the Victims of Crime Service by:

a. increasing the number of counsellors available in each of the Victims of Crime Service offices to at least three in southern Tasmania, two in northern Tasmania and two in the North West

b. promoting the availability of the Victims of Crime Service counselling service to victim-survivors of sexual assault.

Recommendation 21.6

1. The Tasmanian Government should ensure that the needs of particular groups of victim-survivors are met by the therapeutic service system and related contracting of services, including the needs of:
    a. children who are victim-survivors or have displayed harmful sexual behaviours (Recommendation 21.8)
    b. victim-survivors with disability or mental illness
    c. victim-survivors who identify as LGBTQIA+
    d. male victim-survivors
    e. victim-survivors who are from culturally and linguistically diverse backgrounds.
2. The Tasmanian Government should consult on the therapeutic service system with relevant stakeholder groups, including the Interim Disability Commissioner, community groups and representative bodies.

Recommendation 21.7

The Tasmanian Government should improve healing services for Aboriginal victim-survivors and their families and communities by:

a. fully resourcing and supporting recognised Aboriginal organisations across the state to design, develop and deliver Aboriginal-led healing approaches targeted to victim-survivors of child sexual abuse
b. ensuring Aboriginal representation on the boards of management or in the executive structures of sexual assault services.

Strengthening services for children who have displayed harmful sexual behaviours

Recommendation 21.8

1. The Tasmanian Government, in collaboration with key stakeholders, should develop a statewide framework and plan for preventing, identifying and responding to harmful sexual behaviours. The framework should:

a. agree on a common definition and understanding of harmful sexual behaviours, including adopting a recognised, contemporary continuum of sexual behaviours from 'developmentally expected' to 'harmful'

b. use an evidence-informed framework for understanding, preventing, identifying and responding to harmful sexual behaviours

c. clarify the roles and responsibilities of the various agencies and departments involved in preventing and responding to the full continuum of harmful sexual behaviours, including programs delivered by non-government providers

d. meet the needs of particular groups of children (Recommendation 21.6)

e. include structures to support ongoing engagement with emerging evidence regarding harmful sexual behaviours

f. include an evaluation framework.

2. The Tasmanian Government should ensure the therapeutic service system for children who have displayed harmful sexual behaviours:

   a. provides sufficient therapeutic services that can be accessed in a timely manner

   b. ensures timely access to therapeutic services for all children who need them, regardless of their age, identity or location in the state (including in youth detention)

   c. ensures specialist interventions for children with disability

   d. ensures all providers of therapeutic interventions for harmful sexual behaviours have Aboriginal representation in their governance structure.

3. The Tasmanian Government should provide ongoing and increased funding for specialist therapeutic interventions for harmful sexual behaviours that:

   a. ensures children who have displayed abusive or violent harmful sexual behaviours and their families need not wait more than two weeks for support when therapeutic treatment is required

   b. provides an advisory service for child-facing organisations, such as independent schools, childcare, disability and at-risk youth services and Tasmania Police (this service is not intended for the Department for Education, Children and Young People, which will have access to an internal Harmful Sexual Behaviours Support Unit (Recommendation 9.28))

   c. contributes to the statewide plan for preventing harmful sexual behaviours and its agencies' responses to children who have displayed such behaviours.

Recommendation 21.9

The Tasmanian Government should introduce legislation to amend the *Children, Young Persons and Their Families Act 1997* and the *Youth Justice Act 1997* to:

a. give the Magistrates Court explicit power to order that a child who has displayed harmful sexual behaviours (and their family) engage in a therapeutic intervention for harmful sexual behaviours

b. ensure the Magistrates Court has the power to divert from the criminal justice system a child who has been charged with a criminal offence and who has engaged in harmful sexual behaviours, by adjourning the criminal proceeding to enable the child to engage in a therapeutic intervention, and discharging the child where the intervention has been completed successfully.

Recommendation 21.10

Tasmania Police and the Department for Education, Children and Young People should update the *Keeping Children Safe Handbook* to reflect the Tasmanian Government's statewide framework and plan for addressing harmful sexual behaviours, including by:

a. modifying the language used when discussing children who have displayed harmful sexual behaviours to align with the definitions developed through the National Office of Child Safety

b. clarifying the roles and responsibilities of the two agencies in responding to incidents involving harmful sexual behaviours, including the conditions under which each agency will lead the response

c. clarifying the involvement of specialist therapeutic services in responses to incidents.

Chapter 22 – Monitoring reforms

Recommendation 22.1

1. The Tasmanian Government should introduce legislation to establish and fund an independent Child Sexual Abuse Reform Implementation Monitor to:
    a. monitor and report to Parliament annually on the implementation of
        i. the recommendations of this Commission of Inquiry
        ii. any recommendations of the Royal Commission into Institutional Responses to Child Sexual Abuse that were accepted by the Tasmanian Government and have not been implemented
        iii. the recommendations of the Independent Inquiry into the Tasmanian Department of Education's Responses to Child Sexual Abuse
    b. undertake independent evaluations of the effectiveness of the measures and actions taken in response to the recommendations identified above, especially the impact on the safety and wellbeing of children in government and government funded institutions and victim-survivors of child sexual abuse in institutional contexts.
2. Independent evaluations should enable assessment of change over time and involve:
    a. identifying an evaluation framework and baseline data requirements within the first year of the appointment of the Implementation Monitor
    b. commencing collection of data identified in the evaluation framework as soon as possible after the evaluation framework has been developed
    c. assessing the change against the evaluation framework at five- and ten-year intervals following the tabling of this report
    d. making independent evaluations publicly available.
3. The Tasmanian Government should protect the independence of the Implementation Monitor by:
    a. appointing the Implementation Monitor for a fixed term that cannot be prematurely terminated except in extraordinary circumstances
    b. maintaining the role of the Implementation Monitor until implementation of the recommendations identified above is substantively complete
    c. separately and directly funding the Implementation Monitor, rather than through a line agency.

4. The Tasmanian Government, through the Secretaries Board, should be required to report to:
    a. the Implementation Monitor as requested and in the form required by the Implementation Monitor
    b. the public on its implementation and reform activity through the Department of Premier and Cabinet's annual report.
5. The Implementation Monitor should consult as required with:
    a. the Premier's Youth Advisory Council
    b. the adult victim-survivors of child sexual abuse advisory group (Recommendation 19.5)
    c. the peak body for the sexual assault service system (Recommendation 21.3)
    d. the institution-specific advisory groups established within Tasmanian government agencies (Recommendations 9.6, 12.8 and 15.7).

Findings

Chapter 11 – Case studies: Children in youth detention

Case study 1: The nature and extent of abuse in Ashley Youth Detention Centre

Finding—For decades, some children and young people detained at Ashley Youth Detention Centre experienced systematic harm and abuse

Case study 2: Harmful sexual behaviours

Finding—In August 2019, Henry (a pseudonym) was exposed to an unacceptable risk of harm and experienced preventable harm at Ashley Youth Detention Centre[86]

Finding—In August 2019, Max (a pseudonym) was exposed to an unacceptable risk of harm at Ashley Youth Detention Centre[87]

Finding—The issues briefing to the Secretary about the 7 August 2019 incident regarding Henry minimised the incident and was incomplete, which contributed to a delay in reviewing the incident

Finding—In the weeks following the 7 August 2019 incident, Henry continued to be exposed to risk of harm at Ashley Youth Detention Centre despite widespread knowledge about these risks

Finding—Ray's (a pseudonym) placement in the Franklin Unit at Ashley Youth Detention Centre in December 2019 was inappropriate and exposed him to preventable harm[88]

Finding—The 20 January 2020 issues briefing on concerns regarding Ray at Ashley Youth Detention Centre was inadequate and incomplete

Finding—The response to the Serious Events Review Team review of the 7 August 2019 incident did not follow a clear process for implementation and oversight

Finding—Ashley Youth Detention Centre was not equipped to meet the complex needs of children and young people, resulting in at least one young person being transferred to adult prison

Finding—The Department should have fully investigated allegations that staff at Ashley Youth Detention Centre used older detainees to threaten or control younger detainees

Finding—There is a lack of consistent policy and practice at Ashley Youth Detention Centre on unit placements

Finding—Ashley Youth Detention Centre has been aware of harmful sexual behaviours at the Centre and has not taken steps to protect children and young people from these

Case study 3: Isolation in Ashley Youth Detention Centre

Finding—The use of isolation as a form of behaviour management, punishment or cruelty and contrary to the Youth Justice Act has been a regular and persistent practice at Ashley Youth Detention Centre since at least the early 2000s, and the conditions that enabled this practice still exist today

Finding—The Department, and sometimes the Tasmanian Government, have been on notice about potentially unlawful isolation practices at Ashley Youth Detention Centre since at least 2013, and have not taken sufficient action

Finding—There was a consistent failure to include the voices of children and young people detained at Ashley Youth Detention Centre in any reviews, investigations or policy changes relating to isolation

Finding—Ashley Youth Detention Centre and the Department failed to support children and young people in detention who were subjected to isolation practices

Case study 4: Use of force in Ashley Youth Detention Centre

Finding—The excessive use of force has been a longstanding method of abusing children and young people by some staff at Ashley Youth Detention Centre, and the Department and Tasmanian Government have not always responded appropriately

Finding—The Department's responses to excessive use of force do not represent a child-centred approach in line with the United Nations Convention on the Rights of the Child

Case study 5: A response to staff concerns about Ashley Youth Detention Centre

Finding—The Department should not have conducted the Preliminary Assessment and this reflects systemic problems

Finding—The State does not have a clear process for initiating a preliminary assessment when the Secretary has a conflict of interest, including identifying a suitable decision maker

Finding—The delay in the Preliminary Assessment was not acceptable and risked exposing children to ongoing harm

Finding—The Preliminary Assessment was, at least in part, a quasi-investigation into the substantive reports made by Alysha (a pseudonym) about child sexual abuse by staff, due to a lack of clarity about preliminary assessments[89]

Finding—The Preliminary Assessment gave a false impression of the adequacy of the Department's response to reports made by Alysha about child sexual abuse by staff

Case study 6: A complaint by Max (a pseudonym)[90]

Finding—Ashley Youth Detention Centre and the Department did not respond to Max's allegation appropriately

Case study 7: Allegations of child sexual abuse against staff at Ashley Youth Detention Centre

Finding—From at least 2007 the Department should have taken more active steps to use information gained through state redress programs to protect children from the risk of harm

Finding—The State Service disciplinary framework, including its application and interpretation by the Department, did not facilitate an appropriate response to allegations and complaints about Walter (a pseudonym) from the late 1990s to the mid-2010s[91]

Finding—The Department did not take appropriate steps to manage risk, make appropriate notifications and progress investigations against Ira, Lester and Stan (all pseudonyms), which left children and young people at Ashley Youth Detention Centre at potential risk of harm[92]

Finding—The Department failed to adequately consider the safety of detainees and place appropriate weight on public interest considerations in relation to Ira, Lester and Stan until 8 November 2020

Finding—Tasmania Police should improve its responses to allegations of child sexual abuse made by current and former detainees at Ashley Youth Detention Centre

Finding—On occasion, the Registrar of the Registration to Work with Vulnerable People Scheme appeared to adopt too high an evidentiary threshold in assessing whether staff with allegations against them posed an unacceptable risk to children

Finding—The Department of Justice does not have an appropriate process to ensure information in National Redress Scheme applications is shared in a timely manner to protect children

Chapter 14 – Case studies: Children in health services

In accordance with the Restricted Publication Order of the Commission of Inquiry dated 30 August 2023 and section 10(3) of the *Commissions of Inquiry Act 1995* (Tas), the Governor has omitted Volume 6, Chapter 14, Case Study 1 because the public interest in the disclosure of that part of the report is significantly outweighed by other relevant considerations, namely the right of any person to a fair trial.

Case study 2: Response to complaint about Dr Tim (a pseudonym)[94]

Finding—Dr Peter Renshaw failed to comply with Launceston General Hospital's protocol for reporting and management of cases of suspected child abuse

Finding—Dr Peter Renshaw failed to comply with his mandatory reporting obligations in a timely manner, which impacted on the ability to gather evidence and future investigations

Finding—Launceston General Hospital failed to consider and take active steps to stand down Dr Tim while Zoe Duncan's allegations were investigated

Finding—Launceston General Hospital should have formalised, implemented and enforced a chaperone policy as soon as practicable after Zoe Duncan's May 2001 disclosure and not waited until June 2002

Finding—The procedure used by Child Safety Services to investigate Zoe Duncan's allegations against Dr Tim was inappropriate and not consistent with best practice at the time

Finding—Child Safety Services carried out an inadequate investigation of Zoe Duncan's allegations, which affected subsequent investigations

Finding—Tasmania Police carried out an inadequate investigation of Zoe Duncan's allegations

Finding—Launceston General Hospital failed in its overall response and did not offer appropriate support to Zoe Duncan and her family

Case study 3: James Griffin

Finding—Launceston General Hospital failed to respond appropriately to Kylee Pearn's disclosure of abuse by James Griffin in 2011 or 2012, leaving children exposed to potential risk for eight years

Finding—Luigino Fratangelo and James Bellinger received a disclosure of child sexual abuse from Kylee Pearn relating to James Griffin in 2011 or 2012

Finding—Launceston General Hospital did not have adequate processes to ensure the meeting with Kylee Pearn was recorded and that record was retained

Finding—Child Safety Services should not have closed its November 2011 case into James Griffin without making further enquiries and ensuring Tasmania Police had all the information it required

Finding—Tasmania Police should have made further enquiries to receive the notifier's identity and reviewed previous intelligence holdings relating to James Griffin when receiving the November 2011 information from Child Safety Services

Finding—Child Safety Services should have taken further steps to assess the risk James Griffin posed in 2013 when concerns were again reported about him

Finding—Tasmania Police should have reviewed all intelligence holdings about James Griffin in 2013 when a report to Child Safety Services was made

Finding—The child safety system in the mid-2010s was not designed to address child sexual abuse in institutional settings

Finding—Tasmania Police failed to act on highly probative evidence regarding James Griffin provided by the Australian Federal Police in 2015

Finding—Launceston General Hospital's response to Will Gordon's 2017 Safety Reporting and Learning System complaint did not comply with the requirements of a State Service Code of Conduct investigation

Finding—Launceston General Hospital failed to manage the risks posed by James Griffin

Finding—Launceston General Hospital leadership collectively failed to address a toxic culture in Ward 4K that enabled James Griffin's offending to continue and prevented his conduct being reported

Finding—Launceston General Hospital failed to consider the cumulative effect of complaints about James Griffin

Finding—The response of Launceston General Hospital to complaints about James Griffin suggested it was ultimately not concerned about his conduct

Finding—Leadership at Launceston General Hospital collectively failed to provide appropriate supervision and proactive oversight, which is a systemic problem

Finding—Launceston General Hospital did not have a robust system for managing complaints involving child safety

Finding—Launceston General Hospital had no clear system, procedures or process in place to report complaints about James Griffin to external agencies

Finding—James Griffin had the ability to take and misuse medications from Launceston General Hospital

Finding—The response of Launceston General Hospital to revelations about James Griffin's offending was passive and ineffective

Finding—Leadership at Launceston General Hospital was dysfunctional and this compromised its collective response to revelations about James Griffin

Finding—Launceston General Hospital did not have clear accountabilities for child safety

Finding—Dr Peter Renshaw misled the Chief Executive of Launceston General Hospital and the then Secretary of the Department by failing to fully and accurately convey information relating to James Griffin received from Tasmania Police on 31 July 2019

Finding—The human resources team failed to escalate information they received on 11 October 2019 about Kylee Pearn's 2011 or 2012 disclosure

Finding—Dr Peter Renshaw should have escalated and acted on knowledge of Kylee Pearn's disclosure to the hospital once advised about it by Tasmania Police on 29 October 2019

Finding—The lack of a coordinated and transparent response by Launceston General Hospital increased feelings of mistrust among hospital staff

Finding—Dr Peter Renshaw misled the Secretary of the Department about James Griffin

Finding—The Integrity Commission should have ensured Will Gordon's complaint to them was robustly and independently reviewed

Finding—James Bellinger did not conduct a proper investigation into James Griffin's complaints history and misled the Secretary of the Department and the Integrity Commission

Finding—The Integrity Commission's monitoring of the Department's response to Will Gordon's complaint was insufficient and it should have sought further review

Misconduct finding—Dr Peter Renshaw misled our Commission of Inquiry about his state of knowledge

Finding—Launceston General Hospital should ensure open disclosure processes are trauma-informed

Finding—Launceston General Hospital's human resources team should not have been involved in the request or preparation of a statement from Stewart Millar regarding Kylee Pearn's disclosure

Finding—James Bellinger should not have taken the statement from Stewart Millar

Glossary

Term	Definition
boundary breaches / boundary violations	Behaviours that cross the line between a professional and personal relationship. For example, a teacher providing a student with personal contact details.
child / young person	A person below the age of 18 years, as defined by the United Nations Convention on the Rights of the Child.[95] We use the terms 'child' and 'young person' depending on the context. We recognise that many older children prefer being referred to as young people but, at times, using this term may minimise young people's vulnerability and legal status as children, particularly in the context of youth detention.
'child-facing' institutions or services	Institutions that provide services directly to children (such as schools), as distinct from more operational services (such as human resources) where any contact with children is incidental.

Term	Definition
child safe institution / child safe organisation	An institution that puts children first and ensures their safety. It 'consciously and systematically: • Creates an environment where children's safety and wellbeing is at the centre of thought, values and actions. • Places emphasis on genuine engagement with and valuing of children and young people. • Creates conditions that reduce the likelihood of harm to children and young people. • Creates conditions that increase the likelihood of identifying any harm. • Responds to any concerns, disclosures, allegations or suspicions of harm'.[96] We use 'child safe institution' and 'child safe organisation' interchangeably.
Child and Youth Safe Standards	Tasmania adopted Child and Youth Safe Standards in the *Child and Youth Safe Organisations Act 2023*.[97] Under this Act, organisations must also comply with an embedded Universal Principle requiring regulated entities to 'provide an environment that ensures that the right to cultural safety of children who identify as Aboriginal or Torres Strait Islander is respected'.[98] Our references to the new Child and Youth Safe Standards should be read as inclusive of the Universal Principle.
Child Safety Service / Child Safety Services	Formerly known as Child Protection Services, this is the division of Children, Youth and Families (part of the Department for Education, Children and Young People) that acts to 'protect children and young people who are at risk of abuse or neglect'.[99] It investigates child welfare concerns, including child sexual abuse, and is responsible for children in out of home care. We use 'Child Safety Service' and 'Child Safety Services' interchangeably.
child sexual abuse	Any act which exposes a child to, or involves a child in, sexual processes beyond his or her understanding or contrary to accepted community standards. Sexually abusive behaviours can include the touching of genitals, masturbation, oral sex, vaginal or anal penetration by a penis, finger or any other object, touching of breasts, voyeurism, exhibitionism and exposing the child to or involving the child in pornography. It includes child grooming, which refers to actions deliberately undertaken with the aim of befriending and establishing an emotional connection with a child, to lower the child's inhibitions in preparation for sexual activity with the child, and any related matters.[100]

Term	Definition
child sexual exploitation	A form of child sexual abuse where: 'a child is manipulated or coerced to participate in a sexual activity in exchange for, or the promise of, an incentive. This can include incentives such as food, accommodation, clothing, drugs, alcohol, cigarettes or money. It can also include incentives such as love, affection, or safety. Child sexual exploitation is a distinct form of child sexual abuse because of this notion of exchange or reward'.[101]
Counsel Assisting	Lawyers appointed to assist a commission of inquiry. They can perform several roles, including speaking and asking questions at hearings.
detainee / child or young person in detention	A child or young person detained in a youth detention facility (sometimes referred to as residents). We use the terms 'child and young person in detention', 'child in detention', or 'young person in detention' but sometimes use 'detainee' for ease of reading.
Employment Directions	Issued by the Minister administering the *State Service Act 2000*, Employment Directions provide instruction on how the State Service must manage State Service employment matters, including suspensions, investigations of alleged breaches of the Code of Conduct and considerations relevant to whether an employee no longer has the ability to perform their role. Employment Directions replaced Commissioner's Directions and a number of Ministerial Directions from 4 February 2013 (some Ministerial Directions are still being replaced).
ex gratia	Something that is done voluntarily rather than as a result of a legal obligation. For example, an ex gratia payment may be made by an institution to someone who has been harmed in some way, as a gesture of goodwill rather than an acceptance of legal liability.
grooming	A form of child sexual abuse, defined in this glossary under 'child sexual abuse'.
harmful sexual behaviours	A form of child sexual abuse that involves: 'sexual behaviours displayed by children and young people that fall outside what may be considered developmentally, socially and culturally expected, may cause harm to themselves or others, and occur either face to face and/or via technology. When these behaviours involve another child or young person, they may include a lack of consent, reciprocity, mutuality, and involve the use of coercion, force or a misuse of power'.[102]

Term	Definition
Head of Agency / Heads of Agencies	Leaders of Tasmanian Government agencies, including secretaries of departments and chief executive officers of agencies. A Head of Agency 'leads, and is responsible for, the overall management of communications and its integration with other key functions, particularly policy and program management'.[103] In the context of our Commission of Inquiry, Heads of Agencies are most commonly secretaries of departments.
LGBTQIA+	An inclusive term that recognises people's complexity and diversity, encompassing the entire spectrum of gender fluidity and sexual identities. The letters refer to lesbian, gay, bisexual, transgender, queer or questioning, intersex, asexual and other sexually or gender diverse people.[104]
National Redress Scheme	The scheme that allows victim-survivors to seek financial compensation, counselling and a direct personal response from the institution in which their abuse occurred, without needing to interact with their abuser or pursue criminal or civil claims.[105] The National Redress Scheme was set up by the Australian Government in July 2018 and was given effect in Tasmanian legislation in the same year. Non-government institutions may also join the scheme.[106]
National Royal Commission	Refer to 'Royal Commission into Institutional Responses to Child Sexual Abuse'.
related conduct	In relation to child sexual abuse, any unlawful or improper treatment of children that is, either generally or in any particular instance, connected or associated with child sexual abuse.
reportable conduct scheme	A scheme that monitors how organisations investigate and report on allegations of misconduct towards children, with the requirement to report these allegations to an independent body. In Tasmania, a Reportable Conduct Scheme is being established under the *Child and Youth Safe Organisations Act 2023* that enables people to report neglect or abuse by a worker towards a child to an Independent Regulator.[107]
Royal Commission into Institutional Responses to Child Sexual Abuse / National Royal Commission	The Royal Commission into Institutional Responses to Child Sexual Abuse ('National Royal Commission') was established on 11 January 2013.[108] The National Royal Commission investigated child sexual abuse in government and non-government institutions across Australia. It released its final report, including 409 recommendations, in 2017.

Term	Definition
Secretary or Secretaries	Refer to 'Head of Agency'.
State Service	Tasmanian government departments and institutions that develop and deliver government policies, programs and services. Employment in the State Service is established under the *State Service Act 2000*.[109] People who work in the State Service are sometimes called state servants or public servants, as well as government employees, staff or workers.
State Service Code of Conduct	The State Service Code of Conduct outlines how employees of the State Service are expected to behave.[110]
trauma-informed	A way of understanding people and their interactions that is based on an awareness of trauma and its effects, as well as behaving in ways that demonstrate this understanding. This applies to how individuals, organisations and wider society can recognise and respond to people who may have experienced trauma. The core trauma-informed principles are safety, trust, choice, collaboration, empowerment and respect for diversity.[111]
victim-survivor	Someone who has been sexually abused as a child. When we use the term 'victim-survivor', it is to recognise a person's experience and is not a legal determination. For ease of reading, we use the term 'victim-survivor'. We recognise that some people prefer 'survivor' because of the resilience and empowerment associated with the term, and because they do not identify as victims. We also recognise that some people who have experienced abuse do not consider that they 'survived' the abuse and that 'victim' is more appropriate. We also recognise that some people may have died by suicide as a consequence of the abuse they experienced. We acknowledge that 'victim' is more appropriate in these circumstances. We also recognise that some people do not identify with either of these terms, and may prefer terminology such as 'person with lived experience of child sexual abuse'.[112]
2000s, 2010s & 2020s	In this report, we refer to the following time periods: • the '2000s' means the years 2000 to 2009 • the '2010s' means the years 2010 to 2019 • the '2020s' means the decade beginning 2020. To avoid identifying people, we sometimes use 'early', 'mid-' and 'late' with these decades without specifying the relevant years.

Notes

Executive summary

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Findings

86 The name 'Henry' is a pseudonym; Order of the Commission of Inquiry, restricted publication order, 18 August 2022.

87 The name 'Max' is a pseudonym; Order of the Commission of Inquiry, restricted publication order, 18 August 2022.

88 The name 'Ray' is a pseudonym; Order of the Commission of Inquiry, restricted publication order, 18 August 2022.

89 The name 'Alysha' is a pseudonym; Order of the Commission of Inquiry, restricted publication order, 18 August 2022.

90 The name 'Max' is a pseudonym; Order of the Commission of Inquiry, restricted publication order, 18 August 2022.

91 The name 'Walter' is a pseudonym; Order of the Commission of Inquiry, restricted publication order, 18 August 2022.

92 The names 'Ira', 'Lester' and 'Stan' are pseudonyms; Order of the Commission of Inquiry, restricted publication order, 18 August 2022.

93 In accordance with the Restricted Publication Order of the Commission of Inquiry dated 30 August 2023 and section 10(3) of the *Commissions of Inquiry Act 1995* (Tas), the Governor has omitted Volume 6, Chapter 14, Case Study 1 because the public interest in the disclosure of that part of the report is significantly outweighed by other relevant considerations, namely the right of any person to a fair trial.

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Commission of Inquiry into the Tasmanian Government's Responses to Child Sexual Abuse in Institutional Settings

Who was looking after me? Prioritising the safety of Tasmanian children

Volume 2: Establishment and context

August 2023

Commission of Inquiry into the Tasmanian Government's Responses to Child Sexual Abuse in Institutional Settings Report

Volume 2
Establishment and context

The Honourable Marcia Neave AO
President and Commissioner

Professor Leah Bromfield
Commissioner

The Honourable Robert Benjamin AM SC
Commissioner

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1 Establishment, scope and conduct

1 Introduction

This Commission of Inquiry was prompted by a groundswell of community concern in 2019–20 over child sexual abuse in Tasmanian Government institutions. It followed media reporting of incidents of abuse and inadequacies in the Government's response to these incidents. While the Government's initial response to these concerns characterised these matters as 'historical', others in the community and media questioned the extent to which failures to keep Tasmanian children safe were indeed in the past.[1]

On 31 July 2019, Tasmania Police searched the home of paediatric nurse James Griffin. The search revealed large quantities of child exploitation material. Later that day, Mr Griffin was stood down as an employee of the Launceston General Hospital. In October 2019, Tasmania Police arrested Mr Griffin and charged him with numerous sexual offences relating to children, before releasing him on bail. Soon afterwards, Mr Griffin took his own life.[2] These events, and the rumours that circulated about them, caused great concern among the staff of the hospital and the Tasmanian community.

In 2020, the media began reporting allegations of child sexual abuse perpetrated by Tasmanian State Service employees, including teachers and health staff.[3] The media also reported an impending class action against the State of Tasmania, led by people who had 'suffered serious injuries', including sexual abuse, as children while detained in Ashley Youth Detention Centre.[4] These reports prompted others to come forward

with information about current and past child sexual abuse in a range of Tasmanian Government institutions. Some accounts expressed that formal avenues to report and seek redress for child sexual abuse were unavailable or ineffective.[5] One victim-survivor referred to attempts to report abuse that had 'fallen on deaf ears or [been] swept under the carpet'.[6]

These reports and civil claims raised concerns that child sexual abuse had not been properly addressed in Tasmania after previous inquiries and reviews, and that it was not isolated to a single institution or a small number of people. The Honourable Peter Gutwein, the then Premier of Tasmania, noted 'significant community concern and public angst quite rightly—over recent matters that have come to light where historically children have not been safe in our Government institutions'.[7] In particular, government institutions' responses to reports of child sexual abuse perpetrated by Mr Griffin, and others, were subject to significant media scrutiny, which included a podcast, *The Nurse*. As of May 2022, episodes of *The Nurse* had been downloaded about 1.3 million times.[8]

The Tasmanian Government instigated two independent reviews into child sexual abuse in the education and health systems, and an investigation into the conduct of three employees at Ashley Youth Detention Centre.[9] However, as acknowledged by the then Premier, it was clear that despite establishing these reviews and other government actions more needed to be done to protect children.[10]

On 23 November 2020, Premier Gutwein announced that he intended to recommend to Her Excellency Professor the Honourable Kate Warner AC, the then Governor of Tasmania, that she 'establish a Commission of Inquiry under the *Commissions of Inquiry Act 1995* ('Commissions of Inquiry Act') to investigate the responses of Tasmanian Government Agencies in relation to the management of historical allegations of child sexual abuse'.[11] In making this announcement, Premier Gutwein acknowledged that despite the Government's efforts:

> … as the number of allegations coming to light continues to grow, we must take every step necessary to ensure we identify any systemic gaps and put in place measures to fill them.
>
> This situation is nothing short of terrible and we must take further action. I believe one of our greatest responsibilities is to learn from the past, and commit to not repeating its mistakes.[12]

In the announcement, the Premier stated that 'as more claims for redress are progressed there will be more shocking examples come to light'.[13] The Premier referred to five current State Service employees who had been suspended from work due to claims of child sexual abuse, one of whom was stood down pending the outcome of criminal proceedings.[14] A media report in February 2021 suggested that another 14 current State Service employees had been stood down since the Premier's announcement.[15]

By February 2023, the number of state servants in child-facing departments suspended by the Government since January 2000 had risen to 92.[16] Some 38 of those state servants were suspended following the announcement of our Commission of Inquiry in November 2020.[17]

The Commission of Inquiry into the Tasmanian Government's Responses to Child Sexual Abuse in Institutional Settings was established by Order of the Governor on 15 March 2021.[18]

A year after beginning our Inquiry, a personal element in the Premier's announcement of our Commission of Inquiry became apparent. At a media conference in March 2022, Premier Gutwein stated that he is a victim-survivor of child sexual abuse perpetrated by a teacher.[19] He said: 'I'm the first Premier of this state that has taken the steps to have a Commission of Inquiry. The reason that I've done that is that I have great empathy, because I have walked in their shoes'.[20] He further stated: 'I know what the loss of trust feels like; I know what the shame feels like'.[21]

In 2003, Mr Gutwein, a Liberal Member of Parliament, had crossed the floor of Parliament to vote with the Tasmanian Greens in support of establishing a commission of inquiry into child abuse. The then Labor Government and the Liberal opposition opposed the motion. Because he crossed the floor, Mr Gutwein lost the shadow treasury, education and employment portfolios. At the time, he stated: 'If we don't have the courage of our own convictions, how can we expect those people out there that have been abused, that are aware of abuse, to come forward?'[22]

On 8 April 2022, Premier Gutwein resigned as Premier and a Member of Parliament. We commend Mr Gutwein for his bravery in supporting victim-survivors of child sexual abuse and their families, and for sharing his own story of abuse.

2 Establishment and scope

When our Commission of Inquiry was established on 15 March 2021, the Governor appointed the Honourable Marcia Neave AO, Professor Leah Bromfield and the Honourable Robert Benjamin AM SC as members of our Commission of Inquiry, with Commissioner Neave appointed as President. Commissioners Bromfield and Benjamin were born in Tasmania.

The Order of the Governor required and authorised the Commissioners 'to inquire into the Tasmanian Government's responses to allegations and incidents of child sexual abuse in institutional contexts'.[23] The Order specified areas for inquiry that form our Inquiry's terms of reference, which are outlined below.

The Order directed our Commission of Inquiry to make any recommendations arising from our Inquiry that we considered appropriate, including about any policy, legislative, administrative or structural reforms.[24]

We held an opening hearing in Hobart on 26 October 2021. We were required to report by 31 August 2022, and hearings were planned to restart in early 2022. However, after considering advice from the Tasmanian Government on the potential impact of community transmission of COVID-19 in early 2022, we decided to restart hearings in May 2022. Due to the postponement of hearings, and other factors outside our control, we sought an extension to the original reporting deadline. In February 2022, the Tasmanian Government granted an extension to 1 May 2023.[25]

In early 2023, our Commission of Inquiry asked for another extension because of the complexity of information provided to us, our commitment to appropriately and thoroughly address all the issues raised with us, and the need to discharge our procedural fairness obligations under the Commissions of Inquiry Act. In April 2023, the Tasmanian Government granted an extension to 31 August 2023.

We delivered our final report, comprising 8 volumes and 191 recommendations, to the Governor of Tasmania on 31 August 2023.

2.1 Terms of reference

The Order of the Governor asked us to inquire into what the Tasmanian Government should do to:

- better protect children against child sexual abuse in institutional contexts in the future
- achieve best practice in the reporting of, and responding to, reports or information about allegations, incidents or risks of child sexual abuse in institutional contexts
- eliminate or reduce problems that currently prevent appropriate responses to child sexual abuse in institutional contexts, including addressing failures in, and barriers to, reporting, investigation and responding to allegations and incidents of abuse
- address or alleviate the impact of past and future child sexual abuse in institutional contexts, including, in particular, in ensuring justice for victim-survivors through processes for referrals for investigation and prosecution and support services.[26]

As part of our Inquiry, we were also required to consider:

- the experiences of people affected by child sexual abuse in institutional contexts, and provide opportunities for them to share their experiences

- the adequacy and appropriateness of the Tasmanian Government's responses to allegations and incidents of child sexual abuse in institutional contexts generally, and in particular, by:
    - the Department of Education to allegations of child sexual abuse in government schools
    - the Tasmanian Health Service and the Department of Health to allegations of child sexual abuse, particularly in the matter of James Griffin
    - the Department of Communities to allegations of child sexual abuse at Ashley Youth Detention Centre
- systemic issues, recognising that individual cases may need to be referred to appropriate authorities
- changes to laws, policies, practices and systems that have improved the ability of government institutions to better protect against and respond to child sexual abuse in institutional contexts.[27]

We did not have to inquire into matters that had been appropriately dealt with by the Royal Commission into Institutional Responses to Child Sexual Abuse ('National Royal Commission') or by another inquiry, investigation or court proceeding.[28]

2.2 Refinement of scope

With our terms of reference in mind, we clarified and refined the scope of inquiry to:

- accommodate key areas of concern in Tasmania
- ensure we prioritised areas that had not been addressed previously.

2.2.1 Child sexual abuse

The Order of the Governor adopted the victim-centred and legally based definition of child sexual abuse that the National Royal Commission used:

> i. Any act which exposes a child to, or involves a child in, sexual processes beyond his or her understanding or contrary to accepted community standards. Sexually abusive behaviours can include the [touching] of genitals, masturbation, oral sex, vaginal or anal penetration by a penis, finger or any other object, [touching] of breasts, voyeurism, exhibitionism, and exposing the child to or involving the child in pornography. It includes child grooming, which refers to actions deliberately undertaken with the aim of befriending and establishing an emotional connection with a child, to lower the child's inhibitions in preparation for sexual activity with the child; and
>
> ii. Any related matters.[29]

The National Royal Commission also considered the 'production, consumption, dissemination and exchange of child sexual exploitation material' to be child sexual abuse.[30] While the Order of the Governor did not refer to child exploitation material in its definition, the definition captures such material.

The definition of child sexual abuse also includes sexual abuse by other children or 'harmful sexual behaviours'. We use this term to refer to the:

> ... sexual behaviours displayed by children and young people that fall outside what may be considered developmentally, socially, and culturally expected, may cause harm to themselves or others, and occur either face to face and/or via technology. When these behaviours involve another child or young person, they may include a lack of consent, reciprocity, mutuality, and involve the use of coercion, force, or a misuse of power.[31]

While our examinations focused on child sexual abuse, we recognise that other forms of abuse can contribute to an institutionalised culture that treats violence, bullying and harassment as normal, and that sexual abuse can co-occur with other types of abuse and neglect. Such behaviour can create a risk of child sexual abuse and discourage it from being reported by the child or other people in the institution.[32] Therefore, we examined other forms of abuse if there was a link between that abuse and child sexual abuse occurring in institutional contexts.

We consider the definition, nature and impact of child sexual abuse in an institutional context in detail in Chapter 3.

2.2.2 Institutional contexts

The terms of reference directed us to examine child sexual abuse in 'institutional contexts'. According to the Order of the Governor, child sexual abuse happens in an institutional context if, for example:

i. it happens on premises of a government or non-government institution, where activities of the institution take place, or in connection with the activities of the institution; or

ii. it is engaged in by an official of a government or non-government institution in circumstances (including circumstances involving settings not directly controlled by the institution) where ... the institution has, or its activities have, created, facilitated, increased, concealed or in any way contributed to, (whether by act or omission) the risk of child sexual abuse or the circumstances or conditions giving rise to that risk; or

iii. it happens in any other circumstances where ... a government or non-government institution is, or should be treated as being, responsible for adults having contact with children.[33]

For government institutions, we focused on what was then the Department of Education, the Tasmanian Health Service and Department of Health, and the Department of Communities, particularly in relation to Ashley Youth Detention Centre and out of home care. The Order identified public schools, health services and youth detention for particular attention because those institutions provide significant direct services to children. As noted above, there had also been significant media coverage of child sexual abuse in those institutions, and separate inquiries had been announced for each of those institutions. We decided to include a focus on out of home care because the National Royal Commission identified that children in this institutional context are at an increased risk of child sexual abuse.[34] Our case studies in Volumes 3–6 examine child sexual abuse occurring in these institutions.

The Order of the Governor defined a non-government institution as one 'that undertakes, or has undertaken, activities on behalf of the Tasmanian Government to provide services for children'.[35] Based on this definition, we focused on non-government institutions that:

- undertake activities on behalf of the Tasmanian Government and provide services for children, or
- are funded by the Tasmanian Government to provide services for children.

We concluded that non-government institutions must meet the following three criteria to be in the scope of our Inquiry:

- The activities undertaken represent an outsourcing of traditional public functions and so there is a contract for services rather than a grant funding arrangement.
- The Tasmanian Government is the principal funder of the organisation or the amount of funding is substantial.
- The public could reasonably assume that the Tasmanian Government is responsible, directly or indirectly, for the services provided.

Applying these criteria, we focused mostly on non-government institutions that are contracted and funded by the Tasmanian Government to provide out of home care services.

We did not examine child sexual abuse in private or community institutions (churches, non-government schools, sporting organisations, local clubs) unless such institutions were solely funded by the Tasmanian Government to provide services for children.[36] We did not follow up or inquire into areas such as the involvement that abusers might have had with such institutions. We considered that these associations were outside our terms of reference. We have not conducted a thorough inquiry into allegations of abuse by police officers, ambulance officers or in connection with councils. Given the volume of material raised about the institutions identified in our terms of reference or, in the case of out of home care prioritised by us, we did not have the capacity to fully inquire into

these other government institutions. We took this decision to use the time and resources available to our Inquiry most effectively. The State did not make this suggestion, nor did we request extra time or resources from the State to expand our terms of reference for this purpose.

We heard a small number of significant concerns about child sexual abuse in these other institutional contexts, though not to the same extent as allegations of abuse in the education, health, youth justice and out of home care systems. While we did not investigate these other institutional contexts in detail, many of our recommendations apply to them. We ask the Government to consider these government institutions—and all others that provide services for children—when responding to our recommendations.

2.2.3 Current responses to allegations and incidents

We focused on responses to reports of child sexual abuse since 2000 (even if the act or acts of abuse occurred before 2000). This period reflects current responses to child sexual abuse, including community awareness and policy responses. This focus therefore informs our findings on current and ongoing issues and our recommendations for what needs to change.

As noted in the terms of reference, we did not have to inquire into matters that the National Royal Commission or another inquiry, investigation or court proceeding had dealt with.[37] Our Commission of Inquiry complements rather than duplicates the work of the National Royal Commission, which had already closely examined child sexual abuse in institutions prior to 2000, as well as some more recent cases. Consequently, we decided to focus on more contemporary responses to child sexual abuse, in order to consider how effective they are and what has changed since the National Royal Commission concluded. We only examined incidents of child sexual abuse that predated 2000 where they threw light on current issues of concern about preventing, reporting and investigating abuse or official responses to such abuse.[38]

In focusing on the period since 2000, we directed our resources towards identifying current and continuing systemic issues. Within this scope, we have prioritised those issues and circumstances that continued to be present at the time of our Inquiry. We did so with the view that a purposeful focus on current issues was the best way to protect current and future generations of Tasmanians from the profound and lifelong pain caused by child sexual abuse.

2.2.4 Systemic reform

As directed by the Order of the Governor, we focused on systemic problems in institutional contexts and options for reform. This systemic focus has been significantly informed by the experiences of individuals. The accounts of victim-survivors, their families and advocates enabled us to understand current practices and to develop

appropriate recommendations for reform. We have accepted the truth of the accounts of victim-survivors but acknowledge that, except where we have made findings, these accounts have not been examined by reference to the legal test for criminal responsibility, which requires proof beyond reasonable doubt, or civil liability, which requires proof of the allegation on the balance of probabilities.

Equally, examining specific institutions' responses to child sexual abuse has enabled us to identify patterns of behaviour that have gone unaddressed. In particular, we are concerned that a systemic problem in the Government's response to institutional child sexual abuse is a failure to deal with poor conduct or behaviour, including in relation to the conduct of individuals in responding to reports about the behaviour of others. We have identified poor conduct and failures by institutions and by individuals where the evidence before us supported such a conclusion, with the goal of ensuring that persistent and systemic issues are not perpetuated. Under the Commissions of Inquiry Act, we also have the power to make findings of misconduct.[39] We discuss this power further in Section 2.3.4.

We have focused our Inquiry on the institutional response to allegations of child sexual abuse in an institution, rather than investigating whether the abuse occurred. The Order of the Governor recognised that we may need to refer individual cases to appropriate authorities for investigation, including the police. We discuss our referrals in Section 2.3.3.

2.2.5 Organised abuse

Michael Salter, Scientia Associate Professor of Criminology, School of Social Sciences, University of New South Wales, defines organised abuse as 'any case of child sexual abuse in which two or more adult offenders conspire to sexually abuse one or more child'.[40] We have adopted that definition.

Over the course of our Inquiry, we have heard accounts of, or concerns about, organised abuse. We did not have the capacity to undertake proper forensic investigations into these. We consider that these matters are better investigated by other bodies with dedicated funding and mandates for investigating alleged criminal activities. Accordingly, we did not request extra resources to expand our Inquiry to cover these accounts or concerns.

As set out in Section 2.3.3, we have referred all appropriate information to Tasmania Police and other relevant authorities for their consideration. With the consent of the relevant victim-survivors and families, we confidentially identified where such information might suggest organised abuse.

We have not outlined the details of those accounts or concerns in this report because proper forensic investigations have not been undertaken and any premature disclosure may adversely affect investigations. We have also done this to ensure procedural fairness is not denied to relevant people.

We are not in a position to comment on the accuracy or truth of these accounts or concerns. We trust, however, that Tasmania Police and others will appropriately consider the matters we have referred and any support they require to properly investigate those matters.

2.3 Powers

Commissions of inquiry are rare in Tasmania. There have only been two others since 1990.[41] Unlike other forms of inquiry and review, commissions of inquiry have extraordinary powers, which are similar to royal commissions in other Australian states. These include powers to:

- compel witnesses to give evidence and produce documents[42]
- apply for a warrant to enter private premises to conduct a search and take documents[43]
- apply for a warrant to use surveillance or listening devices[44]
- hold public hearings and private sessions, including examining witnesses under oath.[45]

Witnesses do not have the right to refuse to give evidence or produce a document on the grounds that they may incriminate themselves.[46]

In announcing our Commission of Inquiry, the Premier stated that a key reason for recommending its establishment 'is the power of that Inquiry to compel witnesses to provide evidence'.[47]

Unlike many other forms of investigation and review, reports of commissions of inquiry must be tabled in Parliament and are therefore available to the public.[48]

In applying our broad powers, we have conducted a far-reaching examination. We have conducted 37 days of public hearings, held more than 120 sessions with Commissioners, examined more than 160 witnesses, received more than 260 statements and reviewed more than 95,000 documents. More about the conduct of our Commission of Inquiry is set out in Section 3.

2.3.1 Legislative and regulatory amendments

To ensure our Commission of Inquiry was appropriately empowered, several amendments were made to the Commissions of Inquiry Act and associated legislation. In March 2021, Parliament passed the *Justice Miscellaneous (Commissions of Inquiry) Act 2021* to amend various Acts.[49] Most of the amendments were taken to have started on 1 March 2021.[50]

The amendments:

- clarified the Governor's power to amend or vary the matters that a commission of inquiry is directed to examine
- provided for a commission of inquiry to conduct private sessions with individuals when appropriate (refer to Section 3.3.2 for more about the nature of these sessions)
- provided extra support for vulnerable witnesses to give evidence, including giving evidence anonymously and using special measures, such as witness intermediaries
- created additional requirements to provide procedural fairness where a witness to a commission of inquiry or another person may be subject to a finding of misconduct or other adverse finding
- clarified a commission of inquiry's power to use listening and surveillance devices
- empowered a commission of inquiry to inspect documents when privilege is claimed
- enabled a commission of inquiry to share information with law enforcement and other authorities for the purposes of ensuring the safety and protection of children (child safe reporting)
- enabled the Ombudsman to refer matters under the *Public Interest Disclosures Act 2002* to a commission of inquiry
- established exemptions to various confidentiality provisions for people who have been affected by abuse in the child protection and youth justice systems to access their records, to enable them to share that information with a commission of inquiry and to take part in private sessions, as well as the use of that information in civil and criminal proceedings.[51]

In addition, the *Commissions of Inquiry Regulations 2021* commenced on 14 July 2021 to support the operation of our Commission of Inquiry. These regulations negated provisions in various Acts that would otherwise have regulated or restricted information collected by, on behalf of, or provided to our Commission of Inquiry, including in the case of State Service employees who wanted to engage with our Inquiry.

We considered many of these new regulations to be necessary so that we could give the public and State Service employees more information about our processes and their relevant rights. Unfortunately, the delay in these regulations commencing due to consultation and authorisation processes required by the State hampered our capacity to provide this information in a timely manner.

2.3.2 Rights and protections of witnesses who provided information

The rights and protections available under the Commissions of Inquiry Act supported those who gave us information, including confidentially and anonymously.

The Act creates several offences in relation to those rights and protections. For example, it is an offence for:

- an employer to prejudice a person's employment or dismiss them because that person has given evidence or produced any document or thing to our Commission of Inquiry (or because of the content of that evidence, document or thing)[52]
- a person to intentionally prevent, or try to prevent, another person from producing any document or thing to our Commission of Inquiry[53]
- a person to punish another person or cause them loss, damage or disadvantage because that other person has given evidence or produced any document or thing to our Commission of Inquiry (or because of the content of that evidence, document or thing).[54]

The Commissions of Inquiry Act also limits the way information provided to our Inquiry can be used. The evidence that a person has provided to our Inquiry, such as a witness statement or oral evidence, is not admissible in other legal proceedings, except in very limited circumstances.[55] A person who appears before our Commission of Inquiry is given the same protections and immunities as a witness who appears before the Supreme Court.[56] This includes being protected against defamation and negligence actions.

Importantly, however, our Commission of Inquiry is inquiring into certain facts and matters. This does not prevent the State from also inquiring into those facts and matters. If information is available to our Inquiry and the State, both can investigate and, in the case of the State, take action in response to those facts or matters. For example, if it is alleged that a State Service employee has breached the State Service Code of Conduct, the State can still investigate that allegation and take any action it considers appropriate, provided it does not rely solely on evidence before our Inquiry. In this example, the State must already have this information or have obtained it through its own investigations. Also, our Commission of Inquiry can share information with, and refer matters to, the State and appropriate authorities for investigation.

2.3.3 Power to make referrals to appropriate authorities

Commissions of inquiry are not courts. They do not have the power to determine whether someone has committed a crime or is legally liable for their actions. Instead, if a commission of inquiry has any information that may be relevant to a criminal prosecution or disciplinary matter, that information can be referred to the appropriate authorities.[57] In addition, our Inquiry is legally bound to report certain matters. For example, if we reasonably believe matters constitute an 'abuse offence' against a child, we must disclose that information to a police officer as soon as practicable.[58]

During our Commission of Inquiry, we referred more than 100 people to appropriate authorities. Referrals were made to a range of organisations and people, including the:

- Registrar of the Registration to Work with Vulnerable People Scheme
- Australian Health Practitioner Regulation Agency ('Ahpra')
- Assistant Commissioner, Tasmania Police
- Secretary, Department for Education, Children and Young People and, before that, the Secretary, Department of Communities and the Secretary, Department of Education
- Secretary, Department of Health
- Secretary, State Growth
- Teachers Registration Board.

In several cases, a referral was unnecessary because those involved were already subject to an investigation, proceedings, disciplinary findings or criminal conviction.

In addition, the Order of the Governor required us to report to the appropriate authorities where we identified a risk or potential risk to the welfare of a child or children generally.[59] We also had an obligation to take steps to prevent abuse or neglect if we knew, or suspected on reasonable grounds, that a child was suffering, had suffered or is likely to suffer abuse or neglect.[60] These steps can include reporting our concerns to the Secretary of the Department for Education, Children and Young People or a community-based intake service.[61] During our Commission of Inquiry, we made more than 230 referrals to Tasmanian and other authorities regarding risks or potential risks to the welfare of children.

2.3.4 Power to make a finding of misconduct and an adverse finding

Our Commission of Inquiry has the power to make findings or draw conclusions from evidence we gather. Under section 19 of the Commissions of Inquiry Act, if we intend to make an adverse finding against a person, we must first notify the person in writing, including the details of the adverse finding, and allow the person at least 10 working

days to respond to the findings before our Inquiry's report is finalised.[62] The rules of procedural fairness apply if our final report makes an adverse finding about that person.[63] In Volumes 3–6 we make a number of adverse findings against individuals and the State. Each individual and the State were given written notice of these findings.

Under section 18 of the Commissions of Inquiry Act, we also have the power to make a finding of misconduct against a person.[64] Misconduct is defined in the Commissions of Inquiry Act as:

> … conduct by a person that could reasonably be considered likely to result in a criminal charge, civil liability, disciplinary proceedings, or other legal proceedings, being brought against that person in respect of the conduct.[65]

Before making a finding of misconduct, if we are satisfied that an allegation of misconduct should be made against a person before calling that person to give evidence, we must give the person notice of the allegation of misconduct and provide them with an opportunity to respond to the notice (a 'section 18 notice').[66] The notice must give the person a reasonable period before they have to give evidence in response to the allegation.[67] It must outline the allegation and the evidence that supports it.[68] In response, the person may make oral or written submissions, give evidence to contradict or explain the allegation, cross-examine the person making the allegation, and call witnesses.[69] The person has a right to be represented by legal counsel.[70] We issued 30 section 18 notices to 22 people. In Volume 6, we make one finding of misconduct.

During our Inquiry, various interpretations of sections 18 and 19 of the Commissions of Inquiry Act, and the relationship between them, were presented by the State and lawyers acting for individuals. In relation to state servants, some have argued that the interpretations of these provisions have the effect that if our Commission of Inquiry wishes to make an adverse comment about the conduct of a state servant, this may effectively be a finding of misconduct against that person and require the specific process under section 18 to be followed. This argument is based on the fact that the definition of misconduct includes conduct that 'could reasonably be considered likely to result in … disciplinary proceedings' and conduct by state servants that might attract adverse comment could require consideration of whether there has been a breach of the State Service Principles or Code of Conduct, and hence give rise to a disciplinary proceeding (even if the outcome of such proceeding is uncertain). A similar argument could be made about any person who, by virtue of their profession or employment, might be subject to any form of disciplinary proceeding.

We consider that there should be scope for a commission of inquiry to make adverse comments about state servants without this automatically or necessarily also constituting findings of misconduct. We consider the Commissions of Inquiry Act reflects that there can be both types of findings and that a range of conduct might be criticised without it constituting misconduct.

Our view is that section 18 only applies to the extent that we consider any allegations, or make any findings, of misconduct. We consider that, under section 19 of the Act, we can make adverse findings that are not findings of misconduct. In those circumstances, we consider that it is not necessary to issue a notice under section 18, provided we comply with sections 19(2A) and 19(2B) of the Act.

We have maintained that distinction in the language of our report, where we have only designated one of our findings to be a finding of misconduct. We understand that lawyers would adopt the most beneficial interpretation for their clients and seek to minimise any adverse findings or findings of misconduct, but note that the State also advocated for the interpretation that had the effect of combining adverse comment and misconduct in relation to a person's conduct. We quote at length:

> … the findings against individuals in this Inquiry must still be characterised as misconduct findings. The State does not accept any argument that section 18 of the Act must be 'read down' to provide a 'functional interpretation'. This Inquiry is 'out of the ordinary' in that it focuses on workers who are in a highly regulated profession. Unlike many Inquiries which could be constituted under the Act, these are findings made against State Servants. As the Commission is aware, State Servants are subject to the statutory Code of Conduct found within the State Service Act 2000. Any adverse findings will bring the full effect of the Code of Conduct into play against any named individual and accordingly, adverse finding is likely to result in the consideration of disciplinary proceedings against that worker.
>
> … Any finding which may have the result of leading to disciplinary proceedings are findings of misconduct and as such, those workers have all the protections afforded them pursuant to section 18 of the Act.[71]

To avoid drawn-out legal argument and dispute, we adapted our procedural fairness processes to align with this interpretation and to avoid making adverse findings against individuals where they may have been considered to be findings of misconduct.

The Commissions of Inquiry Act shares some similarities with legislation in other Australian jurisdictions in relation to royal commissions and commissions of inquiry. Like most of these other jurisdictions, Tasmanian legislation provides that an inquiry is not bound by the rules of evidence (section 20(1)) and must observe the rules of procedural fairness (section 3(b)(i)).[72] We are not aware, however, of any other Australian jurisdiction imposing the requirements for a finding of misconduct that exist in Tasmania under section 18.[73]

In our view, the procedural requirements under section 18 for making a finding of misconduct are onerous. In particular, the requirement to provide reasonable notice with a level of specificity about the allegation, and the evidence supporting the allegation, while concurrently running an inquisitorial process within a limited timeframe, presents practical difficulties. Also, providing a person who receives a notice of an allegation of misconduct the option to choose how to respond, which might include requiring

further hearings, also significantly limits the capacity of a commission of inquiry to conduct that inquiry in the manner it considers appropriate, including to appropriately address any trauma-informed considerations in relation to vulnerable people.

While procedural fairness—including a person's right to know any potential adverse findings against them and to be able to respond to those findings—is a cornerstone of our legal system, it is not clear to us why this right could not be adequately met through the procedural fairness requirements set out in section 19, as relevantly supported by the common law.

These complexities and challenges were discussed even before the Commissions of Inquiry Act was introduced in 1995. A 1993 report from the Law Reform Commission noted that:

> [a] balance must be maintained between the rights of individuals and the need for the commission conducting the public inquiry to properly and fully investigate and report upon the issues referred to it.[74]

The Commission of Inquiry into the Death of Joseph Gilewicz in 2000 identified specific difficulties in achieving this balance. Some, but not all, of these concerns were addressed in the *Commissions of Inquiry Amendment Act 2000*.[75] Despite the amendments, the section of the Act relating to misconduct was still thought by some to be 'overly complicated' and inflexible, hampering the ability of commissions to achieve their goals.[76] A 2003 Tasmania Law Reform Institute report therefore recommended further amendments to the Act.[77] Once again, some but not all of these concerns were addressed in the Justice Miscellaneous (Commissions of Inquiry) Act, which was said to implement the work of the Tasmania Law Reform Institute and the Australian Law Reform Commission.[78] Relevantly, this amending Act created separate misconduct (section 18) and adverse (section 19) findings processes, which we find overly complicated and ultimately unnecessary. Indeed, the Australian Law Reform Commission focused on adverse findings (that might include findings of misconduct) and suggested that procedural fairness process matters might be better addressed outside legislation (for example, through policy guidance) to offer greater flexibility.[79] This amending Act also sought to amend the definition of 'misconduct' to address concerns it was too broad. But it ultimately inserted a new definition that, as explained above, is also broad and problematic in practice.

As a matter of principle, we consider it would be better for an inquiry to make any findings it wishes, including adverse findings, subject to complying with procedural fairness. It should be a matter for the inquiry to choose whether a finding is of such seriousness, given the subject matter of the inquiry, that it might be appropriate to describe it as a finding of misconduct. In our view, it is unnecessary for an inquiry to follow any other procedural requirements in relation to such a finding, noting that the seriousness of the matter should also be taken into account in any balance of probabilities deliberations.

Also, forcing an inquiry to adopt extra 'misconduct' processes in relation to a broad category of conduct, not all of which may be of equal seriousness, risks unnecessarily increasing the impact on those who receive a notice of such alleged findings. Once again, it would be better for the inquiry to have the flexibility to treat any finding, including an adverse finding, in the way that is most appropriate and fair in the circumstances, rather than being artificially required to treat all adverse comments as 'misconduct'.

In considering other Australian jurisdictions, it is not clear to us why the Tasmanian legislation requires separate misconduct processes. This position is inconsistent with contemporary inquiry practices. Ultimately, we are concerned the Tasmanian legislation invites arguments and disputes that prevent local inquiries from being as effective and efficient as they might be, and so limits the impact they can have for the benefit of the community.

We have outlined our concerns about section 18 and other provisions under the Tasmanian legislation in Chapter 23.

The findings we make in this report are based on a civil standard of proof. That is, we were satisfied that a matter had been proved on the balance of probabilities, rather than proved to the criminal standard of beyond reasonable doubt. We based our assessment on the following principles, as set out by Justice Dixon in *Briginshaw v Briginshaw*:

> … it is enough that the affirmative of an allegation is made out to the reasonable satisfaction of the tribunal. But reasonable satisfaction is not a state of mind that is attained or established independently of the nature and consequence of the fact or facts to be proved. The seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding are considerations which must affect the answer to the question whether the issue has been proved to the reasonable satisfaction of the tribunal … the nature of the issue necessarily affects the process by which reasonable satisfaction is attained.[80]

The findings in this report seek to discharge our terms of reference, which ultimately aim to inform systemic reforms. These findings are not, and cannot be, substitutes for criminal prosecutions or civil or disciplinary proceedings. As indicated above, the State can investigate, prosecute or bring other proceedings in relation to the facts and matters that are relevant to this report, including where our Commission of Inquiry has referred matters to the State or appropriate authorities. Under section 21 of the Commissions of Inquiry Act, the State cannot generally use evidence given before our Inquiry directly. However, the rights and protections under the Commissions of Inquiry Act do not prevent the State conducting its own investigations. Indeed, it would defeat the purpose of a commission of inquiry if the State could not take appropriate action in relation to the underlying facts and matters.

3 Conduct

Our Commission of Inquiry's job was to understand the complexity of institutional responses to child sexual abuse in government funded institutions, and to identify ways to create tangible and lasting change in these institutions. In this section, we outline how we approached our task.

We intend that the work of our Inquiry will protect Tasmanian children and young people from sexual abuse in and in connection with these institutions. We hope it will increase community understanding and improve responses to child sexual abuse and its impacts.

3.1 Who we heard from

To help accomplish our task, we engaged with more than 500 people including:

- Tasmanian children
- victim-survivors—children, young people and adults
- the families, communities and supporters of victim-survivors
- government and institutional representatives
- key service providers and stakeholders
- community members with relevant information
- experts in the field.

We acknowledge the strength and commitment to change demonstrated by many of those who came forward to talk to us about their own experiences or about their attempts to protect children and ensure effective responses to allegations and incidents of child sexual abuse.

3.1.1 Information handling

Much of the evidence we considered was given by victim-survivors and their loved ones and communities. We were particularly careful to treat this evidence respectfully. Accordingly, we put in place a procedure for handling information provided by victim-survivors. This procedure was possible because of recent changes to laws relevant to sexual assault.

The #LetHerSpeak campaign—also known as #LetUsSpeak—was founded in 2018 to 'abolish sexual assault victim gag-laws in Tasmania, the Northern Territory and, more recently, Victoria'.[81] Advocates described these laws as 'gag-laws' because they had the consequence of:

- silencing victim-survivors who wanted to speak out
- removing victim-survivors' control over their experiences and denying personal agency
- maintaining the social stigma around sexual violence
- enabling and protecting offenders
- disempowering victim-survivors
- restricting public education around sexual assault.

After significant public pressure, some laws were changed to allow victim-survivors of sexual abuse to self-disclose or permit third parties to disclose their identity, and for courts to make orders to permit disclosure.[82]

As a result of the #LetHerSpeak campaign and legal amendments, people who shared information with our Commission of Inquiry could tell us how they wanted their information handled. Before we began receiving information from prospective participants, we explained that we could treat their information as:

- public—information could be viewed, referenced, quoted or published as required by Commissioners and Commission of Inquiry staff, and attributed to the participant
- anonymous—information could be used, but identifying details about the participant were removed and not published or made public
- confidential—information could only be viewed by Commissioners and Commission of Inquiry staff, and not used or published in the report.

We told participants that they could choose their preferred information-handling option and could later change their mind about how their information was handled. We also emailed a diagrammatic fact sheet titled 'How will my information be handled?' to victim-survivors who registered their interest in contributing to our Inquiry. This gave them time to digest and consider this information before taking part.

3.1.2 Support for people sharing information

We were aware that providing information about institutional responses to child sexual abuse is a complex process. It could be experienced as challenging, distressing, validating, triggering or healing, and could invoke other reactions. We therefore wanted to ensure our interactions with people sharing information were trauma-informed. This refers to understanding the impact of trauma on a victim-survivor and interacting in ways that support recovery and reduce the possibility of retraumatisation.[83] Chapters 19 and 21 detail why it is important for all services interacting with victim-survivors to provide trauma-informed care.

The core principles of trauma-informed care are safety, trustworthiness, choice, collaboration and empowerment.[84] We sought to implement these principles from our first contact with victim-survivors. We tried to be open and transparent about the Commission of Inquiry's processes so that our role and limitations were clear. In particular, and to reduce the likelihood of retraumatisation, our sessions with a Commissioner were adjusted according to victim-survivors' choices.[85] Victim-survivors could bring a support person, meet in whatever setting felt most comfortable (including online) and control what information to share and how it was used.

People who took part in our Inquiry could also access counselling if needed. During and after their engagement with us, they could speak with an independent counsellor or an appropriately trained member of our team. In this way, we provided psychological first aid, risk assessments, safety planning, referrals to services and other means of support.

Aboriginal engagement officers were also available to provide culturally sensitive support to Aboriginal people who wanted their contribution to our Inquiry facilitated by an Aboriginal person.

3.2 Our staff

Many dedicated and hardworking staff made conducting a comprehensive inquiry possible.

We were well supported in our work by staff across four teams:

- Our Community Engagement Team comprised professionals with experience assisting vulnerable people (such as victim-survivors of child sexual abuse). This team worked closely with two Aboriginal engagement officers. The team supported our Inquiry's consultation processes, including sessions with a Commissioner, stakeholder consultations, engagement with Aboriginal communities, site visits and roundtable discussions and briefings. This team also included a media and stakeholder engagement officer, who assisted with community and stakeholder consultations, and liaised with the media to convey information about our activities and communicate with the public.
- Our Policy and Research Team comprised policy officers and an investigator seconded from the Australian Federal Police (the Australian Federal Police paid for this secondment). This team handled research strategies and programs that informed the strategic direction of our Commission of Inquiry. The team developed investigation strategies and programs, informed the hearings and stakeholder consultations and briefings, led the drafting of our final report and ensured we were well informed to make strong recommendations that could be feasibly implemented.

- Our Operations Team established our Commission of Inquiry's offices and coordinated staff across four states. This team provided logistical support, secured venues for public hearings and other Commission of Inquiry events, made travel arrangements, and ensured that public hearings ran smoothly and efficiently. They also took care of finance, human resources, infrastructure, decommissioning and archiving.
- Our Legal Team included Counsel Assisting, General Counsel and Solicitors Assisting. This team of lawyers provided our Inquiry with legal advice, administered inquiry procedures, sought an extensive amount of material, and conducted proper and effective hearings. The team identified and called appropriate witnesses and questioned them in a way that elicited useful evidence for our consideration. Our Legal Team also helped develop our final report.

Staff of our Commission of Inquiry and the Legal Team are named in Appendix C.

We express our gratitude to the Commission of Inquiry staff and the Legal Team who so ably assisted us to undertake our inquiries, prepare our final report and make recommendations.

3.3 Our forms of inquiry

The information and evidence that have informed the discussions and recommendations in this report have been obtained through multiple forms of inquiry including:

- written submissions
- sessions with a Commissioner
- sessions with our Community Engagement Team
- public and targeted stakeholder consultations
- consultations with Aboriginal communities
- site visits to youth detention and youth justice facilities
- research undertaken by our Legal Team and commissioned researchers
- public hearings
- roundtable discussions and briefings with government and agency representatives.

Because our Commission of Inquiry coincided with the COVID-19 pandemic, some of these forms of inquiry could not go ahead in person as planned. In line with COVID-19–safe protocols and relevant directions under the *Public Health Act 1997* ('Public Health

Act'), we conducted our Inquiry online using remote-access technology, when necessary and appropriate.[86] There were some benefits to technology-facilitated access, such as extending access to victim-survivors and experts based interstate and overseas.

Each form of inquiry is described in the following sections. Rather than standing alone, evidence obtained through each method informed our approach to, and discussions held in, other forums.

3.3.1 Written submissions

On 13 May 2021, we published an information paper calling for written submissions that addressed our terms of reference. The paper explained the scope of our Inquiry and that submissions would help inform our 'understanding of the gaps, challenges and problems with the Tasmanian Government's responses to allegations and incidents of child sexual abuse in institutional settings'.[87] The paper also included a list of guiding questions and details about the submission process.

We welcomed written submissions in any length or format, to be submitted online, by mail or by email. People wanting to submit a hard copy of their written submission could do so with the support of our Operations Team. Those who needed help to write a submission could get support from Tasmania Legal Aid and our Community Engagement Team.

We invited victim-survivors and their supporters to tell us about their experiences and the ways in which the Tasmanian Government's responses to allegations and incidents of child sexual abuse might be improved.[88]

Within a month, we had received 60 written submissions. To enable as many people as possible to contribute, we then simplified the submission process and extended the closing date for submissions from 2 July 2021 to 3 September 2021. Our Commission of Inquiry continued to receive and consider submissions after this time.

By 14 February 2022, we had received 143 submissions from a wide range of people and organisations. Our Legal Team assessed each submission to determine whether the subject matter was within our terms of reference, as well as whether the submission should be treated as public, anonymous or confidential. Some 139 of the 143 submissions were within our terms of reference. Of these, 45 submissions were public, 49 were confidential and 45 were anonymous. Tasmania Legal Aid assisted four people to make submissions.

Our Policy and Research Team reviewed and further analysed the submissions, categorising those making allegations about instances of child sexual abuse and those identifying systemic issues in relation to child sexual abuse.

From 143 submissions, we noted 160 individual allegations of instances of child sexual abuse (excluding one submission that contained hundreds of allegations). We further analysed this material against criteria including whether the allegation concerned an adult abuser or harmful sexual behaviours, and to which relevant case study or thematic area the allegation related. Because submitters were not asked to provide this information, we note that the following quantitative information is an approximation and based on volunteered information available in the submissions.

Of the 160 allegations, 132 related to adult abusers, 14 to harmful sexual behaviours and 14 were unclear.

Among these specific allegations:

- 63 allegations related to child sexual abuse in schools, with many raising concerns about abuse occurring before 2000
- 25 allegations related to Ashley Youth Detention Centre
- 25 allegations related to health services, particularly the offending of Mr Griffin
- 6 allegations related to out of home care.

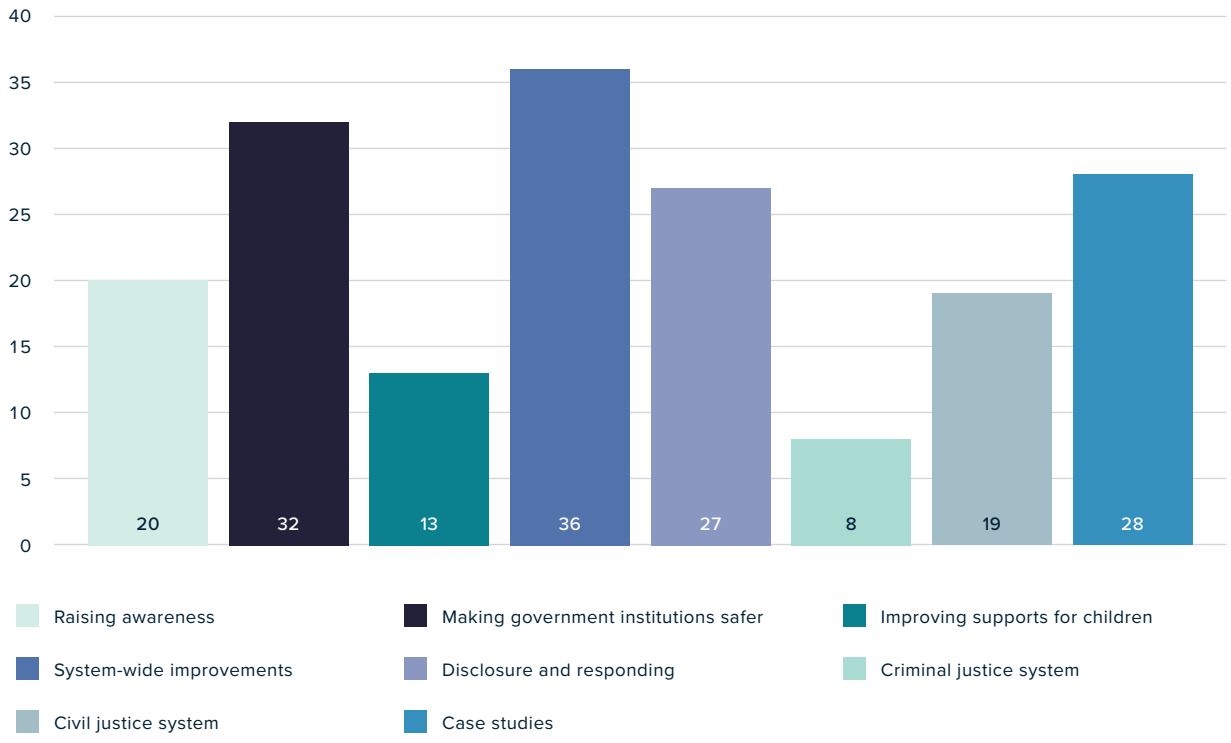
As indicated above, all submissions were coded for systemic issues relevant to child sexual abuse, including the following themes (noting that some submissions addressed more than one theme):

- 20 submissions addressed topics relevant to raising awareness of and preventing child sexual abuse, including calling for prevention and early intervention measures, addressing Tasmanian attitudes to child sexual abuse, and the need for a community-wide response
- 32 submissions addressed topics relevant to making government institutions safer, such as addressing the physical design of buildings, calling for child safe standards, improving screening practices (such as professional registration and registration to work with vulnerable people), training for staff to recognise abuse, and developing codes of professional conduct for staff and a reportable conduct scheme
- 13 submissions addressed topics relevant to improving supports for children, including supporting children with specific backgrounds or experiences (such as being Aboriginal or having disability), how to support adults to understand when children are making disclosures to them, and providing supports, including therapeutic responses, for children displaying or experiencing harmful sexual behaviours

- 36 submissions addressed topics relevant to system-wide improvements, including improving coordination across agencies, strengthening mandatory reporting, improving record keeping, strengthening oversight bodies (such as the Commissioner for Children and Young People, the Ombudsman and the Integrity Commission), and increasing funding
- 27 submissions addressed topics relevant to improving institutions' identification of and response to disclosures, including barriers to making complaints, concerns about Tasmania's culture and size, having clear complaints processes, and difficulties with disciplinary processes and internal investigation processes
- 8 submissions addressed topics relevant to improving the criminal justice system, including police responses, criminal offences and procedures, bail and sentencing, and training legal practitioners in matters relevant to child sexual abuse
- 19 submissions addressed topics relevant to civil justice matters, redress and support for victim-survivors, including the National Redress Scheme, the conduct of civil litigation matters and therapeutic supports for victim-survivors, as well as preserving records and providing official apologies
- 28 submissions addressed topics relevant to our four focus institutions—education, youth detention, out of home care and health.

These themes are summarised in Figure 1.1.

Figure 1.1: Systemic themes from submissions to our Commission of Inquiry



From these submissions, we gained a sense of the problems in the Tasmanian Government's response to child sexual abuse, including:

- a lack of a systemic response to child sexual abuse
- fears of reprisals for speaking out about child sexual abuse
- concerns about misconduct and cover-ups
- a lack of human empathy in responses to child sexual abuse
- a lack of priority given to the safety of children
- problems with disciplinary processes.

The firsthand insight and experiences conveyed in the submissions we received, as well as observations made by organisations, deepened our understanding of the nature and breadth of child sexual abuse in government institutions. We appreciate the time people spent considering and writing their submissions. We are particularly grateful to people who provided accounts of their personal experiences, sometimes for the first time.

3.3.2 Sessions with a Commissioner

By 17 July 2023 (from 13 August 2021), 132 people affected by child sexual abuse had shared their experience with a Commissioner in person, online, by video-conference or on the telephone. Sessions with a Commissioner were due to be completed by the end of February 2023 to allow information shared to be included in our final report. In practice, some sessions were held after this date, and Commission staff continued to receive information from people who wished to share it.

Because it can be distressing and exhausting for victim-survivors and their supporters to recount traumatising experiences, each session with a Commissioner was designed to be welcoming and trauma-informed. Many people who attended a session later reported feeling supported during their engagement with our Commission of Inquiry, which we hope reflects the sense of privilege and respect we felt when people trusted us with their experiences. For example, one participant said after their session with a Commissioner: 'Thank you for listening to my story. I think that, in a way, I can have some closure now'.[89] Another said, 'I'm relieved that I'm being taken seriously, I'm relieved that someone out there aside from me cares this happened and happens … It's validation. I have validation and that means so much'.[90] We discovered while undertaking our Inquiry that the very existence of our Inquiry had a positive impact on many victim-survivors. For example, one participant told us:

> Thank you for all your work. Thank you for addressing the concerns of survivors, and for looking at a difficult problem with a fresh set of eyes … Your work has had a major positive impact on my life experience (and others I'm sure) and has been integral to my own healing.[91]

Sessions with a Commissioner had a profound impact on the Commissioners and inquiry staff. We consider it a privilege to have spent time with the victim-survivors, their loved ones and supporters, who have shared their stories and experiences of sexual abuse and their attempts to obtain justice, healing and the protection of others. The strength and resilience of the people who spoke to us in these sessions often restored our faith in humanity in the face of confronting conduct by others. These sessions have helped us understand the varied and complex ways in which trauma can profoundly alter the everyday lives of many people in our community. Our task would have been made far more difficult without victim-survivors and their supporters placing their trust in us. We do not take that trust for granted.

Registering for a session

Tasmanians became aware of sessions with a Commissioner in several ways. Many learned about sessions because of their previous engagement with us—by writing a submission, contacting us by telephone or email, or attending a stakeholder consultation. Other paths for engagement included referrals from our Aboriginal engagement officers and the 'Sessions with a Commissioner' page on our website. People interested in attending a session with a Commissioner generally registered their interest by emailing us or calling our 1800 number. People in prison could contact us via our 1800 number, which was placed on prison telephone systems.

When a person called to register for a session, they were connected to a member of our Community Engagement Team, who then became their point of contact for the length of their engagement with us. The Community Engagement Team assessed the eligibility of each person to attend a session based on the nature of the information they wanted to share and the relevance of this information to our Inquiry.

Next, the team talked to people about what to expect during a session and supported them to make an informed choice about how the information they may contribute should be managed. We also outlined our mandatory reporting obligations to participants.

The wellbeing of people attending a session was of paramount importance to us. During the registration process, the Community Engagement Team determined each person's support needs and let them know that we would provide them with access to counselling supports before, during and after their session with a Commissioner. The Aboriginal engagement officers offered culturally sensitive support to Aboriginal participants.

Conducting a session

Commissioners spoke with victim-survivors, their loved ones and supporters, as well as people with information about Tasmanian Government institutions. We heard from a diverse group of people who were located variously in regional and metropolitan areas across Tasmania. We spoke with people in prison and other secure or residential environments, and with people from different age groups, including teenagers. We also spoke to people with an experience of child sexual abuse in a Tasmanian Government institution who now live interstate or overseas.

Many parents and caregivers took part in a session on behalf of their children. Although it was open to children to have their own session with a Commissioner, children most commonly contributed to our Inquiry through the child-centred research project discussed in Section 3.3.8.

Sessions usually ran for one hour. They were conducted in a range of formats and settings depending on the needs of the participant. In-person meetings were held in private meeting rooms. Virtual sessions were conducted (primarily using Microsoft Teams) with participants who spoke from locations in which they felt safe and assured of privacy. Sessions were attended by the participant, a Commissioner and a member of our Community Engagement Team. Participants decided how to use the time available and what they wanted to talk about. Participants could also choose to bring a support person or lawyer. People providing support did so on the understanding that information disclosed and discussed during a session would be used only for the purpose of our Commission of Inquiry and in line with the participant's expressed wishes about confidentiality.

When the session concluded, we arranged counselling support and transport home for participants if requested. Table 1.1 displays the data collected about Commissioner sessions and Table 1.2 shows the primary institution type in which session participants described child sexual abuse occurring.

Table 1.1: Sessions with a Commissioner data

Session, submission and participant-specific data	Total
Number of sessions held	132
Sessions held face to face	78
Sessions held by telephone	3
Sessions held by videoconference	51
Sessions held with people living interstate	15
Sessions held with people living overseas	5
Participant location—northern Tasmania	45
Participant location—North West Tasmania	7
Participant location—southern Tasmania	59
Participant location—eastern Tasmania	1
Age of youngest and oldest participant	17 and 72
Gender diverse participants	3
Female participants	82
Male participants	47
Participants who identified as Aboriginal	16
Participants who wanted their information to be public	45
Participants who wanted their information to be anonymous	71
Participants who wanted their information to be confidential	16
Pathway for participant engagement—written submission	44
Pathway for participant engagement—telephone or email	65
Pathway for participant engagement—referral	16
Pathway for participant engagement—stakeholder consultation	7

Table 1.2: Participant information

Primary institution type	Victim-survivor	Supporter of victim-survivor	Third party with information	Total
Health (excluding in relation to Mr Griffin)	7	3	9	19
Health (in relation to Mr Griffin)	11	5	8	24
Education	22	11	13	46
Out of home care	11	2	5	18
Ashley Youth Detention Centre	6	1	6	13
Other*	4	2	6	12
Total	**61**	**24**	**47**	**132**

* 'Other' refers to institutions other than those that could be categorised as health, education, out of home care or Ashley Youth Detention Centre.

Key themes

Participants brought a range of issues to our attention during their sessions with a Commissioner. Many spoke of their lived experience in government funded institutions such as schools, hospitals, out of home care facilities and Ashley Youth Detention Centre.

Below are the themes that struck us from personally attending these sessions:

- Child sexual abuse victim-survivors showed extraordinary courage and generosity in their motivation to make systems better and to protect other children.
- Child sexual abuse has significant and lifelong impacts on emotional, physical and spiritual wellbeing, as well as developmental capacity and milestones.
- Victim-survivors showed tremendous strength and resilience; they make positive contributions to their families, their communities and/or through their work while living with the pain and lasting impacts of child sexual abuse.
- Children have often been poorly treated in institutional settings, particularly children with special needs, children already exposed to abuse and trauma and children without family to stand up for them.
- Institutional responses to allegations, complaints and disclosures of child sexual abuse have sometimes been inadequate. Some responses have minimised the abuse, children have not been believed or not offered support, investigations have been non-existent, hurried and/or inefficient, and abusers have been protected and relocated to other workplaces.
- The responses to child sexual abuse in school, health, out of home care and detention settings, and in the justice system, have often not been informed by an understanding of victim-survivor trauma.
- Clear reporting and complaint mechanisms have often been lacking. At times, staff have feared reprisal, bullying or loss of their job and career prospects if they raised concerns about child sexual abuse.
- At times, toxic workplace cultures have meant that identifying risks and problematic behaviours has been discouraged among staff, and shifting responsibility and blame has been common.
- Too often, staff across institutions have not had the knowledge to recognise grooming or understand child safety reporting requirements.

- At times, redress and compensation processes have been difficult, not adapted to the impacts on victim-survivors and not focused enough on therapeutic supports for victim-survivors.
- Victim-survivors and their parents or supporters have frequently struggled to access affordable, timely therapeutic and practical supports to meet their needs.

3.3.3 Sessions with our Community Engagement Team

If a person was interested in sharing their experiences but did not want to write a submission or talk directly with a Commissioner, or their experience fell outside our terms of reference, we gave them the option of speaking one-on-one over the telephone with a member of our Community Engagement Team.

When we received information this way, the Community Engagement Team member first ensured that the caller felt safe, was in an appropriate location, and had privacy. The same protocols that applied to a session with a Commissioner about the use of information were applied in each session with a member of our Community Engagement Team, and were explained to the caller.

During the conversation, the team member took notes and asked clarifying questions when needed. The conversation was not otherwise recorded.

Eighty-three people chose to share information in this way. Although only 49 of these conversations were in the scope of our Inquiry, we believe it was important to extend an opportunity for all interested people to share information and understand our work.

3.3.4 Stakeholder consultations

Between 13 August and 13 December 2021, we held 21 targeted and public stakeholder consultations. We also held several informal discussions with individuals and groups. We spoke to people with experience of government institutions and relevant sectors, including teachers, social workers, police, healthcare professionals, specialist child sexual abuse professionals, people working with children and young people, academic experts, staff from local councils, community leaders, and representatives of Aboriginal communities and culturally and linguistically diverse communities.[92]

Stakeholder consultations were conducted in metropolitan and regional locations, as well as online. Each consultation ran for about 90 minutes. Consultations with many attendees were guided by an external facilitator, and Commission of Inquiry staff members took notes on the day.

More than 150 people attended these consultations. They provided a wealth of information relevant to our terms of reference and informed other aspects of our Inquiry, such as priority topics for our later public hearings. We thank everyone who attended a consultation for taking the time to share their expertise and insight with us.

Public stakeholder consultations

Of the 21 stakeholder sessions we held, seven were public consultations in Hobart, Launceston, Devonport (two sessions), Burnie, Queenstown and Scamander. Those who wanted to take part registered in advance. Attendance at each session ranged from one person to 41 people (refer to Table 1.3). In total, we heard from more than 100 people during our public consultations.

At each consultation, participants worked in small groups to discuss topics related to current government responses to child sexual abuse. In relation to each topic, participants were asked:

- What works well?
- What is not working well?
- How could the current system be improved?

At the end of each consultation, a Commissioner provided an overview of what we heard.

Table 1.3: Public stakeholder consultations

Date	Location	Number of participants
13 August 2021	Hobart	41
19 August 2021	Launceston	29
23 August 2021	Devonport	13
23 August 2021	Devonport	1
24 August 2021	Burnie	11
27 August 2021	Queenstown	10
31 August 2021	Scamander	4

Information received during public stakeholder consultations was wide-ranging and reflected the lived experiences of participants in dealing with child protection and child safety issues in various institutional settings. Consultations gave us a detailed insight into the struggles that victim-survivors, communities and frontline workers faced, and continue to face, as they try to negotiate systemic gaps and failures.

Importantly, participants in consultations highlighted statewide and regionally-specific issues, giving us a clear and immediate picture of the issues relevant to child sexual abuse in Tasmanian Government institutional settings as a whole.

Key themes

Key themes that emerged from public stakeholder consultations included:

- Many Tasmanians showed persistence and courage in raising issues to protect children.
- There was an absence or failure of mechanisms to respond to known risks and, if there were mechanisms, transparency and/or knowledge about them was lacking.
- There was a fear of reprisal and a sense that those who spoke out (victim-survivor or whistleblower) would be punished.
- There was a lack of care and compassion in responding to victim-survivors.
- Tasmanian institutional responses to prevent and respond to child sexual abuse were absent or out of date and did not incorporate contemporary knowledge.
- There was a failure to understand or consider that child sexual abuse, including grooming, was continuing to take place in Tasmanian Government institutions.

Participants also provided feedback on issues and ideas for improvement—for example, in prevention, reporting and responding, as well as on organisational, systemic and regional issues.

Across all stakeholder consultations, participants were asked about, but most struggled to identify, what was working well.

Targeted stakeholder consultations

We conducted 14 targeted stakeholder consultations in Hobart, Launceston and online (refer to Table 1.4). Attendance ranged from one person to 15 people per consultation. In total, we heard from more than 50 invited participants who regularly dealt with child sexual abuse matters, such as police and judicial officers, service providers, academics and advocates.

These targeted consultations allowed us to focus on a particular theme or issue, often identified through the submissions or the public consultations. Our questions and discussions at these consultations varied according to the stakeholder or stakeholder group we were meeting and the theme we were exploring. Information was provided in a private and closed setting, and although we draw on information provided in these consultations in our report, we have not identified individual participants or identified themes in detail here.

Table 1.4: Targeted stakeholder consultations

Date	Location	Number of participants
19 August 2021	Launceston	4
20 August 2021	Hobart/online	8
25 August 2021	Hobart/online	6
26 August 2021	Hobart	7
1 September 2021	Hobart/online	2
2 September 2021	Hobart	1
2 September 2021	Hobart	4
9 September 2021	Hobart	1
16 September 2021	Hobart	3
15 October 2021	Hobart	1
25 October 2021	Hobart/online	15
29 October 2021	Hobart/online	8
23 November 2021	Hobart/online	2
13 December 2021	Hobart	1

3.3.5 Engagement with Aboriginal communities

One of the continuing impacts of colonisation is that Aboriginal children are over-represented in certain government institutions, including the out of home care system and youth detention (refer to Volumes 4 and 5 for more on these institutions). We worked with two Aboriginal engagement officers to ensure our consultation processes with Aboriginal communities were culturally safe and inclusive, and that Aboriginal perspectives were heard and reflected in our findings.

Tasmanian Aboriginal context

In Australia, the definition of 'Aboriginal' has been subject to different classification systems at different times.[93] In the current Tasmanian context, the issue of who should be able to identify as Aboriginal is contentious and central to longstanding community divisions, notably between the Tasmanian Aboriginal Centre and other Aboriginal-led organisations.[94]

The Tasmanian Aboriginal Centre was founded in the early 1970s. It is the earliest government funded and highest profile Aboriginal organisation in Tasmania.[95] However, Aboriginal communities in Tasmania are diverse and represented by numerous organisations.[96]

The Tasmanian Aboriginal Centre previously endorsed state-based eligibility criteria as a prerequisite to accessing services funded for Aboriginal people, namely documented evidence of Aboriginal ancestry. Concerns have since been raised about this criteria because people who could not prove their ancestry through public records were excluded from accessing services.[97]

In 2016, the Tasmanian Government decided to redefine eligibility criteria for accessing Aboriginal-specific services. The Government adopted a definition of Aboriginal that removed the need for documentary evidence of Aboriginal descent. Currently, eligibility for access to Aboriginal services is based on:

- completing an Eligibility Form for Tasmanian Government Aboriginal and Torres Strait Islander Specific Programs and Services[98]
- providing a statement from an Aboriginal organisation, as well as a statutory declaration of self-identification.[99]

The Tasmanian Aboriginal Centre opposed this change because it was concerned that non-Aboriginal people would identify as Aboriginal to access funding earmarked for Aboriginal communities, and therefore 'put a strain on resources'.[100]

We are conscious of the over-representation of Aboriginal children in some government institutions (such as out of home care and youth detention) as a direct and continuing impact of colonisation. We considered it our responsibility to listen and learn from the experiences and expertise of as many Aboriginal people as possible. We therefore sought to engage Aboriginal organisations across Tasmania, including the Tasmanian Aboriginal Centre, to inform our Inquiry. We did not consider it the role or appropriate function of our Commission of Inquiry to determine who is Aboriginal. We therefore accepted the self-identified cultural identity of all people who engaged with us.

Engagement through community consultation

In mid to late 2021, our Community Engagement Team contacted 22 Aboriginal organisations via letter, telephone and/or email to initiate conversations about how communities might wish to engage with our Inquiry.[101] Ten of these organisations agreed to pass on information about our Commission of Inquiry to their members.

The Community Engagement Team also met with several prominent Aboriginal community members and organisations for further advice on developing an effective engagement strategy. This process led to engaging two Aboriginal engagement officers, who worked with our Inquiry to organise and facilitate statewide community consultations with Aboriginal people. Various community organisations or regions hosted 10 consultations (refer to Table 1.5). We then prepared a summary of reforms we were considering that were most relevant to Aboriginal communities. This was provided

to community members and organisations that had attended consultations, and they were invited to provide feedback. This process was undertaken in response to advice from Aboriginal community members about how our Commission of Inquiry could engage in meaningful consultation.

Before holding consultations, we organised for all Commission of Inquiry staff to attend cultural awareness training. The Community Engagement Team received more in-depth training so they were better equipped to take part in consultations with Aboriginal communities.

Table 1.5: Consultations with Aboriginal communities

Date	Area of Tasmania	Number of participants
8 April 2022	North West	8
24 May 2022	North West	12
31 May 2022	Northern	6
3 June 2022	Southern	6
18 July 2022	Northern	8
19 July 2022	Northern	8
28 September 2022	North West	12
24 October 2022	Southern	16
21 February 2023	Southern	4
22 February 2023	Southern	5

Other forms of engagement

Aboriginal people also took part in our Inquiry in other ways. Some Aboriginal people contacted us independently or after attending a consultation. Others came to us via our Aboriginal engagement officers.

Sixteen Aboriginal people took part in sessions with a Commissioner. Another five people who identified as Aboriginal gave us information over the telephone or in writing. However, we did not routinely collect demographic data from people we spoke with on the telephone, and it was not always appropriate to ask our standard demographic questions of people participating in sessions with a Commissioner. It is therefore likely that these numbers are conservative.

We received a written statement from the chief executive officer of the Tasmanian Aboriginal Centre, who also gave evidence during a public hearing (refer to Section 3.3.9).[102] We also received a written submission from the Tasmanian Aboriginal Legal Service.[103]

Of the 59 children and young people who took part in our primary research project (refer to Section 3.3.8), 11 identified as Aboriginal and/or Torres Strait Islander.[104]

We convey our deepest thanks to the Aboriginal people who contributed their insight to our Inquiry. They have informed our views and the recommendations we make in this report.

Key themes

The information we received from Aboriginal members of the community was wide-ranging. For Aboriginal people, child sexual abuse is inextricably linked to colonisation and its traumatic intergenerational impacts. As with the approach taken by the National Royal Commission, we decided to include information from Aboriginal people that did not fit within our terms of reference but better reflected the whole story that has led to the over-representation of Aboriginal children in child sexual abuse statistics.[105] It was of vital importance that we listened to all that Aboriginal people had to say and reflected their perspectives in our findings and recommendations.

Key themes that emerged from our consultations with Aboriginal people included:

- Prevention and healing
    - There has been a lack of education and prevention programs for Aboriginal communities, specific to child sexual abuse.
    - Significant numbers of Aboriginal children have been abused by members of their own community because of the trauma of colonisation and dispossession. There has been a culture of silence around this and, as a result, these children have been more vulnerable to abuse in institutions, as well as being affected by another layer of trauma.
    - Conversely, there are false assumptions about Aboriginal culture and parenting that inaccurately identify the risk of child sexual abuse.
    - Culture and cultural programs are essential to healing Aboriginal children who have experienced sexual abuse, as well as to strengthening communities and thereby preventing abuse.
- Child Safety Services and Tasmania Police
    - Many Aboriginal families fear that Child Safety Services will remove their children, which has been a barrier to reporting child sexual abuse.
    - There is a lack of trust in police in Aboriginal communities due to experiences of mistreatment, which has also been a barrier to reporting child sexual abuse.
    - Aboriginal children and families have experienced culturally inappropriate and negative treatment from Child Safety Services.
    - Sexual abuse of Aboriginal children in out of home care has been prevalent.

    - There is a need for culturally appropriate alternatives to out of home care and child safety interventions, governed by Aboriginal people.
- Ashley Youth Detention Centre
    - Many Aboriginal children have been negatively affected by Ashley Youth Detention Centre—abuse has been prevalent, and there has been minimal cultural care and follow-up support.
    - There is a need for culturally appropriate youth justice alternatives governed by Aboriginal people.
    - There has been insufficient funding and a lack of culturally appropriate support for victim-survivors of child sexual abuse. There is a need for Aboriginal-led programs and safe cultural spaces.
- Other challenges
    - Designing and implementing initiatives tailored to Aboriginal children in government institutions and their families is complex. There has been a lack of support for Aboriginal people working in these institutions.
    - Distributing resources and implementing new programs across Tasmanian Aboriginal communities has been challenging due to divisions between communities.

3.3.6 Site visits to youth detention and youth justice facilities

In 2021 and 2022, we visited four institutions that detain children and young people. Our first site visit was to the only youth detention centre in Tasmania: Ashley Youth Detention Centre at Deloraine. This detention centre was a major focus of our Inquiry. The other site visits were to youth detention and youth justice facilities in other states and territories. We visited these facilities to understand and compare different models of detention.

During site visits (summarised in the following sections), we saw the facilities and workings of each complex, spoke directly with staff and young people, and learned about their model of care and approach to behaviour management. We also observed the institution's relationship with the community at large.

We discuss Ashley Youth Detention Centre and alternative detention models in detail in Volume 5.

Ashley Youth Detention Centre

On 18 August 2021, President Neave, Commissioner Bromfield and Commissioner Benjamin visited Ashley Youth Detention Centre. They were accompanied by three Commission of Inquiry staff members, as well as representatives of the Solicitor for the

State and the Department of Communities, being the Deputy Secretary and Executive Director for Ashley Youth Detention Centre. These two departmental officials were there to support centre staff. The assistant manager and other centre representatives hosted the visit.

The visit occurred at the insistence of our Commission of Inquiry. Upon arrival, Commissioners were met with consternation about our visit and assurances that there were no issues of concern at Ashley Youth Detention Centre. This was in direct contrast to other youth detention centres in other states, where, despite having no powers, Commissioners were welcomed, visits were low key and staff spoke openly about their strengths and the challenges of operating youth detention facilities. Our experience at Ashley Youth Detention Centre was consistent with the accounts of others who have suggested that the Centre is a closed institution with a culture of cover-up and denial, as further evidenced in Volume 5.

Ashley Youth Detention Centre is Tasmania's sole custodial facility for children between the ages of 10 and 18. At the time of our visit, most children at the Centre were on remand.

On 9 September 2021, the Government announced that Ashley Youth Detention Centre would close within three years.[106]

Adelaide Youth Training Centre—Kurlana Tapa

On 14 October 2021, Commissioner Bromfield and a Commission of Inquiry staff member visited Kurlana Tapa, the Adelaide Youth Training Centre at Cavan in South Australia. The general manager of Youth Justice, South Australian Department of Human Services, hosted this visit. COVID-19 restrictions prevented us from entering the units at the centre, but we could visit other buildings as well as the grounds, including the Aboriginal cultural garden. Commissioner Benjamin also visited the centre on 2 June 2022, which was again hosted by the general manager of Youth Justice. With COVID-19 restrictions now eased, Commissioner Benjamin visited the educational facilities, health facilities, sporting and activity centres, and residential buildings.

Adelaide Youth Training Centre is a custodial facility for young people between the ages of 10 and 20. We were told that the numbers of children detained in South Australia had declined over time, but that most of the smaller number of children placed in the centre require intensive and complex supports and case management.

Cobham Youth Justice Centre

On 18 May 2022, Commissioner Benjamin visited the Cobham Youth Justice Centre at Claremont Meadows in New South Wales. The visit was organised with the executive director of Youth Justice New South Wales and was hosted by the acting centre manager at Cobham and the acting director of Custodial Operations, Youth Justice New South Wales.

Cobham Youth Justice Centre detains boys and young men between the ages of 15 and 20, who often present with drug and mental health issues. A significant proportion are from Aboriginal and Pacific Islander communities.

Bimberi Youth Justice Centre

On two occasions in 2022, Commissioners visited the Bimberi Youth Justice Centre in Gungahlin in the Australian Capital Territory. On 20 May, Bimberi's centre manager hosted Commissioner Benjamin. On 10 October, Bimberi's acting executive branch manager hosted President Neave.

Bimberi Youth Justice Centre uses a 'school campus model' and is the first youth justice facility in Australia to comply with human rights legislation.[107] It accommodates up to 40 children and young people between the ages of 12 and 21. Young people receive a health assessment when they arrive. Some have significant and complex mental health issues. Most are at the centre on remand.

3.3.7 Visit to Launceston General Hospital

On 14 March 2023, Commissioner Benjamin and a Commission of Inquiry staff member visited the Launceston General Hospital's child and adolescent and paediatrics wards. Our Commission of Inquiry instigated the visit, which the Department of Health facilitated. Hospital staff welcomed us and provided a comprehensive tour and explanation of the recently completed renovations.

3.3.8 Research

For further context with regard to what victim-survivors and other stakeholders were telling us and to inform priority topics for our public hearings (refer to Section 3.3.9), we undertook considerable research relevant to our terms of reference. This research included commissioned literature reviews and reviews of policy and related documents provided by the State. We also commissioned independent research to learn directly from the experiences of Tasmanian children and young people.

Literature and policy review

Our Legal Team collated more than 95,000 documents produced by agencies and government departments. We obtained this information in numerous ways, including by exercising our power to issue notice to produce documents. The Legal and Policy and Research teams reviewed this material. Table 1.6 lists documents that informed our hearings.

The National Royal Commission undertook extensive research on child sexual abuse in institutional settings and added significantly to the body of academic work on this issue. We reviewed the work of the National Royal Commission to inform our Inquiry.

In addition, after a targeted tender process, we funded the Australian Centre for Child Protection at the University of South Australia to source peer-reviewed articles on the topic of child sexual abuse, published since 2016.[108] The results of this search provided recent academic insight into five key areas:

- supporting children
- disclosure and response
- systems oversight
- making government institutions safe
- justice and support for victim-survivors.[109]

Table 1.6: Summary of documents that informed the hearings

Topic	Education	Out of home care	Health	Ashley Youth Detention Centre	Access to justice	The future	Other	Total
Requests for statement or information issued	13	7	51	67	12	0	3	**140***
Notices to produce material issued	3	0	13	4	2	0	8	**31**
Questions on notice	2	3	7	5	1	3	6	**27**
Orders made	7	6	2	4	1	1	0	**21**
Material produced	N/A	N/A	N/A	N/A	N/A	N/A	N/A	**95,000+ documents**

* Because requests for statement or information were issued to people under more than one category, the total value is less than the sum. The total also excludes those requests that did not progress for various reasons.

Commissioned research

In 2021, after a targeted tender process, we commissioned research from Associate Professor Tim Moore and Emeritus Professor Morag McArthur, initially via the Australian Centre for Child Protection, University of South Australia. The research project later moved to the Institute of Child Protection Studies at the Australian Catholic University in line with academic convention when Associate Professor Moore changed institutions. The purpose of this research was to hear directly from Tasmanian children and young people about their experiences and perspectives relevant to their safety in institutions.

The research involved speaking with 59 Tasmanian children and young people between the ages of 10 and 20 who had a variety of experiences with Tasmanian institutions in our areas of interest. In line with our key focus areas, participants were invited to reflect on their experiences in government schools, out of home care, hospitals or in Ashley Youth Detention Centre.

The researchers engaged children and young people in discussions about their experiences and feelings of safety in government institutions, their ability to raise safety concerns, and their awareness of high-risk and harmful adult and peer behaviours.

The report of this research, titled *Take notice, believe us and act! Exploring the safety of children and young people in government run organisations*, was provided to us in October 2022. The key findings of this report included:

- Most children and young people felt safe most of the time in institutions, but those who had experienced youth detention or been in out of home care were more likely to share experiences of violence, abuse and victimisation in institutions.[110]
- Access to trusted adults was important to make children and young people feel safe, recognising the role they can play in protecting them and advocating for them.[111]
- Children and young people reported feeling safer when they felt respected, valued and cared for, and they appreciated when adults involved them in decision making and listened to their concerns and ideas.[112]

The research report concluded that for institutions to be (and to feel) safer for children and young people, they needed to:

- embed child safety as a shared responsibility and ensure children and young people feel empowered and supported to share their safety concerns and engage meaningfully with the adults caring for them[113]
- have clear strategies to improve safety that are understood and visible for children and young people, including information about what to do if they are hurt or harmed[114]
- recognise that the past maltreatment of children and young people will heighten their risk of further abuse, requiring institutions to recognise and understand the impacts of trauma and to work with other agencies to minimise risks to children, and ensure they receive any therapeutic support they may need.[115]

Our Commission of Inquiry, along with two young people with experiences in Tasmanian Government institutions, launched the research report and an animation of a report summary designed for children and young people in February 2023.

More specific findings from this research (particularly how it relates to our focus institutions) are described throughout this report.

3.3.9 Public hearings

The primary purpose of holding public hearings was to explore ways in which the Department of Education, the Department of Health (particularly Launceston General Hospital), Ashley Youth Detention Centre and the out of home care system have dealt with the risk and occurrences of child sexual abuse in their institutions. We also dedicated a few hearing days to considering system-wide issues such as oversight of institutions, the statewide response to child sexual abuse, state disciplinary processes and the justice response to child sexual abuse.

In hearings that focused on specific institutions, we examined and evaluated the effectiveness of past and current Tasmanian systems, laws, policies and practices relevant to preventing and responding to child sexual abuse in that institutional context. Where appropriate, these hearings were informed by the accounts of victim-survivors or specific case studies that illustrated the themes we had observed. At these hearings, we also discussed how children might be better protected from sexual abuse in that institutional context, and how the Tasmanian Government might better address and alleviate the impact of past and future child sexual abuse.[116]

We held public hearings over 37 days between October 2021 and September 2022. Hearings took place in three venues: in Hobart at the Mövenpick Hotel and the Tasmanian Civil and Administrative Tribunal, and in Launceston at the Country Club Tasmania. The tribunal kindly provided its facilities free of charge.

Members of the public and the media were generally welcome to attend hearings in person or to watch our livestream. We usually provided public access to records of our proceedings. Daily hearing lists, transcripts, some witness statements and orders were published on our website and were also available in a range of accessible formats on request.

We were committed to being open and transparent, respecting the preferences of victim-survivors, and considering the effect that evidence from these hearings may have on other investigations, legal proceedings and the wider community. At times, our Commission of Inquiry made restricted publication orders to limit the publication of information that may identify victim-survivors, abusers or other people who may have been referred to during the hearings. Our Inquiry made those orders when we were satisfied that the public interest in the reporting on the identities of certain people was outweighed by legal and privacy considerations. We redacted (or did not publish) information in transcripts and witness statements in line with the restricted publication orders. These orders were published on our website and made available outside the hearing room and to media.

We recognised that, in some circumstances, it was important to protect the identity of a witness by allowing them to give their evidence using a pseudonym. In these circumstances, Counsel Assisting read from the witness's statement or their evidence

was not livestreamed. Members of the public could be present to hear that evidence in the hearing room. In addition, we have used pseudonyms to refer to abusers, as required by law, throughout our Inquiry and in this report.[117]

We also received evidence in a closed hearing where we considered it necessary, including to avoid prejudicing current investigations or proceedings. In that circumstance, only certain people could be present in the hearing room. Transcripts of closed hearings were not published on our website.

We conducted hearings in line with our COVID-19 Vaccination Policy and the Public Health Act. We engaged specialist consultants to provide counselling support to witnesses and attendees.

The hearings process

We identified witnesses for public hearings from our stakeholder consultations, sessions with a Commissioner, public submissions and through other research activities. Individuals and organisations were generally issued with a notice to appear or to prepare a witness statement. Interested parties who wanted to give evidence could apply for leave from their workplace to appear at a public hearing. Witnesses were offered help to prepare for a hearing and counselling support.

Counsel Assisting our Commission of Inquiry, supported by our Legal and Policy and Research teams, led the hearings. Counsel Assisting, in consultation with the Legal and Policy and Research teams, determined the topics of hearings and questioned witnesses, subject to President Neave's direction.

Counsel Assisting's general approach to examining witnesses was informed by the victim-survivors and their families and supporters who had been in contact with our Commission of Inquiry. Counsel Assisting aimed to ensure these voices were heard and that the need for systemic change was considered in light of their experiences.[118]

Witnesses gave evidence orally or by written statement or both, and did so under oath or affirmation.

People granted leave to appear could also ask for leave, through their legal representative, to examine or cross-examine a witness, at the discretion of the President. Leave to cross-examine a witness was requested and granted once during our hearings.[119]

The role of Commissioners at public hearings was to listen and learn, and to assess the evidence. This evidence, along with all other evidence that we have received during our Inquiry, has informed our recommendations to the Tasmanian Government.

Hearings schedule

Our first public hearing was held in Hobart on 26 October 2021. Due to the ongoing impact of the COVID-19 pandemic, President Neave attended this hearing remotely. At this hearing, President Neave gave an overview of our Inquiry's progress and next steps. Counsel Assisting summarised the themes and lines of inquiry that had emerged from our work to date.

The next public hearing was held on 2 May 2022. Hearings then continued over the next four months. Each set of hearings had a particular focus, as outlined in Table 1.7.

Table 1.7: Public hearings

Date	Area of focus	Location
26 October 2021	Overview	Hobart
2–6 May 2022	Week 1: Common themes	Hobart
9–13 May 2022	Week 2: Education	Hobart
14–17 June 2022	Week 3: Out of home care	Hobart
27 June–1 July 2022	Week 4: Health	Launceston
4–8 July 2022	Week 5: Health / Criminal justice	Launceston
18–19 August 2022	Week 6: Ashley Youth Detention Centre	Hobart
22–26 August 2022	Week 7: Ashley Youth Detention Centre	Hobart
7 September 2022	Week 8: Ashley Youth Detention Centre	Hobart
8–9 September 2022	Week 8: Health	Hobart
12–13 September 2022	Week 9: Moving forward	Hobart

Who we heard from

We heard from 165 witnesses at public hearings. Most hearings began with evidence from people who had been directly or indirectly affected by child sexual abuse in the institutional settings under review. We heard from victim-survivors and their families and supporters, and from people who have advocated for reform.

We also heard from witnesses who held government and agency roles, including the:

- Secretary of the Department of Premier and Cabinet
- Secretary of the Department of Justice
- Secretary of the Department of Education
- Secretary of the Department of Communities
- Secretary of the Department of Health
- Commissioner of Police

- Director of Public Prosecutions
- Solicitor-General
- Registrar of the Registration to Work with Vulnerable People Scheme
- Registrar of the Teachers Registration Board
- Child Advocate
- Commissioner for Children and Young People
- Ombudsman (who is also the Health Complaints Commissioner and Custodial Inspector)
- Chief Executive Officer of the Integrity Commission.

We also heard from several Deputy Secretaries and managers of government departments, as well as academics, professionals and other experts working in the field of child safety in Tasmania and from other jurisdictions.

Throughout this report, we refer to current Secretaries and staff of relevant government departments by name. These Secretaries are responsible—and therefore accountable—for the Tasmanian Government's current responses to child sexual abuse in institutions. We have chosen not to name most past Secretaries and departmental staff because our recommendations are based on current systems, policies and practice.

Table 1.8 provides a summary of our public hearings across our areas of focus.

Table 1.8: Summary of hearings

Topic	Education	Out of home care	Health	Ashley Youth Detention Centre	Access to justice	The future	Other	Total
Number of hearing days	5	4	9	8	3	2	6	**37** (including opening hearing)
Pages of transcripts	552	503	970	1,054	316	173	137	**3,705**
Witnesses called	21	27	36	36	13	10	31	**165** (some called multiple times)
Witnesses not called but who gave sworn statements	2	5	17	29	0	0	1	**51** (some also appeared in other weeks)*
Documents to support Counsel Assisting and parties appearing during hearings	504	529	1,772	1,497	171	72	254	**4,779**

* Some witnesses gave sworn statements for a hearing topic and then gave oral evidence on a different hearing topic.

What we learned

The public hearings brought much new information to light. They helped us to better understand the systemic and cultural issues relevant to our terms of reference that were unique to Tasmania and had not been addressed by the National Royal Commission. They also allowed us to closely examine the conduct of individuals and institutions in relation to specific reports of child sexual abuse, particularly in education, out of home care, health services and youth detention.

We heard that past and present Tasmanian governments have collectively failed to adequately prioritise the safety of children or the wellbeing of victim-survivors. Prominent among the themes to emerge from the evidence was the need for achievable reform that could be implemented in simple steps.[120]

Public hearings also offered another opportunity for victim-survivors to speak about their experiences, and for the community, including our Commission of Inquiry, to bear witness. We thank victim-survivors for coming forward and sharing their hopes that tangible, meaningful change will result from our work.

We are aware that thousands of people across Tasmania and Australia followed the progress of our hearings, and we thank the community for its interest. We believe there is a greater community awareness of the prevalence and impact of child sexual abuse in government institutions because of our hearings.

3.3.10 Roundtable discussions and briefings

Targeted discussions with senior staff from government agencies and statutory authorities were another source of evidence that informed our Inquiry. These discussions enabled us to better understand aspects of the system and proposals for reform.

On 25 October 2022, we held a roundtable discussion in Hobart with representatives of the Department of Justice, the Director of Public Prosecutions, Tasmania Legal Aid, the Law Society and the University of Tasmania. The topic of this discussion was the Justice Miscellaneous (Royal Commission Amendments) Bill 2022. The Bill introduces legislative amendments in response to the recommendations of the National Royal Commission.[121] The purpose of this discussion was to understand the Tasmanian Government's reform intentions and progress relevant to child sexual abuse.

On 16 November and 5 December 2022, we received briefings from representatives of the Department of Justice on the Bill that became the *Child and Youth Safe Organisations Act 2023*. The Act establishes the Child and Youth Safe Organisations Framework in response to recommendations of the National Royal Commission. The Act also sets out new child safe standards and a reportable conduct scheme.[122]

On 9 December 2022, President Neave and Commissioner Benjamin held a roundtable discussion in Melbourne with representatives of Victoria Police. The topic of this discussion was child sexual abuse specialisation in police services. The purpose of the discussion was to understand how a police service in another jurisdiction responds to child sexual abuse in government institutions, with a view to comparing this model with the current response of Tasmania Police.

On Thursday 29 June 2023, we met with the co-chairs of the Child Safe Governance Review, Adjunct Professors Karen Crawshaw PSM and Debora Picone AO, to receive an update on the implementation of their recommendations by the Department of Health and Launceston General Hospital. The Child Safe Governance Review was established by the Department of Health in July 2022 in response to evidence that emerged from our public hearings in relation to responses to child sexual abuse at Launceston General Hospital.[123]

On Tuesday 4 July 2023, we met with Timothy Bullard, Secretary of the Department for Education, Children and Young People. The purpose of this meeting was to discuss ways to improve responses to allegations of child sexual abuse and harmful sexual behaviours within the Department and across the State Service.

On Wednesday 5 July 2023, we held a roundtable discussion with Jenny Gale, Secretary of the Department of Premier and Cabinet and Head of the State Service, along with representatives from the State Service Management Office. The topic of this discussion was ways to reform the State's disciplinary processes, including the *State Service Act 2000*, the State Service Code of Conduct, and Employment Directions.

4 The structure of this report

This report reflects the evidence we received through all our methods of inquiry. We make findings about the conduct of individuals and the systemic problems we identified. We also outline our recommendations for the future, to help prevent child sexual abuse in Tasmanian Government institutions, and to improve responses when it does occur.

Our report has eight volumes:

- Volume 1 provides a summary of our report and our recommendations.
- Volume 2 (this volume) outlines the establishment, scope and conduct of our Inquiry, the international, national and Tasmanian context of our Inquiry, and our understanding of child sexual abuse in an institutional context.

- Volumes 3–6 outline our findings and recommendations for the specific institutional contexts we were directed, or chose, to inquire into, namely schools (Volume 3), out of home care (Volume 4), youth detention (Volume 5) and health services (Volume 6). These volumes differ in their structure, style and approach, which reflects the nature and extent of the evidence we received and the nature of the response of the relevant organisations (and departments) to that evidence.
- Volume 7 provides our findings and recommendations for the criminal and civil justice systems.
- Our final volume, Volume 8, outlines our recommendations for system-wide reforms, including to support the Government to implement our recommendations and to monitor this implementation.

All material referred to in our report is current at 10 February 2023, unless otherwise specified.

5 Conclusion

Since our establishment in March 2021, we have undertaken extensive work to inform our Inquiry into systemic problems in the Tasmanian Government's response to child sexual abuse in its institutions. We have been informed by submissions, sessions with Commissioners, consultations, engagement with Aboriginal communities, site visits, research, hearings and roundtables, as well as an enormous number of government documents.

Hearing from victim-survivors, their families and supporters has been particularly important to us, and we thank all those who shared their experiences.

All aspects of our Inquiry have informed the views and recommendations in this report. We trust we have done the task justice.

Notes

1 Peter Gutwein, 'Premier's Statement – Commission of Inquiry' (Media Release, 23 November 2020) <https://www.premier.tas.gov.au/site_resources_2015/additional_releases/progress_on_the_new_burnie_ambulance_station/premiers_statement_-_commission_of_inquiry>; Loretta Lohberger, 'Class Action Prepared Against Tasmanian Government Alleging Abuse at Ashley Youth Detention Centre', *ABC News* (online, 28 July 2020) <https://www.abc.net.au/news/2020-07-28/class-action-amid-alleged-abuse-at-ashley-youth-detention-centre/12496558>; 'Episode One: Just Jim', *The Nurse* (Camille Bianchi, Transcript, undated) 73–74.

2 Emily Baker, 'What We Know about the Allegations Against Tasmanian Nurse James Griffin', *ABC News* (online, 8 December 2020) <https://www.abc.net.au/news/2020-12-08/nurse-james-geoffrey-griffin-what-we-know/12953076>.

3 *The Nurse* (Camille Bianchi, 2020) <https://open.spotify.com/show/2CG58YDV7p8vamvYq7WhgK>.

4 Angela Sdrinis Legal, 'The Ashley Youth Detention Centre (AYDC) Class Action', *AYDC Class Action* (Web Page, 2023) <https://www.angelasdrinislegal.com.au/aydc-class-action.html>. Refer to, for example, Amber Wilson, 'Former Rose Bay Science Teacher Jailed for Grooming and Molesting Year 9 Student Over Months', *The Mercury* (online, 29 October 2020) <https://www.themercury.com.au/truecrimeaustralia/police-courts/former-rose-bay-science-teacher-jailed-for-grooming-and-molesting-year-9-student-over-months/news-story/c5b8f5f876e3a80bb560e62624c93699>; Nina Funnell, 'Serial Paedophile James (Jim) Geoffrey Griffin Worked with Sick children in a Tasmanian Hospital', *The Mercury* (online, 13 October 2020) <https://www.themercury.com.au/truecrimeaustralia/police-courts/serial-paedophile-james-jim-geoffrey-griffin-worked-with-sick-children-in-a-tasmanian-hospital/news-story/75b06f07cdf097c140540e9c410e70ba>; Amber Wilson, 'Ashley Youth Detention Centre Abuse Alleged Over Decades', *The Mercury* (online, 29 July 2020) <https://www.themercury.com.au/truecrimeaustralia/police-courts/ashley-youth-detention-centre-abuse-alleged-over-decades/news-story/51525cdb89721476a4b1b4821d2c5f1f>; Emily Baker, 'Rape Accusations Against Three Government Departments – What Comes Next?', *ABC News* (online, 20 November 2020) <https://www.abc.net.au/news/2020-11-20/no-commission-of-inquiry-after-child-rape-allegations/12901386>.

5 Refer to, for example, April McLennan and Edith Bevin, 'Survivors of Child Sexual Abuse Taking Education Department to Court For Negligence', *ABC News* (online, 6 May 2020) <https://www.abc.net.au/news/2020-05-06/education-department-sued-over-sexual-abuse-allegations/12220836>; Amber Wilson, 'Sex Abuse Survivor Takes Govt to Court After Months of Delays', *The Mercury* (online, 4 March 2020) <https://www.themercury.com.au/truecrimeaustralia/police-courts/sex-abuse-survivor-takes-govt-to-court-after-months-of-delays/news-story/770ad2687c11cb6b51b71a54186eaa66>.

6 Katrina Munting quoted in Loretta Lohberger, 'Former Rose Bay High Student Katrina Munting, Sexually Abused by Teacher Marcus Pollard, Speaks Out', *ABC News* (online, 11 November 2020) <https://www.abc.net.au/news/2020-11-11/sexual-abuse-survivor-tells-her-story/12867770>.

7 Peter Gutwein, 'Premier's Statement – Commission of Inquiry' (Media Release, 23 November 2020) <https://www.premier.tas.gov.au/site_resources_2015/additional_releases/progress_on_the_new_burnie_ambulance_station/premiers_statement_-_commission_of_inquiry>.

8 Transcript of Camille Bianchi, 5 May 2022, 445 [4–5].

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34 *Royal Commission into Institutional Responses to Child Sexual Abuse* (Final Report, December 2017) vol 12, 115.

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36 Non-government schools were not within scope because they are predominantly funded by the Australian Government.

37 Order of the Governor of Tasmania made under the *Commissions of Inquiry Act 1995*, 15 March 2021, 4 (refer to Appendix A).

38 If, during our Inquiry, we identify potential contraventions of the law, we have the power to refer these matters to appropriate authorities: *Commissions of Inquiry Act 1995* s 34A.

39 *Commissions of Inquiry Act 1995* s 18(1).

40 Transcript of Michael Salter, 2 May 2022, 71 [40–42].

41 In 1990, a royal commission was established to investigate an attempt to bribe a member of the Tasmanian Parliament to cross the floor of the House of Assembly in Tasmania following the 1989 election. The royal commission, known as the Carter Commission, was established under the *Evidence Act 1910*. In 1995, the Commissions of Inquiry Act was passed. In 2000, the Commission of Inquiry into the Death of Joseph Gilewicz was established. It was the first Commission of Inquiry conducted since the Commissions of Inquiry Act commenced. Our Commission of Inquiry is the second.

42 *Commissions of Inquiry Act 1995* s 22.

43 *Commissions of Inquiry Act 1995* s 24.

44 *Commissions of Inquiry Act 1995* ss 24A, 24B.

45 *Commissions of Inquiry Act 1995* ss 5, 13, 19A, 25.

46 *Commissions of Inquiry Act 1995* s 26.

47 Peter Gutwein, 'Premier's Statement – Commission of Inquiry' (Media Release, 23 November 2020), <https://www.premier.tas.gov.au/site_resources_2015/additional_releases/progress_on_the_new_burnie_ambulance_station/premiers_statement_-_commission_of_inquiry>.

48 *Commissions of Inquiry Act 1995* s 10. Section 10(3) of the Act provides that 'The Governor may omit a part of the report before it is tabled in Parliament if satisfied that the public interest in the disclosure of the matters set out in that part of the report is significantly outweighed by any other consideration, including public security, privacy of personal or financial affairs or the right of any person to a fair trial'.

49 The Act amended the *Commissions of Inquiry Act 1995*, the *Children, Young Persons and their Families Act 1997*, the *Youth Justice Act 1997* and the *Public Interest Disclosures Act 2002*.

50 Parts 2 and 6 commenced upon receiving the Royal Assent on 22 April 2021: *Justice Miscellaneous (Commissions of Inquiry) Act 2021* s 2.

51 *Justice Miscellaneous (Commissions of Inquiry) Act 2021*.

52 *Commissions of Inquiry Act 1995* s 33(3).

53 *Commissions of Inquiry Act 1995* s 33(1).

54 *Commissions of Inquiry Act 1995* s 33(2).

55 *Commissions of Inquiry Act 1995* s 21.

56 *Commissions of Inquiry Act 1995* ss 8(5), 19B(2).

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58 'Abuse offences' include: sexual offences, homicide, grievous bodily harm, assault, various offences endangering life and health, rape, abduction, stalking and bullying. This requirement also applies to attempts to commit these offences: *Criminal Code Act 1924* s 105A(1).

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60 *Children, Young Persons and Their Families Act 1997* s 13.

61 *Children, Young Persons and Their Families Act 1997* s 13(2).

62 *Commissions of Inquiry Act 1995* s 19(2A).

63 *Commissions of Inquiry Act 1995* s 19(2B).

64 *Commissions of Inquiry Act 1995* s 18.

65 *Commissions of Inquiry Act 1995* s 3.

66 *Commissions of Inquiry Act 1995* s 18(6).

67 *Commissions of Inquiry Act 1995* s 18(2), subject to subsection (2A).

68 *Commissions of Inquiry Act 1995* s 18(1).

69 *Commissions of Inquiry Act 1995* s 18(3).

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73 But refer to *Royal Commissions Act 1991* (ACT) s 35A; *Inquiries Act 2014* (Vic) s 36. These provisions concern procedural requirements where adverse comments or findings are proposed to be made. Refer generally to *Royal Commissions Act 1902* (Cth); *Royal Commissions Act 1923* (NSW); *Inquiries Act 1945* (NT); *Commission of Inquiry Act 1950* (Qld); *Royal Commissions Act 1917* (SA); *Royal Commissions Act 1968* (WA).

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104 Tim Moore and Morag McArthur, *Take notice, believe us and act! Exploring the safety of children and young people in government run organisations* (Research Report prepared for the Commission of Inquiry into the Tasmanian Government's Responses to Child Sexual Abuse in Institutional Settings, February 2023) 30.

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123 Jeremy Rockliff and Kathrine Morgan-Wicks, 'Child Safe Governance Review of the Launceston General Hospital and Human Resources' (Media Release, 3 July 2022) <https://www.premier.tas.gov.au/site_resources_2015/additional_releases/child_safe_governance_review_of_the_launceston_general_hospital_and_human_resources>.

2 The Tasmanian, national and international contexts

1 Introduction

Globally, community awareness and understanding of the scale and impact of child sexual abuse in institutional settings has increased significantly over the past 10 to 20 years. Major national and international inquiries put these issues in the spotlight, describing the experiences of victim-survivors, their families and their advocates.

In Australia, the Royal Commission into Institutional Responses to Child Sexual Abuse ('National Royal Commission') ran from 2013 to 2017. The National Royal Commission raised awareness of the experiences of victim-survivors, whose abuse spanned decades and occurred in multiple government and non-government institutions.

In this chapter, we describe the context in which our Commission of Inquiry was established in Tasmania, nationally and internationally. We briefly outline:

- Australia's international obligations in relation to children and international inquiries into institutional child sexual abuse
- the work of the National Royal Commission and the approaches to implementing its recommendations across Australia
- key national offices, strategies and frameworks relevant to child sexual abuse in institutional contexts
- civil litigation and redress schemes

- reports and inquiries relevant to child sexual abuse in Tasmania over the past 30 years
- key frameworks, strategies and plans that form the current policy context in Tasmania
- the current system for responding to child sexual abuse in Tasmania
- our Commission of Inquiry's observations about Tasmania's culture and history in shaping the concerns about child sexual abuse in Government institutions and institutional responses to these concerns.

2 International context

2.1 International obligations and inquiries

Australia has ratified several international treaties, protocols and declarations relevant to safeguarding the rights of children and promoting their best interests. The Tasmanian Government is not a direct party to these international instruments, and their provisions do not automatically apply in Australian domestic law. However, the human rights protections contained in them should underpin any policy response to child sexual abuse in institutional contexts in Australia.

2.1.1 Convention on the Rights of the Child

In 1990, Australia ratified the *Convention on the Rights of the Child*.[1] All children in Australia, including Tasmania, should enjoy the rights contained in the Convention. Its four guiding principles are:

- respect for the best interests of the child as a primary consideration
- the right to survival and development
- the right of all children to express their views freely on all matters affecting them
- the right of all children to enjoy all the rights of the Convention without discrimination of any kind.[2]

Articles 19 and 34 of the Convention are particularly relevant to child sexual abuse. These provisions collectively provide children with the right to be protected from all forms of violence and harm, including sexual abuse in institutions.

Australia is also a party to the *Optional Protocol to the Convention on the Rights of the Child on the Sale of Children, Child Prostitution and Child Pornography*.[3]

2.1.2 Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment

Australia is also a party to the *Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*.[4] The United Nations (UN) Committee against Torture monitors parties' compliance with that Convention.

In 2017, the Australian Government ratified the *Optional Protocol to the Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment* ('OPCAT').[5] The OPCAT establishes a preventive system of regular visits to 'places of detention' to protect incarcerated people against torture and other cruel, inhuman or degrading treatment or punishment. The Australian Government has indicated this would include youth justice facilities but not residential secure facilities.[6]

Parties to the OPCAT must set up independent national bodies for preventing torture and ill-treatment, which are called national preventive mechanisms.[7] The OPCAT also established the UN Subcommittee on Prevention to monitor conditions in detention and to advise on OPCAT implementation.[8]

The Australian Government is implementing a nationwide model, with preventive mechanisms nominated for the Commonwealth and each state and territory.[9] In 2021, the Tasmanian Parliament enacted the *OPCAT Implementation Act 2021* to establish Tasmania's national preventive mechanisms and to enable the UN Subcommittee on Prevention to exercise its mandate in Tasmania. Richard Connock, who exercises additional oversight roles including as the Ombudsman and Custodial Inspector, was announced as the Tasmanian National Preventive Mechanism in February 2022.[10]

In its December 2022 concluding observations on Australia's sixth periodic report, the UN Subcommittee noted that the practice of keeping children in solitary confinement at Ashley Youth Detention Centre contravened the Convention and the United Nations Standard Minimum Rules for the Treatment of Prisoners (the 'Nelson Mandela Rules').[11] The UN Committee stated in relation to youth justice in Australia generally that it was seriously concerned by:

- the low age of criminal responsibility
- the over-representation of Aboriginal children and children with disabilities in the youth justice system
- reports of abuse, racist remarks and use of restraint
- the high number of children in detention
- the lack of segregation between children and adults in detention
- children's lack of awareness of their rights and how to report abuses.[12]

2.1.3 Other relevant instruments

Australia is a party to the *Convention on the Rights of Persons with Disabilities* and the *International Convention on the Elimination of All Forms of Racial Discrimination*.[13] Australia also supports the *United Nations Declaration on the Rights of Indigenous Peoples*, although this is a non-binding instrument.[14] These instruments apply to adults and children.[15] There are no specific provisions in these instruments in relation to sexual abuse.[16] However, Australia's ratification of the two Conventions and its support for the Declaration signals the need to consider the specific vulnerabilities of children with disability, children from culturally and linguistically diverse backgrounds and Aboriginal children.

In addition to these instruments, Australia is a party to the *Hague Convention on Jurisdiction, Applicable Law, Recognition, Enforcement and Co-operation in Respect of Parental Responsibility and Measures for the Protection of Children*, which entered into force in Australia in August 2003 and provides for international cooperation in recognising child protection measures.[17] Australia is also a party to the *1980 Hague Child Abduction Convention*, which also now applies to Australian domestic family law.[18]

2.1.4 International inquiries

Since 1999, there have been extensive inquiries into institutional child sexual abuse conducted in Canada, Ireland, New Zealand, the United Kingdom (with separate inquiries in England and Wales, Northern Ireland, Scotland and Jersey) and the United States.[19] The period under review in these inquiries extends from 1922 to 2018.[20]

These inquiries reported on common themes of physical, sexual and emotional abuse as well as:

- neglect, fear and other factors that prevented children from reporting
- a reluctance among adults, including employees, to report abuse to authorities
- awareness of abuse and known abusers in communities
- a lack of appropriate procedures to prevent and respond to abuse
- where procedures did exist, poor or inconsistent implementation.

3 National context

3.1 Royal Commission into Institutional Responses to Child Sexual Abuse

In November 2012, the Australian Government announced the National Royal Commission.[21] During its inquiry, the National Royal Commission published several interim and topic-specific reports, concluding with its final report in December 2017.[22] Its findings and recommendations applied to the Commonwealth, state and territory governments, and non-government organisations. As previously noted, our Commission of Inquiry builds on, but does not repeat, the work of the National Royal Commission.

As part of its five-year inquiry, the National Royal Commission examined responses to child sexual abuse in Australian public, private, community and religious institutions. It considered in detail child sexual abuse that occurred in those institutions over many decades and the inadequacy of the responses to this abuse.

The National Royal Commission made 409 recommendations aimed at making institutions safer for children, preventing child sexual abuse, improving identification and responses, and providing redress and better supports for victim-survivors. Those recommendations were informed by submissions from and consultations with members of the Tasmanian community including two Tasmanian case studies and 188 private sessions in Tasmania.[23]

The Commonwealth, state and territory governments, together with parts of the non-government sector, are responsible for implementing the recommendations of the National Royal Commission. In their formal responses to the recommendations, each jurisdiction identified which recommendations they were responsible for implementing and those that would be implemented by the Commonwealth Government, other states and territories or non-government institutions. There is considerable variation between the reponses of the states and territories in terms of the level of detail and the action taken in response to specific recommendations.[24]

There is also some variation and uncertainty in the allocation of responsibility for implementation. For example, the Tasmanian Government initially noted that responsibility for recommendations to assess children displaying harmful sexual behaviours and to adequately fund therapeutic responses was ‘to be determined’.[25] However, the Tasmanian Government’s 2022 progress report and action plan noted it had engaged the Sexual Assault Support Service to deliver a statewide therapeutic program for children and young people displaying problematic and harmful sexual behaviours, which began in April 2021.[26] This engagement implemented a commitment under *Safe Homes, Families and Communities: Tasmania’s Action Plan for Family and Sexual Violence 2019–2022*.[27]

More importantly, from its progress report in 2020 onwards, the Government began referring to its action plans for family violence as also including 'sexual violence' and fulfilling many of the National Royal Commission's recommendations.[28] Our concerns about this approach—combining the response to family violence with institutional child sexual abuse—are discussed in Chapter 19.

The Tasmanian Government established a response unit now referred to as the Child Abuse Royal Commission Response Unit ('Royal Commission Response Unit'), in the Department of Justice to lead implementation of the National Royal Commission recommendations.[29] Among other things, the Royal Commission Response Unit coordinates annual reporting requirements in relation to the Tasmanian Government's implementation of the recommendations and the Government's response to relevant National Redress claims.

At the time our Commission of Inquiry began, some National Royal Commission recommendations had been implemented or were in progress, such as reforms to the criminal justice system. However, other key recommendations—such as establishing a reportable conduct scheme and child safe organisations—had not been implemented. As part of our Commission of Inquiry, we considered why there had been little progress and coordination of the Tasmanian Government's response to some recommendations. In some instances, we found a lack of clarity or sense of ownership or responsibility for implementation. We also noted delays and uneven implementation. For example, consultation on the first draft of the Child and Youth Safe Organisations Bill began in December 2020, three years after the National Royal Commission delivered its final report; however, a final version of the Bill was not introduced to Parliament until November 2022 (refer to Chapter 18 for more about the Child and Youth Safe Standards).[30]

3.2 Key national offices, strategies and frameworks

Over the past decade, various national reforms have been introduced to better protect children in institutional contexts and to provide redress for victim-survivors. Many of these strategies and activities implement National Royal Commission recommendations. The following section briefly outlines key offices, strategies and frameworks that promote child safety.

3.2.1 Key agencies and offices

At the national level, the following agencies and offices contribute to promoting child safety, particularly in relation to child sexual abuse:

- National Children's Commissioner—established in 2012, the role sits within the Australian Human Rights Commission.[31] The National Children's Commissioner developed the *National Principles for Child Safe Organisations*.

- Commonwealth Government, National Office for Child Safety—established in 2018, the office leads the development and implementation of several national priorities recommended by the National Royal Commission.[32] These priorities include the *National Strategy to Prevent and Respond to Child Sexual Abuse*, the *National Principles for Child Safe Organisations* and the *Commonwealth Child Safe Framework*. The office is also responsible for improving information-sharing arrangements to strengthen child safety and wellbeing. It receives annual progress reports from non-government institutions on implementing the National Royal Commission recommendations.
- National Centre for Action on Child Sexual Abuse—currently funded by the Australian Government, the centre is a not-for-profit joint venture between the Blue Knot Foundation, The Healing Foundation and the Australian Childhood Foundation. It was established following the National Royal Commission and aims to 'increase understanding of child sexual abuse, promote effective ways for protecting children, guide best practice responses and pathways to healing for survivors and reduce the harm it causes'.[33]
- The Department of Social Services—the Department has responsibility for *Safe and Supported: the National Framework for Protecting Australia's Children 2021–23* and the *National Plan to End Violence against Women and Children 2022–32,* and for administering the National Redress Scheme that compensates victim-survivors of child abuse.[34]

3.2.2 Key strategies and frameworks

The agencies and offices outlined above contributed to various national strategies and frameworks and oversee their implementation. These strategies and frameworks include:

- *National Strategy to Prevent and Respond to Child Sexual Abuse 2021–30*—recommended by the National Royal Commission and overseen by the National Office for Child Safety, the National Strategy was developed by the Australian Government in partnership with state and territory governments. It aims to establish a 'nationally coordinated and consistent way to prevent and better respond to child sexual abuse in all settings'.[35] It is implemented through action plans. The first two action plans run for four years from 2021 to 2024.[36]
- *Safe and Supported: the National Framework for Protecting Australia's Children 2021–2031*—developed by the Commonwealth, state and territory governments, together with Aboriginal representatives and the non-government sector, this national framework supports the right of children and young people to grow up 'safe, connected and supported in their family, community and culture', with the goal of making significant and sustained progress in reducing the rate of

child abuse and neglect and its intergenerational impacts.[37] The framework also embeds the priority reforms in the *National Agreement on Closing the Gap*. It is implemented through two sets of action plans.

- *National Principles for Child Safe Organisations*—the former Council of Australian Governments endorsed the National Principles for Child Safe Organisations in February 2019 to align with and support the child safe standards recommended by the National Royal Commission.[38] The National Principles are designed to 'build capacity and deliver child safety and wellbeing in organisations, families and communities and prevent future harm'.[39]
- *Commonwealth Child Safe Framework*—developed in 2019 in response to recommendations of the National Royal Commission, the framework 'sets minimum standards for Commonwealth entities to create and maintain behaviours and practices that are safe for children'.[40]
- *National Plan to End Violence Against Women and Children 2022–2032*—developed and endorsed by Commonwealth, state and territory ministers with responsibility for women's safety, the plan builds on the previous *National Plan to Reduce Violence Against Women and their Children 2010–2022*. It commits to ending violence against women and children in one generation.[41]

4 Tasmanian context

4.1 Past Tasmanian inquiries and reports

Over the past 30 years, numerous inquiries and reports initiated by the Tasmanian Government and independent agencies have reviewed the treatment of children in institutional contexts in Tasmania.

Since 1989, at least 14 Tasmanian reports or inquiries have considered issues relevant to child sexual abuse in institutional settings.[42] Together, they made almost 600 recommendations for reform. Most of these reports considered system-wide concerns in the context of child protection, while a small number focused on a particular issue such as child sexual abuse. Only two reports, in 1989 and 1998, specifically explored child sexual abuse in institutional settings in detail.[43]

The various reports and inquiries identified recurring themes including:

- a strong desire from agencies and organisations that work with or care for children to keep children safe
- an overwhelmed child protection system that has struggled for many years, if not decades

- a poor workplace culture in Tasmania's child safety system
- unclear and incomplete policies, procedures and guidelines for working with children who have been sexually abused
- deficiencies in information documentation, management and sharing, particularly in relation to decision-making processes concerning children at risk of abuse or neglect
- a lack of training and support for those who work with children who are victim-survivors of abuse, including sexual abuse
- a lack of suitable out of home care placements for children who are victim-survivors of sexual abuse or have engaged in harmful sexual behaviours against other children
- a lack of training and support for carers who look after children who are victim-survivors of sexual abuse or who have engaged in harmful sexual behaviours against other children
- a lack of early intervention in cases involving child sexual abuse, as well as poor availability of specific services for children
- the need for legislative reforms to modernise offences relating to child sexual abuse and improve court processes for children who experience sexual abuse
- resistance to calls for a commission of inquiry into child protection and other related areas.

Past reports repeatedly highlight that the systems in place to protect children from abuse and neglect, including child sexual abuse, do not perform as intended. The reports also highlight that recommendations have not always been implemented in a timely manner, are under-resourced, or, when implemented, are not subject to appropriate monitoring and oversight to ensure the intended outcomes are achieved.

In addition to these 14 inquiries and reports, since 2005 there have been at least eight reports concerning the Tasmanian health system, 18 reports concerning out of home care and 12 reports concerning Ashley Youth Detention Centre.[44] Between them, these reports have made more than 500 recommendations for reform. Most of these reports do not consider the issue of child sexual abuse in detail. However, they concern factors that can influence the culture and safety in these institutional environments, which have the potential to increase the risk of child sexual abuse occurring or not being identified. These factors also shape organisational responses to incidents and allegations of child sexual abuse.

Most recently, the Independent Inquiry into the Tasmanian Department of Education's Responses to Child Sexual Abuse, completed in June 2021, made 20 recommendations about changes to governance and leadership, policies and procedures, training and professional development.[45] The independent review into the health system and investigation of staff at Ashley Youth Detention Centre announced in late 2020 ceased when our Commission of Inquiry started.[46] Relevant reports and inquiries are discussed in more detail in the chapters on these institutions (refer to Volumes 3–6).

Despite these past reports, which have collectively made more than 1,000 recommendations, the increasing concerns about child sexual abuse in institutional contexts suggest there is a pattern of poor implementation of recommended reforms and a need for stronger intervention to adequately protect children.

4.2 Tasmanian Claims of Abuse in State Care Program

Tasmania's Claims of Abuse in State Care Program was announced in 2003 and was accessible to anyone who had been abused in state care in Tasmania.[47] It had tri-partisan support and was designed to 'acknowledge the past failures of the Out of Home Care system and to help those who had been abused in State Government care'.[48] The program offered ex gratia payments of up to $60,000 to claimants, although this was reduced to $35,000 in the program's fourth and final round from 2011 to 2013.[49] Between 2004 and 2013:

- 2,414 claimants applied, of whom 1,848 were assessed as eligible
- $54.8 million dollars in payments were made.[50]

Although each of the program's four rounds produced reports, the third report was not made publicly available and we were not able to access a copy. In addition, there is no overall analysis of the data showing how many claims of child sexual abuse were made in relation to different types of care. Excluding the 995 claimants from the third round for whom data are not available, 510 people made claims of sexual abuse in state care.[51]

Under the scheme, claimants could discuss the effect of the abuse they experienced. They identified a range of physical, psychological and social impacts including:

- ongoing health conditions, mental health issues and trauma
- low sense of self-esteem and self-worth
- difficulties with parenting
- misuse of alcohol and drugs.[52]

Claimants were also offered counselling sessions and the opportunity to receive legal advice.[53]

At the conclusion of the Claims of Abuse in State Care Program, the Abuse in State Care Support Service was established to help people who had not applied for redress under the program.[54] This service is still in operation, although it only offers minimal support. We discuss this scheme in more detail in Volume 5 and Chapter 17.

4.3 Tasmanian policy context

As outlined above, the Tasmanian Government has committed to various national frameworks and strategies and to the National Redress Scheme. It has also enacted civil and criminal justice reforms to implement key National Royal Commission recommendations. Separate to these reforms, the Government has developed state-level frameworks and strategies. This section provides an overview of key frameworks, strategies and plans, which are examined in detail in Chapter 19.

Tasmania has also had a Commissioner for Children and Young People since 2000. The Commissioner's role is considered further in Chapter 18.

To better protect children and respond to incidents of child sexual abuse in institutional contexts, the National Royal Commission recommended that all state and territory governments enact child safe standards and a reportable conduct scheme.[55] The Tasmanian Government's efforts to enact these standards and scheme are discussed in more detail in Chapter 18.

4.3.1 *Survivors at the Centre*

In November 2022, the Tasmanian Government released its third whole of government plan to prevent and respond to family and sexual violence: *Survivors at the Centre: Tasmania's Third Family and Sexual Violence Action Plan 2022–2027*.[56]

Survivors at the Centre, and previous action plans, address family and sexual violence in a single overarching plan. While many of the 38 actions in Survivors at the Centre are relevant to children, particularly in the context of family violence, only two actions specifically concern sexual violence and abuse in relation to children and young people.[57] A further 10 actions are relevant to sexual assault services, which could include child sexual abuse, depending on how they are implemented.[58]

It is important to differentiate between the Government's response to family violence and its response to sexual violence, including child sexual abuse. Family violence can include familial child sexual abuse, but we are concerned that addressing child sexual abuse in the context of family violence does not adequately address abuse within schools, health care settings, out of home care and youth detention. These concerns are considered further in Chapter 19.

4.3.2 *Strong Families—Safe Kids*

In 2016, the Department of Health and Human Services released its report, *Redesign of Child Protection Services Tasmania: 'Strong Families—Safe Kids'*.[59] The report aimed to redesign child protection services to address 'entrenched culture, processes and structures of the current Child Protection Services' identified by the then Minister for Human Services, who further noted in a statement to Parliament that the child protection system 'faces potential collapse if comprehensive reform action is not taken'.[60] The scope of our Commission of Inquiry does not extend to all aspects of the child protection system, although some of the structures in that system are relevant to institutional child sexual abuse.

In response to the report, the Government, among other things, established the Strong Families, Safe Kids Advice and Referral Line ('Advice and Referral Line') as the first point of contact for anyone with a concern about child wellbeing and safety.[61] Concerns about child sexual abuse, including within institutional settings, are reported to the Advice and Referral Line in the first instance.

In June 2018, the Government also published the *Tasmanian Child and Youth Wellbeing Framework*, which aims to implement a common understanding across services and the community.[62] As part of this framework, the Government committed to developing a child and youth wellbeing strategy.[63] The new strategy, *It Takes a Tasmanian Village: Child and Youth Wellbeing Strategy*, was launched in August 2021.[64] The strategy includes a priority to support children and young people at risk. Within this priority, it commits to considering 'the development of a Tasmanian approach, including models of multidisciplinary practice, to address child sexual exploitation'.[65] Other than this commitment, the strategy does not specifically prioritise responses to child sexual abuse.

5 The Tasmanian community, culture and history

Any response to child sexual abuse in Tasmanian Government institutions needs to consider Tasmania's culture and demographics. Tasmania is an island state, with a small, regionally dispersed population. It comprises just over 2 per cent of the Australian population, with about 571,000 residents.[66] Founded as a penal colony for British convicts in the early 19th century, it has a history of relatively low social and economic mobility, high cultural homogeneity and, until the past decade, limited inward migration.

Tasmania's relatively small size, history and geographic isolation create a sense of separation from the rest of Australia. However, this sense is not unique. There are parallels with other island states and nations that have been subject to similar inquiries into child sexual abuse, such as Ireland and Jersey.[67] Like those jurisdictions, social connections in the Tasmanian community are frequently close and deep, established over generations.

These connections create a strong sense of community identity and can be a significant source of strength and resilience. However, they can also be a source of harm. For example, the Independent Jersey Care Inquiry heard frequent references to the 'Jersey Way', noting in its report:

> On some occasions it was used in a positive way, to describe a strong culture of community and voluntary involvement across the island, and this is something we recognise as a strength of the island … On most occasions, however, the 'Jersey Way' was used in a pejorative way, to describe a perceived system whereby serious issues are swept under the carpet and people escape being held to account for abuses perpetrated.[68]

Ultimately, the Independent Jersey Care Inquiry concluded that 'an inappropriate regard for the "Jersey Way" is likely to have inhibited the prompt development of policy and legislation concerning children'.[69]

This section provides a brief demographic profile of Tasmania, with a focus on children and discussion of various socioeconomic factors. It then considers elements of Tasmania's culture and history that have deterred victim-survivors, their families and others from reporting child sexual abuse in institutional contexts and have also contributed to poor responses to reports of abuse.

5.1 Demographics

5.1.1 Children in Tasmania: geography, cultural diversity and vulnerability

Children aged 19 or younger (the age brackets measured by the Australian Bureau of Statistics) make up 23.2 per cent of the Tasmanian population.[70] This is slightly lower than the 25 per cent of the overall Australian population.[71] While this Tasmanian cohort has a broad geographical distribution, most live in the Hobart region (54,904), followed by Launceston and the north-east (33,270), west and North West (25,801) and south-east (8,517).[72]

Tasmania has been relatively culturally homogeneous. In 2014, only 8.8 per cent of Tasmanian children and youth aged 12 to 24 years had culturally and linguistically diverse ancestry, compared with the national average of 25.1 per cent.[73] Cultural diversity is now changing.

Based on Australian Bureau of Statistics data as of 30 June 2021, Tasmania has a high proportion of children who identify as Aboriginal, at 11.4 per cent of children aged 19 years or younger, compared with 6.74 per cent nationally.[74] The proportion is the second highest in Australia after the Northern Territory.[75]

The proportion of children aged 14 years or younger with disability is higher in Tasmania at 10.2 per cent of the population of children, compared with the national average of 7.7 per cent.[76]

Tasmania has a relatively low number of children in contact with child protection services. In 2019–20, 2,234 Tasmanian children received child protection services.[77] This figure represents 19.8 per 1,000 children receiving services, compared with a national rate of 31.0 per 1,000 children.[78] We note that receiving child protection services is defined as one or more of the following occurring: being subject to an investigation of a notification, being on a care and protection order, or being in out of home care.[79] This definition does not include children assessed by child protection intake who are 'screened out'. The data for Tasmania further exclude children not under care and protection orders placed with relatives, for whom a financial contribution is made under the Supported Extended Family or Relatives Allowance programs.[80]

The number of children in youth detention in Tasmania is also low. In the 2019–20 financial year, the average daily number of young people in youth detention was 15.4.[81] While the number of children in detention is low, the rate of children in detention is relatively high. In the June quarter of 2020, the rate of children aged 10 to 17 in detention in Tasmania was 2.3 per 10,000 people, whereas South Australia, Victoria and New South Wales had rates of 1.8, 1.9 and 2.0 per 10,000 people respectively. The national average was 2.6 per 10,000 people.[82]

5.1.2 Socioeconomic profile

Tasmania has a higher proportion of people living in its most socioeconomically disadvantaged areas compared with the national average.[83] It is also marked by low sociogeographic mobility. According to Professor Richard Eccleston of the University of Tasmania:

> Research suggests that those residing in these socioeconomically disadvantaged areas are less mobile and unlikely to move around the State to seek employment or live in other communities … It is also common for families living in socioeconomically disadvantaged areas of Tasmania to have lived in the same community for generations. This creates a strong sense of connectedness in those communities which may also contribute to the lack of intrastate movement amongst these populations.[84]

Tasmania's relatively homogenous population has been maintained, until recently, by low inward migration.[85] However, since 2015, the trend has been reversed, with a net increase in migration from interstate and overseas.[86]

On several key economic metrics, Tasmania performs worse than the national average. For example, Tasmania has the lowest labour market participation rate, the lowest average weekly ordinary time–cash earnings and the highest underemployment rate in the country.[87]

It is generally accepted that, on average, Tasmanians also have poorer literacy rates and educational outcomes than other Australians.[88] A survey undertaken by the Australian Bureau of Statistics found that the literacy skills of Tasmanians aged 15–74 were consistently below the national average, as were numeracy skills, health literacy skills and problem-solving skills.[89] Educational outcomes for Tasmanians are similarly below the national average, as shown by poorer results in the National Assessment Program—Literacy and Numeracy.[90]

5.2 Culture

> What is it about Tasmania as a community that makes us reluctant to deal with this?[91]

During hearings, and through submissions and consultations, we heard about the unique culture and history of Tasmania. Witnesses and participants pointed to the connectedness of local communities as a source of support and resilience. However, many also pointed to a darker aspect of this connection that may deter people from speaking up about abuse, lead them to accept behaviour that should not be tolerated and result in inadequate institutional responses when incidents of abuse are reported. In an article for *The Conversation*, Rodney Croome, a Tasmanian social reform activist, described the contradictions at the centre of Tasmania's culture:

> Tasmania is both the abominable Fatal Shore and the felicitous Apple Isle, together at the same time. The fact that such a paradox can exist in the heart of a single people and place is not easy to grasp. But without at least attempting to grapple with Tasmania's contradictions, the island remains impossible to explain.[92]

When considering the influence of culture, we distinguish between culture in a 'societal' sense and organisational culture. We refer to Tasmanian societal culture as consisting of many intangible aspects of Tasmania's social life including 'shared, socially learned knowledge and patterns of behaviour'.[93] We use the term 'organisational culture' to refer to the values, ethics, attitudes, behaviours and traditions that influence the social and psychological environment of an institution or organisation.[94] However, it is also important to note that, while distinct, there is overlap between 'societal-level cultural influences' and 'organisational culture' because the factors that shape the latter are related to, or are situated within, the former.[95] This section considers how culture in the societal sense has influenced organisational and institutional responses to child sexual abuse in Tasmania.

As previously outlined, Tasmania is a small island community that for much of its history has been relatively remote and, to an extent, isolated from what many in the community refer to as 'the mainland'. Compared with more populous states such as Victoria and New South Wales, Tasmania is a more regionalised community, with families frequently living and working in the same area for generations. Up until the past decade, Tasmania has had low rates of inward migration. As stated by Tasmanian historian Professor Cassandra Pybus:

> Historically, Tasmania has had less multicultural immigration, and more outward migration, than other jurisdictions. Tasmania was an extremely monocultural place in the early 1980s and into the 21st century. As a result, until quite recently, there have been fewer opportunities for cultural change propelled by external influences.[96]

In consultations, sessions with a Commissioner and submissions, people frequently spoke of 'everyone knowing everyone' and of overlapping connections in their personal and professional lives.[97] This overlap is reflected in recent research that found a higher proportion of recruitment for jobs in Tasmania occurs through personal networks compared with other jurisdictions. As cited by Professor Eccleston, a report by the Tasmanian Policy Exchange found that:

> Tasmanian employers rely more heavily on informal networks for recruitment than any other state. Specifically, 32% of recruitment in Tasmania occurs without the job being advertised (the second highest being Northern Territory at 26%) and 38% of recruitment occurs via word of mouth (the second highest being Northern Territory at 24%).[98]

Government institutions are major employers in some local areas, creating a strong connection and economic reliance between the community and local institution. For example, as outlined in Chapter 10, Ashley Youth Detention Centre is a major employer in the area around Deloraine.

5.2.1 Support and resilience: the strengths of close connections

As noted above, we heard of the support and strength many Tasmanians derive from their close community connections. Referring to the socioeconomic measures outlined above, Professor Eccleston stated:

> We've got many strengths in the community which are not captured in those basic economic metrics, with a strong sense of connectedness, community identity and resilience that really comes from our history and I think the nature of our community.[99]

In a 2013 article for *The Conversation*, demographer Lisa Denny wrote:

> Tasmanians are resourceful and innovative people; they have to be, to continually adapt to the challenges presented by the makeup of our population, the diverse terrain and our isolation by virtue of our island status. It is thanks to this resourcefulness that Tasmania exists as it does today ...[100]

We also heard that Tasmania's relatively small size and closely connected communities can make institutions more agile in responding to issues, sharing information and implementing changes to policy and process (or at least they have the potential to do so). For example, in his evidence during the hearings, victim-survivor Samuel Leishman stated:

> We talk about Tasmania as being a small jurisdiction and a small island, and it's isolating and, you know, we don't have the resources and how difficult all of that is because of that and we have to look at other states and see what they're doing … and let's just do this piecemeal approach down here. I sometimes think, well, why do we look at it like that, why can't we look at Tasmania as being a small, isolated state and that's actually our advantage? We are small, we can set the standards and we can be the one that says, this is the benchmark that everyone else has to meet, and we can do that because we're small and because we're isolated. There's no reason why we can't do things better here than the rest of the country.[101]

5.2.2 Silencing, reprisals and denial: the harmful impact of close connections

While close personal and professional connections can be a source of strength, they can also lead to silencing and suppression of those who would otherwise speak out about abuse, retribution against those who do and acceptance of behaviour that should be questioned. They may also cause poor institutional responses to formal reports of abuse, extending in some instances to obfuscation and denial. In addition, there is the human tendency to disbelieve that a person one knows and likes could perpetrate child sexual abuse, which has prevented people seeing the obvious or believing those who speak up. *The Nurse* podcast reported one person expressing fear about raising concerns against the Tasmanian Government:

> I am so sorry I can't do this—I feel it would be a target on my back and I have seen too many others who speak out get victimised. I don't want to spend the rest of my life looking over my shoulder and I'm petrified for the impact this could have on my family. I would never know, if that contract doesn't get renewed, or that job application doesn't go through, if it's because I spoke out against the Tasmanian Government. I would never know if I've put my family at risk and that's the one thing more important than this.[102]

Over the course of our Commission of Inquiry, we heard of instances where fear of reprisal affecting people's personal and professional lives deterred them from making reports of child sexual abuse through official channels. In her statement, Professor Pybus described the link between Tasmania's small size and the reluctance to report and respond to abuse:

> A potential discloser of child sexual abuse is likely to know someone who is in some way connected with or implicated in the abuse. Everyone up and down the chain from the alleged perpetrator would be concerned about the implications of a report,

> and taking action on a report, in terms of negative press, employment prospects and so on. This can create a fear of reprisal and a reluctance to take … proper disciplinary action at the institutional level.[103]

One victim-survivor submitted she felt 'totally powerless against the system' and in making a complaint 'it certainly crosses my mind, that I am committing career suicide as many will "not believe", "view me differently", "treat me as other and a liar"'.[104]

Another victim-survivor, Rachel (a pseudonym), described the impact of living in the same small community as her alleged abuser following a public statement that purported to clear the alleged abuser of a breach of the *State Service Act 2000* ('State Service Act'): 'I wanted to hide. I ended up leaving that community. I didn't want to stay there, and even to today I'm so fearful of being in that community'.[105]

Participants at community consultations gave similar examples of professional repercussions for people who reported abuse or 'dobbed', such as not being given a promotion or being isolated at work. One participant said reminding someone that they owed their position to their connection with another person was a 'very Tasmanian activity', stating 'people were tapped—someone said to me "I own you"—everyone owes their jobs to other people'.[106] These comments align with the Tasmanian Policy Exchange's research previously outlined about the role of informal networks in recruitment.

Victim-survivors and others also worried they would not be believed if they reported the abuse, noting a tendency to believe and protect adults over children. In evidence to our Commission of Inquiry, journalist Emily Baker stated:

> I think in a small place like Tasmania there's a fear about personal repercussions, professional repercussions, what the broader community might think of them, that they won't be believed … that nothing will change.[107]

In sessions with a Commissioner, several people referred to the influence of employee unions in protecting members' interests when allegations of child sexual abuse are made against them, rather than the interests of the child.[108]

Others felt their concerns would be dismissed as an overreaction or misinterpretation of behaviours that in other circumstances would be considered grooming or red flags indicating a risk of abuse. As discussed in *The Nurse* podcast, comments on the behaviour of James Griffin in Launceston were dismissed as 'that's just Jim'.[109] In evidence, Professor Eccleston commented:

> In a very relatively tightly connected community, if you are aware of abuse, misconduct or other illegal activities, perhaps you might be in denial. You know, I know this person's families, forebears … so you may be less willing to disclose.[110]

Because of these pressures, witnesses and others reported feeling a lack of trust in official channels to make complaints. When journalist Camille Bianchi was asked during examination whether she was the first port of call for her sources, she responded: 'I think I was the last port of call … the perception was that there was no other outlet'.[111]

In discussing a systemic 'culture of silence and reprisal' across the State Service, whistleblower Alysha (a pseudonym) described her experience as a member of staff who raised concerns about the treatment of children at Ashley Youth Detention Centre.[112] She felt she had little choice but to go to the media:

> I never wanted to 'blow the whistle' or engage with the media. I could think of nothing worse then or now. It was out of sheer despair and having exhausted all 'typical' and 'more palatable' reporting avenues that I felt I needed to, as a matter of public interest and out of feelings of personal and professional obligation to ensure someone responded in an appropriate manner to what I have witnessed at the Centre. After having had a rewarding, successful life prior to the Centre, I deeply resent what I have been put through and the lengths that I have been required to take to be heard regarding these matters … the media can sometimes be the only effective avenue available to whistle-blowers in Tasmania—which signifies a significant gap in the system. No one should have to feel like they need to choose between public safety and their personal safety.
>
> …
>
> I have witnessed a culture and entrenched belief system that … protects staff accused of wrongdoing, and persecutes those that promote change, or who report misconduct.[113]

Close connections can also drive parochialism, which can create boundaries between communities. We heard about divisions and distinctions that contribute to forming community identity and a sense of loyalty. For example, we heard of the distinction between 'mainlanders' and Tasmanians, and between the north and south of Tasmania. Within these boundaries, distinctions continue to multiply to create smaller and smaller divisions.

These distinctions create a sense of protectiveness within a community that can manifest in a reluctance to criticise or be self-reflective or to publicly acknowledge and respond to problems. In commenting on the role of the local media, journalist Ms Baker noted that when working for the newspaper *The Examiner*:

> … the sense was, we're here to champion the north, we're here to talk up the north, we'll tell good stories about the north and I do think that's an important role that a local newspaper plays, you're part of the community's identity and you should be of course telling the good stories that come with that. Sometimes there are not good stories though …[114]

Journalists also reported being pressured not to report on allegations of abuse because they are 'private matters' that should not be aired in public.[115] Ms Bianchi referred to 'a sense of, "this isn't nice, this isn't productive, this isn't helpful"'.[116] More seriously, journalists referred to pressures from State Service employees suggesting that their reporting would directly harm children and others.[117] Ms Baker stated 'there have been several occasions when I've been told … that I'm going to cause someone to take their own life, my reporting will lead to that dreadful outcome … That is often used'.[118]

This tendency in Tasmanian culture to deny or suppress reports of misconduct affects an institution's responses to allegations of child sexual abuse. It can lead to an institutional culture of 'don't ask, don't tell', where people in hierarchies seek to protect themselves and those in senior positions from knowledge that is difficult to handle. In a government context, this 'don't ask, don't tell' culture may lead public servants to not brief ministers or departmental secretaries on matters of concern. Conversely, ministers and secretaries may benefit from not asking difficult questions.

In consultations, participants spoke of a cultural tendency towards covering up, conflicts of interest and a lack of transparency in responses to allegations of abuse.[119] In the context of limited staff availability in Tasmania, one participant spoke of raising concerns about another staff member and being told: 'Save your breath, we need the person'.[120] In his statement to our Commission of Inquiry, Professor Eccleston suggested a possible link between poor institutional responses and limited workforce mobility in the State Service:

> … longevity of employment within the [State Service] can be a double-edged sword. It results in an older and more stable workforce but is perhaps less dynamic and diverse, and implementing cultural change can be a slower process. Given the broader community dynamics in Tasmania, there is also a risk that obligations to colleagues might trump obligations to uphold high ethical standards in the workplace.[121]

Similarly, we heard evidence of requests for information from government agencies being met with delays and refusals. Ms Bianchi described lengthy processes when seeking documents from the Department of Health under the *Right to Information Act 2009*, which involved referral to the Ombudsman for review.[122] The process to obtain the requested documents took approximately 22 months.[123]

The Ombudsman's *Annual Report 2021–22* states that it was concerning that 95 per cent of the external reviews of Right to Information requests conducted in 2021–22 'identified issues with the manner in which the public authority had responded to a request for assessed disclosure'.[124] While some progress had been made compared with previous years, the Ombudsman wrote:

> The express object of the [Right to Information] Act is clear in relation to its pro-disclosure focus, seeking to increase government accountability and acknowledging that the public has a right to the information held by public

> authorities who are acting on behalf of the people of Tasmania. Too often, sadly, adherence to this object is not evident in practice and a closed, and at times obstructive, approach is taken when responding to requests for assessed disclosure which come before my office.[125]

In 2020, the Ombudsman reported that for the year 2018–19, the rate at which Tasmanian Government institutions refused access to *any* information in response to Right to Information requests (30 per cent) was 7.5 times the rate of Australia's most open jurisdictions, Victoria and the Northern Territory (4 per cent).[126]

Commenting on institutional responses to claims of child sexual abuse and suppression of information, journalist David Killick suggested that: 'Keeping bad news—or any news—from reaching the public isn't some kind of aberration. It is the defining characteristic of this state's political culture'.[127]

5.2.3 The influence of history

Some people suggest that the fear of speaking out in Tasmania has its roots in Tasmania's history as a penal colony and the social structures and cultural norms that have been sustained on the island since that time. Mr Killick said:

> It is a relic of our convict past, this fear of speaking out. It is a straight line from 'Don't upset the overseer' to 'Don't trouble the Minister'.[128]

Professor Pybus said:

> The persistence of colonial societal features—a well-entrenched elite, mistrust of authority within portions of the population, and a pervasive sense of shame—provide some explanation for the occurrence of child sexual abuse in Tasmanian institutions being unreported and unaddressed. In this environment, the silencing of disclosures and conversations about sexual abuse has been normalised over many decades.[129]

Of course, other jurisdictions without a colonial past also experience a reluctance to disclose child sexual abuse—as evidenced by the many international inquiries into child sexual abuse. However, Tasmania's history provides a specific context for this reluctance in relation to our Commission of Inquiry.

Professor Pybus spoke of the division between the descendants of convicts and free settlers, which lasted longer than in other jurisdictions due to low inward migration. She noted that: 'even into the 20th century, there has been less intermarriage between people of the free settler and convict classes in Tasmania, compared to other states'.[130] These divisions are linked to the sense already described that 'everyone knows everyone', with family connections going back generations.

Professor Pybus connected Tasmania's history of brutal penal institutions, which controlled the convict classes and their children, with more recent abusive institutional environments for children. She asked: 'if you look at a place like Point Puer in the 19th century and a place like the Ashley Boys Home in the 20th century, you'd say, what is the difference between these two places? To what extent is the same licence for abuse going to be operating?'[131]

Our Commission of Inquiry's fundamental purpose is to effect genuine cultural change to better prevent and respond to child sexual abuse in institutional contexts. There is some evidence of a cultural shift in this regard. During the hearings, Professor Pybus noted recent changes in the Tasmanian community leading to cultural change. She stated: 'the demographics are changing dramatically and with it is coming a breakdown of the kind of traditional cultural relationships that have kept a sort of code of silence'.[132] She further commented:

> Tasmanian society is now much more cosmopolitan than it was even 15 years ago. It has become an attractive place for others to emigrate. Demographic change in Tasmania has been a key driver of a shift in cultural attitudes. In 2022, I think there is a huge openness in the community, and a greater desire to have difficult conversations and make recompense.[133]

Both Professor Pybus and Professor Eccleston identified that the Commission of Inquiry itself was playing a role in changing the Tasmanian culture of secrecy and staying silent by:

- allowing a process of 'truth-telling'
- acknowledging and raising awareness about the occurrence of child sexual abuse
- making it clear that child sexual abuse is unacceptable
- providing redress and support for victim-survivors
- establishing ways for addressing such abuse when it occurs.[134]

6 Current response to child sexual abuse in institutional contexts

It was difficult for our Commission of Inquiry to determine the current Tasmanian response to child sexual abuse in institutional contexts. We asked the Tasmanian Government to describe their child sexual abuse system but only received brief descriptions of different efforts by various agencies, without an overarching outline of the system.[135] The section below is our best attempt at providing an outline of the current Tasmanian response to child sexual abuse in an institutional context, including efforts for identifying, responding to and preventing child sexual abuse, and supports for victim-survivors. The Tasmanian child sexual abuse response system, as with all jurisdictions, crosses multiple agencies. Each element is discussed in more detail in subsequent chapters.

6.1 Prevention

The Tasmania Government is a party to the recently released *National Strategy to Prevent and Respond to Child Sexual Abuse 2021–30*. The National Strategy focuses on preventing child sexual abuse.[136] The Tasmanian Government has recently announced or implemented some initiatives with a connection to preventing child sexual abuse, including educational programs and resources.[137]

6.2 Individual agencies

Individual agencies within the Tasmanian Government are responsible for preventing, identifying, reporting and responding to child sexual abuse within their organisation. Agencies achieve this by ensuring their organisations are child safe, as recommended by the National Royal Commission and articulated in the National Principles for Child Safe Organisations. This is currently a voluntary process. The National Principles for Child Safe Organisations are:

1. Child safety and wellbeing is embedded in organisational leadership, governance and culture.
2. Children and young people are informed about their rights, participate in decisions affecting them and are taken seriously.
3. Families and communities are informed and involved in promoting child safety and wellbeing.
4. Equity is upheld and diverse needs respected in policy and practice.
5. People working with children and young people are suitable and supported to reflect child safety and wellbeing values in practice.
6. Processes to respond to complaints and concerns are child focused.

7. Staff and volunteers are equipped with the knowledge, skills and awareness to keep children and young people safe through ongoing education and training.
8. Physical and online environments promote safety and wellbeing while minimising the opportunity for children and young people to be harmed.
9. Implementation of the national child safe principles is regularly reviewed and improved.
10. Policies and procedures document how the organisation is safe for children and young people.[138]

A legislative framework that includes a plan for implementing the National Principles for Child Safe Organisations has been underway since 2020, with the Child and Youth Safe Organisations Bill 2022 introduced into the Parliament of Tasmania in November 2022 and passed into law on 13 June 2023. Under the *Child and Youth Safe Organisations Act 2023* ('Child and Youth Safe Organisations Act'), government departments that provide services specifically for children (such as schools) or provide facilities specifically for use by children who are under their supervision (such as out of home care or youth detention) must comply with a set of 10 Child and Youth Safe Standards.[139]

Among other important standards, Standard 6 of the Child and Youth Safe Organisations Act provides that organisations must have child-focused processes to respond to complaints of child sexual abuse. In the National Principles for Child Safe Organisations, this includes processes for making notifications to relevant bodies and disciplinary processes.[140] Staff or organisations may have mandatory or voluntary reporting obligations in relation to child sexual abuse under the *Children, Young Persons and Their Families Act 1997* ('Children, Young Persons and Their Families Act') (to Child Safety Services), the *Criminal Code Act 1924* ('Criminal Code Act') (to police), the Registration to Work with Vulnerable People Scheme, the National Disability Insurance Scheme (to the scheme's Quality and Safeguards Commission) and professional registration frameworks (such as to the regulatory bodies for teachers or health practitioners).[141]

Tasmanian Government organisations' disciplinary processes in response to staff alleged to have committed child sexual abuse or related conduct are governed by the *State Service Employment Framework*. This framework is shaped by:

- the State Service Act, which outlines the rights and responsibilities of state servants and Heads of Agencies (that is, secretaries of departments)
- the State Service Code of Conduct contained within section 9 of the State Service Act, which outlines the expected conduct of public servants
- Employment Directions issued by the minister administering the State Service Act, which outline how Heads of Agencies can respond when they are concerned about the conduct or performance of state servants.[142]

6.3 Agencies responding to abuse

6.3.1 Child Safety Service

Section 13 of the Children, Young Persons and Their Families Act states that an adult who knows, or believes or suspects on reasonable grounds, that a child is suffering, or is likely to suffer, abuse or neglect, has a responsibility to take steps to prevent it from occurring.[143] One step an adult may take is to inform Child Safety Services of their knowledge, belief or suspicion.[144] In addition, under section 14 of the Act, members of certain professions are mandatory reporters. If, in carrying out official duties or during their work (paid or voluntary), a mandatory reporter believes or suspects on reasonable grounds, or knows, that a child has been or is being abused or neglected, they must inform Child Safety Services.[145]

The role of Child Safety Services is to protect children and young people who are at risk of abuse or neglect, including sexual abuse.[146] The Advice and Referral Line is the first point of contact for anyone with concerns about the safety or wellbeing of a child.[147] Staff at the Advice and Referral Line assess reports and may refer callers to appropriate services or determine to take no further action.[148]

When a matter warrants a child safety assessment and response, the case is transferred to Child Safety Services.[149] If a child is at immediate risk of harm, staff will attend as soon as practicable and take responsibility for the care and protection of the child.[150] Where a child has been or is at risk of being sexually abused, or has displayed harmful sexual behaviours, child safety staff are guided by an internal procedure outlining the steps involved in receiving notifications, conducting an assessment, contacting police, arranging a medical examination and completing follow-up actions and referrals.[151]

In some cases, a child who has experienced institutional child sexual abuse may have a protective parent and not need a child safety response, or the reported risk may be about a potential risk to unidentified children. Factors such as these may affect whether a response from Child Safety Services is required in a particular case. It may instead be referred to police.

The Department for Education, Children and Young People (formerly the Department of Communities) has an obligation under the *Registration to Work with Vulnerable People Act 2013* ('Registration to Work with Vulnerable People Act') to notify the Registrar if it becomes aware of, or suspects on reasonable grounds, that a person registered under the Act has engaged in 'reportable behaviour', which includes child sexual abuse and related conduct.[152]

Staff within the Department also have an obligation to report abuse to police as soon as practicable under section 105A of the Criminal Code Act.[153]

6.3.2 Police

A victim-survivor of child sexual abuse or their caregiver can report their abuse to police, as can others. In addition, under section 105A of the Criminal Code Act, it is an offence not to report a sexual offence against a child.

The Tasmania Police Victims Unit manages sexual assault, and the Serious and Organised Crime division manages child exploitation material. Police analyse reports and information about child sexual abuse to determine whether any offences have been committed.[154] Police have several reporting obligations to other agencies concerning child sexual abuse, including to Child Safety Services and the Registrar of the Registration to Work with Vulnerable People Scheme.[155] Under information-sharing frameworks, child sexual abuse may be investigated as part of a joint response by police and Child Safety Services. Tasmania Police is the lead agency in matters involving an alleged offence, and Child Safety Services are the lead agency in ongoing care and protection matters.[156]

6.3.3 Registration to Work with Vulnerable People Act

Under the Registration to Work with Vulnerable People Scheme, people carrying out certain activities must be registered to work with children, including people who work in schools, youth justice, out of home care and child health services.[157] The Scheme is one tool to protect children from people who may pose a risk to their safety.

There are specific obligations to report 'reportable behaviour' (behaviour that poses a risk of harm to vulnerable people, whether by reason of neglect, abuse or other conduct) by a person who is registered under the Registration to Work with Vulnerable People Act.[158] The Registrar may conduct an additional risk assessment on a registered person if there is new, relevant information about them.[159] This risk assessment may include requiring additional information from a registered person.[160] The Registrar may disclose information about the result of a risk assessment, registration and related information to another registration or licensing body.[161] Where a person has received a negative risk assessment or had their registration suspended or cancelled, this information may also be disclosed to 'prescribed entities' (currently government agencies and police) if the Registrar considers it appropriate to protect vulnerable people from harm.[162]

6.3.4 Professional registration bodies

Some professions, such as teachers and many health professionals, need to be registered to work in their professional roles. These registration schemes require a certain standard of conduct from those registered. This is to protect the safety of the community and the reputation of the profession.

In Tasmania, the Teachers Registration Board undertakes ongoing vetting processes to ensure people employed as teachers are of 'good character and fit to teach'.[163] *The Teachers Registration Act 2000* requires an employer to notify the Teachers Registration Board if it takes any disciplinary action or dismisses a teacher due to 'unacceptable behaviour' (behaviour that does not satisfy a standard of behaviour generally expected of a teacher, is otherwise disgraceful and improper, or shows the person is unfit to be a teacher).[164] Employers must also notify the Teachers Registration Board where the person has resigned or retired in circumstances that may have allowed the employer to consider any behaviour of the person to be unacceptable.[165] Registered teachers must also notify the Teachers Registration Board, in certain circumstances, when they are charged with a prescribed offence, as well as when they are found guilty of committing such an offence.[166] Following an inquiry into matters of concern, the Teachers Registration Board can suspend or cancel a teacher's registration.[167]

In the health sector, the Australian Health Practitioner Regulation Agency ('Ahpra') performs a similar role in ensuring that 'only health practitioners with the skills and qualifications to provide competent and ethical care are registered to practise'.[168] Ahpra is the national organisation responsible for implementing the National Registration and Accreditation Scheme in Australia.[169] It works with National Health Practitioner Boards across 15 health professions, from doctors and nurses to dentists and physiotherapists, and has its functions set out in the *Health Practitioner Regulation National Law Act 2009* (Qld).[170]

Registered health practitioners and employers must report 'notifiable conduct', which includes engaging in sexual misconduct in connection with the practice of the practitioner's profession.[171] Following consideration of a notification, a National Board may form the reasonable belief that a health practitioner has engaged in professional misconduct and refer a matter to the relevant state or territory tribunal for determination.[172] In Tasmania, this is the Tasmanian Civil and Administrative Tribunal. The Tribunal may impose conditions or disciplinary actions, including cancellation of registration.[173]

6.4 Oversight bodies

The Tasmanian Commissioner for Children and Young People notes there is 'currently no oversight mechanism which sets the overarching expectation or benchmark' for how government agencies should investigate child sexual abuse.[174] Several Tasmanian institutions or roles provide oversight mechanisms that may respond to complaints about child sexual abuse or about other institutions' responses to such complaints. These include the:

- Commissioner for Children and Young People
- Ombudsman

- Integrity Commission
- Auditor-General
- Health Complaints Commissioner
- Custodial Inspector
- Child Advocate.

The institution-specific volumes in this report discuss oversight bodies that relate to particular institutional contexts or groups of children. These bodies include the Child Advocate, the Custodial Inspector and the Health Complaints Commissioner (refer to Volumes 4, 5 and 6 respectively). There are also national bodies that may provide a degree of oversight, such as the National Disability Insurance Scheme's Quality and Safeguards Commission and the Australian Commission on Safety and Quality in Health Care.

6.4.1 Commissioner for Children and Young People

The Commissioner for Children and Young People is an independent statutory officer established under the *Commissioner for Children and Young People Act 2016* ('Commissioner for Children and Young People Act'). The Commissioner must act independently and impartially in the public interest when exercising functions and powers under the Act.[175]

While not charged with the primary response to reports of abuse, the Commissioner is regularly contacted by community members who have concerns about the wellbeing of children and young people.[176] When this occurs, the Commissioner's office provides information about referral options and, in some cases, may share concerns with a 'relevant authority' where this is lawful and appropriate.[177]

Under the Commissioner for Children and Young People Act, the Commissioner has various powers, including the ability to investigate and make recommendations in relation to systems, policies and practices of organisations (both government and non-government) that provide services affecting children and young people.[178] However, the Commissioner does not have the authority to investigate or review 'a specific decision made in respect of an individual case or specific circumstances' unless requested by the relevant minister.[179]

The Commissioner has specific oversight of some institutions where children are particularly vulnerable to sexual abuse, specifically out of home care and youth detention. The independent Out-of-Home Care Monitoring Program was established in 2018.[180] The program focuses on systemic issues in institutional and administrative

practices, as separate from complaint handling and individual advocacy.[181] It monitors out of home care service provision, visits out of home care providers, has discussions with advocacy organisations, peak bodies and key stakeholders, and engages with children and young people in out of home care.[182]

The Commissioner also undertakes independent oversight of children's rights and wellbeing in youth detention, together with the Ombudsman and Custodial Inspector.[183] The Commissioner has a statutory function to act as an advocate for a young person in youth detention under the *Youth Justice Act 1997* ('Youth Justice Act').[184] This includes assessing the physical and emotional wellbeing of the young person.[185]

The Commissioner's broader functions further contribute to the overall governmental response to child sexual abuse. For example, the Commissioner helps develop legislation and policy, including ensuring the State satisfies its national and international obligations in respect of children and young people generally.[186]

6.4.2 Ombudsman

The Ombudsman is an independent statutory officer appointed by the Governor under the *Ombudsman Act 1978* ('Ombudsman Act'). The Ombudsman investigates the administrative actions of public authorities to ensure they are lawful, reasonable and fair.[187]

The Ombudsman may receive complaints from people with concerns about the administrative actions of public authorities if complaints cannot be resolved directly with the authority.[188] This may include complaints about how child sexual abuse allegations and incidents are handled in institutional contexts.

Most complaints are resolved by way of preliminary inquiries, where public authorities provide information to address complaints and improve processes.[189] However, where appropriate, the Ombudsman may conduct an investigation on the basis of a complaint or on the Ombudsman's own motion.[190] Following an investigation, a report is prepared for the public authority that may contain recommendations to remedy actions.[191] The report may also be provided to the relevant minister and to Parliament.[192] Importantly, the Ombudsman does not have the power to compel a public authority to adopt recommendations, although these are 'ordinarily accepted and acted upon'.[193]

In addition, the Youth Justice Act gives a young person the right to complain to the Ombudsman about the standard of care, accommodation or treatment they receive while in a detention centre.[194] The Ombudsman Act also requires that organisations and agencies take all available steps to help a person detained in custody to make a complaint without delay.[195]

6.4.3 Integrity Commission

The Integrity Commission is an independent statutory authority established under the *Integrity Commission Act 2009* ('Integrity Commission Act'). Under the Act, the Integrity Commission has several functions and powers related to public officers, including:

- receiving and assessing complaints or information relating to matters involving misconduct
- investigating matters related to misconduct
- referring complaints to other appropriate parties for investigation and action.[196]

The Integrity Commission investigates allegations of serious misconduct in line with the investigative processes and powers set out in the Integrity Commission Act.[197] The Act defines 'serious misconduct' as 'misconduct by any public officer that could, if proved, be a crime or an offence of a serious nature, or misconduct providing reasonable grounds for terminating the public officer's appointment'.[198] Child sexual abuse in institutional contexts would likely be covered by this definition, as could some failures to adequately respond to such abuse.

Following an investigation, the Board of the Integrity Commission may dismiss a matter, refer it to a public authority for investigation (along with any recommendations), require the matter be further investigated, recommend the Premier establish a commission of inquiry or undertake an inquiry by the Integrity Tribunal.[199] After determining the outcome of an investigation, the Board of the Integrity Commission also considers whether a report should be tabled in Parliament.[200]

The Integrity Commission also has a responsibility to educate public officers and the public about integrity in public administration, as well as guiding public officers in the conduct and performance of their duties.[201] It encourages public authorities to notify the Integrity Commission when they receive misconduct allegations and undertake internal investigations. This assists the Integrity Commission to identify misconduct trends and risks, as well as the capacity of public authorities to manage allegations of misconduct.[202]

6.4.4 Auditor-General

The functions and powers of the Auditor-General are set out in the *Audit Act 2008*.[203] The Auditor-General is supported in this role by the Tasmanian Audit Office.[204] As an independent statutory officer appointed by the Governor, the Auditor-General is not subject to the direction or control of the Parliament or Government.[205] The purpose of the Auditor-General and the Tasmanian Audit Office is to 'provide independent assurance to the Tasmanian Parliament and the community on the performance and accountability of the Tasmanian Public Sector'.[206]

This is primarily achieved through financial, performance and compliance audits as well as investigations of state entities, the outcomes of which are reported to Parliament.[207] Notably for our Commission of Inquiry, the Auditor-General could inquire into systemic matters relevant to preventing and responding to child sexual abuse.[208]

6.5 Support

There are two main sexual assault services in Tasmania: the Sexual Assault Support Service (in southern Tasmania) and Laurel House (in northern Tasmania). Both services provide immediate and longer-term support for victim-survivors of sexual abuse.[209] Victim-survivors can also get support through the Government's 24-hour crisis line, 1800 MY SUPPORT, which offers immediate support and information concerning sexual abuse.[210]

Victim-survivors may access therapeutic support, particularly longer-term support, via other pathways. These include Victims of Crime, the National Redress Scheme, mainstream counselling or mental health services and national online or telephone sexual support services.

The Tasmanian Government is currently piloting two multidisciplinary centres ('Arch' centres) that will co-locate sexual assault support services with other specialised services for victim-survivors of sexual violence.[211]

6.6 Justice and redress

Victim-survivors can seek formal redress or justice for their abuse through different avenues. They can seek justice through civil compensation claims or the criminal justice system, or they can seek redress via the National Redress Scheme. The criminal and civil justice options place what could be seen as higher demands on the victim-survivor, including the need to provide a statement under oath and provide the alleged abuser with natural justice. The National Redress Scheme allows victim-survivors to seek recognition and justice from the institution in which their abuse occurred, without the need to interact with the person who abused them.

6.6.1 Civil claims

In 2020, the Tasmanian Government introduced significant changes to civil compensation claims for child sexual abuse in response to National Royal Commission recommendations. Amendments to Tasmania's *Limitation Act 1974* and *Civil Liability Act 2002* included removing limitation periods for personal injury proceedings concerning victim-survivors of child abuse, enabling courts to set aside a previously settled right of action in relation to child abuse and expanding organisations' duty to prevent child abuse and vicarious liability.[212]

A victim-survivor may seek civil compensation from the person who abused them or from the institution that may be held legally responsible for the conduct of the abuser, such as by being their employer. In the context of institutional abuse, this means that victim-survivors may initiate civil claims against the State of Tasmania. Claims may be settled out of court or, if contested, the victim-survivor must satisfy a court on the balance of probabilities that their abuse occurred and caused them harm. If satisfied, the court will determine damages.

Recent changes making it easier for the State to be held liable for the actions of employees have resulted in an increase in civil claims against the State. In August 2022, lawyers lodged a class action on behalf of more than 100 claimants seeking compensation from the State of Tasmania, with four lead plaintiffs alleging systemic negligence in the management of Ashley Youth Detention Centre from 1961 to at least December 2019.[213]

6.6.2 Criminal claims

Victim-survivors can also seek justice through the criminal justice system by making a report to police and hoping their abuser is charged, prosecuted by the Office of the Director of Public Prosecutions and convicted by a court. In this scenario, the abuse must satisfy the elements of a child sexual assault offence and be proven beyond reasonable doubt.

There are currently no criminal offences related to institutional responsibility for child sexual abuse, although the Government is proposing to introduce a failure-to-report offence.

6.6.3 National Redress Scheme

The Australian Government set up the National Redress Scheme in July 2018.[214] It enables victim-survivors of institutional child sexual abuse to seek financial compensation of up to $150,000, counselling and a direct personal response from the responsible institution.[215]

The scheme's purpose is to:

- acknowledge that many children were sexually abused in Australian institutions
- recognise the suffering they endured because of this abuse
- hold institutions accountable for this abuse
- help victim-survivors gain access to counselling, a direct personal response from the institution and a redress payment.[216]

The National Redress Scheme is scheduled to run for 10 years and is only available to people abused prior to 1 July 2018, although we express some concerns about this in Chapter 17. The Tasmanian Government joined the National Redress Scheme and enacted legislation to enable non-government institutions to join in 2018.[217] By April 2022:

- 689 claims had been made against Tasmanian Government agencies
- 494 of these claimants were offered redress
- 48 claims were not approved
- a further 147 claims were yet to be determined at the national level.[218]

7 Reforms made during our Commission of Inquiry

The Tasmanian Government and its institutions have responded to problems revealed by our Commission of Inquiry in our public hearings and engagement work. In May 2022, the Government announced a package of *Keeping Children Safer* actions as an interim response to evidence from victim-survivors, state representatives and experts at our first public hearing.[219] During our Commission of Inquiry, the Government continued to make reforms or commitments to reforms.

The Tasmanian Government provided Parliament with an update on their *Keeping Children Safer* actions in November 2022. All 30 actions in this response are reproduced in Appendix D. The Department for Education, Children and Young People also provided an update to our Commission of Inquiry on 9 February 2023.[220] In summary, the Government has already:

- established the Office of Safeguarding Children and Young People in the Department for Education, Children and Young People and drafted the Safeguarding Framework
- appointed a Safeguarding Lead in every government school and established a statewide Safeguarding Network
- appointed extra senior support staff in education as well as two Student Support Response Coordinators who will be responsible for managing responses to incidents of child sexual abuse and harmful sexual behaviours
- rolled out annual, compulsory training on mandatory reporting for all staff in child-facing departments
- commissioned a project designed to improve the safety of children in out of home care

- undertaken the Child Safe Governance Review at Launceston General Hospital
- outlined a plan for Ashley Youth Detention Centre and the youth justice system in the *Keeping Kids Safe: A Plan for Ashley Youth Detention Centre Until its Intended Closure* and the *Draft Youth Justice Blueprint 2022–2032*
- consulted on proposed legislation to introduce a new crime of failing to protect a child or a young person from people in authority, and other changes to the criminal law
- consulted on proposed legislation to introduce child safe standards, a reportable conduct scheme and a framework to ensure compliance (now the *Child and Youth Safe Organisations Act 2023)*
- established the Statewide Complaints Oversight Unit to handle future complaints about misconduct across Tasmanian health services, including child sexual abuse
- issued an apology to victim-survivors in Parliament.

The Government has also committed to:

- measures directed at supporting the rights of victim-survivors such as:
    - improving the Right to Information process
    - reviewing civil litigation procedures to ensure a trauma-informed approach
    - establishing two pilot multidisciplinary centres ('Arch' centres) to offer a best-practice model of support and safety services to victim-survivors of sexual and family violence
- reforming youth justice including:
    - closing Ashley Youth Detention Centre and establishing new youth justice facilities
    - introducing a new service delivery model focused on early intervention, diversion and rehabilitation
    - raising the minimum age of detention from 10 to 14 years
    - preparing the *Draft Youth Justice First Action Plan 2023–2025*
- measures designed to improve Child Safety Services including:
    - establishing out of home care standards and accreditation, and a carers register
    - allocating funding to develop and procure a Wellbeing, Care and Recovery Placement Program (therapeutic residential placement program)

    - establishing a community-led palawa Child Safe and Supported Policy Partnership Working Group to improve outcomes for Aboriginal children and families at risk of entering or in contact with the child safety or out of home care system
    - measures to support a skilled and ready child safety workforce
- actions to safeguard children and support their wellbeing in schools including:
    - appointing a further eight psychologists and eight social workers
    - rolling out safeguarding training for principals and school leaders, and developing Registration to Work with Vulnerable People training
- actions aimed at State Service employees including:
    - expanding the scope of regulated activities under the Registration to Work with Vulnerable People legislation
    - establishing a central register of employees who have been terminated because of an Employment Direction No. 5—Breach of Code of Conduct
    - rolling out trauma-informed training across the State Service
- other actions such as:
    - designing a multimedia resource (*tell someone*) for children, young people and families to raise awareness of child sexual abuse
    - establishing information-sharing groups with other jurisdictions and engaging with representative bodies concerned with the safety and wellbeing of children and young people
    - establishing a whole of government Commission of Inquiry response unit
    - developing a website to publicly report progress on implementation of the interim response actions and expected delivery dates.[221]

The Government indicated that most of the proposed actions were underway. We discuss these recent and proposed reforms, where relevant, in subsequent chapters.

The Government said it will continue to publicly report on these actions via a dedicated webpage, established in January 2023.[222] It will expand the list when it receives our recommendations in August 2023. We understand that the Tasmanian Government has already set up a Commission of Inquiry response unit within the Department of Justice, to coordinate the implementation of our recommendations.

Other reforms the Government has undertaken in response to issues our Commission of Inquiry and other inquiries have identified include:

- bringing services related to children under the responsibility of one new agency —the Department for Education, Children and Young People
- establishing the Keeping Children Safer Working Group, reporting to the Secretaries Board
- implementing the recommendations of the Independent Inquiry into the Tasmanian Department of Education's Responses to Child Sexual Abuse, including establishing the Office of Safeguarding Children and Young People.

In December 2022, the Commissioner for Children and Young People announced an investigation into case management for children and young people in out of home care, focusing on the allocation of Child Safety Officers.

Notes

1 *Convention on the Rights of the Child*, opened for signature 20 November 1989, 1577 UNTS 3 (entered into force 2 September 1990).

2 *Convention on the Rights of the Child*, opened for signature 20 November 1989, 1577 UNTS 3 (entered into force 2 September 1990) parts 2(1), 3(1), 6(2) and 12(1).

3 *Optional Protocol to the Convention on the Rights of the Child on the Sale of Children, Child Prostitution and Child Pornography*, opened for signature 25 May 2000, A/RES/54/263 (entered into force 18 January 2002).

4 *Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*, opened for signature 10 December 1984, 1465 UNTS 85 (entered into force 26 June 1987).

5 *Optional Protocol to the Convention Against Torture and Other Cruel, Inhuman and Degrading Treatment or Punishment*, open for signature 18 December 2002, A/RES/57/199 (entered into force 22 June 2006).

6 Commonwealth Ombudsman, *Implementation of the Optional Protocol to the Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT) Baseline Assessment of Australia's Readiness* (Report Number 3, September 2019).

7 *Optional Protocol to the Convention Against Torture and Other Cruel, Inhuman and Degrading Treatment or Punishment*, open for signature 18 December 2002, A/RES/57/199 (entered into force 22 June 2006) parts 17–23.

8 *Optional Protocol to the Convention Against Torture and Other Cruel, Inhuman and Degrading Treatment or Punishment*, open for signature 18 December 2002, A/RES/57/199 (entered into force 22 June 2006) parts 2, 5–16.

9 Commonwealth Ombudsman, *Monitoring places of detention – OPCAT* (Web Page, 2023) <https://www.ombudsman.gov.au/industry-and-agency-oversight/monitoring-places-of-detention-opcat>.

10 Elise Archer, 'Appointment of the Tasmanian National Preventive Mechanism' (Media Release, 7 February 2022) <https://www.premier.tas.gov.au/site_resources_2015/additional_releases/appointment_of_the_tasmanian_national_preventive_mechanism>.

11 UN General Assembly, *United Nations Standard Minimum Rules for the Treatment of Prisoners (the Nelson Mandela Rules),* GA Res 70/175, UN Doc A/RES/70/175 (8 January 2016, adopted 15 December 2015).

12 Committee against Torture, *Concluding Observations on the Sixth Periodic Report of Australia, 75th sess, UN Doc* CAT/C/AUS/CO/6 (5 December 2022) 11.

13 *Convention on the Rights of Persons with Disabilities*, opened for signature 30 March 2007, 2515 UNTS 3 (entered into force 3 May 2008); *International Convention on the Elimination of All Forms of Racial Discrimination*, opened for signature 21 December 1965, 660 UNTS 195 (entered into force 4 January 1969).

14 *United Nations Declaration on the Rights of Indigenous People*, GA Res 61/295, UN Doc A/RES/61/295 (2 October 2007, adopted 13 September 2007).

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3 Child sexual abuse in institutions

1 Introduction

This chapter sets out what our Commission of Inquiry learned about child sexual abuse in institutional contexts. Understanding the nature, causes and effects of child sexual abuse helped us consider institutional failures and our recommendations to better prevent child sexual abuse in the future and respond appropriately to victim-survivors.

Our work was greatly informed by the Royal Commission into Institutional Responses to Child Sexual Abuse ('National Royal Commission') that ran from January 2013 to December 2017. The National Royal Commission drew on thousands of personal stories, hundreds of written accounts, dozens of hearings and an extensive program of research.[1]

Although the National Royal Commission provided an important foundation for our Commission of Inquiry, our task was to examine the Tasmanian context. To this end, we commissioned our own research and sought and received evidence from many sources about child sexual abuse in Tasmanian Government schools, hospitals, out of home care settings and the Ashley Youth Detention Centre.

We have no reason to believe that the nature, causes and effects of child sexual abuse in Tasmania differ substantially from the national experience, but there may be aspects of the Tasmanian context that require special consideration:

> Tasmania is a small community. People are closely connected through school, work, marriage, partnership or friendship circles. That context of close connection intensifies the concern about reporting and about making allegations against people. This presents difficulties for those individuals on whom we rely to … [raise] concerns and [remain] vigilant about matters of child safety.[2]

Tasmania's small population may also have implications for the availability of financial, human and other resources to address the risk of child sexual abuse.

We consider the specific Tasmanian context in more detail in Chapter 2 and throughout this report. In this chapter, we:

- briefly describe the different forms of child sexual abuse
- examine the factors that increase the risk of child sexual abuse occurring in an institutional context or compromise the ability or willingness of an institution to respond when it does occur
- describe the effects of child sexual abuse in institutional contexts on victim-survivors, their family members, communities and the broader society.

2 What is child sexual abuse?

As discussed in Chapter 1, our Commission of Inquiry has defined child sexual abuse as:

> Any act which exposes a child to, or involves a child in, sexual processes beyond his or her understanding or contrary to accepted community standards. Sexually abusive behaviours can include the [touching] of genitals, masturbation, oral sex, vaginal or anal penetration by a penis, finger or any other object, [touching] of breasts, voyeurism, exhibitionism, and exposing the child to or involving the child in pornography. It includes child grooming, which refers to actions deliberately undertaken with the aim of befriending and establishing an emotional connection with a child, to lower the child's inhibitions in preparation for sexual activity with the child; and
>
> Any related matters.[3]

We acknowledge the dynamics of child sexual abuse and that it may or may not be coercive. Professor Ben Mathews, Research Professor, Queensland University Technology School of Law, states:

> Child sexual abuse can be inflicted by an adult, or by an older (and sometimes even a younger) child. It is inflicted in secret, and usually by an adult who is known to the child or a family member. It can be inflicted in circumstances where force or coercion is clearly apparent, but it can also be inflicted where such coercion is not as stark but where the victim is not developmentally capable of understanding the acts and/or where the child is in a position of physical, cognitive, emotional or psychological vulnerability such that consent is not freely given.[4]

This is recognised in the criminal law, which makes it clear that children below the age of 17 years in Tasmania cannot legally consent to sexual acts, except in very limited circumstances.[5]

2.1 Forms of child sexual abuse

The two most common forms of child sexual abuse reported by victim-survivors to the National Royal Commission were non-penetrative contact abuse and penetrative abuse.[6] Non-penetrative contact abuse includes sexual touching of a child's body or making a child touch the abuser's body. These behaviours are described with terms including 'molestation, indecent assault, [touching], sexual harassment and sexual assault'.[7] Penetrative child sexual abuse refers to 'the insertion of a penis, another body part or an object into the vagina (including labia and other genitalia), anus or mouth'.[8] It may also be described as rape, sexual intercourse with a child or sexual assault.[9]

Other forms of child sexual abuse identified through research, and that we heard more about over the course of our Inquiry, include:

- violation of children and young people's privacy, such as forcing a child to undress or watching them in a private space
- exposing children and young people to sexual acts and material
- child sexual exploitation (historically called child prostitution)
- production, consumption, dissemination and exchange of child sexual exploitation material (historically called pornography)
- forcing children to witness the sexual abuse of others.[10]

'Grooming' is a common strategy used by abusers to enable, facilitate and conceal their sexual abuse of a child or young person by acting to gain the trust of a child over time. Grooming can involve 'psychological manipulation that is subtle, prolonged, calculated, controlling and premeditated', with the ultimate purpose of making a child compliant with abuse.[11] Abusers commonly use grooming to support them to gain access to the child or young person, initiate and maintain the abuse of that person, and conceal the abuse from others.[12]

Grooming behaviours can be difficult to identify because they are not necessarily overtly sexual and can be consistent with non-exploitative and even positive social behaviours.[13] Grooming can be so effective that the child or young person believes they 'consented' to the sexual acts or even that they are in a 'relationship' with the abuser. Victim-survivors told us that at the time of their abuse they admired or even 'loved' their abuser.[14] Leah Sallese gave evidence to our Inquiry that for a long time she understood sexual abuse by her teacher as an 'affair'.[15]

Tiffany Skeggs told us that her abuser:

> … fully groomed me to believe that I loved him and I had to protect him, that was my job. If I didn't do that it would destroy his family, it would destroy me; he was very clear about the fact that I would lose the respect of everybody that ever knew me.[16]

Abusers may also direct grooming behaviours towards adults and other significant people in the child or young person's life. The purpose of grooming others is to establish trust and cooperation that can facilitate the abuser's access to the child and help the abuser avoid detection.

'Institutional grooming' refers to grooming children in an institutional context. It involves abusers exploiting the institutional environment to carry out the abuse and to evade detection.[17] Abusers also groom people who work with children in institutions.[18]

Not everyone who breaches a professional boundary does so with an intent to groom. However, professional boundary breaches are a key warning sign for the risk of child sexual abuse.[19] Abusers may also use professional boundary breaches to 'test' how resistant the organisational culture is to perpetration, with their boundary breaches becoming incrementally more serious with each breach they get away with.[20]

Previous research and inquiries into grooming and professional boundary breaches by child sexual abusers show that boundary breaches should be considered cumulatively. When multiple breaches are considered together, a pattern of behaviour consistent with grooming may be revealed. As separate incidents they can seem innocuous, and it can be easier for abusers to provide plausible excuses to explain the behaviour.[21]

2.2 Child sexual abusers

The National Royal Commission found there is no 'typical profile' of child sexual abusers. Child sexual abusers are diverse and cannot be easily identified based on factors such as age, gender, background or behaviours.[22] However, it also sought to identify and understand characteristics that were frequently noted among abusers in institutional contexts. For example, abusers were frequently described as 'charming, charismatic and popular' when in public.[23] Abusers who use the institution or organisation within which they work to abuse children commonly hold roles associated with positions of leadership, power and authority, such as roles in religious ministries or as teachers.[24] Abusers in institutional settings may use techniques such as 'coercion, favouritism, alienation, secrecy, and boundary violations' to 'groom' or 'entrap' children and young people.[25]

Most victim-survivors who gave evidence to the National Royal Commission reported that their abusers were male.[26] Evidence presented to our Inquiry reflected previous findings that adults who sexually abuse children in institutional settings are predominantly male.[27] We did, however, hear about some female abusers.[28]

The National Royal Commission noted that while most adult abusers are male, most men do not sexually abuse children.[29] However, there is clearly a relationship between gender and sexual abuse perpetration and victimisation. A 2023 Australian study found significant gender differences in victim-survivors of child sexual abuse: women reported 'substantially more childhood sexual abuse' than men.[30] In addition, people who identified as gender diverse were found to be more likely to experience all types of child maltreatment.[31]

The National Royal Commission further identified several 'risk factors' that may contribute to the likelihood of a person becoming a sexual abuser of children.[32] These risk factors include:

- adverse experiences in childhood (such as abuse and neglect)
- interpersonal, relationship and emotional difficulties
- distorted beliefs and thinking errors (such as deviant sexual interests or distorted attitudes about sex and/or children)
- indirect influences such as contextual or trigger factors.[33]

However, while such risk factors may appear at higher rates in child sexual abusers, they cannot be reliably used to determine the likelihood of abuse occurring: 'There is no clear causal link that explains why a person becomes a perpetrator and no clear pathway to perpetration'.[34]

Only some abusers are preferentially sexually attracted to children.[35] They may actively seek out institutional settings that increase their opportunities to sexually abuse children.[36] Other abusers are opportunistic. They may only begin abusing children once they are in an institution where the culture and environment enable them to overcome their inhibitions.[37]

2.3 Harmful sexual behaviours

Harmful sexual behaviours are sexual behaviours displayed by children and young people that may:

- fall outside what is considered developmentally, socially and culturally expected
- cause harm to themselves or others
- occur face to face and/or via technology.[38]

When these behaviours involve another child or young person, they may include a lack of consent, reciprocity and mutuality, and involve the use of coercion, force or a misuse of power.[39]

Harmful sexual behaviours can include behaviours that are criminal. The effects of these behaviours on victim-survivors can be equal to those of adult-perpetrated child sexual abuse.[40] However, the emotional and sexual development of children who have engaged in such behaviour is different from that of adults. The culpability that attaches to children's behaviour, as well as prospects for rehabilitation, also differ from those of adults.[41]

Social and environmental factors that may influence children and young people's propensity to engage in harmful sexual behaviours include 'prior sexual, physical or emotional abuse, exposure to family violence, social difficulties, and exposure to and consumption of pornography'.[42]

The National Royal Commission reported that other children carried out just under one-quarter of the child sexual abuse reported to them.[43]

2.4 Characteristics of children associated with greater vulnerability to child sexual abuse

All children are potentially vulnerable to adult abusers because they depend on adults and lack comparative physical, social and legal power.[44] Aspects of some institutional settings have implications for this vulnerability of children because they are separated from those who usually protect them. In addition, the power imbalance between adults and children can be heightened in some institutional contexts, 'particularly those that are highly controlled, are isolated and exhibit hierarchical and authoritarian features'.[45] It is important to note that, while several factors may increase a particular child's vulnerability to sexual abuse, responsibility for abuse lies only with the abuser and the institution responsible for the child's safety, never with the child.[46]

While all children are vulnerable, some children may be more at risk of sexual abuse at different times, based on certain characteristics or circumstances.[47] Unfortunately, most children who have experienced sexual abuse have also experienced other types of maltreatment (exposure to domestic violence, emotional abuse, physical abuse and neglect).[48] Other risk factors include gender, age and developmental stage, family characteristics and circumstances, and the child's personal and physical characteristics.[49] However, these risk factors do not mean a child will be abused, nor does the presence of protective factors ensure a child's safety.[50]

Some groups of children are more vulnerable to sexual abuse due to being exposed to more of these risk factors. The National Royal Commission reported that, while Aboriginal children, children from culturally and linguistically diverse backgrounds and children with disability are 'not inherently more vulnerable to sexual abuse', they are at increased risk because, among other things, they are more likely to have sustained

contact with institutions within which abusers have opportunities to abuse them.[51] Aboriginal children, children from culturally and linguistically diverse backgrounds and children with disability were also shown to experience added challenges that affected their likelihood of disclosing or reporting sexual abuse.[52]

3 Risks of child sexual abuse in institutions

Child sexual abuse can occur within any institution. However, some institutional contexts and cultures enable sexual abuse more than others.[53] This section focuses on the institutional factors that can increase the risk of abuse occurring in an institution, or an institution failing to identify or respond appropriately to child sexual abuse.

The National Royal Commission concluded that cultural, operational and environmental factors contribute to the likelihood of children being sexually abused and of abuse being identified, reported and responded to appropriately.[54] It explained that:

- Institutional cultural factors include leadership and organisational culture, which shape assumptions, values, beliefs and norms.[55]
- Operational factors include governance, internal structure, day-to-day practices, the approach to implementing child safe policies and the recruitment, screening and training of staff and volunteers.
- Environmental factors include the characteristics of physical and online spaces that enable potential adult abusers and children with harmful sexual behaviours to access victims.[56]

Some of these factors are highlighted in Sections 3.1, 3.2 and 3.3, with particular reference to child sexual abuse in Tasmanian Government institutions.

3.1 Cultural factors

3.1.1 'Closed' or 'total' institutions

There is generally a higher risk of child sexual abuse occurring in institutions that are less 'open' and therefore less accountable to the broader community.[57] 'Closed' or 'total' institutions are those that exercise full control over a child's day-to-day life. In these institutions, children are subject to strict rules and procedures, are entirely dependent on the institution, and are isolated from the outside world.[58] Such institutions are often said to have the purpose of 'reforming' or 'protecting' children.

Because closed institutions are not common environments, they can become 'alternative moral universes'—the cultural norms and rules are established and maintained wholly

within the institution and are distinct from the norms and rules of general society.[59] Closed institutions are also often hierarchical in nature, enforcing obedience to authority.[60] Staff, volunteers, children and young people may therefore be less inclined or feel less able to report or act on abuse. We note in the real world that these factors exist on a continuum that result in some institutions being more closed than others.

3.1.2 Leadership

An institution's leadership affects the risk of child sexual abuse. Leaders have decision-making power and so shape an institution's culture and practices. Leaders influence the culture of their institutions through the people they hire and fire, the behaviours they reward or punish, the issues they prioritise, how they respond to crises, and the attitudes and behaviours they model.[61]

The way leaders work to prevent or respond to child sexual abuse can be distorted by things such as the often competing expectations to avoid public or political exposure, protect budgets and stakeholder confidence, maintain reputational standards and avoid litigation.[62] Prioritising these factors can create a 'damage control' mindset that may lead to minimising or denying abuse, silencing victim-survivors, shifting risks elsewhere, or even, in extreme circumstances, actively concealing abuse.[63]

3.1.3 Trust and values

Some professions and institutions are highly trusted by the community. This can lead to a greater willingness to allow children to be unsupervised in their care, to be deferential and to second-guess suspicions or allegations of abuse when they arise.[64] In the past, such institutions have included religious or spiritual organisations, elite sports organisations and medical practices.[65] Children can find it harder to recognise abuse, or be discouraged from reporting abuse, when their family or community holds the institution, or the people in it, in high regard.[66]

In some settings, staff, volunteers and members can become 'fused' with the identity or 'values' of an institution. This may occur, for example, in relation to an elite school with a strong 'brand' and investment from alumni.[67] People associated with an organisation may overidentify with it, and they may become defensive if they perceive that the organisation is under threat. They may take threats to the reputation of the institution personally, which can lead them to prioritise the institution's reputation over the safety of children.[68]

3.1.4 Institutional culture and behavioural dynamics

Institutions comprise people who are conditioned by social norms and are susceptible to cognitive biases and psychological defences. Certain beliefs, behaviours and biases can influence a person's ability and willingness to identify and respond to child sexual abuse.

Broad community attitudes also inform institutional norms, although it is possible for institutions to develop values and norms that depart from those held in the community, sometimes significantly.[69] The views of people working in institutions are subject to various influences including:

- community attitudes about sexual abuse and the likelihood and frequency of it occurring
- attitudes about children's rights
- attitudes about gender, race and sexual orientation.[70]

Researchers have found that psychological defences, called 'techniques of neutralisation', can stop people from feeling guilty about engaging in misconduct or for failing to intervene when they perceive a person's behaviour as being wrong. In simple terms, these psychological defences can lead a person to:

- dismiss the capacity or humanity of a child or young person
- ignore the harm or distress a behaviour is causing
- believe they have no agency to change a situation
- believe they are doing 'good', or that the good they are doing outweighs the bad
- understand their failures—for example, to intervene in wrongdoing—as no worse than others' failures.[71]

It is generally very difficult for people to overcome these behaviours. The most effective strategies for changing such behaviours involve creating a safe space to consider alternative perspectives and engage in critical self-reflection.[72]

Within institutions, these behaviours can become part of a larger dynamic, or 'organisational culture', that works against protecting children from harm.[73] Organisational culture has been described as the 'assumptions, values and beliefs, and norms that distinguish appropriate from inappropriate attitudes and behaviours in an organisation'.[74] Organisational culture can be shaped through the messages and actions that are formally and informally communicated between staff and others in an institution, as well as by community attitudes.[75]

In the context of contemporary youth detention environments, the National Royal Commission identified the cultural characteristics of institutions that may increase the risk of child sexual abuse.[76] These included:

- failing to prioritise children's welfare and wellbeing[77]
- lack of voice—failing to provide children with the opportunity to communicate their views reflects a culture in which children are not listened to, and their views are not respected[78]

- disrespecting children[79]
- tolerating humiliating and degrading treatment of children—an institutional culture of dehumanising children can weaken the usual inhibitions or concerns of staff[80]
- engendering a strong sense of group allegiance—children are less likely to disclose abuse, and less likely to be believed, in institutions with strong group allegiance between adults[81]
- minimising the significance of harmful acts against children and young people.[82]

Research undertaken for the National Royal Commission found many barriers to identifying grooming or abusive behaviours in organisations. One barrier is the errors of reasoning that humans unconsciously employ daily. Errors of reasoning may contribute to the failure to notice or intervene in behaviours that indicate a risk of child sexual abuse.[83] Three significant errors of reasoning identified in the research are:

- Confirmation bias—being more likely to notice evidence that supports pre-existing views and overlook evidence that challenges them. For example, being unwilling to characterise the behaviour of a well-liked colleague as grooming.[84]
- The representativeness heuristic—assessing people based on assumptions about the category they belong to, such as professionals working in children's services. People tend to assume that employees of children's services are there to act in the best interests of children, even when there is evidence to the contrary.[85]
- The availability heuristic—paying attention to a limited range of information, particularly first impressions and information that is 'vivid, concrete, emotion-laden and recent', rather than considering information that may lead to a different view. For example, forming a positive first impression of someone and thereafter disregarding small indicators of grooming behaviour.[86]

The authors of this research noted that overcoming errors of reasoning can be challenging, so organisations need to actively create environments that help identify and overcome them.[87] In addition, dynamics in a workplace can affect a person's willingness to take any action that may damage their relationships with their colleagues or superiors.[88] In smaller communities, like Tasmania, these behavioural dynamics can extend from the workplace to the wider community; that is, people may fear they will lose their social relationships and standing if they act on a concern about a child or young person's safety where that concern may place them in conflict with existing social hierarchies or consensus (for example, where an alleged abuser has an otherwise 'good reputation' within the community).[89]

Abusers often exploit the beliefs, behaviours and biases of individuals, communities and institutions, which allows them to sexually abuse children and young people freely.

3.2 Operational factors

The nature of the services or activities an institution engages in with children can increase the risk of abuse. Risk is generally greater in institutions where there is:

- a high degree of physical or intimate contact with children—for example, medical, disability and child care[90]
- a high degree of institutional control over the day-to-day lives of children or their living environment—for example, youth detention, out of home care, boarding schools or inpatient health care[91]
- a strong emotional or psychological connection between the child and the institution—for example, religious organisations or sporting clubs[92]
- regular unsupervised contact with children.[93]

In 'closed' or 'total' institutions, control over children is often achieved through strict rules and procedures, and children may depend entirely on the institution to provide care.[94] Youth detention facilities and inpatient mental health services are such institutions.[95]

3.2.1 Management and governance

The management and governance structures of institutions can also affect the safety of children. For example, abuse can be difficult to report if there is a single manager in the hierarchy who is either the abuser or closely allied to them. Abuse can also be difficult to report where there is limited external scrutiny of the institution and its leadership.[96] Conversely, where there is no clear responsibility for child safety within an organisation, abusers can easily go undetected.

3.2.2 Child safe policies and norms

The policies and practices of an organisation provide important practical protections against abuse, as well as signalling the importance of child safety to staff and volunteers.

There is a greater risk of harm to children occurring in institutions that do not have child-centred policies for preventing, detecting and responding to abuse.[97] The absence of clear and appropriate policies creates ambiguity about appropriate standards of behaviour and makes it hard for staff and volunteers to know what to do if they have concerns about or receive disclosures of abuse.[98] People are less likely to make complaints or disclosures if they do not understand or are not confident that such disclosures will be managed effectively through a transparent process that also respects confidentiality.[99]

Child safe policies will not be effective if they do not define and articulate the process for addressing sexual abuse, if they are impractical, if staff are not trained or resourced to implement them, and if they are not promoted, monitored or enforced.[100]

Most organisational policies will also require a degree of interpretation or judgment. For example, legitimate efforts to build rapport and demonstrate care towards children can be mistaken for grooming behaviours. Organisations need to consider the context of the behaviour and promote an open culture that encourages staff to seek advice about concerns.[101] Safer organisations will generally describe in detail and explain discretions and ambiguities within policies and procedures, and support staff to use their judgment. Staff should feel safe to admit mistakes or breaches.[102]

Noncompliance can become normalised and accepted when institutions tolerate departures from otherwise robust policies—for example, by ignoring when teachers spend extra time with students unsupervised, or when staff have inappropriate non-sexual physical contact with children.[103] The effectiveness of the best policies will also erode over time if institutions do not empower the children and young people in their care to speak up about safety concerns.[104]

In 2015, the then Tasmanian Commissioner for Children and Young People, Mark Morrissey, conducted a review into child safe organisations. This review directly engaged with children and young people. It found that many of the children felt they were not listened to by adults, did not understand what abusive behaviour was, and were unaware of their right to safety from all forms of abuse and about what behaviour is unacceptable.[105]

Research we commissioned confirmed that to feel safe, children and young people need to have 'confidence in themselves as well as in adults' and organisations' efforts to keep them safe and respond when they have been harmed'.[106] Without the confidence that institutions will act to keep them safe, children and young people reported being less likely to raise concerns, disclose abuse or seek assistance.[107]

Children are also less likely to experience institutions as safe if the institution is not inclusive or does not embrace diversity.[108] Children who experience discrimination, whether relating to their culture/ethnicity, gender identity, sexual orientation, disability status, faith or other characteristics, are less inclined to report abuse because they may not feel confident they will be believed.[109] This reluctance may be exacerbated if the institution also fails to embrace the diverse backgrounds and characteristics of its staff.[110]

There are links between patriarchal 'macho' culture and abuse. Research shows that abuse is more prevalent in institutions that normalise aggressive or sexualised behaviours as valid expressions of masculinity.[111] Where institutions permit or require the routine use of force or violence (for example, threats, strip searching or restraints), staff can become desensitised. This makes it easier for them to minimise or tolerate harm against children in their care.[112]

In extreme cases, institutions can develop entrenched toxic behaviours involving 'hazing', bullying and overtly sexualised behaviours.[113] There is also evidence that

abusive or bullying behaviours between staff and volunteers can be mirrored between children in institutions.[114]

We talk about the elements of a child safe organisation and their implementation in Tasmania in Chapter 18.

3.3 Environmental factors

An institution's physical environment can also increase the likelihood that a child or young person will be sexually abused. Abusers take advantage of spaces that are monitored infrequently.[115] The risk that sexual abuse will occur in an institutional setting is therefore increased when that setting is enclosed, isolated, difficult to supervise or has limited options for entry and exit.[116] In institutions such as schools, the physical design and layout can play a significant role in increasing or mitigating the risk that sexual abuse will occur by inhibiting or facilitating oversight, particularly in relation to higher risk spaces such as toilet blocks, professional offices or specialist classrooms.[117] More open design including large windows, with fewer closed or hidden spaces, can allow increased lines of sight into and between spaces where children are expected to be, increasing opportunities for oversight and potentially decreasing the risk of abuse.[118]

Inappropriate residential placements in youth detention or out of home care—such as placing younger children with older children or those who have displayed concerning behaviour—can also significantly increase the risk of abuse.[119] Inadequate adult supervision may enable children to display harmful sexual behaviours against others.[120]

Our Commission of Inquiry heard that children and young people in institutions are increasingly using online technology to engage with peers, people outside the institution, and staff and volunteers within the institution.[121] Although there are many positive aspects to online communication, using this type of communication also comes with significant challenges relevant to keeping children safe.[122] Abusers often use online environments, such as social networking sites and mobile phones, to groom children.[123] Children and young people's boundaries can be readily pushed by abusers online, who may progressively expose children and young people to intimate and sexualised messages and imagery.[124] Technology can enable abusers to have ongoing contact with children out of physical sight.[125]

Online environments can also be difficult for parents, institutional leaders and staff to monitor.[126] Mitigating the risk of abuse online relies on a nuanced understanding of how grooming works and when online contact is appropriate.[127] Authorities such as the eSafety Commissioner are undertaking research and developing educational materials and resources for parents and children to support safe online engagement.[128] Critically, in institutional contexts, children are better protected when they are aware of the rules for engagement through technology for adults in authority and are empowered to notify a parent or trusted adult if inappropriate contact occurs with a stranger or someone they know.[129]

4 The risk of child sexual abuse in particular institutions

This section provides an overview of the factors that increase the risk of child sexual abuse and compromise the ability of an institution to respond to abuse in hospitals, schools, detention centres and out of home care. In later chapters, we consider in depth how institutions in Tasmania that fall within these four categories have acted to prevent children from experiencing child sexual abuse and responded to children and adult victim-survivors.[130]

4.1 Hospitals and health institutions

Children in the care of any hospital are inherently vulnerable. Children in need of hospital-based medical care are often temporarily living away from their families and support networks, sometimes for long periods. Hospitals can be frightening and overwhelming places for children. Children who are admitted to hospital for extended periods due to illness or injury experience many of the features of a closed institution.

Risks of child sexual abuse are also present in health services more broadly. As the National Royal Commission observed, children and their parents often do not question a medical practitioner's access to intimate parts of a child's body because they 'believe that a health practitioner is acting in pursuit of a higher purpose … and not out of personal sexual gratification'.[131]

In research we commissioned into the safety of children in Tasmanian institutions, researchers spoke to a range of children and young people who had spent time in hospital. These researchers found that children sometimes did not feel safe or confident in hospital and that they relied heavily on parents or carers to advocate for them.[132] The often private one-on-one nature of medical care, where children and young people may not always have a parent present to advocate, places children in a vulnerable position.[133] Health professionals can also abuse children and young people under the guise of medical treatment (including with medication or medical instruments), which can make it more difficult for patients and their families to recognise the behaviour as abusive.[134]

We report on what we found on preventing and responding to child sexual abuse in Tasmanian health services in Volume 6 and make recommendations for system-wide improvement.

4.2 Schools and educational institutions

In Tasmanian schools, as elsewhere in Australia, teachers and other staff step into the role of supervisors for children, in place of their parents, during school hours. On the whole, Department for Education, Children and Young People employees provide

a safe and supportive learning environment for Tasmanian students. Schools are the most common institution with which children engage; most children attend school, and schools are generally the place children spend the most time outside their homes. Schools are not inherently a high-risk environment, but the large population of children in schools and the length of time they spend there means many concerning sexual incidents have occurred in state school systems.[135]

There is also increasing recognition that some factors in the school environment can expose children and young people to a greater risk of sexual abuse. These factors are 'the amount of time children spend in school, the inherently hierarchical relationship between students and teachers (and other school staff), and the fact that children of different ages attend school together'.[136] It is not feasible within a busy school environment for adults to have their eyes on every child all the time, and incidents of child sexual abuse can occur quickly and do not always occur behind closed doors.

In Volume 3, we examine in detail responses to child sexual abuse in Tasmanian government schools and make recommendations for systemic improvements.

4.3 Youth detention

While the risk of child sexual abuse is present in all residential institutions, youth detention centres 'perhaps illustrate the highest level of risk'.[137] As mentioned, detention centres are 'closed' institutions. The National Royal Commission identified specific characteristics as increasing the risk of child sexual abuse in youth detention:

- a culture of humiliating and degrading treatment of children, deprivation of liberty and invading children's privacy
- a heightened power imbalance between staff and detained children, including the use of strict rules, isolation, discipline and punishment by staff
- young people detained in the centre having no say about their daily lives
- a culture that engenders strong group allegiance among staff, including management.[138]

Children and young people who are held in youth detention centres are more likely to have experienced past abuse or neglect. As noted in Section 2.4, past experiences of abuse and neglect have consistently been found to heighten children's risk of experiencing child sexual abuse. Children in detention are also at a disproportionate risk of being involved with child safety services or to be in the care of the state in out of home care. They are therefore less likely to have a trusted adult to whom they can turn for help.[139]

Children in youth detention face several other barriers to disclosing abuse due to the characteristics of that institution.[140] For example, cultural norms to not speak out or

'snitch' decrease the likelihood of children raising complaints, particularly where they are experiencing harm caused by another child or young person in detention.[141]

People who engage in sexual abuse in youth detention settings can include:

- youth workers and other custodial staff
- doctors, nurses, psychologists and other health professionals
- case managers, community, recreation and educational service providers
- chaplains and other religious personnel
- legal representatives
- people undertaking external inspection and complaint handling functions.[142]

There is also a high risk of young people in youth detention engaging in harmful sexual behaviours.[143] These behaviours may be modelled on how adults or older children have behaved towards them outside and inside detention settings.[144]

We report on what we found in relation to Ashley Youth Detention Centre in Volume 5.

4.4 Out of home care

For the purposes of our Commission of Inquiry, out of home care means formal care that is arranged or provided by the Tasmanian Government for children and young people who cannot live safely at home. Out of home care includes foster care, kinship care, respite care, sibling group care, residential care, third-party guardianship and therapeutic services for children in care.[145]

Children in out of home care spend a lot of time alone with adults who are outside their usual family or social environment. As the National Royal Commission observed, the 'very nature of out of home care involves adults having opportunities to be alone with children, primarily in home-based care but also in residential care settings, and to develop supportive relationships with those children'.[146] Unfortunately, this means that in some instances sexual abuse will occur.

People who sexually abuse children in out of home care include adults within the out of home care system, such as foster carers, residential care workers or child safety officers; adults outside the out of home care system who have access to children and young people in care; and other children within the system, such as another young person in the care setting.[147]

Adults who sexually abuse children in out of home care are more likely to be male, charismatic, controlling and in positions of power.[148] Abuse is often accompanied by grooming so children will trust the abuser and believe they have consented to the abuse.[149] As discussed earlier in relation to health settings, abusers also engage in

'institutional grooming', whereby they manipulate other staff and communities into trusting them so their abusive behaviour is not suspected.[150]

Adults outside the out of home care system can pose a risk to children in out of home care through child exploitation. While child sexual exploitation occurs across the general population, there are adults who actively target children in out of home care, particularly in residential care, due to their increased vulnerability to grooming and abuse.[151]

Children who have engaged in harmful sexual behaviours are a significant concern in out of home care. Research suggests a strong correlation between young people living in residential settings and engaging in, or being subjected to, harmful sexual behaviours.[152] Children in out of home care may be at greater risk of child sexual abuse by other children in their placement than by adult staff members.[153]

The National Royal Commission found that certain factors increase the risk that abusers will target a child or young person in out of home care. These factors generally relate to the vulnerability of the child in the eyes of the abuser and include the child's:

- previous experience of abuse or neglect
- loss of connection to family and culture
- lack of understanding of what constitutes abuse.[154]

Female children and young people seem to be at greater risk of child sexual abuse in out of home care. However, the evidence is difficult to interpret because male children and young people are less likely to disclose abuse.[155] Children with disability are about three times more likely than children who do not have a disability to experience sexual abuse in out of home care.[156] The exposure of Aboriginal children and young people to the risk of institutional child sexual abuse is increased by being in out of home care. Also, when Aboriginal children are placed with non-Aboriginal families, they can experience disconnection from culture that can render them even more vulnerable to sexual abuse.[157]

In Volume 4, we examine in detail responses to child sexual abuse in Tasmania's out of home care settings and make recommendations for reform.

5 The effects of child sexual abuse

This section examines the effects of child sexual abuse in institutional contexts on victim-survivors, as well as on their family members, communities and broader society. We also provide an overview of how institutional responses can reduce or aggravate the effects of child sexual abuse. In this section we draw on the work of the National Royal Commission and on what those affected by child sexual abuse in Tasmania told us.

5.1 Effects on victim-survivors

One victim-survivor told us:

> People have asked me about, you know, the impact and stuff like that and I just want to say that I got to survive but I didn't get to thrive. I will never get to know the person I could have been because of him … [158]

Sexual abuse causes profound trauma. It adversely affects children and young people's emotional and educational development, physical and mental health, the quality of their relationships, their connection to culture, and their sense of identity and wellbeing. These effects often continue into adulthood and can have lifelong consequences for a victim-survivor's ability to work, raise a family, feel part of a community and enjoy intimacy.[159] Trauma expert Bessel van der Kolk writes that traumatic experiences affect humans on multiple levels, leaving 'traces on our minds and emotions, on our capacity for joy and intimacy, and even on our biology and immune systems'.[160] He explains that:

> Trauma, by definition, is unbearable and intolerable. Most rape victims, combat soldiers, and children who have been molested become so upset when they think about what they experienced that they try to push it out of their minds, trying to act as if nothing happened, and move on. It takes tremendous energy to keep functioning while carrying the memory of terror, and the shame of utter weakness and vulnerability.[161]

The timeframe for experiencing the effects of child sexual abuse can vary. For some victim-survivors the effects are immediate and ongoing, for others they are temporary, while for others still they emerge later in life, when the trauma of the abuse is triggered by an event or different life stage.[162]

As the National Royal Commission observed, the factors that influence how a victim-survivor is affected by sexual abuse are complex, unique, profound, enduring and interconnected.[163] Some of these factors include:

- the type, duration and frequency of the abuse
- the relationship of the abuser to the child
- the victim-survivor's circumstances, experiences and characteristics
- the social, historical and institutional contexts of the abuse.[164]

A review of research findings prepared in 2017 for the National Royal Commission found that physical violence, penetration, prolonged/frequent abuse and grooming have all been associated with heightened detrimental effects for victims.[165] Prior maltreatment and trauma, such as exposure to domestic violence and neglect, can also intensify the impacts of sexual abuse.[166] Children with disability may experience particular and severe effects of abuse.[167]

Some victim-survivors experience cumulative or compounded trauma because of child sexual abuse and other forms of mistreatment and adverse life experiences, including heightened vulnerability due to intergenerational and collective trauma.[168]

Many victim-survivors who gave evidence to the National Royal Commission placed importance on the nature of their connection to the abuser and whether the abuser held a position of power over them.[169] This power may arise from the abuser's attributes, including their age, reputation, personality, professional expertise or role.[170] If the abuser was a trusted person or another child, feelings of betrayal were exacerbated for many victim-survivors.[171] One victim-survivor told us:

> That man was my favourite person in the world. He was so funny and kind and I absolutely adored him … He broke my trust so much.[172]

The effects of sexual abuse may also be exacerbated if the abuse occurred in 'closed' institutions that heighten a child's powerlessness and their capacity to remove themselves from the abuse, or to get support.[173] Victim-survivors are often retraumatised by the way that abusers, and those with authority in the institutions where the abuse happened, respond to allegations of child sexual abuse.[174]

We heard from many victim-survivors about the effect that abusers had on their lives. For example, victim-survivor Robert Boost told us that:

> … my whole life since the abuse or since that sort of 13, 14 year age, I have been running away from it and setting goals. So, initially I thought, you know, if I get a girlfriend, I will not feel this way anymore, and then for a moment everything's good, and then sort of the tortoise and the hare: I run away and … the tortoise catches up.[175]

We commonly heard that victim-survivors have problems with mental health and substance use as a consequence of sexual abuse. For example, Erin (a pseudonym) gave the following evidence to our Inquiry:

> … I went down a massive spiral … I started using ice, speed and smoking bongs. I drank a lot. This was my way of blocking things out and helping me forget … I've got PTSD, anxiety and depression. I struggle to trust males in particular. It impacts my relationships, which now impacts my children.[176]

We also heard about the distressing effects that sexual abuse had on victim-survivors' own parenting as adults. For example, victim-survivor Alex (a pseudonym) stated:

> I've got three kids. I won't allow them to have sleepovers. I never bath my eldest child. I'm certainly on a hyperalert status all the time, especially in public. When I take my kids to the park I sit there and I can work out, you know, this child to that family, to this person to that person, and sadly this goes on and these people don't wear red flags.[177]

The National Royal Commission noted that although child sexual abuse in any context has similar effects on victim-survivors, institutional settings can have specific impacts.[178] These include distrust and fear of institutions and authority.[179] Mr Boost told us of the effects of his abuse as a student:

> I have developed a deep distrust of institutions because of the perpetrator. I never thought I'd get to a point that I'd trust another institution, even one like this Commission. However, I realised that it is important for me to give evidence to help me accept that this abuse has happened, to tell the community that it happened to me, and to move forward with my healing process.[180]

Mr Boost went on to describe how his abuse shaped his world view and led him to distrust those who held power and authority in society:

> Through my life, I have come to understand that most people are decent and good-hearted, but there is still a large portion of sick and perverted people in society that will take advantage of vulnerable people. Because of this underground that I witnessed, I find it difficult to trust anyone … I do not like being under the power or control of another; it makes me feel uncomfortable to be in situations where there is a level of control over myself or my family. I try to avoid getting into that position.[181]

The National Royal Commission further found that the social and historical contexts in which child sexual abuse occurs can influence the way victims are affected. Community attitudes that children are inferior, lack of social awareness of child sexual abuse and the extent to which an institution is perceived to be a source of authority in the community can all exacerbate the impacts of sexual abuse on victim-survivors, as can gender stereotypes, racism and discriminatory attitudes to diverse sexual orientations.[182]

5.2 Effects on families and communities

Child sexual abuse can significantly affect the families of victim-survivors, others involved with the institution where the child sexual abuse occurred, religious and cultural groups (including Aboriginal communities) as well as broader society.[183] The National Royal Commission found that people who are affected by the trauma of child sexual abuse in institutional contexts also includes children who witness the abuse, staff in the associated institution, whistleblowers and the family members of abusers.[184]

One mother of a victim-survivor said:

> Sexual abuse doesn't just affect the victim. It affects the whole family. They all had to process this and deal with this and try to keep [name redacted] safe, and I needed support. All she got was a phone number for [a sexual assault service] and a phone call begging her not to go to the media.[185]

Sexual abuse causes 'cultural trauma'; that is, it affects the identity, cohesion and sense of safety of a community.[186] The cultural trauma of child sexual abuse for Aboriginal communities is particularly pronounced because of the underlying 'collective and intergenerational trauma' caused by colonisation, dispossession, discrimination and the forced removal of children from their families.[187]

Parents, partners and siblings of victim-survivors have all reported 'secondary traumatic stress', including hypervigilance, insomnia, exhaustion and hopelessness, after the sexual abuse of a family member.[188] For example, a parent of a victim-survivor said that:

> It's a fourth job for us. There are full-on email trails. Every time we make a complaint we have to revisit all the details and tell the whole story again. It's traumatic. You should only have to tell your story once. They wear you down. They did it the first time she was abused, and they were successful, but this time, no.[189]

Sexual abuse also has an intergenerational effect. Children of victim-survivors may grow up in unstable environments where they are exposed to their parent's trauma, mental illness and substance abuse. This increases the likelihood of victim-survivors' children being placed in out of home care, continuing the pattern of institutionalisation across generations.[190]

A person who witnessed the sexual assault of her friend by a foster carer described to us the traumatic effect of being a witness in the criminal justice process in a case where the abuser was acquitted:

> I lost hope. Later, in [the mid 2000s], when I was 16, I attempted suicide. In part, it was because I was extremely morally injured by the Tasmanian justice system. I couldn't reconcile how to live in a world which was so unjust, and that unjustness was public, and enshrined into law in a power differential that seemed unquestionably sanctioned.[191]

Some whistleblowers told us about their experiences of trying to raise the alarm about institutional handling of complaints of child sexual abuse. Will Gordon, the whistleblower in relation to the Launceston General Hospital's management of complaints about serial offender James Griffin, said:

> I stand by my convictions in my pursuit for the abuse of children to not be hidden behind closed doors and for those who are vulnerable to find their voice to speak and heal. This has caused hardship within my social, personal, and professional life, and yet I have continued in my objective because of my moral principles … I now struggle to have trust in family, colleagues, acquaintances, and friends due to the stories of abuse I have heard since fighting for this.[192]

Alysha (a pseudonym), a whistleblower who exposed failings at Ashley Youth Detention Centre, where she worked, expressed her anguish at trying to improve the safety of detainees:

> I had large boys crying to me and begging me to rescue them from the risk of sexual assault. The helplessness I felt, whilst telling them I would do all I could to ensure their safety—whilst knowing full well my recommendations would be undermined immediately—was soul destroying.[193]

5.3 Effects of institutional responses

How an institution responds to a child or young person who discloses abuse can either compound the distress and trauma they experience, or it can contribute to their healing and sense of justice. Inappropriate responses—including disbelief, hostility, or non-supportive and dismissive responses—can compound the negative effects of abuse and retraumatise a victim-survivor.[194] The responses of other institutions, such as police, the justice system, support services and health services, are just as important as that of the institution where the abuse occurred.[195]

Inappropriate responses—including failing to act after a disclosure, enabling the abuser to remain in their position, and adopting an adversarial, delayed or overcomplicated approach to redressing the abuse—further compound the trauma of the abuse for victim-survivors.[196] For example, one victim-survivor told us that:

> To take a child who is already in a situation of powerlessness—and the powerlessness is extraordinary, particularly in a school environment—but to then be suddenly thrust into this world of police officers and court rooms and lawyers and cross-examination … I've had three, four psychiatric evaluations and they are brutal, you know? So, how do we do this process? How do we find ways that are supportive and not retraumatising?[197]

'Institutional betrayal' describes the experience of a victim-survivor who is harmed by a trusted and powerful institution on which they depend for their security and wellbeing.[198] Institutional betrayal can refer to the failure of an institution to provide a safe environment for a victim-survivor, therefore putting that person at risk. It also refers to institutions that do not act once a disclosure of abuse is made, which can result in the continuation of abuse of the victim-survivor or other children.[199] We identified a sense of institutional betrayal in many of the victim-survivors and staff in the out of home care system, youth detention, schools and hospitals. Tiffany Skeggs, who was abused by Mr Griffin, told us that many of his victim-survivors had lost trust in Tasmanian government institutions:

> Even when I speak to people now, I struggle to tell them that they should come forward, and that they will be safe if they do. Because the reality at the moment is that it is not safe for them to do that … I have absolutely zero faith in referring them to any department, anywhere, in Tasmania.[200]

Victim-survivors reported to the National Royal Commission and to our Inquiry that being silenced or disbelieved after disclosure, punished, blamed for the abuse, or accused of lying, resulted in intense feelings of injustice, anger and shame.[201] The shock of enforced silence is evident in this account:

> One of the most demoralising things in my life was that after the perpetrator was acquitted, my friend and I were told that we couldn't mention his name or tell the truth publicly, because if we did we'd be liable for defamation. This left us feeling extremely angry, demoralised and disillusioned.[202]

Victim-survivors emphasised the importance of being heard and believed, and the importance of associated institutions acknowledging and accepting responsibility for the harm caused.[203] As one young person who participated in the research we commissioned said:

> Children would kinda get depressed [if adults don't protect them] because we're told the teachers are there to look out for us but when they don't help us, who are we supposed to turn to? … It makes you feel unsafe because you are all alone and you have to do it by yourself … You would feel horrible because there's no-one you can trust.[204]

Victim-survivors reported to us that poor institutional responses to their disclosures of abuse had adversely affected their capacity to work, participate in society and to trust or engage with institutions in general. Some victim-survivors said they also avoided accessing services—including services to manage trauma related to the abuse they suffered—which further impeded their healing.

We also heard that victim-survivors faced ostracism after identifying or disclosing child sexual abuse. When abusers continued to be employed or otherwise supported by an organisation after an allegation of abuse was upheld, victim-survivors, their family members and supporters felt isolated and sometimes forced to leave their community.

We have been deeply affected by the accounts we have heard of the profound impacts of child sexual abuse. We have also seen the courage and resilience of many victim-survivors who are living with the effects of child sexual abuse and continuing to make positive and important contributions through their families, communities, careers and advocacy. We are deeply grateful to every victim-survivor of child sexual abuse in Tasmanian institutions who came forward to share their experience with us.

In the following four volumes (Volumes 3, 4, 5 and 6), we discuss the Tasmanian Government's response to allegations of child sexual abuse in schools, out of home care, youth detention and health services, and make recommendations for reform. In Volume 7 we discuss the justice system's response to child sexual abuse, before discussing system-wide reforms in Volume 8. We trust that the recommendations we propose in those volumes will assist in preventing institutional child sexual abuse and improve the lives of those who do experience such abuse.

Notes

1 *Royal Commission into Institutional Responses to Child Sexual Abuse* (Final Report, December 2017) vol 1, 26, 44–45.

2 Statement of Michael Guerzoni, 29 April 2022, 25 [85].

3 For details, refer to the Terms of Reference at Appendix B. Refer also to Order of the Governor of Tasmania made under the *Commissions of Inquiry Act 1995*, 15 March 2021, 5 (refer to Appendix A); *Royal Commission into Institutional Responses to Child Sexual Abuse* (Final Report, December 2017) vol 1, 19. For the purposes of this Commission of Inquiry, we have replaced the word 'fondling' with the trauma-informed term 'touching'.

4 Statement of Ben Mathews, 10 June 2022, 4 [12].

5 Refer to, for example, *Criminal Code Act 1924* s 124.

6 *Royal Commission into Institutional Responses to Child Sexual Abuse* (Final Report, December 2017) vol 2, 32.

7 *Royal Commission into Institutional Responses to Child Sexual Abuse* (Final Report, December 2017) vol 2, 32. For the purposes of this Commission of Inquiry, we have replaced the word 'fondling' with the trauma-informed term 'touching'.

8 *Royal Commission into Institutional Responses to Child Sexual Abuse* (Final Report, December 2017) vol 2, 32.

9 *Royal Commission into Institutional Responses to Child Sexual Abuse* (Final Report, December 2017) vol 2, 32.

10 *Royal Commission into Institutional Responses to Child Sexual Abuse* (Final Report, December 2017) vol 2, 32–34.

11 *Royal Commission into Institutional Responses to Child Sexual Abuse* (Final Report, December 2017) vol 2, 41.

12 Patrick O'Leary, Emma Koh and Andrew Dare, 'Grooming and Child Sexual Abuse in Institutional Contexts' (Research Paper, Royal Commission into Institutional Responses to Child Sexual Abuse, 2017) 10.

13 *Royal Commission into Institutional Responses to Child Sexual Abuse* (Final Report, December 2017) vol 2, 40.

14 Refer to, for example, Transcript of Sam Leishman, 13 May 2022, 1052 [26–30]; Transcript of Robert Boost, 12 September 2022, 3888 [19–26].

15 Transcript of Leah Sallese, 8 July 2022, 2638 [5–9].

16 Transcript of Tiffany Skeggs, 30 June 2022, 2027 [38–42].

17 Anne-Marie McAlinden, 'Organisational Sex Offenders and 'Institutional Grooming': Lessons from the Savile and Other Inquiries' in Marcus Erooga (ed), *Protecting Children and Adults from Abuse After Savile: What Organizations and Institutions Need to Do* (Jessica Kingsley Publishers, 2018) 4–5.

18 *Royal Commission into Institutional Responses to Child Sexual Abuse* (Final Report, December 2017) vol 2, 44.

19 Donald Palmer, Valerie Feldman and Gemma McKibbin, *The Role of Organisational Culture in Child Sexual Abuse in Institutional Contexts* (Final Report prepared for the Royal Commission into Institutional Responses to Child Sexual Abuse, December 2016) 59. For examples, refer to *Child Protection Systems Royal Commission — The Life They Deserve: Child Protection Systems Royal Commission Report* (August 2016) vol 1, Summary and Report; Statement of Alana Girvin, 28 April 2022, 4 [24]–5 [25]; *Royal Commission into Institutional Responses to Child Sexual Abuse, Case Study 2 — YMCA NSW's Response to the Conduct of Jonathan Lord* (June 2014).

20 Donald Palmer, Valerie Feldman and Gemma McKibbin, *The Role of Organisational Culture in Child Sexual Abuse in Institutional Contexts* (Final report prepared for the Royal Commission into Institutional Responses to Child Sexual Abuse, December 2016) 7, 26.

21 *Royal Commission into Institutional Responses to Child Sexual Abuse* (Final Report, December 2017) vol 2, 40–42; Anne-Marie McAlinden, '"Setting 'Em Up": Personal, Familial and Institutional Grooming in the Sexual Abuse of Children' (2006) 15(3)(3) *Social and Legal Studies* 339, 347; Donald Palmer, Valerie Feldman and Gemma McKibbin, *The Role of Organisational Culture in Child Sexual Abuse in Institutional Contexts* (Final Report prepared for the Royal Commission into Institutional Responses to Child Sexual Abuse, December 2016) 24–25.

22 *Royal Commission into Institutional Responses to Child Sexual Abuse* (Final Report, December 2017) vol 2, 34, 94, 126.

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Commission of Inquiry into the Tasmanian Government's Responses to Child Sexual Abuse in Institutional Settings

Who was looking after me? Prioritising the safety of Tasmanian children

Volume 3: Children in schools

August 2023

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Volume 3
Children in schools

The Honourable Marcia Neave AO
President and Commissioner

Professor Leah Bromfield
Commissioner

The Honourable Robert Benjamin AM SC
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Introduction to Volume 3

This volume focuses on children in Tasmanian government schools and how schools and the Department for Education, Children and Young People (formerly the Department of Education) prevent and respond to child sexual abuse.

A note on language

In October 2022, the Department of Education was renamed the Department for Education, Children and Young People, and given expanded functions. In addition to education, the new department is now responsible for the child protection and youth justice systems. In this volume, we use the term 'Department' to refer to either the Department of Education (as it then was) or the relevant functions that relate to education within the new Department for Education, Children and Young People. When we specifically mean the previous Department of Education or the new Department for Education, Children and Young People, we use the full name.

Every day, thousands of Tasmanian children are entrusted to the care of schools with the expectation they will be kept safe.

School is a place of learning, social connection and happiness for many students. Most school staff choose to work in the education system because they value children and want to educate and nurture them with care and compassion. We expect that these staff will welcome the improvements already underway to make children safer each day in the government school system.

However, for some children, schools have been a place of abuse and harm. Victim-survivors told us about their experiences of being abused by staff or fellow students. We heard about the trauma of their abuse and the betrayal many felt when their school or the Department failed to acknowledge the harm, to take prompt and effective action to support them, and to mitigate the risk to other children and young people.

Many of these children did not have a voice, and those who did speak out were often ignored, silenced and disbelieved. They lived with the burden of being abused, often alone and isolated. Their teachers, the Department and indeed the broader community failed to give them the care they needed and deserved.

The responsibility for this rests not with the child but with:

- the abusers who were allowed to work in the public education system
- the teachers and other staff who saw but did not intervene

- the principals and leaders who were told and did not believe
- State Service employees who treated the abuse of a child as an employment issue and focused on the rights and vocation of the adult instead of protecting children.

Many victim-survivors said that protecting others from harm was their main motivation for making a submission to our Commission of Inquiry, for attending a session with a Commissioner or for giving evidence as part of our hearings. We are indebted to everyone who shared their experience with us.

In August 2020, not long before the Government established our Commission of Inquiry, the Department announced the Independent Inquiry into the Tasmanian Department of Education's Responses to Child Sexual Abuse ('Independent Education Inquiry'). That inquiry was completed by Professors Stephen Smallbone and Tim McCormack in June 2021. It highlighted several problems, which we also heard about. These included:

- a narrow understanding of the types of conduct that can constitute or be a precursor to child sexual abuse, including failures to acknowledge the seriousness of professional boundary breaches or to recognise potential grooming behaviours
- unclear policies and procedures that were not fit-for-purpose and were applied inconsistently or were not understood by staff and the broader school community
- inadequate professional and skills development for staff and volunteers to understand their obligations and identify and effectively respond to child sexual abuse and harmful sexual behaviours
- poor responses to disclosures and complaints about child sexual abuse, leading to delayed action to reduce risk, poor-quality investigations and not enough support for those affected
- inadequate guidance and training on how to prevent and respond to harmful sexual behaviours
- a lack of coordination and focus on the safety of children in the Department—with responsibilities for safeguarding children dispersed across different roles and units, too spread out to be effective.

The Department accepted all the Independent Education Inquiry's recommendations.

Through its Office of Safeguarding Children and Young People ('Office of Safeguarding'), set up in August 2021, the Department has been implementing these recommendations at the same time as our Commission of Inquiry has been underway. We endorse the Independent Education Inquiry's recommendations. Rather than duplicate them, we instead recommend that the Implementation Monitor evaluates their implementation (refer to Chapter 22, Recommendation 22.1).

However, some matters did not receive close attention in the Independent Education Inquiry. This was either because they fell outside its terms of reference or due to factors outside of the authors' control. We considered some of these issues in greater detail in our hearings, including:

- inconsistent and inadequate access to child sexual abuse prevention programs, which can—in an age-appropriate way—empower children and young people of all ages to understand their right to be safe from abuse and build their confidence to disclose their concerns to trusted adults
- the broader disciplinary framework to manage misconduct or complaints about employees in an educational context—including the level of arms-length advice and support required to ensure these are managed appropriately, prioritise children's safety, provide procedural fairness and uphold the integrity of disciplinary processes
- the powers and functions of the Teachers Registration Board—particularly its ability (or inability, as the case may be) to share and receive information, maintain visibility of teachers, impose professional development requirements and enforce the requirements of its legislation. We also considered whether the Board is appropriately resourced and empowered to acquit its functions.

To help illuminate the Department's policies, processes and systems, we selected several case studies, which we discuss in Chapter 5. For some of these, we include the voices of victim-survivors who provided firsthand accounts of their experiences.

The Department has long had strategies and safeguards designed to protect children and young people in its care. These include evolving policies and procedures, annual mandatory reporting training and requirements that staff and volunteers hold Registration to Work with Vulnerable People. The Teachers Registration Board also has measures to ensure that people registered to teach are safe and suitable to do so. Yet it was clear—best evidenced in the apologies delivered by the Secretary of the then Department of Education, Timothy Bullard, during hearings—that the Department has significantly failed to protect students. It must invest in change and improvement.

We heard from the Department about initiatives underway to ensure students are safe from sexual abuse. These include refreshed and improved policies, a more expansive training program for staff, introducing Safeguarding Leads in each school, building expertise in identifying and responding to harmful sexual behaviours, and a commitment to system reviews to drive reflection and continuous improvement. We commend and welcome these initiatives.

However, we identified some areas where more work is needed, and we make recommendations accordingly.

This volume has three chapters. In Chapter 4—Background and context—we outline Tasmania's education system, noting that we focus on government schools. We discuss the Independent Education Inquiry and its findings and recommendations in detail given its recency. We then outline the Government's response to the Independent Education Inquiry.

In Chapter 5—Case studies—we outline eight case studies, some of which we explored in detail in our hearings. In these case studies, we pinpoint systemic issues in the Department's responses to allegations of child sexual abuse, as well as recent improvements. These case studies and the problems they highlight informed our recommendations in Chapter 6.

The recommendations we make in Chapter 6 include:

- putting in place mandatory professional development and training requirements for staff and volunteers (targeted at their role responsibilities and degree of interaction with students) to ensure all those engaging with students have baseline knowledge about child sexual abuse and harmful sexual behaviours that can be refreshed and built on over time
- providing greater guidance and mandated professional development on harmful sexual behaviours, recognising the complexity of these matters and the sensitivity, expertise and nuance required to respond to them appropriately
- increasing funding and powers for the Teachers Registration Board to enable it to respond quickly and effectively to identified risks posed by teachers, using a broader suite of regulatory tools and conditions to address concerning conduct by teachers
- establishing an Incident Management Directorate to oversee and manage complaints about child sexual abuse by staff. This Directorate should support schools to deal with distressing incidents according to best practice, while offering a degree of independence that builds the trust and confidence of affected students and their families and carers.

It is tempting to imagine that many of the problems described in this volume are problems of the past. While we can see improvement over time in how schools and the Department have responded to child sexual abuse—in line with growing community awareness and understanding of the dynamics and impacts of abuse—we continued to hear about many of the problems as recently as the time of writing, particularly in relation to harmful sexual behaviours.[1]

There is no room for complacency, and we expect—particularly as the Department's functions expand—a continued commitment to placing the needs and safety of children at the centre.

4 Background and context: Children in schools

1 Introduction

In this chapter, we give background and context to Tasmania's public education system, listing some facts and figures. This discussion notes the significant size of the Department in terms of its number of employees and the number of children and young people who are in its care every day. We briefly set out the Department's internal structure before and after it was expanded to include several functions of the former Department of Communities. We also give a basic overview of the Teachers Registration Board.

We then examine, in some detail, the Independent Education Inquiry's report. After providing some background and context to the report, we describe the key problems it identifies, set out the recommendations it makes and outline the Department's response to the report.

Throughout our Inquiry we have focused on schools, but all children in the Tasmanian education system (including those attending Child and Family Learning Centres) will benefit from efforts to prevent and better respond to child sexual abuse.

2 Tasmania's education system

2.1 The system in numbers

According to departmental data, in 2022 there were 61,252 students enrolled in Tasmanian government schools.[2] Just under half of those students were female (48.3 per cent) and just over half were male (51.6 per cent).[3] There were approximately 7,400 Aboriginal and Torres Strait Islander students enrolled in government schools in 2022, representing 12.1 per cent of all students.[4]

The Department provides education services to these students through 195 government schools across the State.[5] In 2021–22, Tasmania had:

- 125 primary schools
- 29 secondary schools
- 25 combined primary and secondary schools
- eight senior secondary schools (colleges)
- eight support schools.[6]

The Department is also responsible for the State's libraries, which are administered by Libraries Tasmania.

In March 2022, Tasmania had 7,205 fully registered teachers, 3,778 provisionally registered teachers and 233 holders of Limited Authorities to Teach.[7] While the Teachers Registration Board does not have 'reliable information about where a teacher is employed', the Board's Watched Registrations list provides some indication of where teachers are working.[8] The Watched Registrations list (discussed in Chapter 6) gives employers access to information about teachers' Registration to Work with Vulnerable People status and whether or not there are conditions placed on their registration as teachers.[9]

Based on information on the Watched Registrations list, the Registrar of the Teachers Registration Board told us that, as of April 2022, there were 5,830 government school teachers and 3,438 non-government school teachers (1,862 teachers in Catholic schools and 1,576 teachers in independent schools).[10] Across all sectors, the Board had granted 310 Limited Authorities to Teach (noting that a person may hold more than one Limited Authority to Teach at a time).[11] A Limited Authority to Teach allows a person who wants to teach to do so if they have appropriate skills but no qualification or registration to teach. These are generally a temporary solution to fill role gaps.[12]

Overall, the Department employed 11,148 people in 2021–22.[13] Just over half of those (5,700) were employed as teachers (this includes 534 principals and assistant principals).[14] Of those people employed as teachers, 4,193 (73.6 per cent) were female

and 1,507 (26.4 per cent) were male.[15] The average age of all female teachers was 49 years, and the average age of all male teachers was 44 years.[16] While data was provided about the number of female and male teachers by employment status (full-time fixed-term or full-time permanent; part-time fixed-term or part-time permanent), the Department did not publish the number of teachers on the Fixed Term and Relief Employment Register in its 2021–22 annual report. However, the Government stated in early 2022 that there were nearly 1,700 relief teachers in Tasmania.[17] Other support staff employed in government schools in 2022 include teacher assistants (2,116), school psychologists (101), social workers (119), speech pathologists (56), nurses (84) and education support specialists (35).[18]

Our terms of reference require that we examine the Government's responses to child sexual abuse in government institutions. But some of the recommendations in this chapter may have broader application and may therefore also be relevant to non-government schools—particularly in relation to the Teachers Registration Board. This is because all teachers working in Tasmania, whether in government or non-government schools, must be registered with the Teachers Registration Board. According to the Australian Bureau of Statistics, in addition to the more than 60,000 students enrolled in Tasmanian government schools in 2022, there were 26,138 students enrolled in non-government schools.[19] Non-government schools include Catholic schools (38 schools) and independent schools (35 schools).[20] In Tasmania, non-government school registration is the responsibility of the Registrar, Education, and is overseen by the Non-Government Schools Registration Board.[21]

2.2 Department for Education, Children and Young People structure

In February 2022, the Tasmanian Government announced that the functions that support children in the Department of Communities would be transferred to the Department of Education.[22] The Government's rationale for these changes included reducing the 'siloed approach [to] … departmental structures' recommended by an Independent Review of the Tasmanian State Service, and improving services and outcomes for children and young people by strengthening departmental administrative structures.[23]

Timothy Bullard, the Secretary overseeing the expanded Department, told us that the new Department provides the opportunity to:

- combine collective, knowledge, skills, information and resources
- work collaboratively in the best interests of children and young people.[24]

The new Department for Education, Children and Young People began in October 2022. These changes occurred after our Commission of Inquiry was established and were made independently of it.

In our chapter on out of home care (Chapter 9), we note our reservations about the merger of the Child Safety Service into the new 'mega' department. Our main concern is that the attention that child protection requires may be difficult to achieve in a much larger departmental framework.

2.2.1 New departmental structure

Under the newly formed Department for Education, Children and Young People, the 'Keeping Children Safe' division—headed by a Deputy Secretary and encompassing Services for Children and Families and the Office of Safeguarding Children and Young People—reports directly to the Secretary, and the new 'Services for Youth Justice' section reports to the Associate Secretary.[25] Most of the education functions of the new Department report to the Associate Secretary.

The Department has four portfolio services in relation to education:

- Portfolio Services for Development and Support—this portfolio service provides 'those directly working with children and young people with the technical guidance and support they need to build their capability to have the greatest positive impact'.[26] It includes Teaching and Learning, Wellbeing and Inclusion, Improvement Consultants, and People Capability and Development.
- Portfolio Services for Schools and Early Years—this portfolio service aims to 'inspire, support and engage all children and young people to learn more, every day'.[27] It includes Schools, Child and Family Learning Centres, and Learning Services (which support students and staff).
- Portfolio Services for Continuous Improvement and Evaluation—this portfolio service reviews and evaluates individual and system-level impacts of the Department. It includes Strategic Policy and Projects, Strategic Systems Development, External School Review, and Evaluation.
- Portfolio Services for Business Operations and Support—this portfolio provides human, financial and IT support. It includes People Services and Support, Legal Services, Information and Technology Services, and Organisational Safety.[28]

The Office of Safeguarding Children and Young People ('Office of Safeguarding') was established in response to an Independent Education Inquiry recommendation.[29] The Office of Safeguarding drives longer term cultural change and continuous improvement to help the Department be an 'exemplary child safe organisation'.[30] The Executive Director, Office of Safeguarding, is responsible for a strategy and policy framework to embed the national Child Safe Standards across the Department.[31] The work of the Office of Safeguarding also builds on the Department's wellbeing strategy. The Office of Safeguarding and its role in keeping Tasmanian students safe is discussed in Chapter 6.

Other agencies associated with the new Department are Education Regulation (including the Teachers Registration Board), the Office of the State Archivist and the Commissioner for Children and Young People.[32]

Most of the information and evidence provided to us, particularly in the case studies in Chapter 5, referred to the Department's previous structure. The former Department of Education had four divisions, and each had roles for protecting children and young people's safety: Support and Development division, Learning division, Strategy and Performance division, and Corporate and Business Services division.[33]

2.3 Education-related independent bodies

The Teachers Registration Board is an independent statutory body that works with the Department to ensure teachers are appropriately qualified and to investigate complaints.[34] The Board's primary functions include registering teachers to work in government, Catholic and independent schools in Tasmania.[35]

Tasmanian teachers must be registered with the Board to ensure they meet the required standards and have the necessary skills. According to the Board, 'registration promotes community confidence in the work of Tasmanian teachers and validates registered teachers as highly skilled professionals'.[36]

The Board also investigates complaints against teachers, and it may take disciplinary action where appropriate. This can include determining that a person is not of good character or is unfit to be a teacher. The Board works to improve teaching standards and maintains a code of ethics for teachers.[37]

In the financial year ending June 2020, the Teachers Registration Board had 12.8 full-time-equivalent positions. On average, the Board employed 14 part- and full-time employees.[38] The Board had a total revenue (and other income from transactions) of just over $2 million in 2020, with just over one-third of this coming from the Government. Before 2017, almost all the Board's revenue came from teacher registration fees.[39] The Government committed to providing the Board $375,000 in 2022–23 and $383,000 in 2023–24 as part of its Safeguarding Children and Young People initiatives. It said this will allow the Board to engage more staff (up to three more full-time-equivalent positions) to 'support the investigation of complaints and disciplinary processes'.[40]

Through submissions to our Inquiry and in our public hearings, we heard about several issues with the Board's current legislative underpinnings and processes—these are discussed in Chapter 6.

3 Independent Education Inquiry into the Tasmanian Department of Education's Responses to Child Sexual Abuse

The Independent Education Inquiry was announced in August 2020. Its purpose was to:

- examine what, if any, more actions and/or changes to the current systems applicable to, or used by, the Department should be made to minimise the risk of child sexual abuse in Tasmanian government schools
- complement, not substitute, the work of the National Royal Commission.[41]

Because our Commission of Inquiry was announced shortly after the start of the Independent Education Inquiry, the authors of the Independent Education Inquiry considered it appropriate to leave certain questions to be explored by us. Accordingly, the authors did not look at the roles of other government agencies (such as the Office of the Director of Public Prosecutions, the then Department of Communities and Tasmania Police) and the Tasmanian Government itself in responding to child sexual abuse allegations against Department of Education personnel or students. The authors did, however, make recommendations for better information sharing and coordination between the Department of Education and some of these agencies.

Professors Stephen Smallbone and Tim McCormack completed the Independent Education Inquiry in June 2021. The findings and recommendations section of their report was released to the public in November 2021. The Government has identified a range of legal issues, including the potential identification of people who contributed to the inquiry, as the reason for only releasing the section on findings and recommendations.[42] Shortly after this limited release, a full, albeit significantly redacted, version of the report was provided to the Australian Broadcasting Corporation under right to information laws.[43] At the time of writing in 2023, the Tasmanian Government has not made the full report publicly available.[44]

3.1 Systemic problems identified by the Independent Education Inquiry

The report makes observations about systemic problems that have undermined responses to child sexual abuse. These include problems with organisational culture, governance and staffing, policies and procedures, the physical environment of schools, recruitment and transfers, training and knowledge, record keeping and information sharing.

3.1.1 Organisational culture

Through consultations, the Independent Education Inquiry heard that the Department of Education had 'entrenched cultural values' that manifested in the 'prioritisation of adults' interests over those of students'.[45] Although it has improved over time, this culture still manifests in schools in several ways including:

- a belief that adults' voices should be believed over those of children
- a belief that complying with guidelines in interactions with students is primarily to protect adults
- a readiness to disbelieve students who complain of sexual abuse 'because it is easy [for students] to make false allegations' or due to their backgrounds or circumstances.[46] The false belief that children frequently lie about sexual abuse is discussed in Chapter 16.

While the report notes positive recent changes in the culture and leadership of the Department, it states that 'residual cultural problems' nevertheless remain.[47]

The research we commissioned conducted by Associate Professor Tim Moore and Emeritus Professor Morag McArthur about children's perceptions of safety in institutional settings, similarly identified the power imbalance between adults and children in schools. Students talked about double standards creating power imbalances between teachers and students that made them feel unsafe:

> … adults expect young people to be respectful and non-violent, but teachers still use their power over students, they can be disrespectful in the way that they speak to students, they work in ways that showed they were in charge and used that against students for example 'I can swear at you but you can't swear at me'.[48]

These children thought that broader societal attitudes often reflected in the school context: 'There's an issue at a societal level—as a community we don't really take sexual harassment seriously enough or take action. So sometimes that plays out at schools'.[49] They said it was therefore difficult to be sure they would be believed or taken seriously if they disclosed concerns.[50]

3.1.2 Governance and staffing

The report expressed concern that, at the time of its writing, there was:

> … no single point of oversight or responsibility in [the Department] for all aspects of student safeguarding, and therefore no effective restraint on the fragmentation of safeguarding efforts across the organisation.[51]

It recommended establishing a Director of Student Safeguarding position.
The Department has since set up the Office of Safeguarding and appointed Elizabeth Jack as Executive Director.[52] The Office of Safeguarding is discussed in Chapter 6.

The report also stated that in many of the schools visited, the demand for school support staff was far greater than the resources the Department allocated for these positions.[53] It noted that in trying to address this 'chronic shortage', the Department had deployed Student Wellbeing Teams to provide complex student case management support. However, the Independent Education Inquiry heard that the system seldom provided the 'support it was established to deliver', owing in large part to unclear policies and guidelines.[54]

We note that since the Independent Education Inquiry report was released, the Tasmanian Government has committed extra funding for professional support staff in schools. At the time of the Independent Education Inquiry, there were 110 social workers and 93 psychologists employed across Tasmania.[55] The 2022–23 State Budget outlines that funding is allocated to help employ eight more psychologists and eight more social workers 'to support student wellbeing and safety', plus another four senior support staff.[56]

3.1.3 Obligations, policies and procedures

The Independent Education Inquiry heard that the Department's 'policy environment' was 'confused and crowded', with new policies layered on top of existing ones. One senior official referred to the situation as 'dying by policy'.[57]

The difficulties were compounded by the lack of an effective, central portal for staff to access the information they needed. The Independent Education Inquiry observed firsthand 'how frustratingly difficult it is to find relevant policies and procedures, particularly through [the Department's] publicly accessible online Policy Library'.[58] Also, departmental staff had trouble applying or interpreting some policies and reported that policies about certain issues, including responding to harmful sexual behaviours, were lacking.[59]

The report expressed concern that, in some instances, there was a narrow interpretation of the requirement that employees must be acting 'in the course of their employment' for the State Service Code of Conduct to apply to their behaviour. This meant that inappropriate conduct occurring outside school hours or not on school grounds had not been subject to disciplinary proceedings.[60]

The report noted 'broad agreement' among those consulted that the State Service Code of Conduct was not suited to the distinct context of schools.[61] While there could be 'no objection' to the general principles of the State Service Code of Conduct, the lack of a Department-specific code of conduct meant that allegations of sexual abuse against teachers were investigated under the generic provisions of Employment Direction No. 5, and a breach of the State Service Code of Conduct had to be established before formal disciplinary proceedings could be instigated.[62] The report noted that departmental staff 'expressed strong support for a [Department]-specific code of conduct, both to formalise

rules and expectations about behaviour in schools and to enable [Department]-specific responses and investigations'.[63] The report recommended that the Department drafts its own code of conduct.[64]

The Department's policies and procedures that relate to child safeguarding are discussed in Chapter 6.

3.1.4 Physical environment

The report observed that some school layouts created spaces that did not allow for third-party observation, increasing the opportunity for a person to sexually abuse children.[65]

Certain physical areas in schools—such as gyms, changing rooms, dedicated drama/music areas, secluded outdoor spaces behind buildings and other isolated spaces—were noted as common places that posed a risk to student safety.[66] The report recommended that schools be required to undertake 'safeguarding risk assessments' and create risk management plans to help mitigate these safety concerns. The report also noted that, encouragingly, newer school renovations and building projects are incorporating design elements that help reduce these risks.

3.1.5 Staff recruitment and transfers

The report acknowledged that the requirement for staff and volunteers in the Department to obtain Registration to Work with Vulnerable People was well understood and observed. However, it expressed concern about an apparent lack of appreciation for the 'limited, albeit important' role these checks have in safeguarding students.[67] The authors identified several aspects of the Registration to Work with Vulnerable People Scheme that limit its usefulness in preventing child sexual abuse:

- Most convicted sex offenders had no prior record of sex offences and are therefore unlikely to have been discovered through the scheme.
- The impulse to sexually abuse children in an institution may not occur until the person is engaged by the institution, and this will not be picked up in pre-employment screening.
- The scheme does not apply to children, who may be more likely than adults to 'abuse other students'.[68]

The Registration to Work with Vulnerable People Scheme is discussed in Chapter 18.

The report noted other problems involving teacher registration and transfers, in particular the national mutual registration scheme, which unscrupulous teachers can exploit to get registered in another jurisdiction.[69] The report recommended developing a student safeguarding policy that includes clear direction about how 'due diligence is to be exercised in staff recruitment and transfers'.[70]

3.1.6 Staff training, knowledge and skills

The Independent Education Inquiry heard staff were confused about how to respond to allegations of abuse, were not aware of some policies, and thought that policies were difficult to implement.[71] It also heard that trainee teachers were told to make a mandatory report whenever they had a slight suspicion, but many trainee teachers felt they would be perceived as causing trouble or potentially damaging 'a colleague's career or family'.[72] The report noted a lack of adequate training about safeguarding for trainee teachers.[73]

The Independent Education Inquiry heard that:

- there was a lack of training for staff about how to prevent and respond to child sexual abuse
- induction training for new teachers was 'skewed' towards responding to, rather than preventing, allegations of child sexual abuse
- there was a lack of training from the Department about how to receive disclosures and manage information.[74]

The report noted that, at the time of its writing, discussions were occurring at the senior executive level in the Department about rolling out 'preventative training for staff on grooming behaviours and to have ongoing training to recognise signs and patterns, as well as precursors to abusive behaviour'.[75] Training is discussed in Chapter 6.

3.1.7 Record keeping

The Independent Education Inquiry received unanimous feedback that the Department did 'not have a system of record keeping to track the number of cases, trends or features of child sexual abuse in Tasmanian Government schools'.[76] The Department's Legal Services unit provided the Independent Education Inquiry with a spreadsheet as evidence of the main departmental record of 'suspected, alleged or proven sexual abuse incidents involving [departmental] personnel and/or students'.[77] The spreadsheet was created in 2017 in anticipation of questions about the National Redress Scheme, civil claims, police investigations and privacy information requests. The spreadsheet was not a complete record of allegations or incidents of child sexual abuse in schools, nor did its design allow basic statistics to be calculated.[78]

The Independent Education Inquiry also considered the Department's Student Support System in this context, explained as a:

> ... digital repository of school records (including confidential notes by social workers and psychologists) which ... may include information about students affected by sexual and other abuse.[79]

Stakeholders described this system as antiquated, ineffective and time-consuming to use, and schools and individuals in schools used it inconsistently.[80]

The report stated that a lack of record keeping impeded investigations into current and historical allegations of child sexual abuse made against employees. It recommended that the Department implements a robust system for recording complaints.[81]

3.1.8 Information sharing and interagency relationships

The Independent Education Inquiry heard of a lack of systematic information sharing between schools about employment concerns involving teachers and other staff.[82] Also, in investigating teachers subject to child sexual abuse allegations, government agencies were unwilling to share information with one another and with non-government organisations.[83] We understand that some of that lack of information sharing is the result of Office of the Solicitor-General advice on information-sharing restrictions in the *Personal Information Protection Act 2004* ('Personal Information Protection Act').[84]

The report noted that 'one of the most common barriers' to information sharing is the restriction on what information the Department can share with the Teachers Registration Board about allegations of child abuse and vice versa, owing to privacy legislation.[85] This is discussed in Chapter 6.

The Independent Education Inquiry also heard about inconsistencies in how the Department and other agencies, such as police, the Child Safety Service and the Sexual Assault Support Service, interact when dealing with suspected child sexual abuse in educational settings.[86] The authors recommended that the Department develops a memorandum of understanding with police to 'help clarify roles and responsibilities'.[87]

The issue of information sharing, and the scope and effect of Tasmania's privacy legislation, is discussed in Chapter 19.

3.2 Recommendations of the Independent Education Inquiry

The report made 20 recommendations about changes to governance/leadership, policies/procedures, training and professional development. In particular, it made recommendations to:

- improve record keeping to better track patterns and trends of child sexual abuse (recommendation 1)[88]
- ensure safeguarding decisions and actions are based on the principle of acting in the best interests of the child to address the 'residual cultural problem' of putting the interests of adults above those of children (recommendation 2)[89]
- create a focus on prevention rather than just responding to allegations or concerns (recommendation 3)[90]

- develop a comprehensive student safeguarding policy and improve existing policies for mandatory reporting, technology use and duty of care (recommendation 4)[91]
- establish a Director of Safeguarding in the Department (recommendation 5)[92]
- undertake mandatory safeguarding risk assessments in every school (recommendation 6)[93]
- place school safeguarding officers in every government school (recommendation 7)[94]
- improve teacher training and professional development (recommendations 8 and 9)[95]
- improve the ability of staff to identify and report concerning behaviour (recommendations 10 and 11)[96]
- develop a formal code of conduct to allow disciplinary action against staff (recommendation 12)[97]
- integrate student safeguarding policies so their position in the Department's set of safeguarding policies is clear (recommendations 13, 14 and 15; recommendation 15 is the same as recommendation 11)[98]
- develop protocols to respond to different types of sexual abuse (recommendation 16)[99]
- improve interagency relationships between police and the then Department of Communities through memorandums of understanding (recommendations 17 and 18)[100]
- improve public accessibility to policies (recommendations 19 and 20)[101]
- complete a systems review after all significant sexual abuse incidents to continually improve prevention and response (recommendation 21).[102]

3.3 The Department's response to the Independent Education Inquiry

The Department accepted all 20 of the Independent Education Inquiry's recommendations.[103] A publicly available table outlining the Department's planned implementation timeframe for the recommendations indicates that most were to be completed in either 2022 or 2023.[104] In a statement on 10 May 2022, Secretary Bullard provided us with a table outlining the work undertaken so far and the work that is planned in respect of each recommendation. This document indicates that recommendations 16 (response protocols), 17 (partnership with police) and 21 (system reviews to be conducted following an incident of child sexual abuse) have been completed.[105]

The Department told us that it had 'taken immediate action' to implement recommendation 5 (to establish a Director of Safeguarding) and that it had appointed Elizabeth Jack to the position of Executive Director of Safeguarding.[106]

The Department also stated that it has completed one other recommendation —recommendation 19 (improving public access to information about student safeguarding). The Department said this recommendation was satisfied by including on its website 'pages and information relating specifically to Safeguarding Children and Young people'.[107] The Department told us it will continue to update its website.[108] In Chapter 6, we discuss how the Department has generally improved access to safeguarding information.

Secretary Bullard provided us with another update in September 2022 on the Department's progress on implementing the Independent Education Inquiry's recommendations. While not specifically linking the Department's work on implementation to particular recommendations, the Secretary told us that the Department's 'activity in relation to the recommendations' included:

- consulting on a draft policy framework for safeguarding children and young people
- revising current policies and procedures 'to incorporate relevant information on safeguarding children and young people from the harm of abuse, including Mandatory Reporting, Grievance Resolution, Duty of Care, IT Conditions of Use, Work with Vulnerable People, Family Violence, and Billeting Students in Australia and Overseas'
- revising an online mandatory reporting training module
- working on embedding safeguarding officers in government schools
- engaging with the University of Tasmania on incorporating 'material on understanding, preventing, and responding to child sexual abuse, and trauma-informed practice in teacher training courses'
- developing a 'safeguarding professional learning module'
- improving the operation of the Department's case management platform to incorporate integrated 'safeguarding-focused recording, reporting, and monitoring capability'
- reviewing the Department's complaints and grievances processes to improve access by 'children and young people, parents/carers and the community'
- developing an external website with information for children and young people as well as parents and carers about abuse, including signs of abuse and where to go for help.[109]

Secretary Bullard told us that the system review conducted in response to a child sexual abuse incident in 2022 recommended improvements across several areas of the Department's procedures and responses.[110] He said the Department is using existing resources to finish implementing the system review recommendations, but that there

is overlap between these recommendations and those of the Independent Education Inquiry, as well as other work underway in the Office of Safeguarding.[111] We discuss this system review in Chapter 6.

In addition to allocating departmental resources to implement the 'system review' recommendations, Secretary Bullard told us that 'additional funding has … been allocated through the State Budget process to support rollout of the recommendations'.[112] This includes:

- $26.1 million over four years from 2022–23 and $9.7 million ongoing to appoint Safeguarding Officers in every government school
- $2.6 million over four years from 2022–23 and $600,000 ongoing for mandatory professional development for all departmental staff towards understanding, preventing and responding to child sexual abuse in schools
- $1.27 million over two years from 2022–23 to provide more support for children and young people affected by harmful sexual behaviours, including four full-time-equivalent senior support staff with specialist expertise
- $3.8 million over four years from 2022–23 and $1.68 million ongoing to employ additional psychologists and social workers to directly support schools
- $2.6 million over three years from 2022–23 to fully staff the Office of Safeguarding to meet the demands of the work required to support all safeguarding-related activity across the Department.[113]

The 2022–23 State Budget states that resourcing for the following Independent Education Inquiry recommendations will come from the Department's existing resources:[114]

- Recommendation 7—all schools should appoint a school staff person to the role of Safeguarding Officer. This includes allocating $26 million for 72 full-time-equivalent positions across all schools.[115]
- Recommendation 9—training for principals, teachers and assistants should include information about understanding, preventing, identifying and responding to child sexual abuse.
- Recommendation 10—developing training materials, instructions and guidelines for teachers and support staff in relation to 'reporting and recording concerns about staff and student behaviour that may be relevant to preventing sexual abuse, but that fall below the threshold required by the Department's Mandatory Reporting Procedures'.[116]

In April 2023, the Department released *Safe. Secure. Supported. Our Safeguarding Framework*, which sets out an 'overarching approach to safeguarding children and young people from abuse'.[117] Through this framework, the Department may have begun addressing some of our recommendations in this volume, but we could not fully consider this, given that we had ended the inquiry stage of our Commission of Inquiry when the framework was released. We have retained our recommendations considering this.

4 Conclusion

In this chapter, we have described the Tasmanian education system, focusing particularly on children in government schools. We have also discussed the recent Independent Education Inquiry and the Government's response to this. In the following chapter—Chapter 5—we present case studies that highlight the challenges the Department faces in preventing and responding effectively to child sexual abuse in schools.

Notes

1 Our Commission of Inquiry heard of these ongoing problems from victim-survivors, families and third parties who contacted us. For privacy and confidentiality reasons, we cannot publish details of these notifications.

2 Department of Education, *Key Data* (Report, 2022) 16. This figure includes students in Early Special, Kindergarten, Primary, Secondary, and Senior Secondary schools and is based on headcount.

3 Department of Education, *Key Data* (Report, 2022) 16. In respect of gender, 29 students preferred a term other than male or female and six preferred not to nominate a gender.

4 Department of Education, *Key Data* (Report, 2022) 17.

5 Department of Education, *Annual Report 2021–2022* (Report, 2022) 4.

6 Department of Education, *Annual Report 2021–2022* (Report, 2022) 4. The Department of Education also provides eSchool services for students who cannot attend a physical school and 12 Child and Family Learning Centres across the State.

7 Statement of Ann Moxham, 27 April 2022, 3, Table 3.1.

8 Statement of Ann Moxham, 27 April 2022, 3 [3.2–3.4].

9 Teachers Registration Board Tasmania, *Watched Registrations* (Web Page, 2021) <https://www.trb.tas.gov.au/watched-registrations/>.

10 Statement of Ann Moxham, 27 April 2022, 3 [3.6].

11 Statement of Ann Moxham, 27 April 2022, 4 [3.6].

12 Teachers Registration Board Tasmania, *Limited Authority to Teach* (Web Page, 2021) <https://www.trb.tas.gov.au/limited-authorities-to-teach/>.

13 Department of Education, *Annual Report 2021–2022* (Report, 2022) 33. The total full-time-equivalent count was 8,661.94.

14 Department of Education, *Annual Report 2021–2022* (Report, 2022) 33.

15 Department of Education, *Annual Report 2021–2022* (Report, 2022) 33.

16 The calculation of the average age of teachers is based on ages for all teaching positions (Base Grade Teachers, Advanced Skills Teachers, Principals and Assistant Principals, and Non-School Based Band 4).

17 'Tas Education Minister Urged to "Come Clean" on Teacher Numbers', *Education HQ* (online, 4 March 2022) <https://educationhq.com/news/tas-education-minister-urged-to-come-clean-on-teacher-numbers-115236/>; Will Murray, 'Tasmania's COVID-19 Backfill Plan to Use Relief Teachers May Fall Short', *ABC News* (online, 10 February 2022) <https://www.abc.net.au/news/2022-02-10/relief-teachers-reject-covid-backfill-plan/100816986>.

18 Department of Education, *Annual Report 2021–2022* (Report, 2022) 34.

19 Australian Bureau of Statistics, 'Schools', *Education 2022* (15 February 2023) Table 90a <https://www.abs.gov.au/statistics/people/education/schools/2022/Table%2090a%20Key%20Information%2C%20by%20States%20and%20Territories%2C%202021%20to%202022.xlsx>.

20 The number of Tasmanian Catholic schools is reported in Department of Education, *Annual Report 2020–2021* (Report, 2021) 87. The number of independent schools is reported in Australian Bureau of Statistics, '*Schools', Education 2022* (15 February 2023) Table 90a <https://www.abs.gov.au/statistics/people/education/schools/2022/Table%2090a%20Key%20Information%2C%20by%20States%20and%20Territories%2C%202021%20to%202022.xlsx>.

21 Non-Government Schools Registration Board, *Registration of Non-government Schools* (Web Page, 2022) <https://schoolregistration.tas.gov.au/registration-guidelines/>.

22 Peter Gutwein, 'Department Structures to Strengthen Tasmanian Outcomes' (Media Release, 24 February 2022) <https://www.premier.tas.gov.au/site_resources_2015/additional_releases/department_structures_to_strengthen_tasmanian_outcomes>. The media release explained: 'The changes will be phased in from 1 July 2022, in a staged approach to be completed by 30 September 2022 and the Department of Communities will not exist after this date'.

23 Peter Gutwein, 'Department Structures to Strengthen Tasmanian Outcomes' (Media Release, 24 February 2022) <https://www.premier.tas.gov.au/site_resources_2015/additional_releases/department_structures_to_strengthen_tasmanian_outcomes>.

24 Statement of Timothy Bullard, 12 September 2022, 12 [46].

25 Department for Education, Children and Young People, *DECYP Organisational Chart* (Web Page, 30 April 2023) <https://publicdocumentcentre.education.tas.gov.au/library/Shared%20Documents/DECYP-Organisation-Chart.pdf.>.

26 Department for Education, Children and Young People, *DECYP Organisational Chart* (Web Page, 30 April 2023) <https://publicdocumentcentre.education.tas.gov.au/library/Shared%20Documents/DECYP-Organisation-Chart.pdf>.

27 Department for Education, Children and Young People, *DECYP Organisational Chart* (Web Page, 30 April 2023) <https://publicdocumentcentre.education.tas.gov.au/library/Shared%20Documents/DECYP-Organisation-Chart.pdf>.

28 Department for Education, Children and Young People, *DECYP Organisational Chart* (Web Page, 30 April 2023) <https://publicdocumentcentre.education.tas.gov.au/library/Shared%20Documents/DECYP-Organisation-Chart.pdf>.

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33 Department of Education, *Annual Report 2021–2022* (Report, 2021) 7.

34 *Teachers Registration Act 2000* s 6A.

35 Department of Education, *Annual Report 2020–2021* (Report, 2021) 51.

36 Teachers Registration Board, *About Us* (Web Page, 30 April 2023) <https://www.trb.tas.gov.au/about-us/>.

37 Teachers Registration Board, *Annual Report 2020* (Report, 2021) 2; refer also to Teachers Registration Board, *Code of Professional Ethics for the Teaching Profession in Tasmania* (undated).

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39 Transcript of Ann Moxham, 12 May 2022, 1006 [42]–1007 [1].

40 Tasmanian Government, *Government Services: Budget Paper No 2* (2022) vol 1, 55–57.

41 Department of Education, *Department of Education Response to Independent Inquiry into the Tasmanian Department of Education's Responses to Child Sexual Abuse* (9 November 2021) 1.

42 Sarah Courtney, 'Statement on the Release of the Independent Inquiry into the Tasmanian Department of Education's Responses to Child Sexual Abuse' (Media Release, 9 November 2021) <https://www.premier.tas.gov.au/site_resources_2015/additional_releases/statement_on_the_release_of_the_independent_inquiry_into_the_tasmanian_department_of_educations_responses_to_child_sexual_abuse>.

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56 Parliament of Tasmania, *Government Services: Budget Paper No. 2* (2022) vol 1, 57. The amount committed is '$3.8 million over four years from 2022–23 and $1.68 million ongoing to employ additional psychologists and social workers to directly support schools': Statement of Timothy Bullard, 6 June 2022, 13 [53].

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62 Refer to *Employment Direction No. 5 – Procedures for the Investigation and Determination of whether an employee has breached the Code of Conduct*; Stephen Smallbone and Tim McCormack, *Independent Inquiry into the Tasmanian Department of Education's Responses to Child Sexual Abuse* (Report, 7 June 2021) 10.

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64 Stephen Smallbone and Tim McCormack, *Independent Inquiry into the Tasmanian Department of Education's Responses to Child Sexual Abuse* (Report, 7 June 2021) 79, Recommendation 12.

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66 Stephen Smallbone and Tim McCormack, *Independent Inquiry into the Tasmanian Department of Education's Responses to Child Sexual Abuse* (Report, 7 June 2021) 66.

67 Stephen Smallbone and Tim McCormack, *Independent Inquiry into the Tasmanian Department of Education's Responses to Child Sexual Abuse* (Report, 7 June 2021) 11.

68 Stephen Smallbone and Tim McCormack, *Independent Inquiry into the Tasmanian Department of Education's Responses to Child Sexual Abuse* (Report, 7 June 2021) 11.

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70 Stephen Smallbone and Tim McCormack, *Independent Inquiry into the Tasmanian Department of Education's Responses to Child Sexual Abuse* (Report, 7 June 2021) 11–12.

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78 Stephen Smallbone and Tim McCormack, *Independent Inquiry into the Tasmanian Department of Education's Responses to Child Sexual Abuse* (Report, 7 June 2021) 26.

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84 Department for Education, Children and Young People, *Procedural Fairness Response*, 28 March 2023, 28.

85 Stephen Smallbone and Tim McCormack, *Independent Inquiry into the Tasmanian Department of Education's Responses to Child Sexual Abuse* (Report, 7 June 2021) 14.

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88 Stephen Smallbone and Tim McCormack, *Independent Inquiry into the Tasmanian Department of Education's Responses to Child Sexual Abuse* (Report, 7 June 2021) 74.

89 Stephen Smallbone and Tim McCormack, *Independent Inquiry into the Tasmanian Department of Education's Responses to Child Sexual Abuse* (Report, 7 June 2021) 75.

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93 Stephen Smallbone and Tim McCormack, *Independent Inquiry into the Tasmanian Department of Education's Responses to Child Sexual Abuse* (Report, 7 June 2021) 77.

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5 Case studies: Children in schools

Content warning

Please be aware that the content in this report includes descriptions of child sexual abuse and may be distressing or raise issues of concern for some readers.

We encourage readers to exercise discretion in their engagement with this content and to seek support and care if required.

1 Introduction

Many people who engaged with our Commission of Inquiry told us about their experiences of sexual abuse while they were students in a government school. Through written submissions, evidence provided in our hearings and sessions with Commissioners, we heard how children and young people in schools suffered abuse by teachers and, in some instances, by other departmental staff or by students.[1] Often, the trauma that these children and young people experienced was made worse by the inadequate responses of adults who were in a position to help but did not do so. However, in some instances, even when adults did try to help, challenges with the Department's policies and the State's disciplinary processes meant their efforts, while well intentioned, were largely ineffective.

Several victim-survivors told us in detail about the abuse they suffered, the lax responses they received and the devastating and lasting effects this has had on their lives. In each case, the effects of the abuse were worsened and prolonged by multiple systemic problems that meant they have felt the need to continue to advocate for change for many years after the abuse occurred. The experiences of these victim-survivors, when they were children in the aftermath of their abuse and later as adults in their engagement with the Department, reveal shortcomings in how the Department handled these matters. We heard, for example, that:

- In some cases, there was an unwillingness by departmental staff to believe children and young people when they reported child sexual abuse, and their disclosures were not handled in a sensitive, trauma-informed way. Victim-survivors told us about the devastating effects this had on them.[2]
- There was a lack of support provided to children and young people who disclosed abuse. In one case, a victim-survivor said that a member of school staff told her that it was her responsibility to make the abuse stop.[3]
- In seeking information or support from the Department and other entities such as the Teachers Registration Board, some victim-survivors were given inconsistent or inadequate responses. Also, the complexities of the processes involved were sometimes not properly explained, leading to expectations that were not met. Ultimately, this exacerbated the trauma experienced by some victim-survivors.[4]

We provide accounts of their experiences in this chapter (refer to Case study—Kerri, Case study—Katrina, Case study—Sam and Case study—'Wayne', which includes the experience of 'Rachel'). These accounts draw on the submissions made by these victim-survivors, the evidence they gave in our hearings and documents provided to us by the State about these matters. They also include, where possible, responses and explanations from departmental and other government officials. We are deeply thankful to these victim-survivors for sharing their stories.

We also closely examine a further three case studies of allegations against teachers (refer to Case study—'Mark', Case study—'Jeremy', and Case study—'Brad'), as well as one recent case study about harmful sexual behaviours (refer to Case study—'Andy'). Four of our case studies—those of 'Wayne', 'Mark', 'Jeremy' and 'Brad'—were drawn from information the Department provided about its recent responses to child sexual. abuse matters, and they clarify the Department's recent policies and disciplinary systems. We describe the Department's recent responses in general terms in Section 2. The case studies we discuss give a sense of the common challenges across the system and offer a guide to potential solutions.

Even as adults, many of the victim-survivors who engaged with our Commission of Inquiry were still navigating the effects of the abuse they experienced as children.

Their personal accounts and the case studies in this chapter highlight the toll of child sexual abuse in an education setting. These accounts and case studies also illustrate many of the themes we explore in this volume.

While some accounts of child sexual abuse outlined in this chapter were outside our scope because they occurred before 2000, they have continuing relevance to understanding how we can better protect children from child sexual abuse in education settings. Also, several cases in which abuse occurred before 2000 fall within our terms of reference because the Tasmanian Government responses to these incidents continued through the 2000s, 2010s and 2020s.

2 The Department's recent response to child sexual abuse

This section outlines the information the Department provided to our Commission of Inquiry about recent suspensions in response to allegations of child sexual abuse. In Chapter 6, we discuss the Department's responses to child sexual abuse and our recommendations for improving them.

2.1 The Department's recent review of matters

The Tasmanian Government gave us information about the number of employees suspended over allegations of child sexual abuse or related behaviours up until the end of February 2023.[5] In relation to the Department of Education, 43 employees were suspended between January 2000 and February 2023 for child sexual abuse.[6] Almost half of these (20) occurred since November 2020 (the date of the announcement of our Commission of Inquiry).[7]

Timothy Bullard, Secretary, Department of Education, explained (in his statement and in our hearings) the process that led to identifying and suspending these current departmental employees and the steps the Department took in relation to those employees. We give an account of that process below. We note, however, that this information and its analysis is limited to the period covered by the relevant statement or evidence provided to us. Further, the conduct of employees of the Department who have been suspended since 2020 sometimes related to matters that occurred long ago and should have been addressed at the time.

Secretary Bullard explained the process that led to these recent suspensions. He told us that the Department analysed 'matters of concern' involving departmental employees. These matters were identified through a variety of sources, including 'civil claims, redress applications, Right to Information requests, internal records and verbal information'.[8] Matters of concern were entered on a spreadsheet, initially to help the Department

estimate its liability for future redress and civil claims.[9] In December 2020, Secretary Bullard requested that the spreadsheet be analysed to determine how many departmental employees had a matter of concern on their file 'that could involve child sexual abuse'.[10] Initially, 21 employees were identified, but this later increased to 32.[11] By May 2022, we understand there had been 57 preliminary assessments into allegations or incidents of child sexual abuse or grooming behaviours conducted by the Department since January 2020.[12] Preliminary assessments, or 'preliminary investigations' as they are often called, are used to determine if the Head of Agency could, on the available evidence, form a reasonable belief that there has been a breach of the State Service Code of Conduct. We discuss preliminary assessments in more detail in Chapter 6 and Chapter 20.

The Department's Workplace Relations section examined the initial 21 matters in early 2021, with some matters noted as more serious than others.[13] Workplace Relations staff assessed five of these matters as most serious and gave these priority.[14] Secretary Bullard told us that all 21 matters were discussed with police.[15] Secretary Bullard then reviewed these matters to determine if 'further investigation or management action was legally possible and/or required'.[16]

Secretary Bullard consulted the Office of the Solicitor-General to determine whether new Employment Direction No. 5—Breach of Code of Conduct investigations could be initiated (that is, an investigation into whether an employee has breached the State Service Code of Conduct).[17] Workplace Relations then referred each matter to Secretary Bullard separately:

> … via a Minute for determination as to whether [he] had reasonable grounds to believe that a breach of the Code of Conduct may have occurred and an [Employment Direction No. 5—Breach of Code of Conduct] investigation was to be initiated.[18]

As indicated above, by May 2022, the Department conducted 57 preliminary assessments into allegations or incidents of child sexual abuse or grooming behaviours since January 2020, and 21 of these resulted in suspensions.[19] It appears that 50 of those assessments involved current employees.[20] Of the 57 preliminary assessments:

- 32 concerned historical re-examinations (or historical review matters), five of which resulted in Employment Direction No. 5—Breach of Code of Conduct investigations[21]
- 16 individuals, who we believe were subject to contemporary allegations, were also subject to Employment Direction No. 5—Breach of Code of Conduct investigations[22]
- another six matters involved relief employees (who we believe were 'marked as unsuitable for employment on the fixed term and relief employment register')[23]
- three matters were not referred for investigation.[24]

For the 32 employees subject to historical child sexual abuse allegations, the Department re-examined the matters to determine if previous 'management action was appropriate'.[25] As noted above, as at April 2022, five of those matters progressed to Employment Direction No. 5—Breach of Code of Conduct investigations. Secretary Bullard told us that of those five investigations, none had resulted in termination, and:

- two employees had received a sanction (for example, counselling or a lawful and reasonable direction)
- one employee had resigned (but the investigation was ongoing at the time of Secretary Bullard's statement)
- one employee was found not to have breached the State Service Code of Conduct
- one investigation was ongoing at the time of Secretary Bullard's statement.[26]

In relation to the 27 other employees subject to historical child sexual abuse allegations but not subject to an Employment Direction No. 5—Breach of Code of Conduct investigation:

- two were issued with a lawful and reasonable direction
- four relief employees were told they were not eligible for relief employment and would be subject to formal investigation should they seek employment with the Department in the future
- no other action was taken in respect of 20 employees because the Secretary determined the allegations 'as not child sexual abuse or unable to form a reasonable belief the code may have been breached or matter subject to previous formal investigation'[27]
- one matter was still under review at the time of writing.[28]

In September 2022, Secretary Bullard notified us that the Department had suspended another 13 employees between April and September 2022.[29] According to Secretary Bullard, these suspensions were primarily in response to 'allegations of inappropriate touching or inappropriate language … between a teacher and a pupil'.[30] Secretary Bullard said that while the number of new allegations in this period may be 'shocking', it indicates that people are 'getting the message' that:

> … if you are a member of staff that has concerns about the actions of a colleague, report it in; but also too that children and young people are feeling that they have agency to raise these matters with trusted members of staff.[31]

We agree with Secretary Bullard that the wave of new reports is likely to indicate cultural change, but we consider the data should continue to be monitored because effective change would see this number decrease over time.

Secretary Bullard highlighted that the Department has recently improved the supports offered to employees subject to allegations of child sexual abuse. Counselling and psychological support is now available to employees, where requested, and a 'liaison officer' is appointed to communicate with employees about the matter.[32]

We analysed many of the recent suspensions (from an earlier September 2021 list), including the Department's response at the time of the original complaints and Workplace Relations' more recent briefings to the Secretary. Through this process, we selected four case studies to explore in detail. We also discuss three case studies that provide victim-survivor accounts of child sexual abuse that occurred before the year 2000, and the Tasmanian Government's response (including responses by the Department and justice systems post-2000), as well as one recent case study about harmful sexual behaviours.

Case study 1: Kerri

Kerri Collins contacted our Commission of Inquiry to share her experience of reporting sexual abuse as a young child while attending a government primary school in Tasmania. Giving evidence at our hearings, she told us about the difficulties she encountered after disclosing the alleged abuse as a child and the barriers she faced in seeking resolution as an adult. Her story spans several decades and reveals multiple problems in the response of the government departments, agencies and regulators involved.

1 The alleged incident

John (a pseudonym) was a teacher at the primary school Ms Collins attended. He was young, charismatic and well liked.[33] In 1991, Ms Collins and three other girls at the school disclosed to the school counsellor allegations that John had sexually abused each of them on numerous occasions over a two-year period when they were in years 1 to 3.[34] The abuse allegedly occurred during school, usually in an isolated area on school grounds. The girls were 11 years old at the time they made these disclosures.[35]

2 The initial response

Ms Collins told us that while the school counsellor believed her disclosures, responded appropriately and took meticulous notes, the school principal's response was 'highly inappropriate'.[36] When he learned of the disclosures, and before contacting the students' parents, Ms Collins told us that the principal called her and the other students into his office, individually, to question them.[37] Ms Collins recalled that the principal then asked her to sit on the (female) assistant principal's knee to 'demonstrate … the physical position [she] was in when [she] was sexually assaulted [by John]'.[38] Ms Collins told us that it was 'retraumatising for a child to be put in that position', and that:

> It's even distressing thinking about it; at the time I remember feeling extremely uncomfortable about having to be put in that position … not only what I was saying wasn't being believed, I had to actually show them … it was just the two of them … I didn't know if I was in trouble, I didn't know if my parents had been told, I had no idea.[39]

Ms Collins said it was clear to her that the principal did not believe her disclosure, nor the disclosures made by the other girls.[40] This was confirmed much later, in 2018, when a police officer informed Ms Collins that at the time these events had occurred, the principal allegedly told police 'a good Christian man like [John] would not do something like this'.[41]

The school notified Ms Collins' parents of her disclosure, and they contacted police. Ms Collins then made a statement to police; however, as far as she is aware, they did not follow up or investigate these matters at the time.[42] John left the school after several of the girls' parents tried to confront him. Ms Collins told us that the school reported that John had been moved to another school.[43] Ms Collins did not hear anything more about John for many years. Throughout this time, Ms Collins said that:

> I was not offered support or counselling by the school, and it was always my understanding that the principal did not believe us and that John remained employed by the Department of Education. I didn't know what restrictions (if any) were placed on his ability to work as a teacher.[44]

In our education hearings, we asked Ms Collins if she knew what had happened in response to the complaints she and others had made against John in 1991. She replied that she did not because no one had told her, not even when she went to police for the second time in 2001.[45]

Police did not refer the matter to the Director of Public Prosecutions.[46] In a letter to the complainants in 2004, the then Director of Public Prosecutions wrote that he thought the decision not to charge John in 1991 was an error, based on a misunderstanding of evidentiary standards relevant to child sexual abuse at the time.[47] During our hearings, Ms Collins stated that she was not surprised by these comments, describing police failure to proceed with the case against John as just another example of how the system had failed her throughout the process, and continues to do so.[48]

3 What happened next

These events affected Ms Collins into adulthood. While at university, the reality of the fact that John was still teaching—and had most likely been doing so since the time of the original complaints 10 years earlier—came 'crashing down' on Ms Collins.[49] In 2001, Ms Collins contacted the Sexual Assault Support Service and the service arranged an interview with police. The investigation into John was 'reopened'.[50] The three other students who had made complaints about John in the early 1990s also gave statements to police. John was arrested and charged in 2002.[51] The Department of Education varied John's duties so he did not have contact with students.[52]

Ms Collins told us that her experience of providing information to police as an adult in 2001 was vastly different from her experience of being questioned as a child 10 years earlier. As a child, she recalled having been questioned by a male police officer in an interview room with no windows and without her parents present.[53] In contrast, when giving her statement in 2001, Ms Collins told us that the officer she spoke with was a woman, whom Ms Collins felt was clearly trauma-informed, and was open and

transparent about the process. Also, the interview took place at the Sexual Assault Support Service in a comfortable setting and in the presence of a trauma-informed worker from the service.[54]

John was committed to stand trial.[55] However, Ms Collins gave evidence that two weeks before John's trial was to begin, she got a phone call from the Director of Public Prosecutions saying he had decided not to prosecute John.[56] Ms Collins told us that she was 'furious' about the trial not proceeding and about the lack of information provided to her.[57]

We note that the *DPP Prosecution Policy and Guidelines* ('DPP Guidelines') now set out a process for informing complainants when a case is to be discharged. The DPP Guidelines state that such information should be imparted in person or, if this is not possible, by phone. The DPP Guidelines also outline the information that a complainant should be given.[58]

In the mid-2000s, concerned that John still had access to children in his role as a teacher, Ms Collins met with the shadow minister for education and contacted the then Commissioner for Children about her concerns.[59] She also contacted the Teachers Registration Board. Ms Collins told our Commission of Inquiry that her conversation with the Teachers Registration Board at that time left her feeling 'dismissed' and that the person she spoke to was 'extremely unhelpful'.[60]

Ms Collins recalled that the person she had spoken to at the Board told her she would need a lawyer to make a complaint about John and that it was unlikely she would succeed. She was also told that as part of the complaints process, she may have to appear in person with John in the same room. Ms Collins was unwilling to do this. Ms Collins' mother also wrote a letter to the Board about John but did not receive a reply.

In 2004, the Board received a registration application from John.[61] After considering a range of material in relation to John's application, the Board granted John registration.[62] The material the Board considered included a letter sent by the Department of Education advocating on John's behalf. Secretary Bullard and Ann Moxham, Registrar, Teachers Registration Board both condemned this letter.[63] Secretary Bullard agreed that the letter was 'entirely inappropriate' and was not focused on protecting children, and that Ms Collins was entitled to feel betrayed by such a letter.[64] Ms Moxham told us that the letter had two connotations: one was to pressure the Board and the other was to support the individual, both of which were inappropriate.[65]

Ms Moxham told us that, in re-examining the evidence that was before the Board when it made its decision to grant registration to John, it is not apparent that the Board sought any information about John from police (despite John having been charged with several offences). Ms Moxham also told us that the Board appears to have made its decision based on the matter having been dismissed in court.[66]

According to the Board, after contact with Ms Collins, the then Commissioner for Children wrote to the then Minister for Education outlining his concerns about the processes that had led the Board to grant registration to John. Ms Moxham wrote in a statement to us that this led the then Minister to request that the Board:

- develop written procedures for handling complaints
- establish a committee to review the process leading to the finding that John was of 'good character' (and his subsequent registration)
- review the decision to grant John registration if the committee determined that the process leading to John's registration was flawed.[67]

While the review called for by the Minister eventually led to changes to the Board's processes and procedures in respect of several matters, including how it deals with complaints and conducts inquiries, it did not prompt any change to John's registration.[68] John remained a registered teacher.

When we questioned why John's registration status remained unchanged after the review, Ms Moxham said this was 'difficult to understand', and in her view it was 'unforgivable'.[69] Ms Moxham conceded that the Board has still (at the time of our hearings) not examined how this failure occurred.[70] In relation to how the Board had handled Ms Collins' matter, Ms Moxham said: '[i]t is a really nasty black mark on our record, and I think our … current board is quite upset and concerned that this took place'.[71] She apologised to Ms Collins.

Around 2006, having exhausted other avenues, Ms Collins hired a lawyer to see if there was any other way to prevent John from teaching. Her lawyer advised that nothing more could be done.[72] At this point, Ms Collins was 26 years old and said her life had been 'on hold' for the past five years as she tried to navigate a complex and unsupportive system. She told our Inquiry: 'It had taken an enormous personal and emotional toll on me. I felt strangled by all of the doors that were closed as I tried to get someone to listen to me'.[73]

Ms Collins tried to put the alleged abuse, and the school and Department's responses to it, behind her and dedicated herself to her career and family. However, 14 years later, in 2018, she received a phone call from police. Much to her surprise, they wanted to speak to her about John. Another victim, now the fifth complainant to come forward with allegations against John, had told the National Royal Commission that she had been abused by John while she was a student at the same primary school as Ms Collins. Ms Collins agreed to speak with police.[74]

Police sought advice from Daryl Coates SC, Director of Public Prosecutions, in relation to the 2018 allegation against John, and about whether charges should be laid in respect of the historical allegations involving the original complaints.[75] In his response to police, and in his evidence to us, Mr Coates said that changes to the law since 2004 meant

that if the complaints against John had been made in 2022, the prosecution would proceed because the charges would be cross-admissible, and the complaints would be heard together:[76]

> In my view, if each complaint had been made now for the first time, there would be sufficient evidence to charge the accused with indecent assault with respect of the complaints made by [redacted]; aggravated assault with respect of the complaint made by [redacted]; and maintaining a sexual relationship with respect to the complaint made by Kerri Munro [now Collins]. Each complaint would be cross-admissible as tendency evidence in respect of the other complainants' complaint. The evidence shows that he has a sexual interest, which he acts upon, on young girls [around primary school age], who are in his care, where he takes them to [redacted] room and places his hands down their pants. Undoubtedly, if there was a trial the complainants' credibility would be strongly contested, given they had spoken to each other and made some inconsistent statements. However, that now would be a question of fact for the jury to consider and not a question of admissibility.[77]

However, this does not answer the question about whether, given those changes to the law, the original charges against John could now be revived. In short, the answer given to us was 'no'.

Mr Coates told us that because the charges had been 'dismissed' in the Magistrates Court, John could no longer be re-charged nor could the charges be used as tendency evidence in respect of the fifth complainant.[78] We note, however, that in respect of the complaint involving Ms Collins (in relation to which John was charged with 'maintaining a sexual relationship with a young person', now referred to as 'persistent sexual abuse of a child'), there were questions about whether the charges had in fact been dismissed. Mr Coates told us that a prosecution 'cannot now be instituted because the charges of indecent assault (at the time being that which underpinned any indictable charges of persistent sexual abuse of a child) … [were] dismissed in the Magistrates Court'.[79] Refer to Chapter 16 for discussion of this issue.

As to whether Ms Collins' earlier complaint had in fact been dismissed, Mr Coates said in his letter to police:

> There is some doubt whether the complaint was dismissed or just remained adjourned [indefinitely]. The original complaint has been destroyed. It has not been recorded on the accused prior convictions as being dismissed. The Court record appears to state that the complaint was never dismissed. I have spoken to [redacted], who is now a Crown Counsel in my office. He is of the view that if he was asked to dismiss both complaints he would have done so. However, in my view it does not matter because if we proceeded the matter would be discharged by a Court as an abuse of process.[80]

Mr Coates gave several reasons as to why, in his view, proceeding with a prosecution against John would amount to an abuse of process. He stated that while the prosecution may not have formally dismissed the complaint, this was an administrative oversight.[81] He continued:

> Some 14 years have passed since the assurances [that the complaint would be dismissed] were given, the importance of finality, where an accused has been led to believe that the matters have been finalised for so long means that any prosecution now would be so fundamentally unfair as to be an abuse of process.[82]

It is apparent to us that procedural issues and mistakes in this case led to a considerable injustice:

- Police failed to charge John in 1991 because there was 'no corroborating evidence to support the complaints in these allegations, therefore there [was] not sufficient evidence to support any charges under the Criminal Code', based on a mistaken belief that corroboration was required.[83]
- Complaints were laid against John without 'comprehensive advice outlining the law and the evidence', which led to the prosecution being discharged based on difficulties posed by the law and evidence at the time (2004).
- The original complaint was destroyed and was not officially recorded by the Court as being dismissed. This meant there were doubts for some time about whether Ms Collins' complaint against John was legally 'dismissed' or remained adjourned indefinitely. If the former, John could not be tried in the future, nor could Ms Collins' evidence be used as evidence to support that John had a tendency to abuse children in any other charge of child sexual abuse against John. This was viewed as an administrative oversight.
- Mr Coates eventually determined that the case was dismissed. Mr Coates told us that he had spoken to the relevant staff and was satisfied that the complaints were in fact dismissed. This had serious implications for using Ms Collins' evidence in future legal proceedings. Accepting that there was an administrative error, and the charges were dismissed, it appears to us that because of that error, Tasmanian law did not permit the Director of Public Prosecutions to correct that error and required him instead to dismiss the charges, despite the outcome not favouring the complainants.[84]

When asked by Counsel Assisting about the sense of injustice that Ms Collins (and the other victim-survivors) must be feeling in respect of this matter, Mr Coates said:

> Look, I can see, as I said in my letter, I can see from their point of view that it's an injustice: I mean, I think it's an injustice, but there's nothing I can do about it. And, having said that I think it's an injustice, I'm not saying it's an injustice because the 2004 decision was wrong, because I don't think it was wrong in accordance with the law as it stood at that time.[85]

Ms Collins told us that those working on the case informed her that the 2018 complaint did not proceed because, had it done so, John would have been denied natural justice.[86] Mr Coates told us that his advice outlines, in great detail, the legal reasons why the complaint could not proceed and denies that it said that the 2018 complaint did not proceed because John would have been denied natural justice. It is possible that Mr Coates' advice was not accurately communicated to Ms Collins by those working on the case. The investigating officer asked Ms Collins whether she wanted to read the report prepared by the Director of Public Prosecutions in respect of the case. Ms Collins, being upset at the time, declined to read the report. Some months later, however, she changed her mind and asked if she could see the report. She recalled that her request was refused, with police explaining that there had been a direction from 'above' in Tasmania Police not to share information about the case.[87] Despite this, Ms Collins recalled that Tasmania Police told her that the Director of Public Prosecutions' report had stated that if the initial complaints against John had been made in 2018, John 'would be charged, he would be tried, he would be convicted and he would be imprisoned'.[88]

The Teachers Registration Board suspended John's registration to teach in 2020.[89] He retired from teaching in 2021. He has not faced trial in respect of any charges.

Case study 2: 'Mark'

This case study about a high school teacher, Mark (a pseudonym), is based on information the Department provided about its recent responses to child sexual abuse matters.[90]

1 The alleged incident

In 2016, a high school teacher, Jeff (a pseudonym), overheard two year 9 students, Jasmine (a pseudonym) and Heather (a pseudonym), discussing messages allegedly received by Jasmine from another teacher, Mark.[91] Jasmine and Heather told Jeff that Mark had been going through Jasmine's Facebook profile and 'liking' her photos.[92]

Screenshots of Mark's phone showed Mark contacting Jasmine with questions such as 'How's your holidays going?' and 'What you been doing?' Jasmine asked, 'who is this?' and 'why r u messaging me', later saying 'I reckon you should probably leave :)'.[93] Mark signs off 'Sorry my bad, drunk'.[94] Mark also commented 'nice sunset' on a photo Jasmine posted on Instagram.[95]

Jasmine told Jeff she felt quite intimidated by the fact that Mark had started talking to her and kept replying after she asked him to stop.[96] She later told a staff member that she felt uncomfortable about the exchange and avoided talking to Mark when she would see him at school.[97]

2 The initial response

Jeff reported the alleged incident to his principal, Justin (a pseudonym), and prepared a statement, which Justin provided to the Department of Education's Human Resources team.[98] After assessing the matter, the team referred the incident to a regional human resources manager, who conferred with Justin about how to manage the complaint.[99]

Justin sent a letter to Mark, which reflected his view that the alleged incidents did occur.[100] However, he accepted Mark's explanation that the contacts with Jasmine were made without Mark's knowledge, by a friend using his phone on one occasion, and a student using it on another occasion.[101] This explanation appears to have been accepted by Learning Services and Justin.[102] Mark was given a formal direction to ensure all his interactions with students in the future complied with the *Guidelines on Professional Standards for Staff* and that his mobile devices were kept secure to avoid opportunities for misuse.[103] He was warned that further instances of such conduct may constitute a breach of the State Service Code of Conduct, but no formal sanctions were imposed.[104]

There is no record of Workplace Relations being notified of the outcome of the matter.[105] No notifications were made to police, the Child Safety Service, the Teachers Registration Board or the Registrar of the Registration to Work with Vulnerable People Scheme at that time.[106]

3 Departmental review

The Department identified Mark's case as a 'historical' incident warranting re-examination. In 2021, Workplace Relations briefed the Secretary on Mark's case and advised that it 'did not amount to sexual misconduct' and was 'adequately investigated at the time'.[107] The Secretary relied on this advice and no action was taken.[108]
The Teachers Registration Board was notified about the allegation later in 2021.[109]

4 What we heard

We asked for information about the handling of Mark's case, including a statement from Secretary Bullard.

Without making definitive findings in relation to the matter, Secretary Bullard conceded there were some shortcomings in the investigation of Jasmine's complaint, noting that some aspects of the investigation did not comply with policies and procedures at the time.[110]

In relation to the initial response by the school, Secretary Bullard told us:

- There are no records to suggest that Jasmine received any support or contact from a school social worker after making her complaint.[111] The principal, Justin, advised the Department that he was confident he had met with Jasmine on a number of occasions and offered psychological support, recalling that she was 'ok' and stating that the school social worker was likely to have made contact with Jasmine, but this could not be verified.[112]
- Justin did not follow up the allegation that a student had used Mark's phone to contact Jasmine, nor did he try to verify Mark's claim of someone else using his phone, by seeking information or statements that may confirm or contradict such a claim.[113]
- Learning Services did not provide Workplace Relations with copies of the text messages sent to Jasmine, nor Mark's response to the complaint at the time of the investigation.[114]
- Neither Justin nor Learning Services drew Mark's attention to the Social Media Policy (2014) in place at that time, which made it clear that communications of a 'personal nature' with students is inappropriate.[115]
- Neither Justin nor Learning Services reported the outcome of the complaint (being Justin's letter to Mark) to Workplace Relations. This meant that the Teachers Registration Board was not notified about the matter at that time.[116]

In relation to reopening Mark's case, Secretary Bullard accepted he was not bound by the advice of Workplace Relations and was solely responsible for the decision on whether to proceed with an Employment Direction No. 5—Breach of Code of Conduct investigation.[117]

However, he described some problems with the advice he received in relation to Mark. These included:

- Workplace Relations may not have adequately established that Mark was not in control of his device, given that this explanation was not verified in any meaningful way, and that Mark himself claimed that he wrote the message 'sorry my bad, drunk' to Jasmine when he got his phone back.[118]
- Because Workplace Relations had not received screenshots of the messages to Jasmine, nor Mark's responses, these were not provided in the briefing to Secretary Bullard.[119] He only reviewed these later, in response to our questioning about the case.[120]

When making the initial decision, Secretary Bullard conceded he had formed the view that the allegations against Mark did not amount to sexual misconduct and that, at that time, he believed the matter had been dealt with because Mark had been counselled and received a formal direction.[121] However, in reviewing all the materials in light of our questions, Secretary Bullard told us that he has reflected on 'whether this was the right conclusion'.[122]

Secretary Bullard stated at hearings: 'I think there's a question on this one around whether it does constitute child sexual abuse … or simply a breach of a social media policy'.[123] However, he accepted that if the evidence against Mark had been reviewed in an investigation, that investigation might have revealed other 'pieces of data' relevant to Mark's conduct.[124]

Secretary Bullard advised us that he has referred Mark's case to Workplace Relations for fresh advice on a potential Employment Direction No. 5—Breach of Code of Conduct investigation.[125]

4.1 Justin

When we reviewed Mark's case, we learned that the principal of Mark's school, Justin, had been the subject of a disciplinary investigation earlier in his teaching career in response to an allegation that he had sex with a girl in her mid-teens after spotting her walking home intoxicated.[126] Justin denied he had sex with the girl, stating that he had only invited her into his house to ensure her safety.[127] Justin also reported that she had told him that she was 18 years old. During the investigation, the girl admitted that she had lied to Justin about her age but stated that she had told Justin she was under 18 years old.[128] At the time, the then Secretary reprimanded Justin 'for [his] action in leaving [himself] vulnerable to criticism as demonstrated by [the victim's] allegations of sexual intercourse'.[129]

Some years after this incident, Justin supported a teacher who challenged their termination for sexual misconduct towards students. As documented in a legal proceeding, Justin told this teacher that he had been promoted to principal despite being in a similar situation before. The teacher stated that Justin reassured him along the lines that the allegations would 'wash over'.[130]

In 2021, the Department also reinvestigated the allegations against Justin and concluded that he was not acting in the 'course of employment' at the time of the incident, which meant his conduct was not linked to his obligations under the State Service Code of Conduct.[131]

5 What has changed

Secretary Bullard told us that several improvements have been made to policies and practice since 2016. Those most relevant to Mark's case include the following:

- An incident of this nature would now be referred to the Secretary for consideration as a matter of course, rather than managed at the school level.[132]
- The *Social Media Procedure* (2020) is explicit in stating that staff members must not 'friend' or 'follow' a student (or allow students to friend or follow them) unless they are family members, and the contact is reasonable.[133] Mark's conduct would reflect a 'direct contravention' of these guidelines and would be central to any employment investigation.[134]
- Training has been offered in relation to this new policy, particularly aimed at departmental social media administrators (for example, those who manage the Facebook pages of schools).[135]
- Current thresholds of what constitutes 'child sexual abuse' in departmental guidelines have been broadened in line with that used by the National Royal Commission to include grooming behaviours, noting that Mark's conduct was not considered to constitute grooming at that time.[136]
- The Office of Safeguarding has been established and is working to raise awareness among schools about inappropriate conduct and grooming behaviours to ensure principals are equipped to identify such conduct, make appropriate notifications and advise Workplace Relations.[137]

6 Systemic issues

We agree with the reflections of Secretary Bullard about shortcomings in the handling of Mark's case. We would add that the Department's response to this relatively recent incident also demonstrates:

- lack of understanding of the broad range of conduct that can fall within the definition of sexual misconduct—while the messages Mark allegedly sent may not have been overtly sexual in content, the Department should have been open to the question of whether they could be construed as flirtatious and whether they could have been perceived to be grooming behaviours
- a readiness to minimise and downplay the seriousness of incidents without adequate investigation, recognising that in some instances the scale of the risk to children may only be uncovered by taking proactive steps to uncover more information
- poor understanding of the respective roles and responsibilities of Learning Services and Workplace Relations, which appear to have operated independently without adequate information sharing and collaboration
- an inclination to accept the accounts of adults over the reported concerns of children and young people—the Department could have been more sceptical about whether it was plausible that two separate people on two occasions accessed Mark's social media accounts to send messages to students at Mark's school, and his explanation should have been met with greater scrutiny
- too much deference to the view of the principal—while Justin did seek some advice on how to manage the matter from a regional human resources manager, this was largely limited to process and there was no 'check' on his inclination to accept the explanation without further inquiry (this is particularly concerning given Justin's own complaints history)
- the 2021 departmental review was (again) quick to downplay the potential seriousness of this matter and lacked overall rigour.

We note that on a strict interpretation of the State Service Code of Conduct, which requires a direct link between employment and the conduct in question, the earlier incident involving allegations that Justin had sexually penetrated a girl under the age of consent, who had allegedly been drinking at the time, could not be met with the seriousness it deserved. We also have concerns about the Department's framing of that situation as being a risk to Justin's career, rather than a potential risk to students —as well as not acknowledging the harm to the young woman involved.

Case study 3: 'Wayne'

This case study about Wayne (a pseudonym), a high school teacher, is mostly based on information the Department provided in relation to its recent responses to child sexual abuse matters.[138] Rachel (a pseudonym) gave evidence at our hearings.[139]

1 The alleged incident

In the early 2000s, Rachel was a smiley, bubbly and shy student who liked school.[140] Wayne, a teacher at her school, was well known in the small community in which they lived, and had a public image that made Rachel trust him.[141] Rachel told us that Wayne presented himself as 'more of a friend' to Rachel and, at the time, she thought he was a 'cool teacher'.[142] Rachel's mother, Anne (a pseudonym), was a single mother working two jobs who, after some convincing, accepted Wayne's offer to take Rachel to an activity outside school each week in which they were both involved and which Rachel was keen to pursue.[143]

When Rachel was 16 she went on an out-of-town trip connected to this activity with Wayne. Anne attended as her guardian and witnessed Wayne behave in an 'overly familiar' way with Rachel, given their teacher–student relationship.[144] Rachel told us that Anne had allegedly witnessed Wayne piggybacking Rachel, telling her she had a 'nice arse', drawing a penis on her ankle and tucking her into bed.[145] Wayne also gave Rachel a tank top imprinted with the words 'MILF in training'.[146] Anne described being 'in disbelief' when she allegedly saw Wayne kiss Rachel after he tucked her into bed.[147]

Shortly after the trip, in 2005, Anne reported her concerns about Wayne to the Department.[148] From the outset, Anne said the Department was 'very intimidating with my claim'.[149]

2 The initial response

Following a preliminary investigation, the Department advised Wayne of potential breaches of the State Service Code of Conduct in him buying the tank top.[150] An investigator was appointed to conduct a formal investigation.[151] Wayne was suspended from teaching pending the outcome.[152]

Rachel and Anne were allegedly told not to speak to anyone about the investigation and that if they did, they could be sued for defamation.[153] Rachel told us that she and Anne did not receive any counselling, support or check-ins during the process, which was particularly challenging for them because they lived in a small community where 'everyone seems to know everyone's business without actually knowing their business'.[154]

Rachel said that while she and her mother felt 'muzzled' during this time, Wayne allegedly put up petitions around the community asking people to support his reinstatement to his teaching role.[155] Rachel described the process as 'extremely slow and drawn out'.[156] Anne said: 'There was no one to help or advise me, I was not advised to contact the police or a lawyer. I felt isolated'.[157]

Rachel told us that she was scared and nervous speaking with the two male investigators the Department appointed to investigate her allegations.[158] She also told us that the interviews with investigators were 'gruelling'—that the questioning sometimes went for two hours, involved confronting questions and, on occasion, occurred without a support person of her choosing present.[159] Rachel said: 'I just felt like this little person with these men in suits hovering over the top of me'.[160]

Rachel also told us that she withheld some of her experiences with Wayne from the investigators. As an adult reflecting on this decision, Rachel stated: 'They did not make me feel that they would believe me'.[161] She explained that, at the time, she thought some aspects of her abuse were her fault and that she needed to protect Wayne from getting in trouble.[162] She spoke of crying in bed at night, asking herself 'Why me, why me, why can't I just tell them the truth?'[163]

During a later meeting with the Department, Rachel made more disclosures, including allegations that Wayne had kissed her and texted her that he loved her on a number of occasions, had shown her 'dirty jokes or videos' on his work computer and on at least one occasion had rubbed his hand up and down her leg and touched her crotch area over her clothing.[164] While telling investigators and her mother the extent of the alleged abuse, she said she 'had to sit on [her] hands because they would not stop shaking'.[165] Rachel told us that her mother was 'bawling her eyes out' as Rachel spoke.[166] She also told us that she was asked to demonstrate, to the adults in the room, how Wayne had touched her.[167] Other disclosures that Rachel made include allegations that Wayne:

- gave her alcohol
- would sometimes put a finger in her mouth and make her suck or would put her finger in his mouth and suck it
- gave her a letter at school saying he loved her and asking her to reply
- told her that once she left school and was 18 they could start dating
- told her to put her phone down her pants so that if she received text messages it would vibrate near her genitals.[168]

Rachel also made a statement to the Teachers Registration Board a few months after her later disclosures to the Department.[169]

Shortly after Rachel made these additional disclosures, the Department contacted the Child Protection Advice and Referral Service (as it was called then). The service informed the Department that once it formally received the allegations, it would notify police under the mandatory reporting protocol.[170] In mid-2007 the then Secretary of the Department was briefed on the additional disclosures and advised that:

- the allegations about the inappropriate computer material should not be pursued because it was difficult to establish, on the available evidence, whether the material was inappropriate (or the extent of its inappropriateness)[171]
- no other action should be taken in relation to the other allegations because the events took place outside school hours and outside school grounds, and that there were no witnesses and no more sources of evidence that could be pursued.[172]

In relation to the allegation that Wayne had given Rachel a tank top with an inappropriate message on it, the Department found that:

> [Wayne's] behaviour in this matter had the potential to adversely affect the integrity and good reputation of the State Service. However, given that the tank top has not been worn [by Rachel], it is not possible to establish a community view, regarding [Wayne's] actions bringing the State Service into disrepute, about a garment that has not been seen in public.
>
> Accordingly … [the Secretary was] unable to substantiate that a breach of part 14 of the *State Services Act 2000* Code of Conduct has occurred.[173]

Rachel maintains that she did in fact wear the tank top with an inappropriate message on it and that the Department made a mistake in concluding that she did not.[174]

Most of Rachel's complaints were then formally referred to the Child Protection Advice and Referral Service, with a note from the Department that read in part: 'the department is not in a position to investigate the majority of these alleged incidents as they took place outside the school environment'.[175] Police notified the Department that they would not pursue the allegations.[176]

The then Secretary of the Department of Education sent Wayne a letter stating that 'all current [Department of Education] investigations are now concluded and I consider that these matters to be at an end and no formal sanction has been applied'.[177] The letter warned Wayne not to place himself in a position in the future where his 'conduct and behaviour towards students could be deemed to be inappropriate'.[178]

In 2007, a joint statement between Wayne and the Department was published in a local paper, which read: 'After an extensive investigation the Department of Education has determined that [Wayne] has not breached the *State Service Act 2000* Code of Conduct'.[179]

Rachel described feeling 'hurt, confused, betrayed and neglected' by the Department, which had not communicated any outcome to her or given her any reasons for its decision.[180]

Around this time, Rachel reported the allegations of abuse to police.[181] After writing her statement by hand, as instructed by Tasmania Police officers, she was told that a possible charge against Wayne of 'assault with indecent intent' under the *Police Offences Act 1935* ('Police Offences Act') had to have been reported within 12 months of the incident, which meant Wayne could not be charged or convicted of this offence.[182] The brief to the Secretary at the time stated that police had incorrectly advised the Department that the offence had a statute of limitation of two years.[183] Rachel said she felt extremely let down by the justice system and felt she was 'hit with a dead-end; no support and no closure'.[184]

In the same year, Wayne applied for renewal of his teaching registration with the Teachers Registration Board. In his application, Wayne declared that he had been the subject of an investigation.[185] The Board requested more information from Wayne, and from Anne and Rachel.[186] The Board also sought information from the Department about its investigations into Wayne's conduct. The Board was advised that all investigations had been concluded and that no breach of the State Service Code of Conduct had been found.[187] Despite this, the Board determined in 2008 that Wayne was not 'of good character' and refused to renew his registration.[188] Wayne sought to appeal the decision in the Magistrates Court, but his appeal was denied because it was not lodged within the relevant statutory time limit.[189]

In 2009, Wayne tried again to renew his registration. He provided a range of written references in support of his application.[190] Following advice from the Office of the Solicitor-General, the Board granted him registration for one year.[191] This came as a shock to Rachel, who reported receiving assurances from the Board that Wayne would never teach again.[192] She said she did not understand the various registration and renewal processes and what information Wayne had provided as part of those processes.[193] Rachel told us: 'I very much feel that, until this day, that we have been portrayed as liars'.[194]

3 Departmental review

Rachel's allegations were reinvestigated in 2021 as part of a broader review of historical complaints about current employees. As a result of this review, Wayne is the subject of a formal disciplinary investigation.[195]

Wayne's registration as a teacher was suspended in 2021, after his Registration to Work with Vulnerable People was cancelled.[196] Wayne then resigned from his position.[197] Department and Board investigations are ongoing.[198]

4 What we heard

When giving evidence at hearings, Rachel described her motivation for coming forward:

> I just don't want anyone to ever go through what I've gone through …[199]
>
> I want to advocate for those children that usually, that can't speak; I want to advocate for parents or caregivers that—I've seen what it's done to my mother. I've physically seen how it's just ripped her apart, how it's ripped me apart.[200]

Rachel went on to describe the impact of the abuse allegedly perpetrated on her, which includes nightmares, flashbacks and a diagnosis of post-traumatic stress disorder requiring medication to manage.[201] She refuses to place her children in a government school and described being overprotective and hypervigilant about her daughters' safety.[202] She has since left the community where she grew up (and where Anne still lives), saying 'I didn't want to stay there, and even today I'm so fearful of being in that community'.[203]

Anne told us that the impacts of Wayne's conduct and the response of the Department have also been ongoing for her:

> I am currently struggling with the stress and flood of emotions from [that time]. I struggle with trust issues and still feel ostracised by the staff that were at the school at the time of my complaint. The process is flawed and favours the perpetrator and protecting the Education Department's reputation.[204]

In response to requests for information about the handling of Wayne's matter, Secretary Bullard reviewed the Department's records, which caused him 'both personal and professional distress'.[205] He conceded a range of shortcomings in the Department's response, including the following:

- Certain allegations did not form part of a further investigation due to a limitation in the State Service Code of Conduct itself, rather than a shortcoming or failure of the Department, on the basis that they were 'not in the course of employment'.[206] However, the Department should have investigated Rachel's additional disclosures.[207] Secretary Bullard stated that the behaviour Rachel reported is 'entirely inappropriate of a teacher towards a student' regardless of whether it occurred in or outside the school environment.[208] He also stated that the Department's *Conduct and Behaviour Standards* were not referenced in any correspondence between the Department and Wayne. These standards provide that teachers should conduct themselves in a manner that does not bring the Department into disrepute, including outside school hours.[209]
- In relation to Rachel's initial disclosures, the question of whether she wore the offensive tank top was irrelevant to a determination of whether Wayne damaged the integrity and good reputation of the State Service. The gift of the item to Rachel (which he admitted) was grounds to consider that misconduct had occurred.[210]

- Wayne does not appear to have been advised about the additional disclosures Rachel reported.[211]
- Not all of Rachel's additional disclosures were investigated, but one that was —her allegation that Wayne had shown her inappropriate jokes or videos—was not investigated consistent with the relevant employment direction.[212] The allegation that Wayne gave a personal letter to Rachel at school appears to have been overlooked.[213] Secretary Bullard conceded that the failure to investigate all the matters disclosed by Rachel put other children and young people at risk.[214]
- The Department received more information about Wayne's conduct towards other young people, but there were no records to suggest that these allegations were investigated or provided to police.[215] One student made allegations about Wayne's conduct in relation to a former student and was ultimately forced to apologise to Wayne, at Wayne's insistence. Secretary Bullard described this as 'appalling' and as sending a signal to other young people that concerns were not worth raising.[216]

Secretary Bullard also acknowledged:

- Placing an advertisement in the local paper stating that all investigations into Wayne had been concluded was 'a significant failing' of the Department and 'horrifying' for Rachel.[217] It was also misleading, given Rachel's additional disclosures.[218]
- There was no evidence of support offered to Rachel and others involved in the matter.[219]
- The investigation took too long to be completed (more than two years).[220]
- The Department did not proactively notify the Teachers Registration Board of Rachel's complaints (the initial or later disclosures), which meant that the Board did not have knowledge of these matters until Wayne disclosed them when trying to renew his registration. Secretary Bullard conceded that Wayne's summary of the matter to the Board omitted details.[221]
- Correspondence from the Department in response to the Board's request for information when Wayne sought re-registration did not provide a 'proper, complete and accurate outline' of Rachel's disclosures—the Department only provided information about the limited matters that were investigated.[222] Secretary Bullard conceded that the Department, by omission, misled the Teachers Registration Board in this letter.[223]

Secretary Bullard said that if Rachel's complaint were made in 2022, it would be managed differently.[224] He told us that Wayne would be asked to leave the workplace pending a disciplinary investigation, appropriate notifications would be made to all relevant agencies, and the Secretary would make a determination about his conduct.[225]

Also, Rachel and Anne would have access to the school social worker and psychologist, and appropriate referrals would be made to support services, including sexual assault services.[226] There would also be a less restrictive interpretation of what constitutes 'in the course of employment' under the State Service Code of Conduct, to enable the Department to hold teachers to account for inappropriate conduct that occurs outside school hours, as evidenced by the investigation into Wayne.[227]

Reflecting on Rachel's discomfort with the male investigators who interviewed her, Secretary Bullard noted that there have been discussions in the Department about strategies to ensure an appropriate balance in the gender composition of investigators.[228]

Secretary Bullard went on to note that Workplace Relations now provides the Teachers Registration Board with a copy of the Employment Direction No. 5—Breach of Code of Conduct letter sent to the employee and 'all relevant documentary evidence'.[229] The Board also receives the outcome of the Employment Direction No. 5 investigation as well as statements obtained during the investigation, where witnesses have given permission for these to be shared.[230]

Secretary Bullard recommended that, in the future, more wide-ranging language be used in the State Service Code of Conduct to directly capture conduct that 'arises from employment' or is 'connected to employment', such as teachers' conduct outside of school hours.[231] He told us the Department is adopting an expansive interpretation of these terms, which has not (yet) been tested by legal challenge.[232] We make recommendations for changes to the State Service Code of Conduct in Chapter 20.

5 Systemic issues

We agree with Secretary Bullard's reflections on the shortcomings of the Department's handling of Wayne's case. However, we express further shortcomings:

- The investigation process was not trauma-informed, child-centred or designed to elicit the best possible information and evidence to support the investigation. It failed to understand specific considerations that must be given to interviewing children and young people—including the need for shorter sessions, a safe and comfortable environment, the presence of trusted support people, and sensitive and appropriate questioning by an investigator that feels safe for the young person. It also failed to recognise that children and young people often disclose information in stages (as Rachel did) rather than all at once.
- Relevant policies and procedures were not followed, or referenced, in engagement with Wayne. Even at that time, policies required that teachers not bring the Department into disrepute outside the school environment.

Notifications to the Child Protection Advice and Referral Service were only made in response to Rachel's further disclosures, when arguably the Advice and Referral Service should have been notified immediately, ahead of the initial Employment Direction No.5—Breach of Code of Conduct investigation.

- Rachel and Anne did not receive adequate support, care and communication throughout the investigation process. Assurances given to them (for example, that Wayne would not return to the school, or be able to be registered) were not implemented, which was highly upsetting and stressful for both.
- The approach to the investigation was overly technical and legalistic, which led to an unacceptable narrowing of the investigation and a failure to consider a pattern of behaviour that may amount to grooming. These failures meant that Rachel's disclosures were not investigated properly and potential risks to other children and young people were not identified and addressed. The Department appears to have been intimidated by Wayne's litigious and aggressive attitude towards the investigation and adopted an overly conservative approach to its own powers in response.
- The investigation took too long (notwithstanding the subsequent disclosures), which added to Rachel and Anne's distress, particularly given the upsetting dynamics the matter created in the small community in which they lived.
- The publication of the joint statement in the local paper in 2007 suggesting a comprehensive investigation into Wayne's conduct that effectively cleared him of any wrongdoing was appalling and cruel, particularly given the community context and that this was how Rachel and Anne discovered the outcome of the initial investigation.
- The letter from the Department to the Teachers Registration Board about Rachel's disclosures was misleading and inhibited the Board from properly executing its functions and responding to risks that Wayne may have posed to students. Overall, there was poor information sharing between the Department and the Board.
- That Wayne was re-registered (notwithstanding the substantial concerns held by the Board about his fitness to teach) following the Office of Solicitor-General's advice suggests that this advice failed to show adequate regard for child safety.
- Delays and failures by the Department and the school to report Rachel's allegations to child protection contributed to her allegations not being raised with police until after the statute of limitations had expired.
- There should not be a limitation period in the Police Offences Act in relation to offences connected to child sexual abuse. We note that this limitation period was removed in April 2023 through the *Justice Miscellaneous (Royal Commission Amendments) Act 2023*.[233]

Case study 4: Katrina

Katrina Munting gave evidence at our hearings and shared her experience of being sexually abused while attending a state-run high school in Tasmania. Ms Munting enjoyed school; she was studious and wanted to be the first person from her family to go to university. However, Ms Munting told us that her life was drastically changed after being sexually abused by a teacher named Peter (a pseudonym) at her school.[234]

1 The incidents

Ms Munting was in year 9 in 1998 when she attended a school camp with Peter.[235] She recalls that Peter was very accommodating and that he engaged with the students in a friendly and familiar way. However, looking back (and with the benefit of her now considerable experience as a teacher herself), Ms Munting said that she now sees Peter's behaviour on this camp as being too familiar.[236] Peter had brought his dog to the camp, which allowed him to more readily initiate conversation with students and to be in close contact with them, particularly the female students:

> In break times, he would consistently be with groups of predominantly female students and engage in the students' personal conversations, rather than being with other staff … He would give … female students the job of 'watching' his dog. He was overly interested in the private lives of my peers and he was not concerned about how it would look for him to be having one-on-one conversations with students over the duration of the camp, which I observed him doing openly. In retrospect, I am concerned he was attempting to work out who would be an 'available' victim.[237]

A few months after camp, Ms Munting needed help with a school project. Although Peter was not her teacher at the time, he nevertheless volunteered to help. It was during this time that Peter's inappropriate behaviour towards Ms Munting escalated. As they worked together, he would 'accidentally' touch her. This progressed over time to his touching becoming 'more sexualised'.[238] Peter's change in behaviour was subtle and happened over time. It was not until Peter began to touch Ms Munting's breasts and buttocks that she realised it was 'definitely sexualised and not right'.[239] Despite this realisation, Ms Munting told us:

> I froze and allowed him to do as he will. As time progressed and the abuse became more intense, I increasingly realised how wrong it was; however, by then it was all too late to 'get out'.[240]

Later that same year, Peter singled Ms Munting out to go on another camp—one that was generally only attended by year 10 students. Peter's request was highly unusual and, had the invitation been made under different circumstances, Ms Munting told us that she would have been flattered.[241] However, given the ongoing abuse that was happening, she said she suspected Peter had ulterior motives for asking her to attend.[242] These misgivings proved correct, and Peter sexually abused Ms Munting during the camp.[243]

Peter continued to abuse Ms Munting during the school holidays between years 9 and 10. Ms Munting told us that he had her lie on the floor of his ute and drove her to his house where he sexually abused her.[244] Peter also became more intense verbally, telling Ms Munting that he loved her. He also often insisted she phone him (because if he called her, it would raise suspicion with Ms Munting's parents) and during these calls would insist she meet up with him.[245]

Ms Munting began year 10 in 1999 and the abuse continued. The frequency of the abuse was 'similar if not more frequent' during that period, and the amount of time that Ms Munting was spending with Peter had not gone unnoticed.[246] Halfway through term 2, one of Ms Munting's teachers (a senior teacher at the school) allegedly took her aside while she was in the library with her classmates and told her that it was not normal for her to be spending so much time with Peter. Ms Munting was mortified.[247] She told us that she:

> … ran from the room in tears and cried my eyes out in the toilets. I thought that the floodgates of hell were about to open. I thought that I would be in trouble from Peter, my parents and the school.[248]

Ms Munting also told us that she feared that 'her world was about to end', that all her goals and hopes for her future—her perception of what her life was going to be—had 'been shattered' because someone knew about what had been happening.[249] However, some time went by and despite her fears she did not get in trouble—in fact, nothing happened at all. Ms Munting said that her parents were not told and there was no follow-up by the school.[250]

When asked to reflect on how this senior teacher had allegedly communicated with her about Peter, Ms Munting replied that the conversation should not have taken place during class time and in the presence of her peers. Also, the teacher should have known that the nature of the conversation required that support be on hand during and after the conversation. Instead, no teachers came to find her or checked to see if she was okay. Ms Munting pointed out that the teacher who had confronted her clearly had suspicions about Peter and yet did nothing about them, other than to direct a veiled accusation at her:

> In hindsight those words, they haunt me: 'It has been noticed that you and Peter are spending time together or too much time together and that is not normal'. To say those words to a student and then do nothing to make it stop.
>
> Why wasn't Peter the one having that conversation? Why was he not getting in trouble? I was getting in trouble for what I was trapped in, and then for that to not have any follow-up was devastating … they had mortified me by what they had said, but what's even worse is, they hadn't acknowledged what they thought was going on and they did not make it stop. The abuse continued, he did not desist. I was the one that was expected to make it stop, I was the one that made it stop.[251]

Ms Munting said that sometime later she was told Peter had also been approached and told to 'watch himself':

> … that was it. Not that his actions were inappropriate, [or] what he was doing was criminal: 'Watch yourself'. In other words, 'Keep doing it, just do it better so no-one notices, will you?' Like, that's how I read that, 'Watch yourself'. How pathetic.[252]

The conversation with the senior teacher deeply frightened Ms Munting. She began to make excuses whenever Peter summoned her and tried to avoid being in places where he could abuse her. The abuse became less frequent and eventually, despite still being afraid of Peter, she stopped responding to him at all.[253] Ms Munting told us that a part of her thought that once suspicions had been raised, the abuse would stop. However, this was not the case. Ms Munting told us that she was 'devastated' that nothing was done: 'I had to make it stop and that was excruciating trying to work out how do you do that, how do you make something stop? It's essentially an ingrained pattern of power'.[254]

In response to her avoiding him, Ms Munting said that Peter began to leave notes for her in her locker insisting that she continue to meet with him, that he had to see her, and that he loved her. Ms Munting destroyed these letters.[255] Ms Munting told us that eventually Peter's behaviour towards her turned to disdain. She recalls that he would pass her in the hallway and, if no one was close by, he would mutter things like 'bitch' at her.[256]

Later in year 10, the school placed Ms Munting in Peter's class.[257] Three times a week that term, Ms Munting had to sit in class with her abuser for an hour. Ms Munting said she was 'deeply scared about what had happened, and ashamed'.[258] She tried to put it all behind her and focus on her studies.[259]

2 The disclosure

Ms Munting found she could not bury what had happened to her, so in 2000, she disclosed some of the abuse to her boyfriend. Ms Munting's boyfriend and his father then confronted the school.[260] The school principal took the complaint seriously, and Peter resigned from his position soon after.[261] Ms Munting was allegedly told that Peter would never teach again.[262] However, Ms Munting recalls that the school did not contact Ms Munting's parents about the abuse at any time. Nor did the school inform her about any investigation into Peter's behaviour. Ms Munting did not receive any support or counselling from the school. As far as Ms Munting is aware, police were never contacted.[263]

Ms Munting's mental health suffered over the years, and she eventually decided that, to progress in her healing process, she needed to report her abuse to police. With the encouragement and support of a friend who was a police officer, Ms Munting made a formal statement to police. This was a difficult process, and Ms Munting recalled that the detective 'demonstrated belief in all I had to say in my interview. The second detective in the room was a female; this helped'.[264] She told us that it was empowering to be 'heard and believed'.[265]

Peter was charged and eventually pleaded guilty to some of the charges, but he disputed various facts.[266] This meant that Ms Munting was subjected to 'cross examination as part of a "disputed facts hearing"' process that was 'harrowing and mortifying'. She told us that Peter sat close by and made 'dismissive noises and gestures while [she] was … being questioned by the Crown and the defence'.[267] The case was emotionally draining and psychologically painful for Ms Munting, and while she told us that she was well looked after by the Crown Prosecutor and witness support staff, overall, her experience of the criminal justice system was 'devastating'.[268]

Peter was sentenced to three years' imprisonment.[269]

While criminal proceedings were important to Ms Munting, she told us that she also wanted the Department of Education to admit its wrongdoing and to be held accountable.[270] A year after giving her statement to police, Ms Munting began writing to the Minister for Education requesting to speak with him so she could share her story. Each week for 16 weeks, Ms Munting wrote a unique letter to the Minister requesting an audience. She recalled receiving two or three replies—all declining her requests.[271] After the 16th week, she told us she received a reply that was different in nature and a meeting was arranged with the Deputy Secretary of the Department. Ms Munting told us that this was a good discussion and that the Deputy Secretary listened and apologised to her, though she thought that the Secretary should have attended the meeting. She believed she had been palmed off to the Deputy Secretary to shut her up.[272]

Ms Munting said that an apology from the Minister for Education would be 'exceptionally important'.[273] She told us that any such apology needs to be:

> … more than just that they're sorry that I was abused in their institution, you know, they need to be sorry that I was abused in their institution and they chose to ignore it, and they chose not to follow it up, and they chose to ignore me, and … they need to name up exactly what it is that they're sorry for, because I don't want a hollow 'I'm sorry'. What are you sorry for? Because, not only have I been devastated by the abuse, the fallout that I've had to deal with since has made it so much worse.[274]

3 The response

When asked about Ms Munting's and other witnesses' evidence to our Commission of Inquiry, Secretary Bullard apologised for the past failings of the Department and acknowledged the 'lasting, ongoing and negative impact that that has had on victims and survivors'.[275] He also acknowledged the Department's failure to help victim-survivors to recover and heal.

When asked specifically about Ms Munting's evidence in relation to what an apology should mean, Secretary Bullard said that the significance of the apology to Ms Munting was:

> … the Department's recognition of the harm that it's caused … the significance is to each and every person that receives that; they will make a determination about how important or not, how much validity or not they provide to that; all I can do is lead with my heart and provide that apology.[276]

In his statement to our Commission of Inquiry, Secretary Bullard also acknowledged the difficulties that could result from the Department's lack of communication with complainants.[277] Secretary Bullard apologised for the Department's past failings.[278]

Case study 5: 'Jeremy'

This case study about Jeremy (a pseudonym), a teacher, is based on information the Department provided in relation to its recent responses to child sexual abuse matters.[279]

1 The alleged incidents and response

Jeremy was employed by the Department of Education as a teacher until 2022.[280]

In 2012, several students at the same school made allegations about Jeremy's conduct.[281] These included allegations that he failed to maintain appropriate boundaries and that he was making inappropriate comments to them that were of a sexual nature.[282]

Departmental records show that, on becoming aware of the allegations, the assistant principal of the school met with each of the students separately to obtain information relevant to their complaints and had conversations with the students' parents.[283] Departmental records also show that the principal and assistant principal met with Jeremy to discuss the allegations, and that Jeremy admitted his behaviour 'was a bit loose' but 'not inappropriate' in the context of conversations with the students.[284] The principal's notes state that, in response, they told Jeremy that any 'conversation [with students] must be totally non-personal and not involve [a] sexual view of any nature. Not even [the] use [of the] word sex'.[285]

The assistant principal then sent an email to Jeremy outlining the actions that the school had taken in response to the allegations, including that the students involved had been moved out of Jeremy's class.[286]

With the assistance of the human resources team, the principal drafted a letter to the students' parents informing them that Jeremy had been spoken to about his unprofessional and inappropriate behaviour and had been made aware of his obligations under the State Service Code of Conduct.[287] Learning Services also sent a letter to Jeremy, confirming that his behaviour was inappropriate, and that Jeremy recognised that his behaviour was unacceptable. The letter served as 'a formal warning'.[288]

Four years later, in 2016, another student made allegations against Jeremy. This student said that Jeremy had allegedly taken her into a small storeroom that had an automatic lock and sexually abused her.[289] The student alleged that Jeremy had told her that she must not tell anyone what had happened, or he would go to jail and would have to kill himself. Later, Jeremy asked the student if she had enjoyed 'the lesson'.[290] These allegations were reported to police by someone external to the school.[291]

The school principal informed Learning Services of the allegations, advising that the 'student had had a few other instances with this teacher where his actions had been suspicious, [and] noting there was "enough to warrant extreme concern"'.[292]

Human Resources, and then the Department's Conduct and Investigations Unit, were informed of the allegations on the same day.[293]

The following morning Jeremy was sent home from work and, shortly after, the Department suspended him with pay.[294] The Department then initiated an investigation, in line with Employment Direction No. 5—Breach of Code of Conduct, into whether Jeremy had breached the State Service Code of Conduct.[295] School staff were told that Jeremy was on leave.[296]

Departmental records show that the principal also notified the Child Protection Advice and Referral Service (as it was then known) and that two days after the school was made aware of the allegations the student made a statement to police.[297] Learning Services spoke with the student's mother to confirm that the allegations would be investigated, and a human resources team member met with the student and her family shortly after.[298]

The Department also notified the Teachers Registration Board of the allegations, and the Board suspended Jeremy's registration.[299] Jeremy appealed the decision to suspend his registration to the Magistrates Court, which ultimately ordered that the suspension be set aside pending the outcome of the Teachers Registration Board investigation.[300] The Court also directed that a condition be imposed on Jeremy's registration that he 'not seek or accept employment as a teacher within any Tasmanian School or TasTAFE pending the outcome of an enquiry'.[301] Ann Moxham, Registrar, Teachers Registration Board, described the Court's order as 'contrary to the function of the [Board]'.[302]

Soon after, the same student disclosed that there had been other incidents where Jeremy had behaved inappropriately towards her. One such incident occurred in 2015 when Jeremy allegedly hit her on the bottom with a badminton racquet.[303] The Department reported this allegation to police in August 2016.[304] Another incident, also alleged to have occurred in 2015, involved a teacher who had witnessed inappropriate behaviour by Jeremy towards the student, namely that Jeremy had placed his hand on the student's thigh.[305] The teacher had reported this alleged incident to the principal on the same day, but no other action was taken at the time.[306]

In late 2016, police charged Jeremy with two counts of indecent assault.[307]

Jeremy's teacher registration expired in mid-2016 (he had reached the end of his five-year registration cycle) and so he had to apply for a renewal.[308] In 2017, Jeremy's application for a renewal was refused on the basis that he was not registered to work with vulnerable people.[309]

The *Teachers Registration Act 2000* had been amended in 2017 to require that a person seeking to register as a teacher must first be registered under the *Registration to Work with Vulnerable People Act 2013* ('Registration to Work with Vulnerable People Act').[310] When Jeremy applied to be registered to work with vulnerable people in late 2016,

a decision on his application was deferred, on the grounds that the outcome of the charges against him was likely to be relevant to deciding whether to grant him registration.[311] However, the Registrar decided not to grant Jeremy Registration to Work with Vulnerable People ahead of any legal outcome.[312] Jeremy appealed against this decision. His appeal was unsuccessful and so the Department stopped paying him in mid-2017.[313] However, the Magistrates Court stayed this decision (although it is not clear what effect this had on Jeremy's pay).[314]

In 2019, the Supreme Court acquitted Jeremy of indecent assault. He was then granted registration under the Registration to Work with Vulnerable People Act.[315]

In 2020, Jeremy applied to the Teachers Registration Board to have his registration as a teacher reinstated. The Board determined, however, that based on advice from the Office of the Solicitor-General, Jeremy would need to apply to become registered. Jeremy applied for registration in late 2020.[316] The Board has not registered Jeremy and is, at the time of writing, awaiting the outcome of an investigation to determine if he is of good character and fit to teach.[317] The Department lifted his suspension in the same year, on the basis that he could not teach because he did not hold current registration.[318]

2 Departmental review

The Department identified Jeremy's case as part of its review into the management of 'historical' child sexual misconduct allegations involving current employees.

There are few departmental records in relation to the 2012 allegations against Jeremy because the school handled these allegations internally and so they were not referred to the Secretary. Secretary Bullard told us that the 2012 allegations were 'reinvestigated' in 2021, in line with contemporary departmental procedures.[319]

In respect of the 2016 allegations, Secretary Bullard told us the Department had informed Jeremy that he would be subject to an Employment Direction No. 5—Breach of Code of Conduct investigation, but this was 'put on hold' pending the charges against Jeremy and another police investigation into the matter.[320] Jeremy's trial concluded in 2019. The Department initiated its investigation in 2020.[321]

In mid-2021, the Department began another Employment Direction No. 5 investigation into the allegations made against Jeremy in 2012 and 2015.[322] After providing Jeremy the opportunity to show cause as to why his employment should not be terminated, Secretary Bullard terminated Jeremy's employment in early 2022.[323] Jeremy appealed this decision to the Tasmanian Industrial Commission.[324] At the time of writing, the appeal was ongoing.

Secretary Bullard stated that between the time Jeremy was asked to leave the school in 2016 and his termination in 2022, he did not return to 'his employment'.[325]

3 What we heard

Secretary Bullard conceded that there were shortcomings in the school's and the Department's responses to complaints about Jeremy. He told us that in relation to the allegations made by several students in 2012:

- Learning Services found no evidence that the Department supported the students after complaining about Jeremy's behaviour.[326]
- The principal of the school in question and/or Learning Services did not inform the Conduct and Investigations Unit about the allegations, nor was the Unit informed of the outcome of any investigation. This meant that a notification was not made to the Teachers Registration Board in respect of those allegations.[327]
- Notifications were not made to the Child Protection Advice and Referral Service, Tasmania Police or the Integrity Commission at the time.[328]
- A copy of the State Service Code of Conduct was sent to Jeremy, but the Department's *Conduct and Behaviour Standards* policy was not brought to his attention.[329]
- There are no records of the school communicating with the students involved other than the initial meeting between the principal and each of the students, and a letter sent from the principal to the students' parents.[330]

In respect of the allegations about Jeremy's conduct in 2015, Secretary Bullard advised that there were no departmental records of these allegations.[331] The principal was not asked to document the event in which a teacher allegedly witnessed Jeremy put his hand on the student's thigh, nor did the principal report it to the Department.[332] These allegations only came to light during Jeremy's trial in 2019.[333] Further:

- There were no records to show whether the student who made the complaint was given any support: '[t]o date, no records have been identified by Learning Services that indicate that a school teacher, social worker/psychologist offered and/or provided support to [the student] following her disclosure'.[334]
- As with the 2012 complaints, the school did not notify the Conduct and Investigations Unit, police or the Child Protection Advice and Referral Service, nor are there any records of communications between the school and the student or her family.[335]

Secretary Bullard stated that the school's responses to the 2012 and 2015 allegations did not comply with departmental policies and procedures that were in place at the time.[336]

While the school and the Department's responses to the allegations made against Jeremy in 2016 were an improvement on the handling of earlier allegations, there were still aspects that did not comply with departmental policies. As Secretary Bullard noted:

- There was no immediate report made to the Child Protection Advice and Referral Service in line with the *Mandatory Reporting Procedure*.[337]
- According to departmental policy, the student should have been referred to a staff member with specialised skills, and a plan developed to support the student.[338] There is no evidence that this occurred or that the student had access to the school social worker.[339]
- There are limited records of communication with the student (and her family) about the allegations, and there are no records of communications with other students or staff at the school.[340]
- The Integrity Commission was not notified about the allegations at the time.[341]
- There are no records of communication with the student or staff at the school regarding the 2016 allegations.[342]

4 What happened since and what needs to change

The information provided to us about Jeremy's case reveals several systemic and case-specific issues:

- Students' complaints were not adequately scrutinised.
- Not enough consideration was given to the risks posed to any child by a teacher who breached professional boundaries in a sexual manner with a child.
- Children were interviewed by personnel not trained in child interviewing techniques and child sexual abuse.
- The principal had too much discretion in deciding when to escalate concerns to the Department.
- Incidents were not appropriately reported to the Department of Education.
- Record keeping in relation to the complaints was poor.
- Communication between different units in the Department, and between the Department and other regulatory bodies such as the Teachers Registration Board, was poor.
- There was no communication (or communication was inadequate) with students, staff and the school community.
- Policies and procedures were not complied with.

- There was no support offered to students after their disclosures (or it was inadequate).
- There were unacceptable delays in disciplinary processes.

Secretary Bullard told us that the Department's responses to allegations such as those made against Jeremy in 2012 (and to an extent in 2015 and 2016) could be characterised as a 'mosaic of approaches'.[343] Secretary Bullard described this to us as:

> … let's make some decisions around how we might deal with this, is a conversation from a principal or a senior leader enough, do we need to go to Learning Services, Human Resources, or do I need to escalate it? So … there's a judgment made on the ground about the seriousness or otherwise, and as [was] quite rightly pointed out, until such matters are investigated, how are you going to know?[344]

Secretary Bullard also noted that in 2012 there was no protocol in place requiring that such matters be brought to the attention of Workplace Relations.

We heard that the current process for handling such allegations is very different:

> … every allegation that is raised must be referred to Workplace Relations and Workplace Relations must refer it to me [the Secretary]. Every allegation that is raised must be referred to the Teachers Registration Board, the Working with Vulnerable People Check and the Integrity Commission, and Teachers Registration Board where it relates to a teacher, and that is the process that sits in place now.[345]

Secretary Bullard elaborated that a 'best practice response' now involves a Senior Workplace Relations Consultant being briefed about the alleged conduct and discussing the matter with the Manager of Workplace Relations and the Assistant Director of Industrial Relations.[346] An assessment is then made 'as to the nature and seriousness of the allegations'.[347] There is no specific policy guiding this assessment, but the nature and seriousness of the conduct as well as whether the conduct is isolated or part of a pattern of behaviour will form part of the assessment.[348]

If the matter does not involve an allegation of child sexual abuse or inappropriate physical contact, the matter 'may be handled locally in consultation between the Principal and Learning Services, without a referral to the Secretary'.[349] If the matter is assessed as being 'more serious', the Secretary will be briefed by Workplace Relations on whether an Employment Direction No. 5—Breach of Code of Conduct investigation should be initiated. If the matter involves an allegation of a sexual nature, the Secretary will be briefed regardless of the outcome of the assessment.[350] Where child sexual abuse is suspected, 'the employee is asked to immediately leave the workplace and await correspondence from the Secretary, pending any determination'.[351] Notifications are then made to police, the Registrar of the Registration to Work with Vulnerable People Scheme and the Teachers Registration Board if appropriate.[352]

We are pleased that the Department has made improvements in responding to allegations of child sexual abuse, however there are aspects of the Department's current response that continue to raise concerns. For example, the seriousness of allegations that do not involve child sexual abuse is assessed by Workplace Relations and Industrial Relations, apparently in the absence of any specific policy or criteria or subject matter expertise. In such cases, it may be that allegations against departmental staff, such as those made against Jeremy in 2012, are still resolved locally by the school principal and Learning Services. This means that it is possible that allegations that relate to behaviours associated with grooming or precursor conduct may not be brought to the attention of the Department or the Secretary. We have observed a theme across Tasmanian Government services of failure to identify professional boundary breaches as potential grooming behaviours. We note that, despite Secretary Bullard's assurance that he would be notified of all concerns about child sexual abuse including grooming and precursor conduct, it may be that some behaviours are not recognised and reported as such by school staff, or are not assessed as such by Workplace Relations.[353] Secretary Bullard conceded that some behaviours are 'nuanced' and that the Department needed to 'absolutely invest in training [the Department's] workforce to understand something that may or may not constitute a matter of concern'.[354]

In terms of the delay in starting the Employment Direction No. 5—Breach of Code of Conduct investigation into the 2016 allegations about Jeremy's conduct, Secretary Bullard stated that he was:

> … acutely aware of the tension that currently exists between undertaking an [Employment Direction No. 5—Breach of Code of Conduct] investigation in a timely manner, in order to minimise distress to the child or young person who has made the allegation and also the employee being investigated, and the requirement not to jeopardise a police investigation and/or criminal proceedings.[355]

However, this does not adequately explain the time taken between the conclusion of Jeremy's trial in 2019 and resuming the Employment Direction No. 5 investigation in 2020. Secretary Bullard conceded that the delay in reactivating the investigation was 'not acceptable', but said that:[356]

> Workplace Relations … advised that the investigation did not recommence immediately upon the acquittal of [Jeremy] due to a general review of the matter, and meetings to determine the process and a pathway forward, including ongoing discussions about whether an [Employment Direction No.5—Breach of Code of Conduct] should be commenced or ceased.[357]

Secretary Bullard also told us that a complainant is not informed of the outcome of an Employment Direction No. 5 investigation because this is prohibited under legislation.[358] He agreed that not communicating the outcome of an investigation to a complainant was of 'significant concern'.[359] He told us that he had 'asked the Office of Safeguarding Children and Young People to consider [the Department's] approach to these and other similar matters, where victims/survivors seek an outcome'.[360]

Secretary Bullard welcomed 'any thoughts the Commission might be able to share in relation to the Department's future approach to similar complaints and Employment Direction No. 5 investigations from the perspective of the complainant'.[361] We discuss approaches to Employment Direction No. 5—Breach of Code of Conduct investigations, including communication with complainants, in Chapter 20.

Case study 6: 'Brad'

This case study about Brad (a pseudonym), a relief teacher, is based on information the Department provided in relation to its recent responses to child sexual abuse matters.[362]

1 The alleged incidents

Brad was a teacher who worked in New South Wales for several years in the early 2000s. During this time, a number of allegations of sexualised and inappropriate conduct towards students were made against him.[363] Brad always denied wrongdoing, but the New South Wales Department of Education ultimately determined that he posed a 'medium risk of sexual and physical abuse towards students'.[364] As a result of this determination, Brad was formally monitored but allowed to keep teaching.[365] After ongoing concerns about Brad's behaviour, he was directed to undertake an improvement program, which he did not complete because he resigned from his position.[366]

In 2015, Brad moved to Tasmania and applied for registration with the Teachers Registration Board, intending to work as a casual teacher.[367] In his application for registration, Brad did not disclose that complaints had been made about him in New South Wales around a decade before.[368] Brad should have declared these complaints when he applied for registration (and a renewal of his registration) from the Tasmanian Board.[369]

Brad was registered as a teacher in Tasmania and multiple schools employed him for relief work.[370]

2 The initial response

In late December 2019, Principal A (a pseudonym) held concerns about Brad's alleged inappropriate comments to and physical contact with students.[371] Principal A informally contacted principals at other schools where Brad had been employed. Two other principals told Principal A that they also had concerns about Brad's behaviour when he had worked at their schools.[372] Principal A then advised Learning Services at the Department of Education of their concerns, as well as the concerns relayed to them by other principals. This was the first time Brad came to the Department's attention.[373]

The next day, a Senior Human Resources Coordinator from Learning Services contacted Brad. Because Learning Services had assessed the alleged behaviour reported by Principal A as 'at the lower level of seriousness', it deemed that a meeting with Brad was an appropriate response.[374] At the meeting with Learning Services, Brad was taken through his obligations under the relevant guidance material on professional conduct and standards.[375] Learning Services did not notify Workplace Relations or Legal Services about the information received from Principal A, and was apparently

unaware of its ability to have Brad removed from the Fixed Term and Relief Employment Register. Removal from the Register would have barred Brad's employment as a relief teacher by other government schools.[376]

The meeting with Brad to discuss his conduct and professional obligations occurred in early 2020.[377] Following this meeting, Learning Services maintained some concerns about Brad and sought more information from payroll about which schools Brad had previously worked at as a relief teacher.[378] Learning Services also spoke to all schools where Brad was subsequently placed, and monitored his behaviour.[379] Learning Services remained unaware of its ability to remove Brad from the Fixed Term and Relief Employment Register.[380]

Brad continued to be the subject of allegations of inappropriate conduct.[381] A few months after Brad's meeting with Learning Services, Principal B (a pseudonym) contacted Learning Services after a student reported that Brad had allegedly sneaked up on her and touched her shoulders.[382] Principal B requested that Learning Services seek more information about Brad from other schools.[383] Immediately after the student's report, Principal B removed Brad from the classroom and instructed him that he would not work at the school again. Principal B also directed Brad to apologise to the student for his conduct.[384]

Learning Services added the information received from Principal B to the information already on record from Principal A and passed this information to the Teachers Registration Board in mid-2020.[385] Workplace Relations and Legal Services remained unaware of any concerns about Brad.[386]

Having been advised of concerns about Brad, the Teachers Registration Board made enquiries with the Department, including Legal Services, about Brad's conduct.[387] The Teachers Registration Board told Legal Services it had received information that Brad had inappropriately touched female students and that it would investigate the allegations.[388] The Department did not make notifications to the Registrar of the Registration to Work with Vulnerable People Scheme or police on the basis that 'the concerns raised had not been particularised in enough detail to be considered allegations of child sexual abuse'.[389]

Later in 2020, a student at another school reported to a teacher that Brad had allegedly tapped her on the backside, held her hands, touched her shoulders and told her she was beautiful.[390] Principal C (a pseudonym) reported the alleged conduct to Learning Services and was told that Learning Services was aware of a history of similar behaviour.[391] Principal C forwarded their concern to the Teachers Registration Board and contacted Legal Services in the Department.[392]

The report from Principal C triggered a range of notifications.[393] The Board confirmed it would consider an emergency suspension of Brad's registration and would report Principal C's information to the Registrar of the Registration to Work with Vulnerable People Scheme. Legal Services advised the Teachers Registration Board that the matter had been reported to police.[394] At this time, Workplace Relations removed Brad from the Fixed Term and Relief Employment Register.[395]

Shortly after, in October, the Board notified the Department that it had suspended Brad's registration with immediate effect.[396] It also recommended that an inquiry into Brad's behaviour be undertaken to determine whether he was of good character and fit to teach, and that Brad be required to undergo a psychiatric or psychological examination.[397] During this period, Principal C also reported their concerns about Brad to the Strong Families, Safe Kids Advice and Referral Line.[398]

Not long after this, the Advice and Referral Line got several reports from community members about Brad's complaints history in New South Wales and current complaints from Tasmanian schools.[399] As a result, staff at the then Department of Communities sought records and information from New South Wales and information from the Teachers Registration Board to inform their risk assessment.[400]

At the end of 2020, Brad's (suspended) registration lapsed when he failed to make a payment.[401]

In early 2021, the Department of Communities provided the Department of Education with a timeline of Brad's conduct.[402] In addition to the concerns of Principals A, B and C, this timeline included more details about complaints and concerns involving Brad.[403]

The Department of Communities timeline revealed that in 2018, when Brad was teaching at a primary school, he had also allegedly engaged in inappropriate conduct while teaching (which was not overtly sexual in nature). It was also reported that Brad had allegedly made other staff uncomfortable by standing too close to them.[404]

Throughout 2020, another primary school raised concerns about Brad, including that he was allegedly overly friendly with female students and had touched their shoulders and hands. Brad was repeatedly warned to keep his distance from students but continued to teach at the primary school for several months.[405]

Later that year, a different primary school received a complaint from a parent that Brad was allegedly physically touching students (holding their hands and putting his arms around them) and staring at female students. When the school followed up this complaint with Brad's class, students reported more concerns, including that Brad had allegedly been 'checking out' female students, threatening male students with violence (saying 'your head is going into my fist') and using his mobile phone in a way that made students worry that they were being filmed.[406]

Around this time, a senior manager at the Department asked a colleague at the Department of Communities whether their more extensive information about Brad had been provided to the Registrar of the Registration to Work with Vulnerable People Scheme. The colleague responded:

> [The Child Safety Service] practice is we inform [Tasmania] Police when we are investigating matters where a person of concern relating to sexual abuse has direct contact with children. [Tasmania] Police would inform Registrar. This makes the lines of communication clear. [The Child Safety Service] responds to children, [Tasmania Police] responds to offenders. It would get very murky otherwise … We shall use this as a case study though to test the current systems in place and consider if there are any weaknesses in the current system.[407]

Secretary Bullard noted that while some of the other matters in the Department of Communities timeline were known to the Department, this timeline 'provides a far more extensive context'.[408]

The Department of Communities told the Department of Education it had notified the Child Safety Service and that it had provided its timeline to the Registrar of the Registration to Work with Vulnerable People Scheme.[409] It also advised that the matter was the subject of a police investigation.[410]

The Teachers Registration Board began its formal inquiry into Brad's conduct in early 2021.[411] The Board ultimately determined that Brad was not of good character and was not fit to teach.[412] This outcome was communicated to all relevant authorities, including interstate and New Zealand teacher registration authorities.[413]

Secretary Bullard noted that the Department is unaware of what support or communication may have been delivered to any affected students and their families or staff in relation to Brad's behaviour at one of the schools because the need for such supports would have been assessed at the school level.[414]

3 Departmental review

Brad's case was one of the 'historical' matters the Department reviewed in 2021. Secretary Bullard was then briefed on the extra information discovered in the Department of Communities timeline. Workplace Relations advised Secretary Bullard that there were no other steps to be taken because Brad was not an employee, had already been removed from the Fixed Term and Relief Employment Register and was not registered with the Teachers Registration Board.[415]

In mid-2021, Secretary Bullard advised Brad of the allegations against him and sought a response from him. Secretary Bullard noted that because Brad was not a current employee, the Department could not pursue a formal investigation; however, Brad's future employment with the Department would depend on the outcome of an investigation.[416] Around this time the Teachers Registration Board notified Secretary Bullard of its findings in relation to Brad.[417]

4 What we heard

Secretary Bullard conceded that Brad's case highlighted the problem of limited information sharing—between Tasmania and other states and territories, between government departments in Tasmania, and within the Department itself.[418]

4.1 Information sharing

This case study highlights the way a lack of coordinated information sharing can allow complaints about a teacher's conduct to go unaddressed:

- The Teachers Registration Board was unaware of a history of allegations of concerning behaviour when it granted Brad's registration. Relying on Brad to disclose this history is a system weakness, given people in his position may well have a strong incentive to not disclose matters (particularly if they were managed relatively informally).
- The Department's screening process failed to pick up the concerning history of allegations against Brad in New South Wales. It is unclear what screening processes were used and whether any referee checks were undertaken. The fact that Brad had not been teaching for some time could have invited more scrutiny and checks into Brad's work history.
- Some principals who held concerns about Brad's alleged behaviour did not proactively report their concerns to the Department, perhaps opting to simply not re-engage Brad as a relief teacher. This meant that conduct suggesting a pattern of behaviour was not identified.
- Learning Services did not communicate the concerns about Brad to other areas of the Department—most critically, Workplace Relations—which meant that Brad was not removed from the Fixed Term and Relief Employment Register at the earliest opportunity. The failure to communicate also meant that appropriate notifications were delayed and that Workplace Relations and Legal Services were ill-equipped to respond to later queries from the Teachers Registration Board.
- The Teachers Registration Board and the Department were not responding to the same information during the investigation into Brad—each communicated with the other in vague terms about 'concerns'. Secretary Bullard only received the Board's findings (and related information) about Brad after finalising the Department's investigation. Although Brad was no longer working for the Department (and therefore not an active risk to students) there may be circumstances where the Department will need information from the Board throughout its investigation to manage any risks to students. Also, the Department is only obliged to notify the Board about disciplinary matters it is pursuing in relation to 'employees', which means that the conduct of relief or casual teachers may remain unknown to the Board.

- Relevant parties were unclear whether information had been shared with other authorities, in particular police and the Registrar of the Registration to Work with Vulnerable People Scheme, and if information had been shared, what information and when. This required manually checking and double-checking sources and records, which increased the risk of important information being missed or not passed on.

When giving evidence at hearings, Secretary Bullard acknowledged that information sharing is critical for regulators and decision makers to identify patterns of behaviour:

> So, absolutely accept here that the fact that you have a person working in multiple schools displaying behaviour which I would argue on some of that behaviour should have been escalated, but on other behaviour you'd think, well, that's a one-off and a bit odd but, you know, not going to report; it's only when you see that accumulated as a set of evidence that you are alerted, very alerted, to the fact that there is an issue that needs to be dealt with.[419]

He added that the information-sharing provisions are confusing and complex, which might inhibit the ability of regulators to respond more quickly to risks.[420]

Secretary Bullard noted that New South Wales is leading a scoping project on national information sharing for teacher registration, alongside all state and territory education departments and teacher registration authorities. This includes providing advice on the scope of information sharing that will be necessary to support automatic mutual recognition of registration for teachers moving between states and territories.[421]

Secretary Bullard used Brad's situation to reflect on some of the key considerations for this work. For example, if information sharing is limited to formal disciplinary sanctions, then concerns about Brad could not be shared—in this case, the sanctions were not imposed because Brad resigned.[422] However, he noted that the sharing of 'granular details' between interstate agencies raises procedural fairness issues for employees.[423] He also shared his concerns that national mutual recognition reforms allow teachers registered in other jurisdictions to work in Tasmania without the knowledge or approval of the Teachers Registration Board.[424] Ann Moxham, Registrar, Teachers Registration Board, echoed Secretary Bullard's concerns about automatic mutual recognition, noting that it limits the ability of the Teachers Registration Board to carry out its good character and fitness to teach assessments, which are 'much broader' than the Registration to Work with Vulnerable People requirements.[425]

In relation to information sharing between the Department and the Teachers Registration Board, Secretary Bullard pointed to general prohibitions contained in the *Personal Information Protection Act 2004* ('Personal Information Protection Act') that restrict the Department's ability to share information gleaned through an Employment Direction No. 5—Breach of Code of Conduct process with other agencies, including the Board.[426] He noted that this restriction applies to information such as letters to employees

describing alleged breaches of the State Service Code of Conduct, witness statements, investigation reports and the Secretary's determination, unless individuals provide consent for their information to be disclosed.[427] Secretary Bullard also noted that the limited exceptions to this general prohibition likely only apply to criminal conduct or 'seriously improper conduct' and may not be enough to permit information sharing about conduct that does not meet the threshold of these categorisations.[428] He highlighted that the Personal Information Protection Act also creates barriers for information sharing between the Department and non-government schools.[429]

Ms Moxham told us that, on the advice of the Office of the Solicitor-General, the Department is precluded from providing its investigation materials to the Board. This means that the Board has to undertake its own investigation, which can lead to reinterviewing (and retraumatising) affected children.[430] Ms Moxham shared her belief as Registrar of the Teachers Registration Board that, contrary to this advice, the legislation does in fact permit such information sharing between the Department and the Board.[431] We discuss the issue of information sharing between the Department and the Teachers Registration Board in Chapter 6.

Ms Moxham noted that the Board has a range of powers to share information with other regulatory bodies in Australia and with employers, complying with different sections of the governing legislation.[432] She also noted that assessing the suitability of teachers arriving from New South Wales was particularly challenging because the accrediting body there does not conduct enquiries or disciplinary processes. When assessing an application for registration from a teacher who has come from New South Wales, the Teachers Registration Board must therefore ask that teacher's permission to seek information about them from the New South Wales Department of Education.[433]

Ms Moxham told us that the information flow between the Board and Tasmanian agencies such as the Registration to Work with Vulnerable People Scheme and Children, Youth and Family Services is often one-way—when the Board provides information it does not 'get anything back'.[434] She stated, for example, that when the Registrar removes a Registration to Work with Vulnerable People, it will advise the Board of the removal but not the reasons why.[435] She also stated that Children, Youth and Family Services do not provide the Board with information, such as if a report is made to them about a teacher's parenting capacity, unless the teacher had declared the information when either registering or renewing their registration (which occurs every five years).[436] Ms Moxham also described the relatively informal ways in which the Board may become aware of important information about relief teachers—for example, via phone calls from Learning Services.[437]

Following an exchange in public hearings with Counsel Assisting, Ms Moxham was asked 'are there additional barriers to knowing where relief teachers are and how long they are teaching in a particular place?' She replied, '[i]t's 'almost impossible. It's pretty scary, isn't it?'[438]

Ms Moxham noted that, as far as she is aware, there are no reforms in progress to remedy the lack of visibility over where relief teachers are working, except in limited circumstances.[439] She described a current 'workaround' to improve visibility, namely a 'Watched Registration' list, maintained by individual schools (this list is discussed in Chapter 6). She noted, however, that relief teachers are not generally included on this list.[440]

Secretary Bullard said that Learning Services should have notified Workplace Relations about the information it was receiving regarding Brad and, had Workplace Relations been notified, 'swifter action may have occurred' at the departmental level, notwithstanding the challenges of investigating a relief teacher.[441] Secretary Bullard specified such action as earlier referrals to police, the Teachers Registration Board, the Registrar of the Registration to Work with Vulnerable People Scheme and the Integrity Commission.[442] Secretary Bullard attributed the failures to share information to a 'misunderstanding' about the actions that could be taken against relief teachers, which included removing them or flagging them on the Fixed Term and Relief Employment Register.[443] In turn, the failure to remove Brad from the Register meant that he could continue relief teaching at other schools.[444] Secretary Bullard conceded that the mismanagement of Brad's case illustrated a systemic failing in terms of people not knowing the controls needed for relief teachers.[445]

Secretary Bullard highlighted to us that because Brad was a relief teacher rather than an 'employee' for the purposes of the *State Service Act 2000* ('State Service Act'), he could not be subject to an Employment Direction No. 5—Breach of Code of Conduct investigation. The State Service Act does not impose a sanction under the Employment Direction No. 5 process for someone who is not an employee.[446]

We consider that the provisions of the Personal Information Protection Act should be amended to ensure information sharing for protecting the safety of children (even where the conduct may not meet a criminal or serious misconduct threshold) is lawful. While privacy and procedural fairness protections are legitimate and should be respected, the safety of children must always be paramount (refer to Chapter 19 for discussion on this issue).

We also find that the Department should be empowered to undertake an investigation (like that conducted under Employment Direction No. 5—Breach of Code of Conduct) into casual and contracted staff. Where warranted, investigations of this type should continue even where a person is no longer contracted and unwilling to participate.

Following allegations of incidents of the type involving Brad, appropriate support should be offered to students and affected staff. The Department should record the nature and extent of such supports for record-keeping purposes.

4.2 Other systemic problems

In addition to issues around information sharing, Brad's case revealed a range of other problems including:

- inadequate exploration of the initial concerns raised about Brad, partly due to what appeared to be a limited understanding of the range of behaviours that can fall within the definition of child sexual abuse
- no central repository of information relating to complaints or concerns, which made it difficult to get a complete picture of issues of concern relating to employees (particularly relief teachers moving from school to school)
- a lack of clarity between the respective roles and responsibilities of Learning Services, Workplace Relations and Legal Services in responding to such concerns—including confusion about the operation of the Fixed Term and Relief Employment Register
- delays in notifications—including reports to the Teachers Registration Board, the Registrar of the Registration to Work with Vulnerable People Scheme, police and the Child Safety Service—meant information about Brad was not acted upon promptly
- the Department ceasing its investigations into Brad's alleged conduct because he was not an employee, demonstrating an overreliance on industrial and disciplinary mechanisms in its response. Continuing investigations would have provided the Department with valuable information about Brad should he reapply for employment, as well as illuminating systemic issues relevant to other situations.

5 What has changed

Secretary Bullard advised us that since reviewing Brad's case, the Department has made the following changes:

- Since July 2021, if the Department receives complaints or disclosures about child sexual abuse, it notifies Workplace Relations and the relief teacher is immediately removed from any workplace and the Fixed Term and Relief Employment Register.[447] The teacher is also subject to appropriate notifications to police, the Registrar of the Registration to Work with Vulnerable People Scheme and the Teachers Registration Board.[448] The Department invites the relief teacher to respond to the complaint and they must submit to an investigation before being able to return to work.[449]

- In October 2020, the Department updated its pre-employment questions for potential applicants to the Fixed Term and Relief Employment Register. Applicants must now declare whether they have been the subject of current or past disciplinary matters or if they have been charged (or were convicted of) criminal charges, with disclosures assessed by Workplace Relations (although this requirement does not guarantee that they will do so).[450]
- The Department is developing and will trial a new case management platform. This platform will provide a mechanism for more information to be shared with schools (while 'ensuring fairness to employees') where previous concerns about conduct have been raised and investigated.[451] Secretary Bullard said the case management platform 'will provide a very easy way that schools can enter information of concern, with the matter then going through a chain of decision-making without schools having to take further action'.[452]
- As a matter of practice, people who give statements as part of Employment Direction No. 5—Breach of Code of Conduct investigations are advised that those statements may be used for other purposes (for example, statements may be forwarded to the Teachers Registration Board so it can assess an individual's fitness to teach). Those informing an Employment Direction No. 5 investigation can withdraw their consent to their statement being used in this way.[453]

Case study 7: Sam

Sam Leishman gave evidence at our hearings and shared his experience of being sexually abused as a young child while attending a government school in Tasmania. Mr Leishman grew up the youngest of five, in a happy and nurturing family environment.[454] In 1978, he began high school and met a science teacher known as Darrel Harington, despite not being in any of Mr Harington's classes.[455]

1 The incidents

Mr Harington took an interest in Mr Leishman. Mr Leishman told us: 'I guess I felt a little bit singled out, like, he was particularly interested in my activities … to the point of taking piano lessons off my piano teacher and that sort of thing'.[456] Mr Harington also came to know Mr Leishman's parents at various school events.[457]

In 1978, when Mr Leishman was 12 years old, Mr Harington began to sexually abuse him.[458] Mr Leishman shared with us an experience of spending time with Mr Harington outside school. He said his parents had allowed him to go to Mr Harington's house because 'they knew [Mr Harington] and obviously trusted him'.[459] On that day, Mr Harington bought fried chicken and Mr Leishman was impressed by Mr Harington's ability to name the various bones of the chicken.[460] Mr Leishman reiterated: 'This was a teacher I really admired, I really liked a lot'.[461]

Mr Harington began to ask Mr Leishman about girls, including whether he had a girlfriend. When Mr Leishman replied that he didn't, 'the mood sort of quickly changed'.[462] Mr Harington drove Mr Leishman to the shops and purchased an adult magazine, which he then began flicking through with Mr Leishman, asking him if it turned him on.[463] Mr Leishman described how he felt at this time: 'There was this nervous, terrifying excitement about me, within me'.[464]

Mr Harington then began a 'play fight sort of thing' with Mr Leishman, which ultimately led to Mr Harington sexually abusing him in a bedroom.[465] As part of this 'game', Mr Harington invited Mr Leishman to 'retaliate'. As Mr Leishman did not know what the word meant at the time, he needed Mr Harington to explain what this word meant.[466] Mr Leishman told us:

> So, as well as submitting to this [abuse], I also complied; I did what he wanted, or tried to do what he wanted me to do to him. And that was the first incident and he drove me home.[467]

When Mr Harington dropped Mr Leishman home that day, Mr Leishman was grappling with confusion and shame. He described Mr Harington looping back to ring the doorbell to check on him. When greeted by Mr Leishman's parents, Mr Harington invited himself into their home.[468] Mr Leishman explained how he felt:

> I was terrified initially, first of all, that he was going to tell my parents of this disgusting act that I'd just done with him, but he didn't, it just turned into a big drinking session with my parents and, they didn't know, they thought he was a friend.[469]

The abuse continued. Mr Leishman spent more time with Mr Harington, including going away with him for days at a time.[470] Mr Leishman described how after the 'initial terror' of the abuse, he began to feel 'more comfortable with what we were doing together'.[471] He explained, 'I thought at the time that I was equally responsible for my teacher's behaviour towards me, and that I had encouraged it'.[472]

However, over time, Mr Harington's interest in him waned: 'things shifted, there was no longer that connection'.[473] Mr Leishman described the complex feelings that resulted from this perceived rejection:

> So, what I thought was some sort of a relationship, I sensed it wasn't all of a sudden and it was just a physical thing, and that left me feeling, it's tough to say, but I felt pretty isolated and let down because I really admired this person.[474]

One day, some boys from Mr Leishman's school witnessed him going into a home with Mr Harington. Mr Leishman recalled:

> When we arrived at the unit there were two boys from my year in the carpark kicking a ball around, just messing around playing, and I thought—I just felt 'Oh my God I've been spotted in a car, these boys are going to know what's going on'. And because [Mr Harington] was so confident and sort of blasé, he just hopped out of the car, [and said] 'How are you going kids?' I just remember standing there thinking, 'Oh, this is so uncomfortable'. And after that he starts walking away towards the door of the unit and beckons me over, and I—it was terrible.
>
> The next day at school everything changed.[475]

Mr Leishman recalled the boys taunted him, saying 'how did you like sucking Harington's cock last night?'.[476] Mr Leishman described being the victim of bullying after this time:

> I'd managed to fly under the radar quite well until that point, but when—I mean, you can imagine in Tasmania in 1978 that quickly sort of bubbled and festered and turned into a huge problem for me.[477]

As the teasing and bullying became more widely known across the school, Mr Leishman told us that a teacher spoke to him, using words to the effect: 'I don't know what's going on between you and Mr Harington, but obviously something is and you need to make it stop'.[478]

The abuse continued for 12 months until Mr Harington transferred to another school.[479]

2 The disclosure

In 2014, when Mr Leishman was in his late 40s, he heard about the National Royal Commission and began to look at the materials on the website.[480] He realised his experiences were 'not uncommon' and began to recognise what Mr Harington did to him as child sexual abuse.[481] He decided to share his experience with the National Royal Commission. Mr Leishman described engaging with the National Royal Commission as 'a light bulb moment':[482]

> I rang the Royal Commission and that was—that was a great moment for me because it was like a little bit of a weight off my shoulder, and they were fantastic; they arranged a hearing for me—a private session for me and that initiated a lot of things that eventually led to me—the charges and everything against him.[483]

He told us that 'by speaking openly and honestly, I was able to view Harington's behaviours objectively and I began to put things into perspective'.[484] The process also revealed to him that Mr Harington had abused other students. This knowledge encouraged Mr Leishman to engage with the criminal justice process.[485]

In 2015, Mr Harington pleaded guilty to multiple charges of sexual abuse related to several victim-survivors, including Mr Leishman.[486]

Mr Leishman described his experiences of the National Royal Commission, police and the Tasmanian justice system more broadly as 'an overwhelmingly positive one'.[487] Of police, he said: 'The police get a lot of bad press, but they were very good with me'.[488] He described how valuable it was to feel like his matter was important and relevant, even though it happened a long time ago.[489] In giving his victim impact statement in court, he said: 'I was able to defend a child [myself] that had been confused, ashamed and bullied to the point of despair—forced to manage the most complex of emotions in isolation'.[490]

3 The response

After Mr Harington was sentenced, Mr Leishman expected to hear from the Department of Education. He said:

> I guess that was naïve to think that, but I thought that the Education Department must be curious about how this has happened and they must—they must at least want to investigate and find out how this could have possibly happened so, to me, it seemed sort of reasonable to expect that perhaps they might have got in touch with me.[491]

Secretary Bullard acknowledged that Mr Leishman's assumption was not unreasonable but explained that the Department does not receive information from the Director of Public Prosecutions about proceedings involving employees, ex-employees or students to enable such proactive contact.[492]

After allegedly receiving no contact from the Department, Mr Leishman wrote to the then Deputy Premier and Minister for Education and Training.[493] In that letter, dated November 2015, he wrote that he wanted to be heard and understood and to better understand the extent to which other teachers may have been aware of Mr Harington's abuse.[494]

Around a month later (in December 2015), the then Minister for Education, the Honourable Jeremy Rockliff MP, acknowledged the letter, indicating he was seeking advice from the Department about whether he could provide the information that Mr Leishman was requesting.[495] Mr Leishman assumed this meant he would hear something more in the new year.[496] However, months later, he told us that he still had not heard, and he wrote again in early 2016 expressing his disappointment at not having received a response.[497] Secretary Bullard noted that it was difficult to ascertain from Mr Leishman's file what contributed to the delay in responding to his letter but agreed that there did not seem to be 'an agile response'.[498]

We were told that it was not until 2017 that the Department contacted Mr Leishman. A meeting was arranged with the Deputy Secretary, Learning, which Mr Leishman attended. He described the meeting as 'a nice sort of two-way conversation' where he felt listened to 'to some degree'.[499] Secretary Bullard stated that in this meeting, the Deputy Secretary offered Mr Leishman an apology, listened to his experience and discussed the counselling support Mr Leishman was receiving.[500]

Mr Leishman told us that:

> … by that point I had questions as well: I wanted to know why he was teaching at my school, what other complaints they had about him, who knew what, was there any record of any sort of meetings and so forth that had taken place, what were the circumstances around his transfer to another school: I thought they were reasonable things to want to know.[501]

The Deputy Secretary committed to following up his queries, and ultimately advised that a Right to Information request was required. She offered Mr Leishman a fee waiver in respect of this request, direct access to a Right to Information Officer and offered to support him through the process.[502]

Mr Leishman told us that a few weeks after the meeting, Mr Leishman received a letter from Legal Services confirming that he would need to file a Right to Information request and that Mr Harington's consent would be required before any records could be released.[503] Mr Leishman reflected that:

> I felt completely stymied by the process. I felt like I was up against a wall, and I just didn't understand the implications of it. How does it sit with, I've given—I've been responsible for this man going to gaol, and then I'm going to ask him permission to give me information about the circumstances pertaining to that: it just didn't sit well at all. I thought, I just—this is a rabbit hole I'm not gonna go down, I just can't do it.[504]

Secretary Bullard acknowledged the 'real conflict' in situations where a victim-survivor seeks a record, such as a disciplinary file, that contains information about another person.[505] He confirmed that in such cases the Department requires the abuser's permission to release the information or must at least consult them on their views about the release of information about them. Secretary Bullard stated: 'my understanding is that Mr Leishman felt uncomfortable with that, and who wouldn't?'[506]

At hearings, Mr Leishman was asked whether he had since received the answers he was seeking. He replied: 'No, not fully. I still don't feel like everything's been laid out on the table'.[507] He ultimately withdrew his Right to Information request and his legal representative submitted a new request.[508] Secretary Bullard explained that when Mr Leishman sought information through his lawyer, Mr Harington refused the information release, but the decision-maker relied on public interest grounds to release some of the record.[509]

Mr Leishman told us that he received some information about Mr Harington's history of offending but not all the information that he wanted about his time at Mr Leishman's school.[510] Secretary Bullard informed us that there were no records to suggest that the Department was aware of Mr Harington's abuse of Mr Leishman until Mr Leishman wrote to the Department in 2015.[511]

In his statement to our Commission of Inquiry, Mr Leishman described what he felt was needed to improve the Department's response to victim-survivors in his situation:

> The process for victims to engage with and obtain information from the Department needs to be much clearer, with fewer barriers. It also needs to be focused on the needs of the individual victim-survivor. People like me need answers—even if they are not easy to hear.[512]

When asked whether there was a process in the Department to guide engagement with victim-survivors, Secretary Bullard noted that people in Mr Leishman's situation would generally be referred to the Redress Unit in the Department of Justice, which he described as 'trauma-informed'.[513] However, he accepted that the response to Mr Leishman's request for support and assistance from his Department following his letter to the Minister in 2015 was 'entirely inadequate'.[514] Secretary Bullard noted that, apart from Ms Pearce's interaction with Mr Leishman, he did not consider the Department's response to Mr Leishman to have been trauma-informed.[515] Secretary Bullard agreed that there should be a policy or procedure in the Department to 'assist in meeting the expectations necessary to demonstrate support, care, compassion and understanding of victim-survivors' experiences'.[516] He noted that he was conscious of the need to deal with circumstances such as this in a trauma-informed way and had asked the Office of Safeguarding to 'consider our approach to these and other similar matters'.[517]

Reflecting on Mr Leishman's evidence at hearings, Secretary Bullard said:

> I think that Mr Leishman's courage in revealing the betrayal of trust that happened to him as a result of an association that he made whilst he was in one of our schools is very confronting to hear, but also the barriers that then existed when he came forward later with an expectation that he would seek and receive support or acknowledgment from the Department of Education also makes me feel very disappointed and I have apologised to Mr Leishman and I'm very sorry, I'm very sorry for that.[518]

Mr Leishman acknowledged the personal apology he received from Secretary Bullard, which he feels he was 'gracious in accepting'.[519] He also said:

> I hope that by speaking about my experiences, this can lead to a change to the way in which the Department engages with victim-survivors of child sexual abuse from within the education system in Tasmania. It is my hope that Commissions of Inquiry, solicitors and formal processes don't need to get involved to encourage the Department to constructively engage with people like me, who have already suffered so much.[520]

Case study 8: 'Andy'

Andy (a pseudonym) is a young boy with a history of childhood trauma and child protection involvement.[521] We heard allegations that Andy had engaged in harmful sexual behaviours towards several children and young people. We heard from two families impacted by his alleged behaviour as recently as 2021. His alleged behaviours can be characterised as frequent, persistent and severe. We did not explore this case study through our hearings process, but we received information from the Department about this matter.

1 'Family A'

Family A (a pseudonym) has two children who are younger than Andy. The children met Andy through primary school but also spent time with him outside school hours.[522]

The parents told us they noticed some behavioural changes in their children, particularly one of them. These included difficulties regulating emotions, wetting themselves and becoming secretive. The child eventually disclosed that Andy was sexually abusing them, with their sibling often witnessing the alleged abuse. The children described these sexual behaviours as 'games', but allegedly involved violent and coercive sexual acts that occurred multiple times a week, including on school grounds, in circumstances where Andy was alone with the children.

The children's parents described some of the challenges they experienced in the aftermath of Andy's alleged behaviour. They felt the response was inadequate and that the school failed to recognise just how serious it was. The parents said they received an apology from the principal but were otherwise left in the dark about steps taken (including whether the matter was reported to the Department). They said that privacy concerns and Andy's right to an education were cited as justifications for not communicating with the parents or removing Andy from the school, and they felt that nothing was done.

The parents told us they ultimately removed their children from the school for the children's safety and wellbeing. They said the children continue to experience the effects of trauma from Andy's alleged behaviour. A lack of appropriately qualified mental health professionals made it difficult to access specialist child psychologists, and public waiting lists for psychologists are long.

The parent said of Andy: 'I'm sorry for that boy, I am truly—I don't blame him, I blame everyone else'. They reported hearing of Andy allegedly harming other children at the school.

2 ‘Family B’

A parent of two primary school aged children also described changes in the behaviour of one of their children not long after starting at Andy’s primary school.[523] Their child would regularly complain of ‘tummy aches’, not want to go to school and find it difficult to separate from their parent. The parent said that their child’s drawings became dark in content and their child began wetting themselves at school.

The child eventually disclosed that Andy was allegedly ‘doing things’ to them at school. The alleged harmful sexual behaviours were serious. Sometimes the child’s sibling would hold their hand during the abuse, so the child was not alone. The child said they were frightened of Andy because he would allegedly threaten to kill them.

The parent went to police with their child and the child made a statement. Andy was not interviewed because his parents allegedly did not consent. Based on the evidence available to us, it does not appear that any further action has been taken by police. When the parent reported the behaviour to the school, the parent said they waited nine days for the principal to come back to them. As with Family A, Family B (a pseudonym) said they also received no information about any potential responses to Andy’s alleged behaviour, with the principal citing confidentiality as the reason.[524] They felt that the school did nothing.

Family B said their child had changed since the alleged abuse by Andy. The parent stated that their child had changed their appearance, is often fearful and calls their parent at lunchtime for reassurance. The parent felt like there was great concern about Andy and what he may have been through, but that no one was worried about their child. The parent said: ‘I feel like we’ve been treated like the perpetrators’. They also referred to being aware of other victims.

3 The response

We did not ask the Department to respond during hearings to the information we received from Family A or Family B. However, the Department has since informed us of the following:

- The Department was not aware of any complaints, concerns or otherwise in respect of Andy’s alleged harmful sexual behaviour until Family B made allegations against Andy to the Department.
- School staff notified the Strong Families, Safe Kids Advice and Referral Line and engaged with police regarding Andy’s alleged harmful sexual behaviours.
- The Department convened a School Leadership Team (including the principal, senior departmental staff and senior school employees) and a Student and Family

Support Team (including a social worker, psychologist, a police officer, a support worker and a representative from the Child Safety Service) in response to the allegations made against Andy.

- The Department convened a Planning Team (including the principal, senior school staff, psychologists, a social worker and the student support leader) to respond to the needs of students affected by Andy's alleged harmful sexual behaviour, including Andy.
- The Department offered psychological support, social support, assistance with moving schools, tutoring, financial support and ongoing communication to Family B following the parent's complaints about Andy's alleged behaviour.
- The information provided by the Department did not suggest any comparable supports had been provided to Family A, who told us they were struggling to access appropriate therapeutic supports.
- School staff engaged in ongoing discussions with Andy's family about Andy's alleged behaviour.
- School staff prepared Risk Management Plans for Andy, including regular supervision.
- The Department offered psychological and other support to Andy's family.
- The Department increased the level of funding to Andy's school, to assist in putting necessary supervision and supports in place for Andy.
- The school communicated with families of children at the school about the supports available.[525]

4 Future responses to harmful sexual behaviours

We consider that a range of preventative actions may be taken to minimise the impact of severe harmful sexual behaviours such as those alleged to have been displayed by Andy:

- Clear policies are needed that guide principals to report more severe harmful sexual behaviours to the Department, to ensure they are supported to provide a best practice response (including the involvement of all appropriate school staff and other professionals or services).
- Appropriate referrals and reports should be made to specialist treatment services, the Child Safety Service and police in relation to the child displaying the behaviours. In cases regarding more severe harmful sexual behaviours, Child

Safety Service or police intervention may be required if the child's carers are unable to take appropriate protective actions. In some cases, the child displaying the behaviours may be at risk of abuse and neglect, and require a Child Safety Service response.

- The ongoing local response within schools should be guided and supported by harmful sexual behaviours practice specialists who can advise on the development of safety and participation plans proportionate to the changing level of risk a child may pose. Where specialist treatment services are involved, they may also inform the safety and participation plan and ongoing risk assessments.
- Schools should be supported in deciding what should be communicated to whom, including consideration of the information needed by parents whose children have been harmed to feel confident their and other children will be safe.
- Schools should be supported to identify all children known or suspected to have been harmed so that children and families affected may access support.
- Where there are concerns that multiple children may have been harmed, schools may need to be supported to implement additional tailored sexual abuse education sessions to encourage further disclosures, and there may need to be appropriate communications to the school community.
- Where there are indications that a child has sexually harmed multiple children in a range of settings, agencies including the Department, Child Safety Service and police should share information to form a comprehensive understanding of the behaviours displayed, to inform the response.

Refer to Chapter 6 for our recommendations about harmful sexual behaviours.

3 Conclusion

The case studies we discuss in this chapter identify shortcomings in the Department's response to allegations of child sexual abuse, particularly regarding addressing allegations in a timely way, conducting proper investigations, and facilitating appropriate and ongoing supports for children and young people, their families and school staff affected by abuse. Over the course of our Commission of Inquiry, there have been changes to the Department's approach to dealing with child sexual abuse matters. We are encouraged by this progress. However, there is still work to do.

While the changes the Department has made will go some way to improving responses to the issues that are apparent in the victim-survivors' experiences and case studies we discuss in this chapter, and the issues identified more broadly through our Inquiry and the Independent Education Inquiry, further improvements are needed. In Chapter 6, we explore what improvements should be made and how they can help to safeguard children and young people in the Department's care.

Notes

1 As noted in Chapter 1, we heard about 63 allegations of child sexual abuse in government schools. The number of people who made allegations does not necessarily correspond to the number of allegations, as some information we received contained more than one allegation.

2 Refer to Case studies 1, 3 and 4.

3 Refer to Case studies 1, 3 and 4.

4 Refer to Case studies 1, 3, 4 and 7.

5 A table detailing the number of state servants suspended due to allegations of child sexual abuse is regularly updated by the Department of Premier and Cabinet through its routine disclosures. Refer to Tasmanian Government, Department of Premier and Cabinet, *Routine Disclosures* (Web Page) <https://www.dpac.tas.gov.au/rti/routine_disclosure_log_-_departmental_information>.

6 Department of Education, 'ED tracker' (Excel spreadsheet), 22 February 2023, produced by the Tasmanian Government in response to a Commission notice to produce. Refer to Appendix H for the methodology used to calculate these figures. There are, at times, discrepancies between the data provided to us by the Tasmanian Government through the ED trackers and the numbers provided by Secretaries of the Departments in their evidence and statements, or differences in the methodology adopted to calculate figures. We have highlighted these discrepancies throughout our report as relevant.

7 Department of Education, 'ED tracker' (Excel spreadsheet), 22 February 2023, produced by the Tasmanian Government in response to a Commission notice to produce. Refer to Appendix H for the methodology used to calculate these figures.

8 Statement of Timothy Bullard, 10 May 2022, 48 [276].

9 Transcript of Timothy Bullard, 11 May 2022, 908 [29–33].

10 Statement of Timothy Bullard, 10 May 2022, 49 [278].

11 Statement of Timothy Bullard, 10 May 2022, 49 [278]; Transcript of Timothy Bullard, 11 May 2022, 909 [8–13].

12 Statement of Timothy Bullard, 10 May 2022, 50 [296], [298]. We note that in evidence provided to us, the term 'preliminary investigation' is commonly used. However, we prefer the term 'preliminary assessment' because it more accurately reflects the nature of this process. Preliminary assessment is also the term the Integrity Commission prefers.

13 Statement of Timothy Bullard, 10 May 2022, 49 [278].

14 Statement of Timothy Bullard, 10 May 2022, 49 [281].

15 Statement of Timothy Bullard, 10 May 2022, 49 [280].

16 Statement of Timothy Bullard, 10 May 2022, 49 [282].

17 Statement of Timothy Bullard, 10 May 2022, 49 [288].

18 Statement of Timothy Bullard, 10 May 2022, 49 [289].

19 Statement of Timothy Bullard, 10 May 2022, 50 [296], [298].

20 Statement of Timothy Bullard, 10 May 2022, 51 [304].

21 Statement of Timothy Bullard, 10 May 2022, 51 [305–306].

22 Statement of Timothy Bullard, 10 May 2022, 50 [298].

23 Statement of Timothy Bullard, 10 May 2022, 50 [296].

24 Statement of Timothy Bullard, 10 May 2022, 50 [298].

25 Statement of Timothy Bullard, 10 May 2022, 51 [305].

26 Statement of Timothy Bullard, 10 May 2022, 51 [308].

27 Statement of Timothy Bullard, 10 May 2022, 51 [309].

28 Statement of Timothy Bullard, 10 May 2022, 51 [308–309].

29 Transcript of Timothy Bullard, 12 September 2022, 3938 [41–43].

30 Transcript of Timothy Bullard, 12 September 2022, 3939 [4–7].

31 Transcript of Timothy Bullard, 12 September 2022, 3939 [12–17].

32 Statement of Timothy Bullard, 10 May 2022, 10 [60].

33 The name 'John' is a pseudonym; Order of the Commission of Inquiry, restricted publication order, 9 May 2022; Transcript of Kerri Collins, 9 May 2022, 606 [28–30].

34 Transcript of Kerri Collins, 9 May 2022, 606 [36–39]; Statement of Kerri Collins, 11 April 2022, 1 [6].

35 Statement of Kerri Collins, 11 April 2022, 1 [7].

36 Transcript of Kerri Collins, 9 May 2022, 607 [40].

37 Statement of Kerri Collins, 11 April 2022, 1 [7]–2 [9].

38 Statement of Kerri Collins, 11 April 2022, 1–2 [7].

39 Transcript of Kerri Collins, 9 May 2022, 607 [45]–608 [10].

40 Statement of Kerri Collins, 11 April 2022, 2 [8].

41 Statement of Kerri Collins, 11 April 2022, 2 [8].

42 Statement of Kerri Collins, 11 April 2022, 2 [9].

43 Statement of Kerri Collins, 11 April 2022, 2 [10].

44 Statement of Kerri Collins, 11 April 2022, 2 [11].

45 Transcript of Kerri Collins, 9 May 2022, 613 [37].

46 Statement of Daryl Coates, 6 June 2022, 120 [395].

47 Statement of Daryl Coates, 6 June 2022, 120 [395].

48 Transcript of Kerri Collins, 9 May 2022, 614 [9–18].

49 Transcript of Kerri Collins, 9 May 2022, 612 [3–30].

50 Statement of Kerri Collins, 11 April 2022, 2 [12].

51 Statement of Kerri Collins, 11 April 2022, 2–3 [12].

52 Department of Education, 'Conduct of Investigation File of "John"', 21 February 2006, 11, produced by the Tasmanian Government in response to a Commission notice to produce.

53 Ms Collins said she was invited to have her father present, but recalls being too embarrassed to talk about her abuse in front of her father: Transcript of Kerri Collins, 9 May 2022, 615 [1–37].

54 Transcript of Kerri Collins, 9 May 2022, 614 [25]–615 [37].

55 Statement of Kerri Collins, 11 April 2022, 3 [14–16].

56 Transcript of Kerri Collins, 9 May 2022, 616 [31–37].

57 Transcript of Kerri Collins, 9 May 2022, 616 [39–44], 617 [3–10].

58 Director of Public Prosecutions, *DPP Prosecution Policy and Guidelines* (2022) 17–18.

59 Statement of Kerri Collins, 11 April 2022, 3 [15]; Transcript of Kerri Collins, 9 May 2022, 622 [12–22].

60 Transcript of Kerri Collins, 9 May 2022, 620 [25–27]; Statement of Kerri Collins, 11 April 2022, 3 [16].

61 Materials provided to us indicate that the Department had moved John to a non-teaching position from around 2001—2002 as a result of the police investigation into the earlier allegations. Although not specifically stated, John's application to teach in 2004 was either a result of the fact that he was not previously required to be registered—the *Teachers Registration Act* received assent in late 2000—or because his registration had lapsed.

62 Transcript of Ann Moxham, 12 May 2022, 1017 [14–17].

63 Transcript of Ann Moxham, 12 May 2022, 1016 [46]–1017 [12]; Transcript of Timothy Bullard, 12 May 2022, 967 [38]–968 [2].

64 Transcript of Timothy Bullard, 12 May 2022, 967 [38]–968 [2].

65 Transcript of Ann Moxham, 12 May 2022, 1017 [3–12].

66 Statement of Ann Moxham, 27 April 2022, Annexure 17 (Summary of complaints or allegations received in relation to 'John', 29 March 2022) 4.

67 Statement of Ann Moxham, 27 April 2022, Annexure 17 (Summary of complaints or allegations received in relation to 'John', 29 March 2022) 5.

68 Transcript of Ann Moxham, 12 May 2022, 1018 [25–37].

69 Transcript of Ann Moxham, 12 May 2022, 1018 [39]–1019 [5].

70 Transcript of Ann Moxham, 12 May 2022, 1019 [7–10].

71 Transcript of Ann Moxham, 12 May 2022, 1019 [30–32].

72 Statement of Kerri Collins, 11 April 2022, 4 [17].

73 Statement of Kerri Collins, 11 April 2022, 4 [18].

74 Statement of Kerri Collins, 11 April 2022, 4 [20]–5 [21].

75 Refer to letter from Daryl Coates to Tasmania Police, 29 November 2018.

76 Statement of Daryl Coates, 6 June 2022, 123 [403].

77 Statement of Daryl Coates, 6 June 2022, 123 [404].

78 Transcript of Daryl Coates, 7 July 2022, 2624 [47]–2625 [3]. The process for charges 'dismissed' in the Supreme Court differs from the process for charges 'dismissed' in the Magistrates Court. Charges cannot be used, even as tendency evidence, where a matter has been 'dismissed' in the Magistrates Court (refer to *Tasmania v Finnegan* [2011] TASSC 74 [3]). However, where a matter has been 'dismissed' in the Supreme Court, the *Director of Public Prosecution Guidelines*, which restate section 350(2) of the *Criminal Code Act 1924*, provide an avenue to allow that matter to be proceeded with again, providing that: 'Once a final decision has been made to discharge an accused, the decision will not be reviewed unless it is plainly wrong, i.e. it was based on incorrect or irrelevant material, or it was unreasonable, or unless new evidence becomes available' (refer to Director of Public Prosecutions, *DPP Prosecution Policy and Guidelines* (2022) 10). In this case, the fifth complaint would constitute new evidence.

79 Statement of Daryl Coates, 6 June 2022, 124 [405].

80 Statement of Daryl Coates, 6 June 2022, Annexure E (Letter from Daryl Coates to Tasmania Police, 29 November 2018) 9.

81 Statement of Daryl Coates, 6 June 2022, Annexure E (Letter from Daryl Coates to Tasmania Police, 29 November 2018) 10.

82 Statement of Daryl Coates, 6 June 2022, Annexure E (Letter from Daryl Coates to Tasmania Police, 29 November 2018) 10.

83 Report of Tasmania Police regarding allegations made against 'John', 29 July 1991, 1; Letter from then Director of Public Prosecutions, 25 February 2004, 6.

84 *Tasmania v Finnegan* [2011] TASSC 74 [3].

85 Transcript of Daryl Coates, 7 July 2022, 2626 [4–10].

86 Statement of Kerri Collins, 11 April 2022, 4 [20]–5 [22].

87 Statement of Kerri Collins, 11 April 2022, 5 [23].

88 Statement of Kerri Collins, 11 April 2022, 5 [23].

89 Transcript of Ann Moxham, 12 May 2022, 1020 [2–4].

90 Order of the Commission of Inquiry, restricted publication order, 11 May 2022.

91 Statement of Timothy Bullard, 'Mark', 4 April 2022, Annexure 9(b)(ii) (Statement by 'Jeff', 12 September 2016); The names 'Jeff', 'Jasmine' and 'Heather' are pseudonyms; Order of the Commission of Inquiry, restricted publication order, 30 August 2023.

92 Statement of Timothy Bullard, 'Mark', 4 April 2022, Annexure 9(b)(ii) (Statement by 'Jeff', 12 September 2016).

93 Statement of Timothy Bullard, 'Mark', 4 April 2022, Annexure 9(c)(i) (Notes of interview with [redacted], 12 September 2019) 2.

94 Statement of Timothy Bullard, 'Mark', 4 April 2022, Annexure 9(c)(i) (Notes of interview with [redacted], 12 September 2019) 2.

95 Statement of Timothy Bullard, 'Mark', 4 April 2022, Annexure 9(c)(i) (Notes of interview with [redacted], 12 September 2019) 2.

96 Statement of Timothy Bullard, 'Mark', 4 April 2022, Annexure 9(b)(ii) (Statement by 'Jeff', 12 September 2016).

97 Statement of Timothy Bullard, 'Mark', 4 April 2022, Annexure 9(c)(i) (Notes of interview with [redacted], 12 September 2019) 1.

98 The name 'Justin' is a pseudonym; Order of the Commission of Inquiry, restricted publication order, 11 May 2022; Statement of Timothy Bullard, 'Mark', 4 April 2022, 19 [76(a)–(b)].

99 Statement of Timothy Bullard, 'Mark', 4 April 2022, 19 [76(c)].

100 Statement of Timothy Bullard, 'Mark', 4 April 2022, Annexure 9(c)(iii) (Letter from 'Justin' to 'Mark', 15 September 2016).

101 Statement of Timothy Bullard, 'Mark', 4 April 2022, Annexure 9(c)(iii) (Letter from 'Justin' to 'Mark', 15 September 2016).

102 Statement of Timothy Bullard, 'Mark', 4 April 2022, 21 [76(j)].

103 Statement of Timothy Bullard, 'Mark', 4 April 2022, Annexure 9(c)(iii) (Letter from 'Justin' to 'Mark', 15 September 2016).

104 Statement of Timothy Bullard, 'Mark', 4 April 2022, Annexure 9(c)(iii) (Letter from 'Justin' to 'Mark', 15 September 2016).

105 Statement of Timothy Bullard, 'Mark', 4 April 2022, 21 [76(l)].

106 Statement of Timothy Bullard, 'Mark', 4 April 2022, 12 [59].

107 Statement of Timothy Bullard, 'Mark', 4 April 2022, 11 [55].

108 Statement of Timothy Bullard, 'Mark', 4 April 2022, 13 [59(i)].

109 Statement of Timothy Bullard, 'Mark', 4 April 2022, 12 [58].

110 Statement of Timothy Bullard, 'Mark', 4 April 2022, 23 [84].

111 Statement of Timothy Bullard, 'Mark', 4 April 2022, 22[79].

112 Statement of Timothy Bullard, 'Mark', 4 April 2022, 22 [78–79].

113 Statement of Timothy Bullard, 'Mark', 4 April 2022, 23 [85(a)–(b)].

114 Statement of Timothy Bullard, 'Mark', 4 April 2022, 18 [76(l)].

115 Statement of Timothy Bullard, 'Mark', 4 April 2022, 23 [59(f)].

116 Statement of Timothy Bullard, 'Mark', 4 April 2022, 12 [59(d)].

117 Statement of Timothy Bullard, 'Mark', 4 April 2022, 14 [59(m)].

118 Statement of Timothy Bullard, 'Mark', 4 April 2022, 13 [59(i)].

119 Statement of Timothy Bullard, 'Mark', 4 April 2022, 13 [59(j)].

120 Statement of Timothy Bullard, 'Mark', 4 April 2022, 15 [59(k)].

121 Statement of Timothy Bullard, 'Mark', 4 April 2022, 14 [59(n)].

122 Statement of Timothy Bullard, 'Mark', 4 April 2022, 14 [59(h)].

123 Transcript of Timothy Bullard, 12 May 2022, 975 [17–20].

124 Transcript of Timothy Bullard, 12 May 2022, 975 [25–37].

125 Statement of Timothy Bullard, 'Mark', 4 April 2022, 14 [59(o)].

126 Timothy Bullard, 'Reasons for decision regarding reasonable grounds to believe there may have been a breach of the State Service Act Code of Conduct regarding "Justin"', 18 June 2021, 1 [2–4].

127 Timothy Bullard, 'Reasons for decision regarding reasonable grounds to believe there may have been a breach of the State Service Act Code of Conduct regarding "Justin"', 18 June 2021, 1 [2].

128 Timothy Bullard, 'Reasons for decision regarding reasonable grounds to believe there may have been a breach of the State Service Act Code of Conduct regarding "Justin"', 18 June 2021, 1 [3].

129 Minute to the Secretary, '"Justin" – Referral for Consideration of Investigation into Alleged Breaches of the *State Service Act 2000* Code of Conduct and Suspension with Pay (Employment Direction 5)', 18 June 2021, 3.

130 The legal proceeding is not cited to protect the identities of the persons involved.

131 Timothy Bullard, 'Reasons for decision regarding reasonable grounds to believe there may have been a breach of the State Service Act Code of Conduct regarding "Justin"', 18 June 2021, 4 [25]–5 [29].

132 Statement of Timothy Bullard, 'Mark', 4 April 2022, 24 [86].

133 Statement of Timothy Bullard, 'Mark', 4 April 2022, 13 [59(g)].

134 Statement of Timothy Bullard, 'Mark', 4 April 2022, 24 [88].

135 Statement of Timothy Bullard, 'Mark', 4 April 2022, 17 [72].

136 Statement of Timothy Bullard, 'Mark', 4 April 2022, 15 [62].

137 Statement of Timothy Bullard, 'Mark', 4 April 2022, 24 [87].

138 Order of the Commission of Inquiry, restricted publication order, 11 May 2022.

139 Order of the Commission of Inquiry, restricted publication order, 11 May 2022.

140 Transcript of 'Rachel', 11 May 2022, 801 [46]–802 [1].

141 Statement of 'Rachel', 14 April 2022, 1 [4].

142 Transcript of 'Rachel', 11 May 2022, 802 [15–21].

143 The name 'Anne' is a pseudonym' Order of the Commission of Inquiry, restricted publication order, 11 May 2022; Transcript of 'Rachel', 11 May 2022, 803 [46]–804 [22]; refer also to Submission 092 'Anne', 1–2.

144 Statement of 'Rachel', 14 April 2022, 1–2 [6].

145 Transcript of 'Rachel', 11 May 2022, 805 [27]–806 [11].

146 Request for Statement to Timothy Bullard (RFS-TAS-003) 4 [5], affirmed as correct in Statement of Timothy Bullard, 'Wayne', 4 April 2022, 13 [59]; refer also to Transcript of 'Rachel', 11 May 2022, 806 [26].

147 Submission 092 'Anne', 2.

148 Request for Statement to Timothy Bullard (RFS-TAS-003) 4 [3], affirmed as correct in Statement of Timothy Bullard, 'Wayne', 4 April 2022, 13 [59].

149 Submission 092 'Anne', 2.

150 Letter from then Secretary of the Department of Education to 'Wayne', 14 March 2006.

151 Letter from then Secretary of the Department of Education to 'Wayne', 14 March 2006.

152 Request for Statement to Timothy Bullard (RFS-TAS-003) 4 [3], affirmed as correct in Statement of Timothy Bullard, 'Wayne', 4 April 2022, 13 [59].

153 Statement of 'Rachel', 14 April 2022, 3 [13].

154 Transcript of 'Rachel', 11 May 2022, 808 [30–32]; 809 [15–17].

155 Transcript of 'Rachel', 11 May 2022, 809 [19–24].

156 Statement of 'Rachel', 14 April 2022, 2 [8].

157 Submission 092 'Anne', 2.

158 Statement of 'Rachel', 14 April 2022, 2–3 [11].

159 Statement of 'Rachel', 14 April 2022, 3 [12]. Refer also to Transcript of 'Rachel', 11 May 2022, 810 [25–40].

160 Transcript of 'Rachel', 11 May 2022, 810 [1–3].

161 Statement of 'Rachel', 14 April 2022, 2 [10].

162 Statement of 'Rachel', 14 April 2022, 2 [9].

163 Transcript of 'Rachel', 11 May 2022, 811 [21–22].

164 Request for Statement to Timothy Bullard (RFS-TAS-003) 5 [7], affirmed as correct in Statement of Timothy Bullard, 'Wayne', 4 April 2022, 13 [59].

165 Statement of 'Rachel', 14 April 2022, 3–4 [16].

166 Transcript of 'Rachel', 11 May 2022, 813 [46–47].

167 Transcript of 'Rachel', 11 May 2022, 815 [33–36].

168 Statement of Timothy Bullard, 'Wayne', 4 April 2022, 25–26 [106(b)].

169 Statement of 'Rachel', 14 April 2022, 5 [25].

170 Request for Statement to Timothy Bullard (RFS-TAS-003) 5 [8], affirmed as correct in Statement of Timothy Bullard, 'Wayne', 4 April 2022, 13 [59].

171 Request for Statement to Timothy Bullard (RFS-TAS-003) 5 [13(a)], affirmed as correct in Statement of Timothy Bullard, 'Wayne', 4 April 2022, 13 [59].

172 Request for Statement to Timothy Bullard (RFS-TAS-003) 6 [13(b)], affirmed as correct in Statement of Timothy Bullard, 'Wayne', 4 April 2022, 13 [59].

173 Request for Statement to Timothy Bullard (RFS-TAS-003) 4 [5], affirmed as correct in Statement of Timothy Bullard, 'Wayne', 4 April 2022, 13 [59].

174 Transcript of 'Rachel', 11 May 2022, 806 [31–34]; Email from 'Rachel' to Commission of Inquiry, 9 May 2023.

175 Request for Statement to Timothy Bullard (RFS-TAS-003) 5 [11], affirmed as correct in Statement of Timothy Bullard, 'Wayne', 4 April 2022, 13 [59].

176 Request for Statement to Timothy Bullard (RFS-TAS-003) 5 [12], affirmed as correct in Statement of Timothy Bullard, 'Wayne', 4 April 2022, 13 [59].

177 Request for Statement to Timothy Bullard (RFS-TAS-003) 5 [9], affirmed as correct in Statement of Timothy Bullard, 'Wayne', 4 April 2022, 13 [59].

178 Request for Statement to Timothy Bullard (RFS-TAS-003) 5 [9], affirmed as correct in Statement of Timothy Bullard, 'Wayne', 4 April 2022, 13 [59].

179 Request for Statement to Timothy Bullard (RFS-TAS-003) 6 [14], affirmed as correct in Statement of Timothy Bullard, 'Wayne', 4 April 2022, 13 [59]; Transcript of Timothy Bullard, 12 May 2022, 943 [39–46].

180 Statement of 'Rachel', 14 April 2022, 4 [21–22].

181 Statement of 'Rachel', 14 April 2022, 7 [32].

182 Statement of 'Rachel', 14 April 2022, 7 [33].

183 Department of Education, 'Briefing note – "Rachel" complaint (2007) against "Wayne"', 1 August 2007, 3.

184 Statement of 'Rachel', 14 April 2022, 7 [34].

185 Statement of Ann Moxham, 27 April 2022, Annexure 10 (Summary of complaints or allegations against 'Wayne', 31 March 2022) 2 [1].

186 Statement of Ann Moxham, 27 April 2022, Annexure 10 (Summary of complaints or allegations against 'Wayne', 31 March 2022) 2 [2].

187 Request for Statement to Timothy Bullard (RFS-TAS-003) 6 [16–17], affirmed as correct in Statement of Timothy Bullard, 'Wayne', 4 April 2022, 13 [59].

188 Statement of Ann Moxham, 27 April 2022, 22 [18.2].

189 Statement of Ann Moxham, 27 April 2022, Annexure 10 (Summary of complaints or allegations against 'Wayne', 31 March 2022) 2 [6].

190 Statement of Ann Moxham, 27 April 2022, Annexure 10 (Summary of complaints or allegations against 'Wayne', 31 March 2022) 2 [7].

191 Statement of Ann Moxham, 27 April 2022, 22 [18.3].

192 Statement of 'Rachel', 14 April 2022, 6 [29].

193 Transcript of 'Rachel', 11 May 2022, 821 [30–35].

194 Transcript of 'Rachel', 11 May 2022, 809 [29–30].

195 Statement of Timothy Bullard, 'Wayne', 4 April 2022, 26 [107–108].

196 Statement of Ann Moxham, 27 April 2022, 22 [18.5].

197 Statement of Timothy Bullard, 'Wayne', 4 April 2022, 27 [109].

198 Statement of Ann Moxham, 27 April 2022, Annexure 10 (Summary of complaints or allegations against 'Wayne', 31 March 2022) 1.

199 Transcript of 'Rachel', 11 May 2022, 817 [33–34].

200 Transcript of 'Rachel', 11 May 2022, 824 [24–28].

201 Transcript of 'Rachel', 11 May 2022, 823 [37–44].

202 Transcript of 'Rachel', 11 May 2022, 823 [32–35], 824 [18–19].

203 Transcript of 'Rachel', 11 May 2022, 819 [36–38].

204 Submission 092 'Anne', 3.
205 Transcript of Timothy Bullard, 12 May 2022, 945 [41–42].
206 Statement of Timothy Bullard, 'Wayne', 4 April 2022, 25 [106(a)].
207 Statement of Timothy Bullard, 'Wayne', 4 April 2022, 25 [106(a)].
208 Statement of Timothy Bullard, 'Wayne', 4 April 2022, 26 [106(c)].
209 Statement of Timothy Bullard, 'Wayne', 4 April 2022, 21 [94(b)].
210 Statement of Timothy Bullard, 'Wayne', 4 April 2022, 25 [105(b)].
211 Statement of Timothy Bullard, 'Wayne', 4 April 2022, 21 [94(c)].
212 Statement of Timothy Bullard, 'Wayne', 4 April 2022, 21 [94(c)].
213 Statement of Timothy Bullard, 'Wayne', 4 April 2022, 21 [94(c)].
214 Transcript of Timothy Bullard, 960 [44]–961 [2].
215 Statement of Timothy Bullard, 'Wayne', 4 April 2022, 26 [106(d)].
216 Transcript of Timothy Bullard, 12 May 2022, 963 [14–22].
217 Transcript of Timothy Bullard, 12 May 2022, 944 [1–2] and 945 [5].
218 Transcript of Timothy Bullard, 12 May 2022, 944 [45].
219 Statement of Timothy Bullard, 'Wayne', 4 April 2022, 30 [124].
220 Transcript of Timothy Bullard, 12 May 2022, 926 [1].
221 Transcript of Timothy Bullard, 12 May 2022, 946 [28–31].
222 Statement of Timothy Bullard, 'Wayne', 4 April 2022, 31 [128].
223 Transcript of Timothy Bullard, 12 May 2022, 950 [19–22].
224 Statement of Timothy Bullard, 'Wayne', 4 April 2022, 23 [101].
225 Statement of Timothy Bullard, 'Wayne', 4 April 2022, 23 [101].
226 Statement of Timothy Bullard, 'Wayne', 4 April 2022, 30 [124].
227 Statement of Timothy Bullard, 'Wayne', 4 April 2022, 22 [95]; Statement of Timothy Bullard, 'Wayne', 4 April 2022, 22 [96].
228 Transcript of Timothy Bullard, 12 May 2022, 926 [25–29].
229 Statement of Timothy Bullard, 'Wayne', 4 April 2022, 32 [129].
230 Statement of Timothy Bullard, 'Wayne', 4 April 2022, 32 [130–131].
231 Statement of Timothy Bullard, 'Wayne', 4 April 2022, 22 [99].
232 Statement of Timothy Bullard, 'Wayne', 4 April 2022, 22 [99].
233 *Justice Miscellaneous (Royal Commission Amendments) Act 2023* s 39; *Police Offences Act 1935* ss 35(5A) and (3).
234 The name 'Peter' is a pseudonym; Order of the Commission of Inquiry, restricted publication order, 10 May 2022.
235 Statement of Katrina Munting, 5 April 2022, 2 [8].
236 Statement of Katrina Munting, 5 April 2022, 2 [8].
237 Statement of Katrina Munting, 5 April 2022, 2 [8].
238 Statement of Katrina Munting, 5 April 2022, 2 [9].
239 Statement of Katrina Munting, 5 April 2022, 2 [9].
240 Statement of Katrina Munting, 5 April 2022, 2 [9].
241 Transcript of Katrina Munting, 10 May 2022, 703 [26–35].
242 Transcript of Katrina Munting, 10 May 2022, 703 [26–35].
243 Transcript of Katrina Munting, 10 May 2022, 703 [37–39]; Statement of Katrina Munting, 5 April 2022, 3 [11].
244 Statement of Katrina Munting, 5 April 2022, 3 [12].
245 Transcript of Katrina Munting, 10 May 2022, 704 [18–29].
246 Transcript of Katrina Munting, 10 May 2022, 705 [11–17].
247 Transcript of Katrina Munting, 10 May 2022, 705 [23–35].

248 Statement of Katrina Munting, 5 April 2022, 3 [13].

249 Transcript of Katrina Munting, 10 May 2022, 705 [31–35].

250 Statement of Katrina Munting, 5 April 2022, 3 [14].

251 Transcript of Katrina Munting, 10 May 2022, 707 [11–15], [39–47].

252 Transcript of Katrina Munting, 10 May 2022, 708 [12–16].

253 Statement of Katrina Munting, 5 April 2022, 3 [16].

254 Transcript of Katrina Munting, 10 May 2022, 711 [39–43].

255 Transcript of Katrina Munting, 10 May 2022, 709 [44]–710 [10].

256 Transcript of Katrina Munting, 10 May 2022, 710 [12–21].

257 Transcript of Katrina Munting, 10 May 2022, 710 [29–37].

258 Statement of Katrina Munting, 5 April 2022, 4 [19].

259 Statement of Katrina Munting, 5 April 2022, 4 [19].

260 Statement of Katrina Munting, 5 April 2022, 4 [20–21].

261 Statement of Katrina Munting, 5 April 2022, 4 [22].

262 Statement of Katrina Munting, 5 April 2022, 4 [22].

263 Statement of Katrina Munting, 5 April 2022, 5 [23–24].

264 Statement of Katrina Munting, 5 April 2022, 6 [28].

265 Statement of Katrina Munting, 5 April 2022, 6 [29].

266 Statement of Katrina Munting, 5 April 2022, 7 [36].

267 Statement of Katrina Munting, 5 April 2022, 7 [36].

268 Statement of Katrina Munting, 5 April 2022, 6 [32], 7 [33], 8 [37].

269 Statement of Katrina Munting, 5 April 2022, 8 [39].

270 Transcript of Katrina Munting, 10 May 2022, 713 [9–16].

271 Transcript of Katrina Munting, 10 May 2022, 713 [39]–714 [18].

272 Transcript of Katrina Munting, 10 May 2022, 714 [28]–715 [18].

273 Transcript of Katrina Munting, 10 May 2022, 716 [19–29].

274 Transcript of Katrina Munting, 10 May 2022, 716 [31–40].

275 Transcript of Timothy Bullard, 11 May 2022, 888 [43–47].

276 Transcript of Timothy Bullard, 11 May 2022, 894 [8–20].

277 Statement of Timothy Bullard, 10 May 2022, 12 [77–79]; Statement of Timothy Bullard, 10 May 2022, 6 [31]; Transcript of Timothy Bullard, 11 May 2022, 889 [2–5].

278 Transcript of Timothy Bullard, 11 May 2022, 888 [43]–889 [6].

279 The name 'Jeremy' is a pseudonym; Order of the Commission of Inquiry, restricted publication order, 11 May 2022.

280 Statement of Timothy Bullard, 'Jeremy', 4 April 2022, 31 [107]. Note, however, that Jeremy 'did not return to his employment' after 2016.

281 The facts of these incidents are outlined in Statement of Timothy Bullard, 'Jeremy', 4 April 2022, 33–34 [124]. They are also outlined in the Request for Statement served on the Department of Education, 24 February 2022, 4 [2]. Secretary Bullard accepts the facts outlined in the Request for Statement served on the Department of Education, 24 February 2022, as accurately reflecting the allegations against Jeremy and responses of the Department—refer to Statement of Timothy Bullard, 'Jeremy', 4 April 2022, 12 [58].

282 Statement of Timothy Bullard, 'Jeremy', 4 April 2022, 60 [231(a)]–61[231(c)]; Transcript of Timothy Bullard, 12 May 2022, 969 [13–20].

283 Statement of Timothy Bullard, 'Jeremy', 4 April 2022, 33 [124(b)], 35 [124(j)].

284 Statement of Timothy Bullard, 'Jeremy', 4 April 2022, 34 [124(g)].

285 Statement of Timothy Bullard, 'Jeremy', 4 April 2022, 34 [124(g)].

286 Statement of Timothy Bullard, 'Jeremy', 4 April 2022, 34 [124(i)].

287 Statement of Timothy Bullard, 'Jeremy', 4 April 2022, 35 [124(j)–(k)].

288 Statement of Timothy Bullard, 'Jeremy', 4 April 2022, 35 [124(m)].

289 Transcript of Timothy Bullard, 12 May 2022, 972 [1–12]; refer also to Request for Statement served on the Department of Education, 24 February 2022, 5 [4].

290 Transcript of Timothy Bullard, 12 May 2022, 972 [1–12].

291 Statement of Timothy Bullard, 'Jeremy', 4 April 2022, 47 [169(b)]; refer also to Request for Statement served on the Department of Education, 24 February 2022, 5 [5].

292 Statement of Timothy Bullard, 'Jeremy', 4 April 2022, 47 [169(c)].

293 Statement of Timothy Bullard, 'Jeremy', 4 April 2022, 47 [169(c)].

294 Statement of Timothy Bullard, 'Jeremy', 4 April 2022, 31 [109], 47 [169(f)]; refer also to Request for Statement served on the Department of Education, 24 February 2022, 5 [6–7].

295 Statement of Timothy Bullard, 'Jeremy', 4 April 2022, 31 [109], 47 [169(f)]; refer also to Request for Statement served on the Department of Education, 24 February 2022, 5 [6–7].

296 Statement of Timothy Bullard, 'Jeremy', 4 April 2022, 49 [171].

297 Statement of Timothy Bullard, 'Jeremy', 4 April 2022, 48 [169(g), (j)].

298 Statement of Timothy Bullard, 'Jeremy', 4 April 2022, 49 [172].

299 Statement of Timothy Bullard, 'Jeremy', 4 April 2022, 31 [111]–32 [112]; refer also to Request for Statement served on the Department of Education, 24 February 2022, 5 [9–10].

300 Statement of Timothy Bullard, 'Jeremy', 4 April 2022, 31–32 [112]. The Secretary had suspended Jeremy's pay when his teacher registration was suspended. However, the Department began paying Jeremy again because of the decision of the Magistrates Court to set aside his suspension.

301 Statement of Timothy Bullard, 'Jeremy', 4 April 2022, 31–32 [112]; refer also to Request for Statement served on the Department of Education, 24 February 2022, 6 [20–21].

302 Statement of Ann Moxham, 27 April 2022, 22 [21.2].

303 Statement of Timothy Bullard, 'Jeremy', 4 April 2022, 61 [231(e)].

304 Statement of Timothy Bullard, 'Jeremy', 4 April 2022, 44 [155]; refer also to Request for Statement served on the Department of Education, 24 February 2022, 5 [8], 6 [12].

305 Statement of Timothy Bullard, 'Jeremy', 4 April 2022, 43 [151], 61 [231(d)].

306 Statement of Timothy Bullard, 'Jeremy', 4 April 2022, 43 [151].

307 Statement of Timothy Bullard, 'Jeremy', 4 April 2022, 51 [182].

308 Statement of Ann Moxham, 27 April 2022, Annexure 11 (Summary of complaints or allegations received against 'Jeremy', 30 March 2022) 4 [9].

309 Statement of Ann Moxham, 27 April 2022, Annexure 11 (Summary of complaints or allegations received against 'Jeremy', 30 March 2022) 5 [10].

310 Statement of Timothy Bullard, 'Jeremy', 4 April 2022, 32 [115].

311 Statement of Timothy Bullard, 'Jeremy', 4 April 2022, 32 [116].

312 Statement of Timothy Bullard, 'Jeremy', 4 April 2022, 32 [116].

313 Statement of Timothy Bullard, 'Jeremy', 4 April 2022, 32 [116].

314 Request for Statement served on the Department of Education, 24 February 2022, 6 [19].

315 Statement of Timothy Bullard, 'Jeremy', 4 April 2022, 33 [121–122]; refer also to Request for Statement served on the Department of Education, 24 February 2022, 6 [20–21].

316 Statement of Ann Moxham, 27 April 2022, Annexure 11 (Summary of complaints or allegations received against 'Jeremy', 30 March 2022) 6 [18]–7 [21].

317 Statement of Ann Moxham, 27 April 2022, Annexure 11 (Summary of complaints or allegations received against 'Jeremy', 30 March 2022) 1, 6 [17]–8 [29].

318 Statement of Timothy Bullard, 'Jeremy', 4 April 2022, 32 [117].

319 Statement of Timothy Bullard, 'Jeremy', 4 April 2022, 60 [230].

320 Statement of Timothy Bullard, 'Jeremy', 4 April 2022, 31 [109], 51 [181–182].

321 Statement of Timothy Bullard, 'Jeremy', 4 April 2022, 52 [186].

322 Statement of Timothy Bullard, 'Jeremy', 4 April 2022, 52 [190].

323 Statement of Timothy Bullard, 'Jeremy', 4 April 2022, 53 [201].

324 Statement of Timothy Bullard, 'Jeremy', 4 April 2022, 43 [149].

325 Statement of Timothy Bullard, 'Jeremy', 4 April 2022, 31 [107].

326 Statement of Timothy Bullard, 'Jeremy', 4 April 2022, 13 [59(a)].

327 Statement of Timothy Bullard, 'Jeremy', 4 April 2022, 13 [59(b)].

328 Statement of Timothy Bullard, 'Jeremy', 4 April 2022, 13 [59(c)–(e)].

329 Statement of Timothy Bullard, 'Jeremy', 4 April 2022, 13 [59(f)].

330 Statement of Timothy Bullard, 'Jeremy', 4 April 2022, 13 [59(a), (g)].

331 Statement of Timothy Bullard, 'Jeremy', 4 April 2022, 14 [60(b)].

332 Statement of Timothy Bullard, 'Jeremy', 4 April 2022, 43 [151]; refer also to Request for Statement served on the Department of Education, 24 February 2022, 5–6 [8], 6 [12].

333 Transcript of Timothy Bullard, 12 May 2022, 971 [1–23].

334 Statement of Timothy Bullard, 'Jeremy', 4 April 2022, 14 [60(a)].

335 Statement of Timothy Bullard, 'Jeremy', 4 April 2022, 14 [60(b)].

336 In relation to the 2012 allegations refer to Statement of Timothy Bullard, 'Jeremy', 4 April 2022, 38 [134]–40 [144]; in relation to the 2015 allegations refer to Statement of Timothy Bullard, 'Jeremy', 4 April 2022, 45 [162]–46 [167].

337 Statement of Timothy Bullard, 'Jeremy', 4 April 2022, 56 [214].

338 Statement of Timothy Bullard, 'Jeremy', 4 April 2022, 57 [219].

339 Statement of Timothy Bullard, 'Jeremy', 4 April 2022, 49 [170] and 57 [219].

340 Statement of Timothy Bullard, 'Jeremy', 4 April 2022, 15 [61(d)–(e)].

341 Statement of Timothy Bullard, 'Jeremy', 4 April 2022, 15 [61(c)].

342 Statement of Timothy Bullard, 'Jeremy', 4 April 2022, 15 [61(e)].

343 Transcript of Timothy Bullard, 12 May 2022, 955 [25–26].

344 Transcript of Timothy Bullard, 12 May 2022, 970 [10–20].

345 Transcript of Timothy Bullard, 12 May 2022, 955 [22–33].

346 Statement of Timothy Bullard, 'Jeremy', 4 April 2022, 20 [77(b)].

347 Statement of Timothy Bullard, 'Jeremy', 4 April 2022, 20 [77(b)].

348 Statement of Timothy Bullard, 'Jeremy', 4 April 2022, 20 [77(b)].

349 Statement of Timothy Bullard, 'Jeremy', 4 April 2022, 21 [77(f)].

350 Statement of Timothy Bullard, 'Jeremy', 4 April 2022, 20 [77(c)].

351 Statement of Timothy Bullard, 'Jeremy', 4 April 2022, 20 [77(c)].

352 Statement of Timothy Bullard, 'Jeremy', 4 April 2022, 20 [77(d)].

353 Transcript of Timothy Bullard, 12 May 2022, 970 [10–20].

354 Transcript of Timothy Bullard, 12 May 2022, 957 [21–29].

355 Statement of Timothy Bullard, 'Jeremy', 4 April 2022, 23 [88].

356 Transcript of Timothy Bullard, 12 May 2022, 972 [25–41].

357 Statement of Timothy Bullard, 'Jeremy', 4 April 2022, 51–52 [185].

358 Statement of Timothy Bullard, 'Jeremy', 4 April 2022, 55 [208–209].

359 Transcript of Timothy Bullard, 12 May 2022, 972 [43]–973 [9].

360 Statement of Timothy Bullard, 'Jeremy', 4 April 2022, 55 [211].

361 Statement of Timothy Bullard, 'Jeremy', 4 April 2022, 55 [211].

362 The name 'Brad' is a pseudonym; Order of the Commission of Inquiry, restricted publication order, 11 May 2022.

363 Request for Statement to Timothy Bullard (RFS-TAS-002) 1 [1], affirmed as correct in Statement of Timothy Bullard, 'Brad', 4 April 2022, 12 [57], 13 [59(a)].

364 Request for Statement to Timothy Bullard (RFS-TAS-002) 5 [5], affirmed as correct in Statement of Timothy Bullard, 'Brad', 4 April 2022, 53.

365 Statement of Ann Moxham, 27 April 2022, Annexure 14 (Summary of complaints or allegations received against 'Brad', 31 March 2022) 2 [4].

366 Statement of Ann Moxham, 27 April 2022, Annexure 14 (Summary of complaints or allegations received against 'Brad', 31 March 2022) 2 [4].

367 Statement of Ann Moxham, 27 April 2022, Annexure 14 (Summary of complaints or allegations received against 'Brad', 31 March 2022) 1 [1].

368 Statement of Ann Moxham, 27 April 2022, Annexure 14 (Summary of complaints or allegations received against 'Brad', 31 March 2022) 2 [5].

369 Statement of Ann Moxham, 27 April 2022, Annexure 14 (Summary of complaints or allegations received against 'Brad', 31 March 2022) 2 [5].

370 Request for Statement to Timothy Bullard (RFS-TAS-002) 5 [11], affirmed as correct in Statement of Timothy Bullard, 'Brad', 4 April 2022, 12 [53], 13 [61(a)]–14 [61(f)].

371 Statement of Timothy Bullard, 'Brad', 4 April 2022, 13 [61(c)]; The name 'Principal A' is a pseudonym; Order of the Commission of Inquiry, restricted publication order, 30 August 2023.

372 Statement of Timothy Bullard, 'Brad', 4 April 2022, 13 [61(c)], 33 [121(a)]; refer also to Department of Education, Timeline: Allegations of Inappropriate Conduct, 'Brad', undated, 1.

373 Statement of Timothy Bullard, 'Brad', 4 April 2022, 13 [61(c)].

374 Statement of Timothy Bullard, 'Brad', 4 April 2022, 13 [61(d)]–14 [61(e)].

375 Request for Statement to Timothy Bullard (RFS-TAS-002) 5 [13], affirmed as correct in Statement of Timothy Bullard, 'Brad', 4 April 2022, 12 [53], 14 [61(e)].

376 Statement of Timothy Bullard, 'Brad', 4 April 2022, 14 [61(f)], 33 [121(c)–(d)], 38 [142].

377 Statement of Timothy Bullard, 'Brad', 4 April 2022, 14 [61(d)].

378 Statement of Timothy Bullard, 'Brad', 4 April 2022, 14 [61(f)].

379 Statement of Timothy Bullard, 'Brad', 4 April 2022, 33 [121(b)(ii)].

380 Statement of Timothy Bullard, 'Brad', 4 April 2022, 14 [61(f)].

381 Request for Statement to Timothy Bullard (RFS-TAS-003) 5 [12]–6 [19], affirmed as correct in Statement of Timothy Bullard, 'Brad', 4 April 2022, 12 [53], 34 [125], 35 [131].

382 Statement of Timothy Bullard, 'Brad', 4 April 2022, 34 [126]; The name 'Principal B; is a pseudonym; Order of the Commission of Inquiry, restricted publication order, 30 August 2023.

383 Statement of Timothy Bullard, 'Brad', 4 April 2022, 34 [127(a)(iii)].

384 Statement of Timothy Bullard, 'Brad', 4 April 2022, 34 [127(a)(i), (ii)–128].

385 Statement of Timothy Bullard, 'Brad', 4 April 2022, 34 [127(b)].

386 Statement of Timothy Bullard, 'Brad', 4 April 2022, 34 [127(c)].

387 Statement of Timothy Bullard, 'Brad', 4 April 2022, 34 [127(b)–(c)].

388 Statement of Timothy Bullard, 'Brad', 4 April 2022, 14 [61(i)].

389 Statement of Timothy Bullard, 'Brad', 4 April 2022, 15 [61(k)].

390 Statement of Timothy Bullard, 'Brad', 4 April 2022, 35 [131].

391 Statement of Timothy Bullard, 'Brad', 4 April 2022, 35 [132(a)(ii)]; The name 'Principal C' is a pseudonym; Order of the Commission of Inquiry, restricted publication order, 30 August 2023.

392 Statement of Timothy Bullard, 'Brad', 4 April 2022, 35 [132(a)(iii)–(iv)].

393 Statement of Timothy Bullard, 'Brad', 4 April 2022, 15 [61(n)].

394 Statement of Timothy Bullard, 'Brad', 4 April 2022, 15 [61(n)].

395 Statement of Timothy Bullard, 'Brad', 4 April 2022, 15 [61(n)(iii)].

396 Statement of Timothy Bullard, 'Brad', 4 April 2022, 15 [61(o)], 39 [148].

397 Statement of Ann Moxham, 27 April 2022, Annexure 14 (Summary of complaints or allegations received against 'Brad', 31 March 2022) 2 [6(iii)–(iv)].

398 Statement of Timothy Bullard, 'Brad', 4 April 2022, 16 [61(p)].

399 Email from Mandy Clarke, Department of Communities, to Trudy Pearce, Deputy Secretary Learning, Department of Education 19 February 2021.

400 Email from Mandy Clarke, Department of Communities, to Trudy Pearce, Deputy Secretary Learning, Department of Education 19 February 2021.

401 Statement of Ann Moxham, 27 April 2022, Annexure 14 (Summary of complaints or allegations received against 'Brad', 31 March 2022) 2 [8].

402 Statement of Timothy Bullard, 'Brad', 4 April 2022, 16 [61(q)].

403 Statement of Timothy Bullard, 'Brad', 4 April 2022, 16 [61(q)].

404 Minute to the Secretary Timothy Bullard, '"Brad" – Referral for Consideration of Alleged Misconduct and Review of Historical Allegations', 13 July 2021, 2–3.

405 Minute to the Secretary Timothy Bullard, '"Brad" – Referral for Consideration of Alleged Misconduct and Review of Historical Allegations', 13 July 2021, 3.

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407 Email from Mandy Clarke, Department of Communities, to Trudy Pearce, Deputy Secretary Learning, Department of Education, 'Re: "Brad"', 21 February 2021.

408 Statement of Timothy Bullard, 'Brad', 4 April 2022, 13 [60].

409 Statement of Timothy Bullard, 'Brad', 4 April 2022, 16 [61(q)].

410 Minute to the Secretary Timothy Bullard, '"Brad" – Referral for Consideration of Alleged Misconduct and Review of Historical Allegations', 13 July 2021, 3.

411 Statement of Ann Moxham, 27 April 2022, Annexure 14 (Summary of complaints or allegations received against 'Brad', 31 March 2022) 3 [9].

412 Statement of Ann Moxham, 27 April 2022, Annexure 14 (Summary of complaints or allegations received against 'Brad', 31 March 2022) 3 [11].

413 Statement of Ann Moxham, 27 April 2022, Annexure 14 (Summary of complaints or allegations received against 'Brad', 31 March 2022) 3 [12].

414 Statement of Timothy Bullard, 'Brad', 4 April 2022, 33 [122–123].

415 Statement of Timothy Bullard, 'Brad', 4 April 2022, 16 [61(r)].

416 Statement of Timothy Bullard, 'Brad', 4 April 2022, 16 [61(s)].

417 Letter from Ann Moxham to Timothy Bullard, 16 July 2021.

418 Statement of Timothy Bullard, 'Brad', 4 April 2022, 17 [63].

419 Transcript of Timothy Bullard, 12 May 2022, 979 [27–34].

420 Transcript of Timothy Bullard, 12 May 2022, 985 [27–35].

421 Statement of Timothy Bullard, 'Brad', 4 April 2022, 17 [66]. Note that 'Brad' was not eligible for mutual recognition as he was not registered at the time he sought to begin teaching in Tasmania.

422 Statement of Timothy Bullard, 'Brad', 4 April 2022, 18–19 [72].

423 Statement of Timothy Bullard, 'Brad', 4 April 2022, 19 [73].

424 Transcript of Timothy Bullard, 12 May 2022, 977 [21–30].

425 Transcript of Ann Moxham, 12 May 2022, 1003 [27–34].

426 Statement of Timothy Bullard, 'Brad', 4 April 2022, 18 [69].

427 Statement of Timothy Bullard, 'Brad', 4 April 2022, 18 [69].

428 Statement of Timothy Bullard, 'Brad', 4 April 2022, 17 [70–71].

429 Statement of Timothy Bullard, 'Brad', 4 April 2022, 22 [85].

430 Transcript of Ann Moxham, 12 May 2022, 995 [18–25].

431 Transcript of Ann Moxham, 12 May 2022, 1010 [7–11]. The Department emphasises that the legal advice it receives from the Office of the Solicitor-General is binding on the Department—refer to Department for Education, Children and Young People, *Procedural Fairness Response*, 28 March 2023, 28.

432 Transcript of Ann Moxham, 12 May 2022, 1000 [6–12].

433 Transcript of Ann Moxham, 12 May 2022, 1002 [38–46].

434 Transcript of Ann Moxham, 12 May 2022, 1000 [21–25].

435 Transcript of Ann Moxham, 12 May 2022, 1000 [33–36].

436 Transcript of Ann Moxham, 12 May 2022, 1005 [11–25].

437 Transcript of Ann Moxham, 12 May 2022, 1008 [33–44].

438 Transcript of Ann Moxham, 12 May 2022, 1009 [8–11].

439 Transcript of Ann Moxham, 12 May 2022, 1009 [19–24].

440 Statement of Ann Moxham, 27 April 2022, 3 [3.3], 3–4 [3.6].

441 Statement of Timothy Bullard, 'Brad', 4 April 2022, 37 [135].

442 Statement of Timothy Bullard, 'Brad', 4 April 2022, 38 [141], 39 [151].

443 Transcript of Timothy Bullard, 12 May 2022, 980 [34–39].

444 Statement of Timothy Bullard, 'Brad', 4 April 2022, 38 [142], [144].

445 Transcript of Timothy Bullard, 12 May 2022, 982 [6–8].

446 Statement of Timothy Bullard, 'Brad', 4 April 2022, 12 [54].

447 Statement of Timothy Bullard, 'Brad', 4 April 2022, 12 [56], 40 [156].

448 Statement of Timothy Bullard, 'Brad', 4 April 2022, 12 [56].

449 Statement of Timothy Bullard, 'Brad', 4 April 2022, 12 [56].

450 Statement of Timothy Bullard, 'Brad', 4 April 2022, 20 [79].

451 Statement of Timothy Bullard, 'Brad', 4 April 2022, 26–27 [110].

452 Transcript of Timothy Bullard, 12 May 2022, 982 [17–21].

453 Transcript of Timothy Bullard, 12 May 2022, 985 [1–5].

454 Statement of Sam Leishman, 15 March 2022, 1 [3].

455 Statement of Sam Leishman, 15 March 2022, 1 [4].

456 Transcript of Sam Leishman, 13 May 2022, 1048 [40–44].

457 Transcript of Sam Leishman, 13 May 2022, 1048 [26–32].

458 Statement of Sam Leishman, 15 March 2022, 1 [5].

459 Transcript of Sam Leishman, 13 May 2022, 1049 [13–16].

460 Transcript of Sam Leishman, 13 May 2022, 1049 [18–27].

461 Transcript of Sam Leishman, 13 May 2022, 1049 [38–39].

462 Transcript of Sam Leishman, 13 May 2022, 1048 [29–32].

463 Transcript of Sam Leishman, 13 May 2022, 1049 [29–45].

464 Transcript of Sam Leishman, 13 May 2022, 1050 [2–4].

465 Transcript of Sam Leishman, 13 May 2022, 1050 [10–15].

466 Transcript of Sam Leishman, 13 May 2022, 1050 [21–24].

467 Transcript of Sam Leishman, 13 May 2022, 1050 [24–27].

468 Transcript of Sam Leishman, 13 May 2022, 1050 [29]–1051 [5].

469 Transcript of Sam Leishman, 13 May 2022, 1051 [6–11].

470 Transcript of Sam Leishman, 13 May 2022, 1051 [27–33].

471 Transcript of Sam Leishman, 13 May 2022, 1051 [33–36].

472 Statement of Sam Leishman, 15 March 2022, 1 [5].

473 Transcript of Sam Leishman, 13 May 2022, 1052 [12–13].
474 Transcript of Sam Leishman, 13 May 2022, 1052 [26–30].
475 Transcript of Sam Leishman, 13 May 2022, 1053 [4–8], [16–17].
476 Transcript of Sam Leishman, 13 May 2022, 1053 [21–22].
477 Transcript of Sam Leishman, 13 May 2022, 1053 [22–27].
478 Transcript of Sam Leishman, 13 May 2022, 1053 [35–40].
479 Statement of Sam Leishman, 15 March 2022, 1 [5].
480 Statement of Sam Leishman, 15 March 2022, 1 [7].
481 Statement of Sam Leishman, 15 March 2022, 1 [7].
482 Transcript of Sam Leishman, 13 May 2022, 1055 [1–3].
483 Transcript of Sam Leishman, 13 May 2022, 1056 [3–8].
484 Statement of Sam Leishman, 15 March 2022, 1 [7].
485 Transcript of Sam Leishman, 13 May 2022, 1056 [16–29].
486 Statement of Sam Leishman, 15 March 2022, 2 [8].
487 Statement of Sam Leishman, 15 March 2022, 2 [9].
488 Transcript of Sam Leishman, 13 May 2022, 1056 [34–35].
489 Transcript of Sam Leishman, 13 May 2022, 1057 [5–10].
490 Statement of Sam Leishman, 15 March 2022, 2 [10].
491 Transcript of Sam Leishman, 13 May 2022, 1058 [40–45].
492 Transcript of Timothy Bullard, 13 May 2022, 1066 [31–41].
493 Statement of Sam Leishman, 15 March 2022, 2 [12].
494 Statement of Sam Leishman, 15 March 2022, 2 [12].
495 Statement of Timothy Bullard, regarding Sam Leishman, 8 April 2022, Annexure (Letter from Jeremy Rockliff to Sam Leishman, 23 December 2015) 1.
496 Transcript of Sam Leishman, 13 May 2022, 1060 [29–34].
497 Transcript of Sam Leishman, 13 May 2022, 1060 [40–46].
498 Transcript of Timothy Bullard, 13 May 2022, 1069 [17–18].
499 Transcript of Sam Leishman, 13 May 2022, 1061 [20–21].
500 Statement of Timothy Bullard, regarding Sam Leishman, 8 April 2022, 5 [31].
501 Transcript of Sam Leishman, 13 May 2022, 1061 [22–28].
502 Statement of Timothy Bullard, regarding Sam Leishman, 8 April 2022, 5 [33].
503 Statement of Sam Leishman, 15 March 2022, 2 [14].
504 Transcript of Sam Leishman, 13 May 2022, 1062 [1–8].
505 Transcript of Timothy Bullard, 13 May 2022, 1071 [7–17].
506 Transcript of Timothy Bullard, 13 May 2022, 1071 [26–27].
507 Transcript of Sam Leishman, 13 May 2022, 1063 [9–10].
508 Statement of Timothy Bullard, regarding Sam Leishman, 8 April 2022, 5 [36].
509 Transcript of Timothy Bullard, 13 May 2022, 1071 [29–34].
510 Transcript of Sam Leishman, 13 May 2022, 1063 [10–16].
511 Statement of Timothy Bullard, regarding Sam Leishman, 8 April 2022, 4 [25–26].
512 Statement of Sam Leishman, 15 March 2022, 2 [16].
513 Transcript of Timothy Bullard, 13 May 2022, 1070 [1–14].
514 Statement of Timothy Bullard, regarding Sam Leishman, 8 April 2022, 6 [41].
515 Statement of Timothy Bullard, regarding Sam Leishman, 8 April 2022, 6 [46].
516 Statement of Timothy Bullard, regarding Sam Leishman, 8 April 2022, 6 [46].

517 Statement of Timothy Bullard, regarding Sam Leishman, 8 April 2022, 6 [43].

518 Transcript of Timothy Bullard, 13 May 2022, 1066 [15–24].

519 Transcript of Sam Leishman, 13 May 2022, 1063 [35–38].

520 Statement of Sam Leishman, 15 March 2022, 2 [17].

521 The name 'Andy' is a pseudonym; Order of the Commission of Inquiry, restricted publication order, 30 August 2023.

522 The name 'Family A' is a pseudonym; Order of the Commission of Inquiry, restricted publication order, 30 August 2023. Anonymous session, 12 October 2022. The summary in this case study is from this anonymous session.

523 Anonymous session, 17 February 2022. The summary in this case study is from this anonymous session.

524 The name 'Family B' is a pseudonym; Order of the Commission of Inquiry, restricted publication order, 30 August 2023.

525 Department for Education, Children and Young People, *DECYP Summary – Case Summary 'Andy'* (March 2023).

6 The way forward: Children in schools

1 Introduction

In this chapter, we outline measures the Tasmanian Government should take to prevent child sexual abuse in government schools and improve responses when it does occur, noting that the Department for Education, Children and Young People has begun making significant changes, including developing an overarching child safeguarding policy framework. The Department's current child safeguarding measures are part of a shifting landscape as the Department responds to recommendations from the National Royal Commission, the Independent Education Review and matters identified through our Commission of Inquiry.

In Chapter 5, we identify shortcomings in the Department and other government entities' responses to allegations of child sexual abuse and harmful sexual behaviours. We outline the measures the Department has taken to address these. In this chapter, we consider more steps the Department, and other government entities, should take to make schools safer for children, including:

- implementing mandatory child sexual abuse prevention education
- limiting the focus of the Office of Safeguarding primarily to safeguarding children in education settings
- refreshing and regularly reviewing child safeguarding policies and working to embed them in schools

- developing an education-specific professional conduct policy for staff and volunteers
- implementing a mandatory professional development program for educators, staff and others who work with children and young people (including volunteers) in schools
- establishing a Child-Related Incident Management Directorate to lead the response and investigation of complaints of child sexual abuse and related behaviours by staff
- developing education-specific policies, protocols and guidance for preventing, identifying and responding to harmful sexual behaviours in schools, noting our recommendation in Chapter 9 that the Department establishes a Harmful Sexual Behaviours Support Unit to support all the Department's portfolios
- strengthening the Teachers Registration Board's ability to safeguard children through changes to the law.

We consider our recommendations in this chapter will help the Department to further improve its approach to safeguarding students (and younger children) in its care, and increase the ability of the Teachers Registration Board to protect all children in Tasmanian schools—government and non-government.

2 Child sexual abuse prevention education in schools

Targeted child sexual abuse prevention education programs can help children and young people to identify grooming or sexually abusive behaviours, give them confidence about asserting their boundaries, and empower them to report any violations. Such programs can also help challenge harmful norms or attitudes at an early stage, particularly around issues of consent. They can be a powerful tool in preventing child sexual abuse.

In this section, we examine the role of child sexual abuse prevention programs in schools. These programs vary in design and delivery and are discretionary in Tasmania. We outline evidence of the elements of successful programs and recommend that best practice programs form part of the mandatory curriculum in Tasmanian schools, together with respectful relationships and consent education.

Prevention programs in schools should form only part of a broader prevention strategy. In recommending more investment in prevention programs, we want to be clear that the burden of preventing abuse should not fall on children and young people. It is not their responsibility to know or interpret adult behaviour, nor is it their job to keep themselves

safe from abuse and harm. Even the objectives of the best programs can be overborne by abusers, who often deploy a range of tactics and manipulations to enforce compliance and silence.

However, we do consider that prevention education programs have an important role to play in educating and empowering children and young people about their bodily autonomy and about what constitutes healthy and acceptable sexual behaviour. Such programs are a source of important information about how to navigate or respond to any threats to their safety. These programs should complement other prevention efforts including national community-wide prevention strategies.[1] For more discussion on prevention, refer to Chapter 18.

2.1 Children's perceptions

Some children who took part in research we commissioned, conducted by Associate Professor Tim Moore and Emeritus Professor Morag McArthur, told us that sex education in schools did not cover everything they thought was relevant:

> You talk about relationships and stuff but not really like modern day issues like online stuff and, no offence, adults can be pretty clueless about this stuff. And if they teach you in a way that proves they've got no idea then you're not going to go with them.[2]

They thought there was not enough teaching about adult–child sexual abuse, institutional child sexual abuse and who to turn to if they experience harm.[3]

We heard from a number of victim-survivors who did not recognise their experiences as abuse until much later in life—sometimes only becoming aware of the dynamics and features of grooming and abuse as adults. For example, Leah Sallese, a victim-survivor, described the following interaction with her psychotherapist:

> I said: 'I had an affair with my teacher' and he said, 'Wait a minute, what?' He said: 'No, you didn't, that's childhood sexual abuse'. So that's the first time, as a 40-something-year-old woman, that I ever questioned what I had in my mind as a narrative my whole life.[4]

Sam Leishman, another victim-survivor whose experience we discuss in Chapter 5, described having a similar revelation as an adult:

> I happened to see a grab of news and it was Julia Gillard talking about the [National] Royal Commission and how it was progressing, and I'd never thought about what happened to me as child abuse, funnily enough. I thought it's something that I initiated, that I had done and that it was just a one-off thing that this man was attracted to me for some reason and it was—it was a single thing that happened. And, out of curiosity I got on to the website … I was just staggered, because by that stage there was volumes and volumes and volumes of work that they had done, and story after story, and I started reading through them and I thought, 'Shit, that happened to me', yeah. So it was sort of like a light-bulb moment.[5]

Victim-survivor Rachel (a pseudonym), whose experience we discuss in Chapter 5, recommended to us that an 'educational program promoting awareness for appropriate student–teacher relationships in and out of school is implemented into the curriculum'.[6]

Victim-survivor Kerri Collins noted how sex education helped her understand what had happened to her and fellow victim-survivors when she was very young:

> You knew it was wrong but you didn't understand, because we were so young, and then after that you did understand—like, you'd done sex education at school and those sorts of things and you knew that what happened wasn't right. But then, how do you tell somebody that, and how do you—you know, as a child you're second guessing yourself, like, is that me, did I do that, was that my fault?[7]

We also saw evidence of problematic attitudes towards consent and relationships among Tasmanian children and young people, which is particularly relevant to harmful sexual behaviours between children. A study conducted by Anglicare Tasmania's Social Action and Research Centre heard from 17 young Tasmanians about their experiences of domestic violence. Collectively they described 18 separate relationships involving sexual violence or abuse they had experienced.[8] One participant in the study, Sahar, said:

> They [young men and boys] envision like a big scary man, like dragging a woman into an alleyway and raping her, a stranger. But it's not like that at all. It's usually almost always somebody that you know, and it's partners. But they don't recognise that. They've got this, like, such a movie vision of what rape is in their head that they wouldn't even realise if they'd done it themselves.[9]

Contrary to the common belief that gender equality is improving through generational change, those working to address violence in the community told the study author about young men in particular holding worryingly regressive views, with one worker known as Bernie saying: 'That 1970s attitude, male attitude, exists here strongly in Tasmania'.[10] A family violence worker known as Jo said she noticed young women tending to experience more extreme violence than older generations at the hands of younger partners, saying: 'Young people are supposed to be getting all of this preventative stuff … But these young guys can be very traditional in their views of women'.[11]

We are also conscious that online digital technology is rapidly changing and some aspects of this can continue to support harmful attitudes. For example, the rise in pornography on the internet creates a high risk of children and young people seeing or seeking pornography online. The eSafety Commissioner notes that:

> … exposure to graphic, violent or misleading messages about sexual practices and gender stereotypes could give [children and young people] the wrong idea about sex and intimate relationships.[12]

Kathryn Fordyce, Chief Executive Officer, Laurel House, pointed to the absence of statewide consistency in prevention programs across primary and high school students, as well as in early childhood support services.[13] Ms Fordyce said:

> There is a lot more work needed in organisations of all types including schools, health and disability services to ensure that we address the drivers of sexual violence, to teach children about respectful relationships and how to speak up when they feel unsafe or when something has happened to them. Unfortunately, there are social norms that mean we condition children, especially those with disabilities and health conditions, to be compliant and submissive … All too often adults ignore a child's attempt to maintain their bodily autonomy, and then those same adults are surprised when children are abused and do not report it.[14]

2.2 National Royal Commission recommendations

The National Royal Commission recommended that the Australian Government implements a national strategy to prevent child sexual abuse. This strategy would encompass complementary initiatives, including prevention education delivered through school settings 'that aims to increase children's knowledge of child sexual abuse and build practical skills to assist in strengthening self-protective skills and strategies'.[15] The National Royal Commission also recommended that schools extend education on issues of child sexual abuse and online safety to parents and carers.[16]

The National Royal Commission commissioned an Australia-wide audit of child sexual abuse prevention policies and curriculums across 32 primary school systems, covering government, Catholic and independent school sectors.[17] The audit found that only 12.5 per cent of school systems had curriculums that included specific child sexual abuse prevention education and there was considerable variation across jurisdictions in the type of material available on prevention.[18] There is no equivalent audit for secondary school policies and curriculums, but there may be opportunity in the Health and Physical Education learning area to address child sexual abuse.[19]

The audit report also found a lack of strategies to help teachers adapt content for particular groups of students such as Aboriginal children, children with disability or children from culturally and linguistically diverse backgrounds.[20]

The National Royal Commission recommended a nationally consistent approach to prevention education in all schools and preschools, stating: 'Child sexual abuse prevention education could be integrated with education aimed at preventing all forms of violence against children, in any setting'.[21]

2.3 Features of effective child sexual abuse prevention programs

Professor Kerryann Walsh, an expert in child sexual abuse prevention, told us that although there are different examples of prevention education programs, good programs share common features, including that they:

- cover topics such as body ownership, private parts, appropriate versus inappropriate touching, distinguishing types of secrets, and who and how to tell
- are delivered interactively in groups, where teachers and children engage with the content together through strategies such as rehearsal and role-play
- use resources and materials that are diverse, spanning film, plays, songs, puppets and other methods
- are delivered in shorter modules over an extended period, which enables them to be discussed and absorbed (for example, 20-minute sessions delivered once per week over five to six weeks).[22]

Professor Walsh said that child sexual abuse prevention education should begin as early as possible—by parents in the earliest years, then in childcare, long daycare and kindergartens.[23] She also said that prevention education should continue until the end of schooling.[24]

Professor Walsh also explained that, while it is important to teach about risks of child sexual abuse from adults with sensitivity and care, studies have shown that such education does not tend to increase or decrease children's fear or anxiety across the board.[25] She also noted that the risk of prevention programs increasing a child's anxiety is lower 'as programs have improved over the years and become more sensitive to children and more developmentally appropriate'.[26]

Through submissions and hearings, we heard about the importance of parents and carers also engaging with content delivered about child sexual abuse. Body Safety Australia described its work designing and delivering professional development for teachers, young people and their families, noting:

> We believe education for children is most effective when delivering in conjunction with information sessions for parents and teachers. Preventative education for parents, teachers and children facilitates discussion between children and the adults in their lives. While schools can and must provide some measure of protection, it is essential that parents and families continue to be the main providers of safety and assistance to children.[27]

Professor Walsh echoed this, saying that 'homework' (where the school sets activities to be completed at home) can help to engage parents or carers in the programs, plus

it provides an avenue for them to reinforce the content.[28] She acknowledged that some children do not have the benefit of engaged and supportive parents, which makes accessing information at school particularly important.[29]

Body Safety Australia cited common reasons teachers prefer prevention education to be delivered by external providers. These include teachers feeling unequipped to deliver the content, a belief that it is easier for children and young people to ask questions about this content and engage with a person they do not see every day, and a fear of damaging the parent–teacher relationship if they deliver confronting content.[30] We heard similar concerns in our Burnie stakeholder consultation, with one participant expressing concerns that there could be difficulties with teachers delivering respectful relationships programs because the programs involve discussions with children that could be inappropriate for teachers to participate in.[31]

Professor Walsh noted that not all teachers will be suited or able to deliver such curriculum (noting some may be victim-survivors themselves).[32] Professor Walsh suggested that a smaller cohort of teachers with specialist training and ongoing supervision could be tasked with delivering the material across year levels.[33] Children and young people may feel more comfortable disclosing their worries or concerns to teachers. Using teachers, rather than external providers, to deliver this material would help avoid sending an unintentional message that teachers are unwilling to talk to students about child sexual abuse. Incorporating prevention education into the curriculum will support it being delivered by teachers in a school.

2.4 Child sexual abuse programs in government schools

Child sexual abuse prevention education programs are varied and largely voluntary in Tasmania. This is consistent with most other jurisdictions. As noted by Professor Walsh, the availability of programs across Australia is 'patchy'.[34] Only two jurisdictions—Western Australia and South Australia (the latter of which is discussed in Section 2.5)—have mandated sexual abuse prevention programs in schools.[35]

Departmental Secretary Timothy Bullard informed us that the Department 'supports a range of evidence-based and age-appropriate programs to address respectful relationships, consent, sexuality, body ownership and protective behaviours'.[36] For government schools, the prevention curriculum is generally contained in the Health and Physical Education area of the Australian Curriculum under the 'relationships and sexuality' and 'safety' focus areas.[37] Secretary Bullard foreshadowed further work to support teachers to implement the Australian Curriculum on respectful relationships and consent, including updates and revisions to support the latest version endorsed nationally by education ministers in April 2022.[38]

Safe Homes, Families, Communities: Tasmania's Action Plan for Family and Sexual Violence 2019–2022 committed to implementing prevention strategies, including embedding respectful relationships education in schools and delivering a program for children and young people targeted at harmful sexual behaviours.[39] The Tasmanian Government's *Third Family and Sexual Violence Action Plan 2022–2027: Survivors at the Centre* expands on this commitment by developing 'a suite of resources' that improves the Tasmanian community's understanding of 'consent, coercive control and grooming'.[40] The plan also states that a dedicated position will be created in the Department to help schools embed respectful relationships education.[41]

According to the Department's website, the Respectful Relationships Program is an 'essential element' of *Safe Homes, Families, Communities*.[42] The program consists of resources to support schools, communities and individuals to understand the causes of family and sexual violence, and to reduce violence.[43] This includes the *Respectful Schools Respectful Behaviour: Building Inclusive Practice in Schools* resource, which 'supports school communities to build respectful, safe and supportive learning environments'.[44] Our understanding is that this resource focuses on preventing family and gender-based violence but does not directly address child sexual abuse, harmful sexual behaviours or the online environment.

The Department also supports other programs and initiatives that 'align with and complement content covered through the Australian Curriculum', although these are not mandatory and are at the discretion of principals.[45] Elizabeth Jack, Executive Director, Office of Safeguarding, explained:

> Schools tend to use the programs that they believe work best for their context because all our schools are in different environments, they're a different size, they might have different issues with their student cohort. The principal and school leaders normally make that determination. So there will be professional support staff, for instance, that might contribute to that so that they determine what is best to be run in their school.[46]

Secretary Bullard highlighted some programs and educational activities for young people in school settings in Tasmania including:

- Ditto's Keep Safe Adventure Program from the Bravehearts Foundation, delivered in the early years of school[47]
- the Sexual Assault and Prevention Program and 'Consent is a Conversation' workshops delivered by the Sexual Assault Support Service[48]
- the Prevention, Assessment, Support and Treatment program, delivered by the Sexual Assault Support Service, focusing on children and young people exhibiting harmful sexual behaviours.[49]

Ms Jack identified more than 20 programs delivered in schools, highlighting to us that there is no consistent approach across Tasmanian government schools.[50] At our Hobart consultation, we heard that although information about prevention was available in schools, some principals may be reluctant to engage with it.[51] The Launceston consultation also highlighted the discretionary nature of many programs.[52]

Some prevention programs at schools are fee-based, and others are offered at no charge if the Department has a formal agreement with a program provider (under a grant deed) to provide a certain number of programs.[53] Where a school wishes to have a program that is not available under a grant deed, they generally need to fund this through individual budgets, known as School Resource Packages, in consultation with the school principal.[54]

Decisions about which programs the Department endorses are 'guided by departmental policies and guidelines, with consideration being given to alignment with the curriculum and the quality of the program'.[55] Ms Jack noted she has received advice that suggests the programs currently running in schools are appropriate and accredited.[56] However, she indicated that the Office of Safeguarding, together with other business units across the Department, would undertake 'a review of available programs to ensure the programs being offered by schools are appropriate at a whole-of-system level, while still suiting the context for each individual school'.[57]

The Department usually captures participation data for programs funded through a grant deed, but for other programs, this data is generally 'maintained at the local school level'.[58] Noting this variability and the voluntary nature of such programs, Ms Jack confirmed the Office of Safeguarding's intention to work with other business units across the Department, to better capture engagement data 'including outcomes and trends related to program participation'.[59]

2.5 Mandated sexual abuse prevention education

Professor Walsh told us that programs are more likely to be delivered when they are compulsory.[60] Professor Walsh warned that in a tight resourcing environment, principals can overlook programs that require discretionary funding:

> I think the literature would tell us that [schools] will only look for a sexual abuse prevention program when they have an incident; it will be reactionary why they do it. So, that is very hard for schools to do when they commit their budget at the start of the school year, there's just no wriggle room in budgets to suddenly get somebody in to deliver a program when an event happens, even though we know that's not what should happen but in practice that's often how it plays out.[61]

On the question of mandated programs, Ms Jack noted:

> The Office [of Safeguarding] is in the early stages of discussion with both the Support and Development and Learning divisions regarding opportunities to better

identify, recommend, monitor and (where necessary) make mandatory, prevention programs in schools, noting that schools also need the ability to make decisions based on their own local context and need.[62]

Secretary Bullard listed considerations for making these programs mandatory including:

- alignment with the curriculum and how the program can be integrated in school timetables
- consideration of who delivers the program (teachers, social workers or external providers) and the resourcing required to enable effective delivery
- acknowledging a parent or carer's right to request their child not participate in a particular program
- the need to evaluate the impact of any programs delivered.[63]

Secretary Bullard went on to note the risk that such programs could be seen as a 'substitute for other services and processes that protect children'.[64] Also, programs should not be viewed as a 'solution' alone but should be placed in a broader safeguarding system.[65] We agree with this statement.

In addition to the Australian Curriculum (and complementary to its 'relationships and sexuality' and 'safety' focus areas), South Australia has the Keeping Safe: Child Protection Curriculum.[66] Professor Walsh described South Australia's program as the 'soundest' model because it has been developed over some time and has been 'so well thought through'.[67]

The Keeping Safe: Child Protection Curriculum is mandated in all South Australian Department for Education preschools and schools for children and young people from the age of three through to year 12 and covers child safety and respectful relationships. It is delivered by teachers in the school setting. It has support materials specifically for Aboriginal children and young people, children from culturally and linguistically diverse backgrounds and children with disability or additional needs.[68] It also has resources for parents and carers.[69] We understand schools in other jurisdictions have adopted this curriculum, as have some independent schools in South Australia.[70]

We consider it is important that children and young people receive child sexual abuse prevention education throughout their schooling. While we recognise the multiple competing priorities in school curriculums and budgets, the finding in the Australian Child Maltreatment Study that more than one in four Australian young people aged 16 to 24 years have experienced child sexual abuse suggests this is a priority that must be addressed.[71] For this to occur, prevention education needs to be mandated across all schools and in Tasmanian government funded early learning preschool programs, through to year 12. All Tasmanian students should have the benefit of programs designed to help them learn and understand their right to be safe from sexual abuse or harmful sexual behaviours. It is also efficient to have a single, consistent approach to programs

across the State. We are not convinced there is justification for the existing variety of approaches at the local level, but note that individual schools may wish to supplement mandated curriculum content to reflect their own context or circumstances.

We consider that the Department should adopt the South Australian model of mandated prevention education. This is a significant reform agenda but one we consider vital to preventing child sexual abuse. Safeguarding Leads, supported by the Office of Safeguarding, should actively support and champion the mandatory curriculum in schools. The Department may wish to explore opportunities for cross-jurisdictional collaboration with South Australia for implementing this mandatory curriculum.

The Department should develop a plan for sustained implementation that clearly articulates the goals and objectives of the curriculum and defines the roles and responsibilities of key participants. We see potential to incorporate the Respectful Relationships and Consent Education program committed to by the Government in this curriculum, as is the approach in South Australia.[72] The Department should evaluate the effectiveness of the mandatory curriculum after five years of implementation, with evaluation criteria created as part of the process of developing the curriculum.

The Tasmanian Government could also consider making the mandatory child sexual abuse prevention curriculum available to non-government schools.

Recommendation 6.1

1. The Department for Education, Children and Young People should introduce and fund a mandatory child sexual abuse prevention curriculum as part of the mandatory respectful behaviours curriculum from early learning programs to Year 12, across all types of government schools (including specialist schools).
2. This mandatory prevention curriculum should draw on expert evidence of best practice and successful approaches adopted in other states and territories, including South Australia's mandatory curriculum.
3. The Department should develop a plan for sustained implementation of the mandatory prevention curriculum. The plan should:
    a. set out the goals and objectives of implementing the mandatory prevention curriculum
    b. define the roles and responsibilities of key participants
    c. include criteria for evaluating the curriculum.
4. The Department should evaluate the effectiveness of the mandatory prevention curriculum five years after its implementation.

3 Office of Safeguarding Children and Young People

This section examines the purpose and functions of the Office of Safeguarding and offers some early reflections on its operation. We acknowledge that the Office of Safeguarding is in the process of implementing recommendations from the Independent Education Inquiry. It is important that this occurs effectively, in line with the recommendations' objectives.

Given that the Office of Safeguarding is in its relative infancy, we did not receive extensive evidence about its performance. However, we have made some early observations of its work, as well as offering our reflections on how it may best deliver on its ambitions. We recommend that the Office of Safeguarding focuses its attention on the school and educational context, concentrating on prevention, risk identification, policy development and related workforce development.

3.1 Establishing the Office of Safeguarding

The Independent Education Inquiry recommended establishing a Director of Safeguarding in the then Department of Education in order to, among other things, develop a student safeguarding policy, support risk assessments and management plans in every school, be a point of contact for School Safeguarding Officers and oversee their induction and training.[73] One of the Independent Education Inquiry's primary concerns was how the Department could embed prevention into its child safeguarding system.[74]

Elizabeth Jack was appointed as the inaugural Executive Director of Safeguarding Children and Young People.[75] The role's Statement of Duties outlines its function as:

> To promote and protect the wellbeing of children and young people in all Education Department settings by leading and providing strategic advice and direction in relation to the Department's culture, systems, practices, processes, procedures and professional learning, relating to safeguarding children and young people from harm of abuse.[76]

Ms Jack described the duties of the Executive Director of Safeguarding Children and Young People as including:

- implementing the recommendations of the Independent Education Inquiry and of the National Royal Commission allocated to the Department of Education (Ms Jack also noted that she would likely be responsible for implementing relevant recommendations of our Commission of Inquiry)[77]

- supporting 'operational responses to safeguarding children and young people' led by other departmental business units, including Workplace Relations, Legal Services, Learning Services and Student Support[78]
- championing child safeguarding issues with the Department's Executive Group, other senior staff, school principals and departmental staff[79]
- ensuring strategic communications with students, staff and stakeholders to raise awareness of safeguarding issues.[80]

The Office of Safeguarding has (at the time of writing) six dedicated staff (primarily roles in policy analysis, project management and communications) and receives some support from the Department's Strategic Policy and Planning and Strategic Systems Development areas.[81]

Secretary Bullard confirmed a State Budget allocation of $2.6 million over three years beginning in 2022–23 to 'fully staff the Office of Safeguarding Children and Young People to meet the demands of the work required to support all safeguarding-related activity across the Department'.[82]

We understand Ms Jack has now moved to the position of Deputy Secretary, Keeping Children Safe, which oversees the Office of Safeguarding as well as Services for Children and Families (which includes the Child Safety Service, the Strong Families, Safe Kids Advice and Referral Line and out of home care).[83] We discuss our concerns with this organisational structure in Chapter 9. Here we focus on the role of the Office of Safeguarding.

3.2 Working strategically and sustainably for greatest impact

The Office of Safeguarding has an ambitious program of work considering its relatively small team. It relies on the cooperation and goodwill of a range of other parties—including the various departmental portfolios, departmental business units and individual schools—to achieve its objectives. In this section, we discuss some of its early areas of responsibility, including appointing Student Safeguarding Officers, undertaking systemic reviews and commenting on the Department's responses to allegations of child sexual abuse by staff.

We also note that the Office of Safeguarding led the Department's work on developing *Safe. Secure. Supported. Our Safeguarding Framework* ('Safeguarding Framework') for safeguarding children and young people, which was released in April 2023.[84] We discuss this Safeguarding Framework in Section 4.

3.2.1 Student Safeguarding Officers

Student Safeguarding Officers (also referred to as Safeguarding Leads) can expand the reach and impact of the Office of Safeguarding and embed its priorities at the local level.

The Independent Education Inquiry recommended appointing Student Safeguarding Officers in schools with the following responsibilities:

- ensuring relevant safeguarding information is reported and recorded
- contributing to school safeguarding risk assessment and management plans
- acting as a point of contact for students and staff about safeguarding concerns
- ensuring the best interests of students are at the forefront of decisions and actions of the school.[85]

Secretary Bullard gave evidence that the State Budget allocated $26.1 million over four years (and $9.7 million ongoing) to appoint Student Safeguarding Officers in every government school.[86]

Ms Jack described the role of Student Safeguarding Officers as:

> … the Safeguarding Officer will be there to help the principal lead the work we're doing to put children and young people at the centre of every decision and action we take. They will be there to help with the development of risk assessment plans and monitor those plans …[87]

The Office of Safeguarding will induct and train Student Safeguarding Officers and support them to develop local safeguarding assessments and risk management plans, as recommended by the Independent Education Inquiry.[88]

Professor Walsh supports creating specialist portfolios to help lift overall capability in a school. She noted that the:

> … development of specialised roles would mean not every teacher would need to possess the maximum level of expertise. Instead, teachers could readily consult with an expert within the school as necessary.[89]

She said that, ideally, there would be a child protection and safeguarding lead as well as a digital safety lead, accompanied by 'elevated status, remuneration and progression commensurate with the degree of expertise required'.[90]

Ms Jack was adamant that the Office of Safeguarding would not simply add a title or give staff extra responsibilities without adequate resourcing. She explained:

> … it may be that we take some of an existing person's role away and give them the safeguarding role if they are the right person, or it might be a recruitment of new staff depending on the skills and experience we require.[91]

We agree that safeguarding roles should be recognised, resourced and rewarded. Student Safeguarding Officers will have an important role in making the work of the Office of Safeguarding tangible and meaningful.

In his February 2023 update, Secretary Bullard told us that, as part of the Department's response to the Independent Education Inquiry, a 'staged roll out' of its 'Safeguarding in Schools' model had begun in November 2022.[92] Implementing Safeguarding in Schools requires all government schools to nominate a Safeguarding Lead during the 2023 school year. Safeguarding Leads are to then receive 'tailored safeguarding resources and supports to ensure they are equipped with the skills and understanding needed to plan and implement strategies to support the safety of all students'.[93] Secretary Bullard told us that all Safeguarding Leads will be provided with 'professional learning' in mandatory reporting and in identifying and addressing child sexual abuse, 'including grooming, and risk management'.[94] Under the model, the Office of Safeguarding will work with Safeguarding Leads to help them improve their skills in risk management and assessment, to enable them to 'put in place risk management plans that focus on preventing, identifying and mitigating the risks of child sexual abuse'.[95]

Children interviewed for our commissioned research said they wanted a trusted confidant who was accessible and preferably proactive in engaging students about worries or concerns.[96] They also told our commissioned researchers that they felt safer when they were asked for their feedback about how things could be improved. They said that schools might feel safer if they had feedback channels such as a 'worries' box where children could confidentially raise concerns with the principal, or that the principal should proactively seek feedback from students and hold regular 'safety sessions' with students in focus groups to reflect on and improve safety measures.[97] We consider Safeguarding Leads could actively encourage the engagement and participation of students to enhance their sense of safety in their school.

3.2.2 Systemic reviews

Every 'incident or episode of sexual abuse in a school can be seen as a failure of its primary safeguarding systems'.[98] The Independent Education Inquiry recommended conducting reviews following incidents to encourage reflection and examine opportunities to strengthen safeguarding responses.[99]

In November 2021, the Department's Executive Group endorsed the process for conducting systemic reviews, noting that it may be subject to change following a 'test and try' approach in December 2021.[100] This 'test and try' review followed a report of child sexual abuse by an employee against a high school student, in which criminal charges were laid.[101]

The members of this Review Panel, as agreed by the Executive, were:

- Executive Director, Safeguarding Children and Young People (Chair)
- Director, Learning Services (Southern Region)
- Director, Legal Services and Workplace Relations
- Deputy Secretary, Corporate Services of the then Department of Communities
- Senior Project Manager, Safeguarding Children and Young People (Secretariat).[102]

The review focused 'on the systems, processes and policies that were used by [departmental] staff involved in the incident or episode, rather than any one individual's actions or decisions'.[103] It was also not designed to be a formal audit or a precursor to any disciplinary or punitive action.[104]

On 3 December 2021, the Review Panel met and discussed the process. Questions for consideration covered the themes of 'prevention of abuse, early intervention and support for action and decision-making'.[105] Other matters considered included the physical environment of the school, records and information capturing the response to the incident and support available to the student and affected staff.[106]

Members of the review team met with key staff (including the principal) and conducted a site visit to observe the physical environment of the school.[107] The team also considered record keeping and information sharing in the response to the matter.[108]

The review made 16 wide-ranging recommendations, covering professional development, internal and external communication, policies and guidelines, consideration of risks in future capital works, and awareness and understanding of relevant policies and procedures.[109]

A survey of the participants interviewed for the review revealed generally positive feedback about the process. One participant described it as 'liberating'; another felt 'supported, respected and heard'.[110]

It is pleasing that the Department has begun these reviews, and we note that the review process itself will be refined and improved over time. However, we make the following observations:

- On the face of the review, its intended audience and distribution are unclear. The Department has since clarified that the review was undertaken to provide the Department's Executive and senior staff with information about system gaps and opportunities to improve the way the Department supports staff to prevent, identify and respond to child sexual abuse. Where the Review Panel saw other opportunities for system improvements, these were shared with relevant business units across the agency.[111]

- The review made several recommendations, some of which overlap with existing recommendations or planned work and others that reflect new initiatives. Some of the Review Panel's recommendations are ambitious and would require significant investment and effort to meaningfully embed. Others were drafted in ways that make acquittal or 'success' ambiguous.
- Any new or added recommendations should be drafted so that outcomes can be meaningfully measured and evaluated against specified objectives. A role holder should be allocated to act on those objectives. The implementation of recommendations should be monitored and reported on at regular intervals. Effective implementation of changes or improvements flowing from systemic reviews is key to building trust and credibility in the review processes.
- On the face of the review, it does not appear that it contemplated involving the relevant young person and/or their family.[112] We acknowledge this may not always be appropriate (including potentially in this case) and, if undertaken, would need to be conducted by skilled professionals in a trauma-informed and age-appropriate way. However, systemic reviews should recognise the valuable information that children and young people, as well as their families and others in the school community, can provide about their experiences of safeguarding. Reviews should also empower young people to share their experiences if they wish to do so. Inviting young people and their carers and families to be involved can also show that the Department has taken their experiences seriously and is committed to improvement into the future. We would suggest that if a Review Panel determines not to invite a young person and/or their family to participate, it should include an explanation of this decision in its report.
- It is not clear that a particular method was used to conduct the review. Using a predefined method (or a combination of methods)—for example, a root cause analysis or after-action review—helps provide consistency across reviews and ensure they are comprehensive and objective. Also, a framework for review questions should be considered before conducting a review.
- The Review Panel does not appear to have included a subject matter expert; we suggest that future panels should include someone with relevant expertise. For example, for a matter involving child sexual abuse, at least one member of the Review Panel should have expertise in child sexual abuse and perpetrator tactics to help advise other panel members in interpreting information. This will also help ensure all aspects of the incident are thoroughly examined and that reviews are comprehensive.

- The review process demonstrated by the then Serious Events Review Team in the former Department of Communities appears much more targeted and reflects a better process (Serious Events Review Team investigations are discussed in Chapter 9 and Chapter 12).

In general, implementing effective systemic reviews can contribute to a workforce culture that is reflective rather than defensive, that acknowledges mistakes, and that values feedback and suggestions for improvement. We acknowledge that achieving this takes time and strong leadership, and we consider that a clear and considered framework for systems reviews will help to achieve this. We commend the Department on having completed its first systemic review and offer the comments above as reflections to support continuous improvement in the review process itself rather than criticism. We particularly commend the conduct of the review resulting in positive feedback from review participants.

3.2.3 The role of the Office of Safeguarding in incidents—Integrity Commission audit findings

Our Commission of Inquiry was given an audit report, prepared by the Integrity Commission, into the Department's handling of a complaint about the conduct of a teacher towards some students. Overall, the Integrity Commission's audit was positive about the Department's management of the matter, but it did make some critical observations about the contribution of the Executive Director, Office of Safeguarding, in relation to the complaint.

The auditor's assessment of the Executive Director was largely based on a one-page document that was at the front of the complaint file and appeared to be a 'review' of the file. The Executive Director noted on this document that the conduct subject to the complaint was inappropriate and did not comply with the State Service Code of Conduct. However, the Executive Director also noted that 'there was no intent behind these actions/behaviours to indicate grooming behaviour'.[113] The Integrity Commission disagreed with this assessment.[114]

The Integrity Commission expressed concern about the role of the Executive Director in 'reviewing' the file, in particular:

- The Executive Director's role (and influence over decision-making) is unclear on disciplinary and misconduct matters.[115]
- There is no clear framework for the 'review' or evidence of a method or supporting evidence for the assessment.[116]
- It did not appear, in the view of the Integrity Commission, that the Executive Director had relevant skills or expertise to assess whether behaviour constitutes grooming.[117]

In relation to the Executive Director, the Integrity Commission concluded:

> While Ms Jack's role may have overall Agency responsibilities, in relation to [Employment Direction No. 5—Breach of Code of Conduct] matters it is important to clarify the role of the Safeguarding Children and Young People division. The Secretary must be confident that senior executives in the Department will provide comprehensive, considered, probative and relevant advice. In contrast to the considered, reasoned advice and recommendations provided by the Department's Workplace Relations officers, Ms Jack's advice is of limited value and seems misleading. The value of her review is unclear, and—from my perspective—undermined an otherwise appropriately managed matter.[118]

Ms Jack told us that she did not have a 'direct operational role in responding to allegations, incidents, disclosures or suspicions of child sexual abuse'.[119] The Department in fact advised that the Executive Director did not undertake a formal review of this specific case because the Office of Safeguarding is not formally involved in investigating breaches of the State Service Code of Conduct. The Department told us that the Executive Director was asked to consider the information as a 'critical friend' and offer her initial views.

The role and functions of the Office of Safeguarding should be clearly defined to avoid duplication and confusion, and to properly recognise where the Office of Safeguarding can add value relative to other divisions and business units.

We consider that the Office of Safeguarding should focus on policy, guidance and prevention in education, rather than engaging in investigating individual incidents. We are aware of the importance for those working in policy roles to be informed by what is occurring in practice. We consider it useful for the Office of Safeguarding to have some visibility of incidents (particularly high-level trends or areas of concern) to help inform its priorities, and we suggest that communication between the Office of Safeguarding and our proposed Child-Related Incident Management Directorate regularly occurs. However, the Office of Safeguarding should not have a role in assessing or evaluating the appropriateness of responses to incidents. We consider that this role sits most appropriately in our proposed Child-Related Incident Management Directorate, discussed in Section 6.

3.3 Focusing the Office of Safeguarding's role in an expanded Department

We asked Secretary Bullard about how the Office of Safeguarding will operate in an expanded Department for Education, Children and Young People. We were particularly interested to know whether the Office of Safeguarding will assume functions beyond education, such as youth justice and out of home care. Secretary Bullard stated that the Office of Safeguarding will 'work right across the new department'.[120]

Extending the role of the Office of Safeguarding to work across all portfolios in the expanded Department presents some challenges:

- A large reform agenda—The Independent Education Inquiry proposed a large reform agenda for schools, and our recommendations in this chapter add to that agenda.
- The need for specialist expertise in out of home care, youth detention and child protection—In Chapter 9 we identify that child protection, including out of home care, has unique features that require the Department to have a high level of expertise as well as active and engaged executive leadership. In Chapter 12 we outline the specific need for reform in youth justice and outline a substantial reform agenda. These portfolios require different considerations and a deeper understanding of abuse, neglect and perpetration than may be required in an education context.
- Increased workload—We note in Section 3.1 that the Office of Safeguarding had a staff of six with plans to recruit another four staff, and that it received some support from the Department's Strategic Policy and Planning and Strategic Systems Development areas. We consider that in an expanded Department, the increase in size and complexity of the role of the Office of Safeguarding, which was recommended by the Independent Education Inquiry specifically regarding schools and education, would place significant pressure on existing staff and would likely require a considerable increase in staff to cope with the increased workload.

For these reasons, we are sceptical about the effectiveness of the Office of Safeguarding operating across all portfolios in the expanded Department. We recommend that responsibility for policy formulation and implementation remains with the respective portfolios of out of home care and youth justice and that the role of the Office of Safeguarding remains (or refocuses) on schools and education.

The Office of Safeguarding must have clearly defined priorities and appropriate resourcing. To achieve its ambitions, the Office of Safeguarding will need to be disciplined and strategic. We consider that the Office's priorities should closely align with the yet-to-be implemented recommendations of the National Royal Commission, the Independent Education Inquiry and our Commission of Inquiry in relation to schools and education. The implementation of these complex recommendations must reflect intended outcomes in all their depth and complexity. This will take time.

We are keen to see the Office of Safeguarding succeed and add genuine value to the safeguarding efforts of the Department in relation to schools and education. We do not wish to make premature judgments on its performance, but it is important that the Office of Safeguarding is accountable for its work. Establishing the Office of Safeguarding, and its associated work program, should support children to feel safe at school.

In Chapter 22, we recommend that a Child Sexual Abuse Reform Implementation Monitor evaluates the Government's child safeguarding measures, including the implementation of the Independent Education Inquiry's recommendations. In relation to schools and education, this evaluation could consider children's sense of safety in schools.

Recommendation 6.2

1. The Office of Safeguarding within the Department for Education, Children and Young People should focus primarily on safeguarding children in the education context, with a particular focus on prevention, risk identification, policy development and related workforce development.
2. The Office of Safeguarding should not be involved in critical incident management beyond learning from systemic reviews and trend data.

4 Policies, procedures and guidance

Policies and procedures support schools to respond to child sexual abuse and harmful sexual behaviours. Their importance is reflected across several National Principles for Child Safe Organisations, particularly Principle 10, which states: 'Policies and procedures document how the organisation is safe for children and young people'.[121]

Professor Walsh noted that because teachers encounter incidents of child sexual abuse or harmful sexual behaviours infrequently, they require 'access to high quality, on demand guidance materials', which should be regularly updated.[122]

In this section, we discuss the evidence we heard about the Department's policies on child sexual abuse, including the findings and recommendations of the Independent Education Inquiry.

We recognise the significant reform happening in relation to the Department's policies, including the recent release of an overarching Safeguarding Framework (discussed further in Section 4.1.2). Many policies and procedures that the Independent Education Inquiry examined or were provided to us have since been revised, retired or are under development at the time of writing. Some examples of how policies have changed over time (and how these changes would affect child sexual abuse complaints) are explored in the case studies in Chapter 5.

We are pleased that this area is receiving the attention it needs. We recommend that the Department ensures its child safeguarding policies are publicly available and regularly reviewed. We also recommend developing an education-specific professional conduct policy for schools. Of course, policies alone are ineffective in improving practice

if they are not part of a cohesive policy framework that is accessible and integrated into operations. In Section 5, we recommend mandatory professional development and training for all staff and volunteers, which should occur with close reference to the refreshed safeguarding policies.

4.1 Policy improvements

4.1.1 Independent Education Inquiry

The Independent Education Inquiry made several observations about the Department's policies and procedures, including that its safeguarding policies were numerous, confusing and inaccessible, and that there was not enough focus on harmful sexual behaviours.[123] Similarly, one teacher told us:

> The Department may have had policies and procedures about child sexual abuse detection and response, or harmful sexual behaviours, but I was not ever made aware of them, and I do not know where they were located, if they existed.[124]

Some of the Department's policies on child sexual abuse were out of date or did not reflect best practice. Social worker and victim-survivor Kerri Collins described documentation on mandatory reporting, in particular, as being 'very old'.[125] Fellow social worker Debra Drake told us that the responsibility for updating, customising and delivering outdated and ill-suited mandatory reporting materials often fell to social work staff.[126]

Our case studies identified several shortcomings in relation to policies and procedures, namely:

- characterisations of child sexual abuse were not broad enough to capture grooming behaviours and did not identify professional boundary breaches as serious or as possible indications of grooming behaviour—refer to the 'Wayne' and 'Mark' case studies in Chapter 5
- an absence of clear procedures for managing the inappropriate conduct of relief teachers and a lack of feedback pathways on their performance, which meant that concerning behaviour may only be identified due to proactive school leaders—refer to the 'Brad' case study in Chapter 5
- lack of clarity around appropriate social media use by school staff, which can create difficulties disciplining staff in response to complaints that a staff member has sent inappropriate messages to students—refer to the 'Mark' case study in Chapter 5

- neither the State Service Code of Conduct nor departmental policies clearly covered inappropriate conduct outside the school environment. The Solicitor-General has interpreted the law strictly, making it difficult to discipline teachers whose behaviour occurs outside the school setting. Even when the Code of Conduct arguably applies, it may be difficult to substantiate serious complaints by a student against a teacher—refer to the 'Wayne' case study in Chapter 5.

The Independent Education Inquiry recommended that the Department does the following in relation to policies and procedures:

- develops a comprehensive student safeguarding policy and improves existing policies on mandatory reporting, use of technology and duty of care (recommendation 4)[127]
- improves the ability of staff to identify and report concerning behaviour (recommendations 10 and 11)[128]
- develops an education-specific code of conduct to facilitate disciplinary action against staff (recommendation 12)[129]
- integrates student safeguarding policies so their position within the Department's safeguarding policies is clear (recommendations 11, 13 and 14)[130]
- develops protocols to respond to different types of sexual abuse (recommendation 16)[131]
- improves public accessibility to policies (recommendations 19 and 20).[132]

4.1.2 The Department's response

The Department accepted these recommendations and set up the Office of Safeguarding, which is tasked with implementing them—this work is due to be completed by the end of 2023.[133] We discuss the role of the Office of Safeguarding in Section 3.

Since the Independent Education Inquiry report was released, the Department has undertaken the following activities in relation to policies:

- examined 'approximately 70 existing policies and procedures that all contribute in some way to the Department's safeguarding system' to inform development of an overarching safeguarding framework recommended by the Independent Education Inquiry[134]
- updated the mandatory reporting procedure to ensure it is clear and easy to understand[135]

- updated the processes for recording and checking Registration to Work with Vulnerable People statuses, including introducing kiosks to ensure any visitors to school sites have been appropriately screened[136]
- developed a new Safeguarding Children and Young People website to provide students and their families and carers with information on child sexual abuse and how to report concerns[137]
- developed and internally published *Advice for Staff on Responding to Incidents, Disclosures and Suspicions of Child Sexual Abuse*, with accompanying flowcharts for principals (including a flowchart for harmful sexual behaviours)[138]
- distributed updated flowcharts on 'preventing, identifying and responding to child sexual abuse' to schools[139]
- implemented an interim *Child Safe Code of Conduct* for its staff.[140]

We heard some positive feedback about the recent policy changes. For example, Ms Collins described some policies relating to grooming and sexual assault as 'quite good'.[141] Principal Monique Carter also noted that recently revised flowcharts designed for principals to respond to child sexual abuse and harmful sexual behaviours were clearer and easier to follow.[142]

The Department published its framework for safeguarding children and young people in April 2023.[143] The Safeguarding Framework is structured around the National Principles for Child Safe Organisations 'with a particular emphasis on sexual abuse'.[144] It provides some definitions of various forms of child sexual abuse and gives detailed examples of conduct that may constitute grooming.[145] The Safeguarding Framework encompasses the broader remit of the Department, which includes out of home care and youth justice.[146] It lists the relevant policies in relation to child safeguarding, which include:

- a child safe culture
- reporting obligations
- responding to incidents, disclosures and suspicions
- worker conduct and professional conduct
- duty of care
- risk management
- information sharing
- record keeping.

The Safeguarding Framework provides a welcome overarching framework to the Department's response to child sexual abuse, although we note many of the relevant policies listed in the Safeguarding Framework are not publicly available.[147]

We were particularly pleased to note that the Safeguarding Framework adopts a child participation model that is 'grounded in the [United Nations] Convention on the Rights of the Child and promotes a rights-based approach to the active involvement of children and young people in decision-making'.[148]

We hope that child participation is carried through in policy development and review. As noted, children and young people need to be involved in the systems and processes that impact them at schools.

4.2 Learning from South Australia—policies and guidance

Alana Girvin, former Director, Incident Management Directorate, South Australia, described fundamental changes to the way the South Australian Department for Education responds to child sexual abuse following the 2012–13 *Report of the Independent Education Inquiry* ('Debelle Inquiry'). The Debelle Inquiry began in response to the mishandling of a sexual abuse case, which was the subject of significant community concern.

We heard that the South Australian Department for Education relies on the following policies:

- Code of Ethics (similar to Tasmania's State Service Code of Conduct), by which all public servants are bound
- *Protective Practices for Staff in their Interactions with Children and Young People: Guidelines for Staff Working or Volunteering in Education or Care Settings* ('Protective Practices Policy')—this policy is 'relatively prescriptive' and gives examples of boundary violations, such as the unaccompanied transport of young people, filming or photographing of students when not authorised to do so, or initiating or permitting unnecessary or inappropriate physical contact with a child or young person (massage, kisses or tickling games).[149] It forms part of the Code of Ethics[150]
- *Responding to Problem Sexual Behaviour in Children and Young People*, which describes processes for managing harmful sexual behaviour[151]
- *Information Sharing Guidelines*, which dictate what information is shared about child abuse allegations, when and with whom[152]

- *Managing Allegations of Sexual Misconduct in SA Education and Care Settings*, which provides a comprehensive step-by-step guide on how to respond to a complaint or disclosure. Ms Girvin told us that all staff are trained to know this guide 'inside out'.[153]

These policies are publicly available and central to the accompanying mandatory professional development program in South Australia, outlined in Section 5.

Ms Girvin described how South Australia's *Protective Practices Policy* forms part of the South Australian Department for Education's Code of Ethics.

The National Royal Commission also found that:

> … institutions that deal with children should have a code of conduct that outlines behaviour towards children that the institution considers unacceptable, encompassing concerning conduct, misconduct and criminal conduct.[154]

The National Royal Commission recommended that a child-focused code of conduct should:

- include clear definitions of child sexual abuse and grooming
- require that all breaches or suspected breaches of the code be reported
- outline clear processes for responding to breaches
- specify consequences for breaches
- detail the protections available to those who make complaints or report potential breaches.[155]

In relation to the South Australia's *Protective Practices Policy*, Ms Girvin noted:

> In my opinion, it is important in an education setting … to have bespoke policies to clearly identify conduct with respect to children, including boundary breaches and child sexual abuse.[156]

She added that the level of detail in the policy helps staff feel confident about the Department's expectations.[157] Ms Girvin emphasised that protective policies are 'designed to safeguard children, not to protect adults against allegations of misconduct':[158]

> Policies must assist adults to understand appropriate boundaries in relation to their role and interactions with children and young people. Bespoke policies enable staff to feel confident about the Department's expectations and conduct obligations and enable line managers to clearly address any concerns raised in performance management discussions and written records.[159]

Ms Girvin went on to describe how the *Protective Practices Policy* serves an 'educative function' by defining what grooming is and giving examples of how it can occur.

The policy creates proactive obligations on teachers to report any suspected grooming by colleagues or risk being in breach of the Code of Ethics themselves.[160] She told us that the clarity of the policy helped minimise discretion and prevarication: 'I think it changed the culture immediately; whether people thought it was right or wrong, didn't matter, it wasn't a debate'.[161]

We were impressed by the nuance in the guidance provided to staff working in rural and regional communities, where maintaining professional boundaries may be more challenging due to shared social and community events with students and their families.[162] We believe the Department could benefit from the experience of its South Australian counterpart in implementing child safeguarding policies.

4.3 Our observations

We acknowledge the Department is working to refresh, combine and promote safeguarding policies. This reform must translate into meaningful improvements to child safety in schools.

We consider that the best way to support the Department's new policies and procedures being adopted broadly across schools is through the mandatory professional development and training we recommend in Section 5. We also consider that the Department should ensure its new policies stay up to date by establishing a regular policy review program. These policies should also be publicly available so children and their parents and carers know what to expect in relation to the conduct of staff and volunteers, as well as in relation to the Department's response to concerns or allegations of child sexual abuse.

In relation to professional conduct, in Chapter 20 we recommend that all Heads of Agencies whose agencies provide services to children should develop a professional conduct policy for the agency's staff, contractors and volunteers. We specify that a breach of such policies may be taken to be a breach of the State Service Code of Conduct. Professional conduct policies should be based on National Royal Commission recommendations about codes of conduct and should focus on the distinctive operational environments and challenges presented in each of these sectors.[163] As outlined in Chapter 20, the professional conduct policy should have the following features:

- explain what behaviours are unacceptable including concerning conduct, misconduct or criminal conduct
- define and prohibit child sexual abuse, grooming and boundary violations
- acknowledge the challenge of maintaining professional boundaries in small communities and provide clear identification of, instructions about, and examples of how to manage conflicts of interest and professional boundaries in small communities

- provide guidance on identifying behaviours that are indicative of child sexual abuse, grooming and boundary violations that are relevant to the particular context of the organisation (in this case schools)
- outline the types of behaviours that must be reported to authorities, including what behaviours should be reported to police, child protection authorities, the Registrar of the Registration to Work with Vulnerable People Scheme and the Independent Regulator of the Reportable Conduct Scheme or other relevant agencies, such as the Teachers Registration Board
- provide that not following reasonable directions is a breach of professional standards
- provide that a failure to report a breach or suspected breach of the policy may be taken to be a breach of the policy
- outline the protections available to individuals who make complaints or reports in good faith
- provide and clearly outline response mechanisms for alleged breaches of the policy
- specify the penalties for breach, including that a breach of the policy may be taken to be a breach of the State Service Code of Conduct and may result in disciplinary action
- cross-reference any other policies, procedures and guidelines that support, inform or otherwise relate to the professional conduct policy, for example, complaint handling or child protection policies or other codes of conduct relevant to particular professions.

In Chapter 20, we also specify that the professional conduct policy should be:

- easily accessible to everyone in the Department and communicated by a range of mechanisms
- explained to, acknowledged and signed by all employees
- accompanied by training and professional development
- communicated to children and young people and their families through a range of mechanisms including publication on the Department's public-facing website.

We are pleased to note that the Safeguarding Framework lists different professional conduct policies for 'learning', the Child Safety Service and out of home care, and youth justice. We consider this approach appropriate to account for the distinct risks that arise in different areas. These professional conduct policies should apply to staff, volunteers and contractors.

In relation to responding to incidents, concerns and complaints about child sexual abuse, we recommend in Section 6 establishing a Child-Related Incident Management Directorate to help schools (and other agencies) respond to allegations of child sexual abuse by staff. We also recommend this Directorate develops guidelines and resources to support this response. The Department's policies should reflect the new process this Directorate will support.

In Section 7, we make recommendations about harmful sexual behaviours, including developing appropriate policies, protocols and guidance to support staff responding to incidents in schools.

Recommendation 6.3

1. The Department for Education, Children and Young People should make its child safeguarding policies publicly available, including policies on mandatory reporting, professional conduct, and responses to allegations and concerns about child sexual abuse.
2. The Department should establish a regular review process for its child safeguarding policies.

Recommendation 6.4

The Department for Education, Children and Young People, in developing a professional conduct policy (Recommendation 20.2), should ensure:

a. there is a separate professional conduct policy for staff who have contact with children and young people in schools

b. the professional conduct policy for schools, in addition to the matters set out in Recommendation 20.2, specifies expectations outlined in other relevant school policies and procedures, including those covering online technology and a duty of care owed by staff members

c. the professional conduct policy for schools spells out expected standards of behaviour for volunteers, relief teachers, contractors and sub-contractors

d. the Department uses appropriate mechanisms to ensure compliance by volunteers, relief teachers, contractors and sub-contractors with the professional conduct policy for schools.

5 Professional development for school staff

Teachers, other staff and volunteers in schools should have appropriate professional development to understand their obligations towards students, particularly as these obligations relate to maintaining professional boundaries and complying with relevant policies and procedures. Appropriate professional development clarifies the Department's expectations of adult behaviour and supports them to identify and respond to inappropriate behaviour by other adults.

In addition, teachers are uniquely placed to identify signs of abuse and harm. They know their students, often over many years, and will frequently be able to notice concerning changes in behaviour. Teachers may also be aware of risks faced by a student outside school (for example, if the student is known to the Child Safety Service), allowing them to pay closer attention to signs of abuse. Students often regard teachers as trusted adults, particularly if they do not have protective parents or other adults in their lives. For all these reasons, teachers should be equipped to identify abuse and harm at the earliest opportunity and to respond with sensitivity and confidence if they receive a complaint or disclosure.

5.1 Current training

During our hearings we heard that only mandatory reporting training was compulsory for departmental staff.[164]

Teacher Nigel Russell gave evidence that apart from one session on mandatory reporting training:

> In all the time that I was teaching in the Tasmanian education system, I don't remember receiving any training from the Department around child sexual abuse or harmful sexual behaviours.[165]

Mr Russell emphasised the importance of teachers being able to 'spot' risks to children and to normalise conversations about child sexual abuse and harmful sexual behaviours. He noted that this might be achieved through increased training.[166]

Principal Monique Carter noted that there is no central provision for annual mandatory reporting training and that this is resourced by schools themselves through their social work budgets.[167] As a result, we heard that child safety training is often informal (for example, managed locally by principals) or ad hoc, depending on the priorities and budget of the school. Ms Collins said:

> The Department of Education does not mandate a particular content to mandatory reporting training. This means that not all schools undertake that training, and

> it is generally up to the principal as to whether this takes place, and in what form … I sometimes find that mandatory reporting training is not treated with the prominence or seriousness that it deserves.[168]

We heard that principals play a critical role in promoting and reinforcing policies in their school environment. They are responsible for ensuring their staff understand child safety policies at the beginning of every school year.[169]

Ms Collins described the importance of a principal's attitude when promoting and reinforcing policies:

> There are some principals who are just incredible, you know, and they have just got such really good insight around what is and isn't okay, staff boundaries, all of those things. There's others that get nervous and either want to maintain the relationship with the family or, I'm not sure why, but there are staff that aren't allowed to or don't feel they're allowed to mandatory report without running it past the principal first. We tell them that that's not the case, but that's definitely a culture that's developed within the school and it's also by the principal.[170]

As a principal, Ms Carter also described the value and importance of policies in dictating appropriate behaviour for staff, as well as the valuable reference point they offer when counselling staff on their behaviour.[171] However, she acknowledged that the success of policies and procedures relies on a principal's motivation to embed them. She stated that if a principal is not motivated to promote safeguarding policies, this could impede the school's effective application of policies overall.[172]

Steven Smith, Senior Industrial Advocate of the Australian Education Union Tasmanian Branch, also believes that the degree to which different principals and other school leaders promote policies varies from school to school: 'The impression I have is that employees are aware of these policies. However, the extent of understanding is variable'.[173] Mr Smith said he was not aware of any methods the Department uses to record or track whether staff have read or understood policies.[174] He also highlighted a 'concerning gap' in training and policy induction for relief educators and teaching assistants and was unclear about how schools might convey policies to new staff who have joined the school after the annual policy refresher, which generally occurs at the beginning of term 1.[175]

We consider that mandatory professional development on child sexual abuse, harmful sexual behaviours and relevant child safeguarding policies, for all education staff and volunteers, would address this inconsistency in knowledge and training across schools.

5.2 Recent departmental initiatives

The Department has recently made efforts to offer broader professional development beyond the compulsory mandatory reporting training.

When reflecting on barriers to implementing changes, Secretary Bullard noted that the scale of the then Department of Education (which had more than 10,000 employees across 200 sites) was a challenge in developing and delivering professional development, as was the 'diversity of skills, knowledge and capabilities' of the workforce.[176] Ms Carter said that the volume of information for teachers and 'ensuring we have access to the best and most accurate learning resources and materials is also a challenge'.[177]

Secretary Bullard felt that these challenges could be overcome with strong leadership, a 'differentiated approach to training and delivery' and appropriate engagement strategies.[178] By way of example, he highlighted the Department's recent efforts to raise awareness of child sexual abuse with staff through a range of communication forums, including via its website and intranet, emails to staff, online presentations, discussions at its Divisional Leaders Group and Principal Briefings, and discussions with peak organisations such as the Tasmanian Principals' Association, the Tasmanian Association of State School Organisations, Tasmanian School Administrators' Association, Catholic Education Tasmania, Independent Schools Tasmania and the Department's LGBTIQ+ Working Group.[179]

In May 2022, Secretary Bullard described a range of initiatives underway to strengthen professional development of staff while recognising that 'processes alone will not change behaviour'.[180] These initiatives include:

- a review and update of mandatory reporting training as a priority, to be rolled out as compulsory annual training no later than the start of term 1, 2023[181]
- new professional development modules for school principals covering a range of topics on preventing, understanding and responding to child sexual abuse, which will also form part of compulsory annual training[182]
- new mandated professional development requirements as part of school leadership and management prerequisites, with topics covering core legal responsibilities, safeguarding children and young people, parental and community engagement, issues and complaints, the ethical conduct framework and industrial relations[183]
- a move to an online training environment, which will enable the Department to track training completion at the individual level, rather than relying on principal certification.[184]

Secretary Bullard informed us in February 2023 that the Department had developed professional development modules for all staff on mandatory reporting and Registration to Work with Vulnerable People. The mandatory reporting module is compulsory for all staff and must be completed annually. The Department tracks when staff complete the module. If staff do not complete it, this triggers a reminder.[185] The Registration to Work with Vulnerable People module is, at the time of writing, being amended to incorporate Child and Family Services and Youth Justice. An online module is expected to be rolled out 'later in 2023'.[186]

The Department also 'soft launched' (in October 2022) an online professional development module for principals and site leaders on student safeguarding. The module gives an overview of the National Child Safe Standards and the Rights of the Child and advice on trauma-informed approaches to 'incidents, disclosures or suspicions of child sexual abuse in school settings'.[187] Secretary Bullard said that work has now begun on 'amending and augmenting' the module so it can be used by all departmental staff and that it will be made available 'department-wide later in 2023'.[188]

Secretary Bullard further noted that extra funding has been allocated through the State Budget, including $2.6 million over four years from 2022–23 (and $600,000 ongoing), for 'mandatory professional development' for all departmental staff in 'understanding, preventing and responding to child sexual abuse in schools'.[189]

We support this increased focus on professional development and outline in Sections 5.3 and 5.4 some of the components needed for professional development directed at preventing and responding to child sexual abuse.

5.3 Learning from South Australia—professional development

South Australia's Debelle Inquiry recommended that all key staff be trained to implement policies and procedures effectively.[190] In South Australia, anyone who works or volunteers in an education setting must have completed the 'Responding to Risks of Harm, Abuse and Neglect: Education and Care' training. This training is delivered at two levels:

- masterclass course—for all new staff who work directly with children and young people, covering the fundamentals as well as another four-hour facilitator-led masterclass
- fundamental course—a two-hour self-directed online course designed as a refresher for those already certified, and as core knowledge for volunteers, bus drivers, canteen workers or corporate staff who do not work directly with children.[191]

The training focuses on the South Australian Department for Education's key child sexual abuse policies, which are listed in Section 4.2—particularly the *Protective Practices Policy* and mandatory reporting obligations.[192] This training is compulsory for all staff and volunteers working in the South Australian Department for Education. Ms Girvin reflected that this training has led to more proactive responses to complaints and concerns:

> Because of the training I truly believe that—and because of the culture we're in—I truly believe that teachers believe children in the main and respond immediately. And, even if they have doubts, that whole thing, it's not for me to make a judgment, it's for somebody else to make a judgment, so they report.[193]

5.4 Compulsory and ongoing professional development

We were impressed that the South Australian model requires training of all adults working in schools. In addition to employed and registered teachers, other staff encounter children and young people on school grounds. Ms Carter said that schools often have a range of other staff and volunteers onsite, including grounds people, cleaners, office staff, literacy support staff and others who would benefit from regular training.[194]

We recommend an approach that, in line with the South Australian model, provides foundational as well as more advanced professional development for staff on school premises. This professional development approach should closely align with the Department's policies, procedures and guidance material. Specifically, such training should include information about the prevalence and impacts of child sexual abuse and harmful sexual behaviours, common signs of grooming and abuse, professional and ethical behaviours with students, and importantly, what to do if a disclosure or complaint is made (including mandatory reporting requirements). It should be compulsory, with a requirement to update regularly.

There is an opportunity for Tasmania to improve on the South Australian model by supplementing the masterclass and fundamentals modules with advanced modules that could help develop the expertise of Tasmanian teaching staff, rather than having them solely participate in 'refresher courses' for core knowledge. Professor Walsh highlighted the importance of ongoing professional development for teachers (including principals) to 'refresh, update, and build their knowledge about child sexual abuse throughout their careers'.[195]

We make similar recommendations for professional development for all the government institutions we have examined in this report. The Tasmanian Government could consider increasing efficiency by sharing foundational child sexual abuse training content across child-facing service areas.

Recommendation 6.5

1. The Department for Education, Children and Young People should adopt and implement a training certification program that is mandatory for all education staff and volunteers. This training should be structured to provide basic and advanced levels of training for different role holders and targeted most directly at staff and volunteers operating in higher-risk settings.
2. Training should cover:
    a. key safeguarding policies of the Department, including appropriate standards of behaviour between adults and students and what to do if child sexual abuse or harmful sexual behaviours are witnessed or disclosed
    b. relevant legal obligations, including requirements for reporting to Tasmania Police, Child Safety Services, the Registrar of the Registration to Work with Vulnerable People Scheme, the Independent Regulator under the *Child and Youth Safe Organisations Act 2023*, and the Teachers Registration Board.
3. Training should be refreshed periodically and delivered at a time and in a format that will maximise engagement. It should be centrally recorded to monitor participation.
4. The Department should work with the Teachers Registration Board to establish the minimum training requirements for teachers (Recommendation 6.15).

5.5 Tertiary-level teacher education

Future teachers should be supported to understand their professional obligations and the risks of child sexual abuse during their teacher education. As the Independent Education Inquiry noted:

> The disparity in power [between teachers and students] needs to be emphasised in training at the very start of their career—while teachers in training are being inducted into the profession.[196]

We agree with the Independent Education Inquiry's recommendation and the National Royal Commission that child safeguarding should form part of teachers' tertiary training.

There is limited child safety content embedded in the teacher curriculum at the University of Tasmania, where most teachers in Tasmanian government schools are educated.[197]

The Australian Professional Standards for Teachers, which inform the tertiary curriculum, contain responsibilities connected to mandatory reporting and appropriate standards of behaviour in the following areas:

- Standard 7.1 stipulates that teachers 'understand and apply the key principles described in codes of ethics and conduct for the teaching profession'.
- Standard 7.2 stipulates that teachers understand 'relevant legislative, administrative and organisational policies and processes … according to school stage'.[198]

The focus of the Professional Standards reflects the Independent Education Inquiry's finding that training and education on child sexual abuse at the tertiary level is generally confined to mandatory reporting, duty of care and the ethical obligations of teachers.[199]

The Department has a strong interest in the tertiary training the University of Tasmania delivers, given that so many of its graduates go on to become employees. Yet the Independent Education Inquiry described a 'largely indirect' relationship between the Department and the University of Tasmania, as follows:

- A Teachers Registration Board-approved and Australian Institute for Teaching and School Leadership-supported panel of nationally trained accreditation members accredits the Bachelor of Education and Master of Teaching courses.[200]
- The Teachers Registration Board then undertakes an annual reporting process as part of the ongoing oversight of the programs in line with the national standards and Australian Institute for Teaching and School Leadership processes, as well as undertaking a review of accredited courses every five years.[201]
- Departmental staff sit (alongside non-government school representatives) on the Course Advisory Committee for the same courses.[202]

The Independent Education Inquiry recommended that the Department works with the University of Tasmania to introduce content on preventing and responding to child sexual abuse in schools into its curriculum.[203] Professor Walsh similarly recommended that education on child sexual abuse and harmful sexual behaviours should begin during tertiary training and 'build incrementally from that point'.[204] She added that 'quality service provision in educational settings is dependent upon the acquisition of specialist knowledge and skills'.[205]

The National Royal Commission noted that education for tertiary students is 'part of a career-long continuum of building capacity in staff to prevent child sexual abuse and harmful sexual behaviours by children'.[206] It suggested that a curriculum should be included in all tertiary courses aimed at preparing students 'for child-related occupations' and that any such curriculum covers topics including:

- the nature and incidence of child sexual abuse, and the risk and protective factors for victim-survivors and abusers
- the long-term impacts of child sexual abuse and the critical importance of preventing abuse for children in the future

- how to talk to children, recognise behavioural indicators of abuse, including the grooming of children and adults, and the importance of maintaining professional boundaries with child clients
- online safety, including the impact of online pornography on attitudes and its use as a grooming tool
- common myths and stereotypes that can enable abuse to occur and impede identification and disclosure of abuse
- best practice approaches to the prevention of and early intervention for child sexual abuse and harmful sexual behaviours by children and young people
- how and where to seek help for people who are concerned that a child may be at risk
- common psychological and other impacts on victim-survivors and their families
- the spectrum of healthy to harmful sexual behaviours displayed by children and young people.[207]

The Department and the University of Tasmania both acknowledge that course content on understanding and preventing child sexual abuse is not yet embedded in either the Bachelor of Education or Master of Teaching and agree that it should be.[208] We also heard that harmful sexual behaviours content is not a core component of teacher training or continuing professional development.[209]

Secretary Bullard said that the Department has been working with the University of Tasmania on incorporating suitable content about child sexual abuse into university courses and professional development activities.[210] This includes the University of Tasmania establishing a Trauma Informed Practice Research Lab. The Lab will build an evidence base for trauma-informed practice and principles that support classroom educators to recognise behaviours associated with child sexual abuse (including grooming), and how to prevent and respond to it.[211]

Correspondence between the Department and the University of Tasmania reflects a commitment that:

> [The University of Tasmania's] School of Education, the Trauma Informed Practice Research Lab and [the Department] will work together over the course of 2022 to support the development of a set of principles, protocols and practices relating to responsibilities and responses to child sexual abuse.[212]

We endorse the efforts of the Department and the University of Tasmania to address this gap in its tertiary curriculum. While outside our terms of reference, we note the potential for child sexual abuse to co-occur with other forms of abuse and neglect, and we encourage the Department and the University of Tasmania to ensure these reforms also improve knowledge about other forms of abuse and neglect.

6 Responding to and investigating complaints and concerns

The Department has a vital role in keeping children safe by responding to incidents of child sexual abuse in education settings. This role includes investigating complaints (often in consultation with police), supporting victim-survivors, making findings and disciplining employees if an allegation is substantiated, as well as making relevant notifications to external authorities.

The case studies we discuss in Chapter 5, like the Independent Education Inquiry, identify shortcomings in the Department's response to allegations of child sexual abuse, particularly in addressing allegations in a timely way, conducting proper investigations and facilitating appropriate and ongoing supports for children and young people, their families and school staff affected by abuse. More specifically, the systemic problems we identify include:

- School leaders had a high degree of discretion when responding to concerns or complaints of child sexual abuse, leading to inconsistent responses.
- Complaints were not fully explored, due partly to poor understanding of child sexual abuse and grooming behaviours and, sometimes, the belief that complaints made by children were unreliable.
- Record keeping was inadequate and there was no comprehensive central source of information about complaints or concerns. This made it difficult to get a complete picture of issues of concern relating to individual employees (particularly relief teachers moving from school to school).
- There was a lack of clarity about the different roles and responsibilities of Learning Services, Workplace Relations and Legal Services in responding to concerns.
- There were delays in notifications to relevant entities, including in reports to the Teachers Registration Board, the Registrar of the Registration to Work with Vulnerable People Scheme, Tasmania Police and the Strong Families, Safe Kids Advice and Referral Line.
- There was poor information sharing between these entities.
- Narrow and legalistic interpretations of the State Service Code of Conduct meant that, despite information suggesting that children might be at risk, the behaviour did not result in disciplinary action. This was particularly the case when behaviour occurred outside school grounds.

- Investigations tended to consider each individual allegation in a complaint separately rather than assessing whether the allegations reflected a pattern of behaviour consistent with sexual abuse or grooming.
- Investigation processes were slow, not trauma-informed, did not reflect good practice in interviewing children, and did not appear to understand grooming behaviours.
- Some recent briefings by Workplace Relations to the Secretary were poor, included little detail of the allegations and lacked an understanding of child sexual abuse and related concerns.
- Investigations ended if a teacher resigned.
- There was not enough support, care and communication provided to children, parents, staff and the school community.

The South Australian Debelle Inquiry made extensive recommendations about responding to allegations of child sexual abuse, including how the disciplinary process should be conducted. The South Australian Department for Education implemented these recommendations through its Incident Management Directorate. This Directorate receives, investigates and coordinates the response to incidents and allegations of employee misconduct. In this section, we recommend that the Tasmanian Government sets up a similar Directorate.

Given many recent changes to the Department's procedures following the Independent Education Inquiry, we begin by providing an overview of the Department's response framework at the time of writing, before discussing some of the ongoing issues that have become clear over the course of our Inquiry.

In the final part of this section, we consider the South Australian model in some detail to give a sense of best practice in responding to child sexual abuse. On the evidence before us, this model appears to have built the trust and confidence—among children and young people, their families, site leaders and school staff—that complaints of misconduct will be taken seriously and addressed appropriately.[213]

We note that the Tasmanian Government has legislated Child and Youth Safe Standards and a Reportable Conduct Scheme in the *Child and Youth Safe Organisations Act 2023*. All schools will be captured by these schemes.[214] The Reportable Conduct Scheme will require heads of relevant entities to notify an Independent Regulator of any reportable conduct (which includes inappropriate sexualised contact with children or sexual abuse) by staff and volunteers regardless of where that conduct occurred, and provide an outline of the steps taken to respond to that conduct as soon as possible, and no later than 30 days.[215] The Independent Regulator will oversee investigations and be empowered to offer guidance and assistance, and to intervene in the event it is not satisfied with the approach adopted.[216]

We consider the introduction of the Reportable Conduct Scheme and Child and Youth Safe Standards will encourage prioritising children's safety in managing concerns about staff and volunteer conduct, lead to greater rigour and transparency in investigations, and improve information sharing between agencies. This will address many of the problems raised in our hearings. (For further discussion of the Reportable Conduct Scheme, refer to Chapter 18.)

Our recommendations to strengthen the Department's responses to complaints and concerns about child sexual abuse will support the Department to show best practice in managing complaints and complying with its obligations under the Reportable Conduct Scheme.

6.1 The Department's response to child sexual abuse

In this section, we outline how the Department currently responds to allegations of child sexual abuse.

6.1.1 Guidance for staff on the initial response

As previously noted, the Department has published flowcharts to help guide staff responses to an allegation or incident of child sexual abuse. The flowcharts give step-by-step instructions on reporting obligations, supporting the complainant, contacting parents or carers, 'critical reflection' and record keeping.[217] The flowcharts also state that all actions are to be guided by the principal, site leader or delegate.

The *Advice for School Staff: Responding to Incidents, Disclosures and Suspicions of Child Sexual Abuse* flowchart sets out the steps staff must take when an incident is witnessed or disclosed, or an allegation is made, of child sexual abuse. The flowchart advises, in step 1, that the need for emergency action (such as contacting emergency services) must be assessed.[218]

Step 2 sets out reporting, advising that mandatory reporting obligations must be followed. If the matter involves a current member of staff then the principal must be notified of the incident or allegation (unless the principal is the subject of the allegation, in which case the Director of Operations, Learning, must be notified). The school must then contact Workplace Relations.[219] Within 24 hours of an allegation being reported to Workplace Relations, the Department must notify police, the Registrar of the Registration to Work with Vulnerable People Scheme, the Teachers Registration Board (if the allegation is about a teacher), the Integrity Commission and the Department's Legal Services unit.[220] If the matter involves a former employee, then Legal Services must be contacted. The flowchart advises that if the person who is the subject of the allegation is confirmed to be working at another location as an employee of the Department, then Legal Services will refer the matter to Workplace Relations. In matters involving former employees, Legal Services must (as soon as possible or within 24 hours)

notify police, the Registrar of the Registration to Work with Vulnerable People Scheme and the Teachers Registration Board (if the matter involves a teacher).[221]

Step 3 involves ensuring the school provides appropriate support for the child or young person and advises that staff should not interview a child or young person.[222]

Step 4 provides information on contacting parents or carers, including that the staff member who is appointed as the lead for the matter must first consult with Workplace Relations, Legal Services and/or Learning Services to be advised on what information can be shared, and at what stage.[223]

Finally, step 5 gives instructions for ongoing support, critical reflection and documentation. It sets out that staff involved may need to be supported, that critical reflection on the incident may be required and that all aspects of the incident must be recorded in line with the Department's *Records Management Policy*.[224]

Secretary Bullard explained the Department's process for responding to an allegation of child sexual abuse if a departmental (as distinct from a school) employee is the 'first receiver' of the allegation (for example, if Learning Services receives the complaint).[225]

If the subject of the allegation is a current employee, the 'first receiver' at the Department must, within 24 hours, inform the Strong Families, Safe Kids Advice and Referral Line, the relevant school principal (if the allegation relates to a school-based employee), Workplace Relations (if the allegation relates to a principal) or the relevant departmental director or manager (if the allegation or incident does not relate to a school-based employee).[226]

Within Workplace Relations, notifications are made to the Assistant Director, Industrial Relations or the Manager, Workplace Relations (for clarity, we will refer only to Workplace Relations unless it is necessary to draw a distinction between these two positions). Once notified, Workplace Relations will provide the person referring the complaint with preliminary advice about what information may need to be gathered and whether the employee subject to the allegations should be 'immediately directed to leave the workplace pending receipt of formal correspondence from the Secretary'.[227] Workplace Relations will also direct the referrer to make a mandatory report to the Strong Families, Safe Kids Advice and Referral Line, if this has not already been done.[228]

If the incident or allegation relates to a permanent or fixed-term employee, Workplace Relations will advise the employee of the allegation and ask them to 'remain away from the workplace whilst the matter is given further consideration'.[229] If the employee is a relief teacher, Recruitment and Employment (within Human Resources at the Department) is instructed to 'mark' the employee as unsuitable for employment on the Fixed Term and Relief Employment Register, which means the relief teacher can no longer be employed by government schools.[230] The process for dealing with relief employees is discussed below.

Within 24 hours of a notification, Workplace Relations must also notify the Secretary of the Department and 'the relevant Deputy Secretary, Director of Workplace Relations and Legal Services' about the complaint.[231] Notifications must also be made to police, the Registrar of the Registration to Work with Vulnerable People Scheme, the Teachers Registration Board (if the employee is a teacher), the Integrity Commission, the Head of the State Service and the Minister's Office (deidentifying the employee).[232]

If an allegation is raised about a former employee, Workplace Relations should be immediately contacted.[233] Workplace Relations will then refer the matter to Legal Services. Within 24 hours of being notified, Legal Services must notify police, the Registrar of the Registration to Work with Vulnerable People Scheme and the Teachers Registration Board (if the employee is a teacher).[234]

Secretary Bullard told us that support for complainants, parents and other students is coordinated directly through the relevant school and can involve contact with 'onsite professional support staff or more broadly via contact with the Professional Support unit within Learning Services'.[235] He noted that ongoing communication with complainants, parents, other children and officials is carried out by senior staff at the school, including 'the principal, Social Workers and Senior School Psychologists'.[236]

Secretary Bullard also told us there are no formal reporting lines between schools that would allow them to share information about an allegation or incident of child sexual abuse.[237] He stated that if there was an allegation or incident against an employee who had worked at multiple schools, Workplace Relations would check with those schools to determine whether there were any other matters of concern related to the employee's conduct.[238] We heard that, in some instances, schools rely on informal networks to assess the 'safety' of prospective employees.[239]

6.1.2 The investigative process

Secretary Bullard informed us that after the Department has been notified of an incident, allegation or suspicion of child sexual abuse by an employee or volunteer in an education context, an investigation is initiated within 48 hours.[240]

The investigation process will follow one of two courses, depending on whether the employee is fixed term or permanent, or a relief employee. If the employee is fixed term or permanent, the allegation is referred to the Secretary of the Department 'for consideration of an [Employment Direction No. 5—Breach of Code of Conduct] … investigation for an alleged breach of the *State Service Act 2000* Code of Conduct'.[241]

Workplace Relations will prepare a brief and accompanying documents for the Secretary.[242] If the Secretary forms a reasonable belief that the State Service Code of Conduct may have been breached, the allegation must be investigated. The Department then appoints an external investigator.[243] The investigator will interview the child or young person and other relevant parties as required, and the employee

against whom the allegation has been made. The investigator will prepare an investigation report for the Secretary, which the relevant employee also receives.[244] The Secretary will consider the report and decide if a breach of the State Service Code of Conduct has occurred. If a determination is made that there has been a breach, the Secretary will decide what sanctions should apply.[245] Possible sanctions for breaches of the Code of Conduct include counselling, a reprimand or termination.[246] Employees may also be required to comply with any lawful and reasonable direction given by the Secretary.[247]

Investigations of potential breaches of the State Service Code of Conduct examine the employee's conduct against the provisions in the Code of Conduct. Usually, the employee's conduct is assessed against the following sections of the *State Service Act 2000* ('State Service Act'):

> 9(1) An employee must behave honestly and with integrity in the course of State Service employment.
>
> 9(2) An employee must act with care and diligence in the course of State Service employment.
>
> 9(3) An employee, when acting in the course of State Service employment, must treat everyone with respect and without harassment, victimisation or discrimination.
>
> 9(14) An employee must at all times behave in a way that does not adversely affect the integrity and good reputation of the State Service.[248]

The first three of these provisions require that the relevant conduct be 'in the course of State Service employment'. Secretary Bullard told us that an Employee Direction No. 5—Breach of the Code of Conduct investigation will be triggered 'even where a question remains as to whether or not the conduct was "in the course of employment"', acknowledging that this is a matter that he considers 'should be explored as part of the investigation rather than impede an investigation commencing'.[249] (We discuss the requirement for conduct to be 'in the course of employment' in more detail in Chapter 20 and make recommendations to modify that requirement.)

As noted above, if the subject of the allegation is a relief employee, a different investigatory process follows. A matter involving a relief employee is referred to the Secretary, who will determine if there has been a breach of departmental policy (for example, the *Conduct and Behaviour Standards* policy), not the State Service Code of Conduct, because relief employees are not covered by the State Service Act.[250] If the Secretary considers there may have been a breach of a departmental policy, the Secretary will write to the employee seeking a response to the allegations.[251] Depending on the relief employee's response, further enquiries, coordinated through Workplace Relations and the relevant principal, may be made.[252]

After considering the relief employee's response, the Secretary determines whether the person poses an unacceptable risk to students or whether conditions should be imposed on the person before they are eligible for future employment.[253] A determination that the

relief employee poses an unacceptable risk and is therefore unsuitable for employment will result in their removal from the Fixed Term and Relief Employment Register.[254] Secretary Bullard emphasised that a different test is employed for relief staff because they are not subject to restrictive code of conduct provisions:

> … once a relief employee has been marked as unsuitable for employment on the fixed term and relief register, they are no longer available for employment, nor does the Department have any obligation to offer further employment. However, this process and the resulting decisions have been adopted through a duty of care lens, which is outside the existing employment framework, particularly code of conduct provisions, but is the paramount consideration.[255]

We are unsure what, if any, benefit is gained by using different investigative processes for relief employees. As we understand it, the reason for the difference is that relief teachers are not covered by the State Service Act and therefore cannot be subject to sanctions for breaches under the State Service Code of Conduct.[256] We discuss how to hold contractors, volunteers and temporary staff, including relief teachers, accountable for their professional conduct in Chapter 20.

6.2 Current challenges

We have identified gaps in the Department's response to allegations of child sexual abuse that require further reflection and improvement. In particular, we are concerned with aspects of the Department's investigative process, the lack of appropriate support for complainants and victim-survivors after an allegation is made, and whether the State Service Code of Conduct is suitable for assessing allegations of, and sanctions for, child sexual abuse. This section considers the Department's response to allegations of child sexual abuse perpetrated by adults and does not include harmful sexual behaviours displayed by children. We discuss the Department's response to harmful sexual behaviours displayed by children in Section 7.

6.2.1 Preliminary assessments

There is considerable discretion in undertaking preliminary assessments. Secretary Bullard told us that any allegation of child sexual abuse is referred to him for consideration as to whether there has been a breach of the State Service Code of Conduct (based on a reasonable belief that this may be the case).[257] He explained that:

> In circumstances where a matter is unclear as to whether child sexual abuse may have occurred and following initial assessment there is no risk to children, an action can include further preliminary inquiries to enable further and better particulars to be obtained. This may involve discussions with staff or students and obtaining statements or similar material.[258]

We understand that, in some instances, the Department may need to gather more information before it can proceed with a matter—such as whether the alleged abuser worked at a particular school—but we are concerned that preliminary assessments occur outside policy or legal frameworks and are not subject to any formal rules. Essentially, as we have observed across our institution-specific inquiries, preliminary assessments appear to have been treated as mini-investigations and have developed as a way to deal with disciplinary matters before engaging with the more involved Employment Direction No. 5—Breach of Code of Conduct process. The quality and appropriateness of the preliminary assessment can rely heavily on the skills and experience of the staff member undertaking it. A poor preliminary assessment can result in non-trauma informed, harmful engagements, such as Kerri Collins told us she experienced (refer to Chapter 5).

The lack of formal processes for a preliminary assessment means that even the small protections in place to support a trauma-informed investigation for disciplinary processes do not apply to preliminary assessments. For example, Steven Smith of the Australian Education Union told us that while Employment Direction No. 5 requires that interviews conducted with children be 'sensitive and appropriate', this is not a requirement for 'preliminary investigations', including for interviews with students conducted by educators and principals.[259] Mr Smith's view was that from the time an allegation is raised, 'there should be a clear process for engaging with the children involved and trained staff who undertake those interviews and processes'.[260]

We are pleased to note that the Department's flowchart, *Advice for School Staff—Responding to Incidents, Disclosures or Suspicions of Child Sexual Abuse* cautions that in supporting a child or young person who has suffered sexual abuse, staff should not question or conduct an interview with the child or young person.[261] However, we would like to see a specific policy on the process of conducting a preliminary assessment, which specifies the scope and timeframes of any preliminary assessments, as well as who can conduct them. The Integrity Commission's *Guide to Managing Misconduct in the Tasmanian Public Sector* outlines best practice for preliminary assessments.[262] We make recommendations about the State Service Code of Conduct and associated investigative processes, including preliminary assessments, in Chapter 20.

6.2.2 Accountability and flexibility

Employment Direction No. 5—Breach of Code of Conduct is specific in the processes that must be followed and does not allow for different responses depending on the level of seriousness of the allegations. During our hearings, we asked Secretary Bullard how the Department decides which investigations should be prioritised. He responded that under Employment Direction No. 5, matters were assessed as they came to his attention.[263] Secretary Bullard informed us that there is sometimes a queue of matters requiring investigation.[264] He noted that in the past, a Head of Agency could refer more serious matters directly to the State Service Commissioner, providing for greater efficiencies in handling complaints.[265] The Department later told us that all allegations of serious misconduct, including child sexual abuse, are dealt with immediately.[266] It said:

> … if a serious matter is reported to [the Department], it is progressed immediately through our established process and is responsive to the level of seriousness. All allegations that involve serious misconduct, e.g. assault, theft or child sexual abuse, are dealt with immediately. Lower-level conduct, though still regarded as serious (such as an allegation involving verbal comments or exchanges), is still dealt with expeditiously, but due to [Employment Direction No. 5—Breach of Code of Conduct] provisions, must follow the same process.[267]

Despite the Department's statements about how they prioritise investigations, we are concerned that the Employment Direction No. 5—Breach of Code of Conduct process leaves little flexibility to triage complaints and ensure the most serious are dealt with promptly. Quite apart from the effect of delay on the child who may have been abused, this may delay action to protect other children and young people. We outline an alternative process in Chapter 20. We also consider that it must be clear that all types of allegations about child sexual abuse and related matters (including verbal comments and exchanges, and professional boundary breaches) should be regarded as high priority.

We also asked Secretary Bullard what accountability mechanisms were in place to give the Department confidence that their processes for dealing with allegations of child sexual abuse are working. Secretary Bullard responded:

> … every allegation that is raised must be referred to Workplace Relations and Workplace Relations must refer it to me. Every allegation that is raised must be referred to the … Working with Vulnerable People Check and the Integrity Commission, and Teachers Registration Board where it relates to a teacher, and that is the process that sits in place now.[268]

Secretary Bullard said staff now have increased awareness of the requirement to report all matters of concern. He acknowledged that the Department can only respond to an allegation if conduct is recognised by observers as child sexual abuse, grooming or a professional conduct breach, and he noted the importance of training in this regard.[269] We make recommendations about improved training in Section 5.

6.2.3 Investigations where the person is no longer an employee

In some instances, workers will resign or retire before an investigation into their conduct is complete. At the time of giving evidence, Secretary Bullard said that the Department did not have the jurisdiction to carry out an investigation in relation to a former employee—that is, an employee who had resigned or retired.[270]

The practice was for the Secretary to write to the employee letting them know:

> … that a condition precedent of future employment will be for an investigation to be undertaken and a resolution attained prior to commencing employment. … Furthermore, recruitment screening mechanisms also apply should an application for employment be made.[271]

We note some of the problems with this process in Chapter 5 (refer to the 'Brad' case study).

We are pleased that under the recently passed *Child and Youth Safe Organisations Act 2023,* investigations into workers whose employment with the Department ends during the investigation must be completed.[272] Also, the Act allows for information sharing (including investigations into the conduct of a previous employee) between relevant entities, such as the Teachers Registration Board, which enables important information to be shared in circumstances where teachers may move to another school in the State or to another jurisdiction.[273] We note, also, that the *Teachers Registration Act 2000* ('Teachers Registration Act') requires employers to notify the Teachers Registration Board if a registered teacher resigns or retires in circumstances where the employer may have had grounds to consider the teacher's behaviour to be unacceptable.[274]

In Chapter 20, we recommend that investigations be conducted, where appropriate, even if an employee has resigned before an investigation begins—that is, investigations should be conducted into former employees if warranted—and that all misconduct-related matters be recorded, regardless of the outcome (refer to Recommendation 20.9).

In addition, where the Department cannot undertake disciplinary action, it should ensure it has made all reports to relevant bodies—such as the Registrar of the Registration to Work with Vulnerable People Scheme, the Teachers Registration Board and the Independent Regulator of the Reportable Conduct Scheme.[275] The Department should also report breaches of the Code of Conduct by former employees to the new Register for Tasmanian State Service Code of Conduct Breaches in the State Service Management Office, Department of Premier and Cabinet, to ensure they are not employed elsewhere in the State Service in the future.[276] Agencies should check with the State Service Management Office if people are on this register when screening new staff. In our chapter on State Service disciplinary processes, we further discuss a register of misconduct-related matters (refer to Chapter 20).

6.2.4 Investigators

It is fundamental to ensure that the investigation process does not further traumatise victim-survivors. The qualifications, skills and approach of investigators is central to achieving this aim. Victim-survivor Rachel told us that, in her case, investigators did not conduct themselves in a trauma-informed way and so she felt unable to tell them what had happened to her:[277]

> … there were, from what I remember, two men in suits in a small office at school; I didn't—it wasn't a safe place for me, reflecting back, because I wasn't willing to come out with anything, but I just felt like this little person with these men in suits hovering over the top of me, and scared, I feared it.[278]

Secretary Bullard gave evidence that the 'vast majority of recent investigations' into allegations of child sexual abuse are conducted by a single, independent investigation service.[279] That service is staffed by two male investigators.[280] The Department also occasionally uses three other investigative services, each staffed by single investigators—two of these investigators are female and one is male.[281] While Workplace Relations helps investigators to contact schools and to gather documents and other relevant information, investigators are independent of the Department (including the Secretary).[282]

Mr Smith, of the Australian Education Union, pointed out that Employment Direction No. 5—Breach of Code of Conduct instructs the Head of Agency to ensure investigatory interviews with children are conducted 'sensitively and appropriately', but he has not seen a policy in this respect, nor any practices 'to monitor compliance'.[283] Mr Smith believes that investigators should be trained to recognise grooming behaviours, as should others involved in decisions about the investigative process.[284]

While the Department's investigators may each have many years of experience and various qualifications, we note that none of them has qualifications in interviewing children, trauma-informed interviewing techniques, or identifying and responding to child sexual abuse.[285] Also, the Department does not provide specific training for investigators who investigate matters involving children or child sexual abuse, or in trauma-informed interviewing techniques.[286]

Secretary Bullard reported that investigations must also be conducted with 'procedural fairness and in a timely manner, that is within a reasonable time and free from unreasonable delay'.[287] When the Department's investigation into Rachel's case was undertaken in the 2000s, she told us that it took two years:

> … two years is a very long time [for the alleged abuser] to be investigated. I wasn't coping at all. I started drinking. I hated myself. I would see him … and when I saw him I was so fearful of running into him. I did run into him, he smiled arrogantly and I had to run away from him.[288]

Lengthy delays may also place other children at risk.

Secretary Bullard said that factors affecting how long an investigation takes include the complexity or seriousness of the allegations, the number of witnesses and whether police were also investigating with a view to charging the employee (in which case, police may request that the Department waits for the outcome of the police investigation).[289] Secretary Bullard noted that when a delay does occur, it can be 'compounded at a number of points' in the investigative process.[290]

When questioned about why there were no specific timeframes placed on investigators, Secretary Bullard stated that the Department does not want to appear to be 'fettering the independence' of the investigator, adding that, in a small jurisdiction like Tasmania,

there is a limited pool from which people capable of undertaking these investigations to the required standard can be drawn.[291]

We consider it reasonable that the Department sets a timeframe at the outset of an investigation that accounts for the complexity of the matter and provides the investigator with an opportunity to explain why more time may be needed before this timeframe expires.

We are pleased to note that in September 2022, in response to evidence provided by victim-survivors, the Department stated it was revising its approach to conducting investigations, including:

> .... ensuring that departmental staff and investigators take a trauma-informed approach in their dealings with children and young people impacted by sexual abuse as well as adult victim-survivors.[292]

Specific measures taken by the Department include:

- Setting a general timeframe of 12 weeks (from the appointment of an investigator), within which the investigation report should be completed.[293] The Department now requires 'early notification of any delay including whether an extension will be required'.[294] Investigators must provide monthly progress updates on the investigation to the Department.[295] Investigators are further required to communicate to the Department any discovery of information during their investigation that may constitute a (further) breach of the State Service Code of Conduct.[296]
- Ensuring that if an investigation requires interviewing students, that 'trauma-informed practice' is used.[297] This may include considering the 'time, location, and support to ensure the student feels safe, with appropriate trust, empowerment and choice built in' to the interview process.[298]

We also understand that, under further planned changes, the Department will require potential investigators to demonstrate 'a range of standards' including:

- experience in engaging with children and young people in stressful or traumatising situations
- training in trauma-informed practices, including the ability to apply trauma-informed practices to investigations
- experience and training (or the commitment to attend training) in contemporary interviewing techniques for children and young people.[299]

Secretary Bullard told us that the Department will set up a Standing Panel of investigators to ensure investigators have appropriate qualifications. The Standing Panel will be recruited through a tender process.[300] Investigators appointed to the panel

will conduct State Service Code of Conduct investigations for the Department as well as other State Service agencies.[301] The Department should consider seeking tenders from investigators in other Australian jurisdictions as well as Tasmania.

We support these changes to the Department's approach. However, in terms of the required qualifications for investigators, we note that training in child sexual abuse, in particular identifying grooming behaviours and boundary breaches, is missing. We are concerned that some developments that have improved best-practice police responses to child sexual abuse are not being adopted in non-criminal settings. We discuss these developments in more detail in Chapter 16, but they include:

- taking a 'whole story' approach to interviewing a victim-survivor to allow for a pattern of behaviour and extra corroborating context to be apparent
- ensuring the environment of the interview is comfortable for the victim-survivor, and that they have a support person present if they choose, to minimise the need for multiple interviews through techniques such as video recordings
- engaging in a developmentally appropriate and trauma-informed interaction with vulnerable witnesses (for example, children and young people, people with disability, adult victim-survivors).

We recommend that training in child sexual abuse and related concerns be included in the relevant standards.

6.2.5 Support for victim-survivors

Research we commissioned highlighted the importance of supporting children and young people who have disclosed abuse. The researchers found that a key concern of children and young people following an incident is that the response is not visible—for example, there may be little or no communication with the child or young person about what the school is doing or intends to do about the complaint, and little or no support offered by way of counselling.[302]

Victim-survivors told us they received limited or no support from the school or the Department following their allegation of abuse:

- Victim-survivor Katrina Munting (refer to Case study 4 in Chapter 5) told us that after her disclosure she was not informed about what, if any, action was taken in response: 'so far as I know, there were no inquiries made to determine the extent of what Peter had done. I received no support for the psychological issues that arose for me then, which have persisted'.[303]
- Victim-survivor Kerri Collins (refer to Case study 1 in Chapter 5) similarly attested that after she alleged abuse in the late 1980s: 'I was not offered with support or counselling by the school, and it was always my understanding that the principal did not believe us'.[304]

- In an extraordinary scenario, Rachel (refer to Case study 3 in Chapter 5) described her hurt and confusion when she discovered the outcome of an investigation into her complaints in the local paper. The paper reported that following an 'extensive' investigation, it was determined that her abuser had not breached the Code of Conduct. Rachel told us that she did not receive any reasons from the Department for the decision and felt 'betrayed and publicly humiliated' by the Department: 'they had failed to support their student and chose instead to protect the teacher'.[305]

We also heard about the impact child sexual abuse and harmful sexual behaviours can have on staff and parents. Staff may witness abuse or harmful sexual behaviours and receive disclosures. They may need to come to terms with complaints about colleagues and manage ongoing anxiety or concerns with families and carers. Some will inevitably see the effects of abuse on victim-survivors in their classrooms:

- Nigel Russell, a former high school teacher, told us about the devastating and lasting effects he suffered after witnessing an incident involving harmful sexual behaviours in his classroom. Mr Russell said: 'The principal of the school refused to acknowledge the incident for what it was, a sexual assault'.[306]
- Robert Boost gave evidence that, in 2020, a relief teacher at his daughter's school made inappropriate comments to some of the girls at the school. Mr Boost told us that teachers made complaints to the principal. Mr Boost said that neither the school nor the Department communicated anything about the situation to parents, nor was the incident raised with staff—the member of staff who had made the inappropriate comments simply did not show up for work the next day and nothing was ever communicated by the Department about what had happened.[307]

When asked what sort of information from the Department would have helped him, as a parent of a child at that school, Mr Boost responded that 'it didn't need to have any detail, just that there was an incident and … if any kids needed counselling or if parents had queries, to contact the principal, just as simple as that'.[308]

He also reflected:

> … how do we instil trust in an institution like the Department of Education when this person potentially the next day could have just gone to another school and done the same thing. … [The Department is] so worried about adults' feelings that they're not … protecting the kids … they're so worried about it not getting out and it being bad publicity or whatnot. That kind of behaviour needs to be called out and … it's for everyone's benefit that they knew that that happened at that school.[309]

A clear and consistent process for communicating with victim-survivors is important beyond any initial departmental response. This is evident in the impact of poor communication on victim-survivor Sam Leishman, who was not contacted by the

Department after the high-profile conviction of teacher Darrel Harington in early 2020 (refer to Case study 7 in Chapter 5).[310]

In this respect, we note that the *Child and Youth Safe Organisations Act 2023* provides for feedback to children and young people after an investigation.[311]

At hearings, Secretary Bullard acknowledged that a lack of communication from the Department to victim-survivors could be construed as inaction and can inhibit their ability to achieve closure.[312] He stated that:

> … providing information and communicating with the various parties involved is difficult given confidentiality provisions and procedural fairness requirements particularly in relation to unsubstantiated allegations and with disciplinary actions imposed on an employee.[313]

We are pleased to note that since hearing from victim-survivors, the Department is planning to allocate dedicated case managers when an allegation of sexual abuse is made. The case manager will be 'accountable for ensuring that the supports required are provided to the child and their family, both immediately and over the course of time'.[314] This support should be extended to adult victim-survivors where required. We consider this case manager role should sit within the Child-Related Incident Management Directorate we recommend in Recommendation 6.6.

In an update provided to us in February 2023, Secretary Bullard said that the Department had filled two 'Student Support Response Coordinator' positions. He explained that the coordinators are:

> … responsible for professional management of responses to incidents of child sexual abuse and harmful sexual behaviour, ensuring that the best interests of the children and young people are the central consideration.[315]

Other responsibilities include ensuring the 'capture and storage' of school records about child sexual abuse and harmful sexual behaviours 'meet legislative and departmental requirements and can support analysis to understand trends' and inform improvements.[316] On the information provided to us, it is unclear what role the coordinators will have, if any, in supporting students and how they will work with case managers.

6.2.6 Codes of conduct

The Independent Education Inquiry noted there was 'broad agreement' that the State Service Code of Conduct is not suited to the distinct context of schools and that this creates difficulties for the Department when responding to concerns or allegations of child sexual abuse.[317] Formal disciplinary proceedings require a breach of the State Service Code of Conduct. Also, the requirement that the conduct must have occurred in the course of their employment 'has been interpreted narrowly to mean that if the conduct in question did not occur at school or on a school activity the employee cannot

be subjected to disciplinary proceedings'.[318] We heard that this interpretation has allowed some teachers to argue that allegations of child sexual abuse against them have no merit because the conduct did not occur on school grounds or during school hours.[319]

The Independent Education Inquiry recommended that the Department develops a 'schools-specific' code of conduct covering employees and volunteers.[320] As discussed in Chapter 4, the Department accepted all the recommendations.

When asked how the Department was approaching recommendations that an education-specific code of conduct be developed, Secretary Bullard told us that there were challenges with having two codes—that is, an education-specific code as well as the State Service Code of Conduct—because under the current drafting of the State Service Act there are practical barriers to introducing more codes of conduct.[321]

In Section 4, we discuss the need for an education-specific professional conduct policy, and we make a recommendation for this (refer to Recommendation 6.4). We consider this will avoid the problems associated with a separate education-specific code of conduct, while meeting the intent of the recommendation of the Independent Education Inquiry.

6.3 Learning from South Australia: a model for responding to child sexual abuse in educational settings

One of the recommendations of the Debelle Inquiry in South Australia was establishing an Incident Management Directorate ('the Directorate') in the South Australian Department for Education.[322]

The role of the Directorate is to:

> … coordinate the receipt, assessment and response of incidents, particularly those of a severe/critical nature, those requiring urgent attention and/or the investigation of allegations of employee serious misconduct and all associated disciplinary processes.[323]

In contrast to the Department's current responses to allegations of child sexual abuse, which occur primarily through Workplace Relations within the human resources unit, the South Australian Directorate operates independently of human resources in the South Australian Department for Education.

The policies that inform the Directorate's work include the South Australian Public Sector Code of Ethics and the *Protective Practices Policy*, which have prescriptive guidelines on matters that may be subject to disciplinary action, such as boundary breaches and grooming.[324] The Directorate's work is also informed by the South Australian Department for Education's *Managing Allegations of Sexual Misconduct in SA Education and Care Settings* guidelines, which are based on recommendations in the Debelle Inquiry report.[325]

We heard that the outcome of establishing the Directorate, alongside implementing the Debelle Inquiry's recommendations, has provided a comprehensive framework for responding to child sexual abuse in educational settings in South Australia. Alana Girvin, former Director of the Directorate, told us that part of the success of the unit is due to an awareness among departmental and school staff that clear processes will be followed in the wake of any allegations of child sexual abuse. This includes informing the school community of the allegations, informing families when a person is charged and activating processes for terminating employment if an allegation is upheld.[326] According to Ms Girvin, 'although the Directorate is concerned with investigation and response, my strong feeling is that its work has also had a preventative effect'.[327]

Ms Girvin's further observations about the success of the Directorate are worth quoting at length:

> While I was the Director of the Directorate, the Directorate received a lot of informal feedback from site leaders who were so thankful for the support they received from their Case Manager. For example, I heard lots of feedback along the following lines, which I think is a sign of the Directorate's success: 'thank you for your support. This was obviously a horrible situation and I never wanted to have to go through it in my career, but I felt supported and it has gone as smoothly as it possibly could have. You were there to listen to me at 9 o'clock at night'.
>
> In relation to allegations of sexual misconduct matters the Directorate measures its success in terms of the timely response, flow of accurate information, the effectiveness of the case management and single file and adherence to the guidelines/procedures.
>
> In my view, another reflection of the Directorate's success is that the education union was supportive, or at least did not object, to the Directorate's work and its implementation of the Debelle recommendations.[328]

Other key features instrumental to the success of the Directorate include:

- its operational independence from the South Australian Department for Education's human resources unit
- an articulated process which applies even when conduct does not amount to criminal behaviour
- a close relationship with South Australia Police and an obligation on South Australia Police to notify the South Australian Department for Education of particular matters
- the use of investigators with policing backgrounds who act on the evidence
- a case manager to support every principal in relation to responding to an allegation.[329]

In the box below, we outline in detail key aspects of the South Australian Directorate model, as a starting point for the Tasmanian Government to adopt a similar model—a Child-Related Incident Management Directorate. We consider this a central recommendation that will support a significant change to the Tasmanian Government response to allegations of child sexual abuse by staff.

South Australia's Incident Management Directorate

The South Australian Incident Management Directorate has three key units: the Incident Report Management Unit ('Response Unit'), the Investigations Unit and the Misconduct and Disciplinary Advice Unit. Importantly, the Directorate's role extends to independent schools.[330]

Response Unit

The Directorate's Response Unit case manages allegations of sexual abuse and oversees the Incident Report Management System.[331] The Response Unit aims to ensure that:

- parents and carers can be confident that the wellbeing and safety needs of their children are met
- 'incidents (particularly those of a severe/critical nature) and reports of serious misconduct are responded to in an effective and timely manner, with respect, transparently and professionally'.[332]

Ms Girvin told us that case management involves assisting site leaders and principals to implement the *Managing Allegations of Sexual Misconduct* guidelines.[333] Importantly, the Response Unit acts as the 'prime point of contact for site leaders' and oversees the 'single file' for all matters involving allegations of child sexual abuse.[334]

All 'critical incidents', which include harmful sexual behaviours by students, as well as fights and 'inappropriate parent behaviour', are logged in the Response Unit's Incident Report Management System.[335] When an incident report is entered into the system, a 'severity rating … is automatically applied to … [the] incident report … dependent upon the categories and site actions selected by the person completing the report'.[336] Critical Incident Coordinators review the incident reports each day to ensure 'all appropriate actions are being taken' by 'sites' (schools).[337]

Ms Girvin told us that when an allegation is referred for investigation:

> … an Intake and Assessment Officer (whose role is line managed under the Incident Report Management Unit) assesses whether an allegation or incident is capable (if established) of constituting serious misconduct. If the answer to that question is 'no', then the Directorate will refer the matter to the Performance Management and Incapacity Unit within the corporate office. This unit will assist site leaders with performance management matters and minor misconduct matters.
>
> If the Intake and Assessment Officer determines that it is not to be investigated, the report will be referred to the appropriate corporate office and recorded in the central online Incident Report Management System, as well as in any documentation kept on site. If there are ongoing problematic behaviours, [the report] may be relevant for the Directorate to investigate [those other behaviours].[338]

When an Intake and Assessment Officer receives a report that contains allegations of serious misconduct, such as child sexual abuse, the Officer will gather all relevant information and present it to an Assessment Panel.[339] Assessment Panels are composed of the '[Directorate] Director, Assistant Director, Investigations Unit Manager and Misconduct Unit Principal Investigator'.[340]

Because school principals often have little to no experience with managing serious allegations involving child sexual abuse, the Response Unit has a vital role in offering support and assistance to navigate the response process. The Response Unit provides principals and other site leaders with a case manager who is available during and outside work hours.[341] Case managers also help to minimise a site leader's discretion in the process, allowing them to focus on the aspects of their role that are within the scope of their skills and training.[342]

According to Ms Girvin, once parents have been informed about an allegation of child sexual abuse, 'rumours and gossip can run rampant. It often follows that the site leader is blamed'.[343] While the Directorate does not play a role in managing information in this situation (with responsibility for this resting with site leaders and their managers), the assigned case manager can provide support to, and discuss concerns with, the site leader in this situation.[344]

Investigations Unit

The Directorate's Investigations Unit investigates all allegations of 'possible serious employee misconduct'.[345]

Investigators gather evidence, interview witnesses and take witness statements. They then prepare reports for the adjudicators to consider.[346] Adjudicators sit in the Directorate's Misconduct Disciplinary Advice Unit. The South Australian process distinguishes between investigators who gather the evidence and adjudicators who make recommendations based on that evidence for review

by the Department's Chief Executive (or Chief Operating Officer and the Director of the Directorate).[347]

All Investigation Unit investigators have a policing background and must complete 'Specialist Vulnerable Witness Forensic Interview Training', which is provided by the Centre for Investigative Interviewing at Griffith University.[348]

Ms Girvin noted that if, during an investigation, the investigator identifies ways in which aspects of the response process could be improved, the Directorate may request that the Executive Director of Partnerships, Schools and Preschools reviews the relevant process, ensuring a pathway for continual improvement over time.[349] We envisage that Tasmania's Office of Safeguarding could play a similar role.

Misconduct Disciplinary Advice Unit

The Directorate's Misconduct Disciplinary Advice Unit is staffed by 'Misconduct Adjudicators'. The primary function of the unit is to examine the reports prepared by the Investigations Unit and 'determine if the evidence demonstrates serious misconduct'.[350] If it does, a briefing is prepared for the 'delegate (Chief Executive/ Chief Operating Officer)' outlining:

a. a summary of the allegation and the evidence gathered by the investigators

b. the adjudicator's conclusion as to whether there is evidence of serious misconduct

c. the adjudicator's recommendation as to any disciplinary sanction that should be made.[351]

Ms Girvin told us that adjudicators in the Misconduct Disciplinary Advice Unit have legal qualifications. Unlike investigators, they have not met the accused or any witnesses, allowing them to appraise the evidence with 'an independent eye'.[352]

6.4 An Incident Management Directorate

The National Royal Commission identified a number of ways institutions should handle complaints and respond to child sexual abuse allegations (using a 'child safe' approach), including for:

- Investigating complaints—investigations should be conducted by impartial, objective, trained investigators.[353]
- Interviewing children—children should not be questioned by someone 'without relevant specialist skills, such as child development, trauma-related behaviours, indicators of abuse and investigative techniques'.[354]

- Communicating with the affected parties—many people associated with the institution will be affected by a complaint of child sexual abuse, and policies and procedures should outline what information can be shared, when and in what circumstances.[355]
- Providing support and assistance to complainants—'concern and support' for the person making the complaint 'must be at the heart of an institution's response'.[356] Institutions should respond in a supportive and protective way to child and adult victim-survivors of child sexual abuse. Responses should be sensitive so as to not compound or cause more harm.[357] Victim-survivors and other affected parties (including the subject of the complaint) should have access to support, therapeutic treatment services and advocacy.[358]
- Providing support and assistance to others—'secondary victims may also require information, advocacy, support and therapeutic treatment as part of an institution's complaint handling process'.[359]

The South Australian model embodies many of the features that the National Royal Commission recognised as being instrumental to an institution's ability to respond to concerns or complaints of child sexual abuse in a way that is sensitive and child focused.

We recommend that the Tasmanian Government establishes a Child-Related Incident Management Directorate to oversee and respond to allegations of child sexual abuse by staff, including grooming, breaches of professional conduct policies and sexual misconduct (as defined by the Reportable Conduct Scheme). This Directorate should be based on the South Australian model and have three distinct units and functions—case management of the response, investigation and adjudication.

We recommend that this Directorate oversees the response to allegations about staff in relation to the education, the Child Safety Service, out of home care and youth justice contexts (refer to also Chapter 9 and Chapter 12). In addition to child sexual abuse, the Child-Related Incident Management Directorate should respond to other forms of staff-perpetrated abuse in schools, out of home care and youth justice, including other serious care concerns, excessive use of force and inappropriate isolation and search allegations. It could also respond to child-related critical incidents in health or family violence and homelessness services. To enable this, the unit responsible for case management should be staffed by people with knowledge and expertise of each of these organisational contexts.

During our hearings, Secretary Bullard was asked for his views on the South Australian model. He stated that he was very supportive but questioned whether a similar model should perhaps apply across the State Service in Tasmania rather than sit within the Department, considering the relatively small size of the Department and the Tasmanian State Service.[360] We note that the State has indicated that a shared capability framework

for the investigation of serious Code of Conduct breaches would be developed by June 2023 and a Project Manager was appointed in September 2022.[361] We encourage the State to consider the role of the Directorate within the context of the shared capability framework.

We note in Chapter 5 that there have been many matters raised with the Department in recent years. Given we propose that the Directorate oversees schools, out of home care and youth justice, we consider that there will be a significant workload for the Directorate.

Despite this, we have not specified where this Directorate should be established in the Tasmanian Government, but note that the Department of Premier and Cabinet, with its responsibility for all State Servants, or the Department for Education, Children and Young People, with its responsibility for most child-facing state services, are obvious options. We recommend a similar functional capacity in the Department of Health, although again have not specified if this should form part of the same Directorate or a health-specific one (refer to Chapter 15, Recommendation 15.17).

Recommendation 6.6

1. The Tasmanian Government should establish a Child-Related Incident Management Directorate to respond to:
    a. allegations of child sexual abuse and related conduct by staff, breaches of the State Service Code of Conduct and professional conduct policies, and reportable conduct (as defined by the *Child and Youth Safe Organisations Act 2023*) in schools, Child Safety Services, out of home care and youth justice
    b. other forms of staff-perpetrated abuse in schools, Child Safety Services, out of home care and youth justice, including other serious care concerns and allegations of excessive use of force, inappropriate isolation or inappropriate searches of children and young people in detention.
2. The directorate should comprise three units tasked as follows:
    a. **Incident Report Management Unit.** This unit should be responsible for case management—that is, assisting child-facing services within the Department for Education, Children and Young People with the management of incidents or allegations of child sexual abuse and related conduct, including being the point of contact for these services.
    b. **Investigations Unit.** This unit should undertake preliminary assessments and investigations. It should comprise appropriately trained and skilled investigators or use external investigators with the requisite qualifications and training.

c. **Adjudication Unit.** This unit should examine the investigation reports prepared by investigators and make recommendations to the Head of Agency about what disciplinary decisions are available and the appropriate response. The unit should be staffed by personnel with relevant experience, including a background in law.

3. The directorate should appoint staff with knowledge of schools, Child Safety Services, out of home care, and youth justice.
4. Within 12 months of appointment, all staff in the Investigations Unit should:
   a. undertake specialist training in interviewing vulnerable witnesses
   b. undertake training in child development, child sexual abuse and trauma-related behaviours.
5. The directorate should maintain a case management platform and oversee a 'single file' for all child sexual abuse allegations and concerns about staff, including recording matters that do not result in disciplinary action.
6. The Tasmanian Government should decide where in the State Service this directorate should be established. Wherever it is established, it should be separated from traditional human resources functions.

6.5 Guidelines for managing allegations of sexual misconduct

Government and non-government education sectors in South Australia jointly developed the guidelines for *Managing Allegations of Sexual Misconduct*. This is to 'ensure that staff, children and parents can expect the same standards of child protection practice no matter which sector they access'.[362]

The guidelines cover the government, independent and Catholic school sectors in South Australia. They apply to situations involving sexual misconduct by adults against children or young people. They aim to reduce further trauma for children and young people, parents and the staff involved when an incident occurs.[363]

The guidelines support the work of the Incident Management Directorate by guiding the response to an allegation of misconduct from first notification, through to the investigation and beyond. They are easily accessible on the South Australian Department for Education's website, rendering the process publicly accountable.

6.5.1 The immediate response

Staff and volunteers who are involved in managing an incident of child sexual abuse may need to recall events or conversations later, such as in court proceedings. Accordingly, the Debelle Inquiry emphasised that it was critical for site leaders and other members of staff to 'keep a written record of all conversations relating to the allegations' of child sexual assault.[364] The importance of making notes as soon as possible after conversations occur is incorporated into the South Australian guidelines.[365]

Ms Girvin summarised the immediate response to an allegation of sexual misconduct under the guidelines as follows, noting that these steps are not always undertaken in a sequential order and that some actions may be undertaken at the same time:[366]

> (a) Step 1: Obtain medical assistance for the child or young person if required.
>
> (b) Step 2: Receive report of the allegation. If the allegation is made to a staff member, it should be immediately reported to the site leader. If the allegation concerns the site leader, the report should be made to the relevant sector office.
>
> (c) Step 3: Report the allegation to SA Police.
>
> (d) Step 4: Notify the Child Abuse Report Line.
>
> (e) Step 5: Take basic steps to preserve any evidence, if applicable. For example, by blocking access to the site's computer network if an allegation regarding child pornography is made or locking the room in which an incident is alleged to have occurred.
>
> (f) Step 6: Inform the sector office and establish who will be assisting.
>
> (g) Step 7: Prevent the accused person from having any access to or further contact with children and young people.
>
> (h) Step 8: Inform parents of the victim of the allegation, unless the parent is the accused person.
>
> (i) Step 9: Inform the accused person of his or her immediate work requirements.
>
> (j) Step 10: Complete sector specific reporting requirements, including for State schools, the Department's critical incident report through the Incident Response Management System.
>
> (k) Step 11: Document all information/discussions/observations.

In our analysis, the Tasmanian Department's flowcharts outline a similar immediate response.[367]

6.5.2 The ongoing response

Unlike the Tasmanian flowcharts, the South Australian guidelines take a comprehensive approach to responding to allegations of misconduct beyond the initial response. The guidelines provide direction on:

- the employment status of the 'accused person'
- delivering counselling and support to affected parties
- undertaking a risk assessment
- responsibly providing appropriate information to affected parties.[368]

In relation to the employment status of the accused person, the guidelines provide that the site leader should consult with the relevant 'sector office' (in the case of the public sector, the Directorate) to determine whether to suspend the person from duty pending the outcome of an investigation. If suspended, a formal letter is sent to the accused person. If the accused person is a volunteer, their role is terminated immediately.[369]

The Debelle Inquiry noted in its report that in the aftermath of the event that precipitated its inquiry, a common complaint of parents was the lack of appropriate counselling.[370]

The Inquiry recommended that continuing support should be offered to victim-survivors, their parents, other children or parents in the school community, and staff.[371]

The South Australian guidelines are detailed and require that appropriate support is provided to:

- victim-survivors and their parents—site leaders should meet with the parents and discuss continuing support for the child or young person. A written report of the meeting should be prepared and signed by the parents. Next, 'a support and safety plan should be finalised, covering all aspects of the victim's and the family's ongoing needs and agreed actions'. Site leaders or the relevant sector office must monitor the wellbeing of the victim and the victim's family through regular reviews of the plan[372]
- other children or young people and parents of the school—the counselling or support offered to children or young people and parents should vary depending on the circumstances of the incident. If a risk assessment finds that a wider group of parents should be informed, 'then, generally speaking, the same services as outlined above should be offered'[373]
- staff members—staff (including the site leader) can be profoundly affected by sexual misconduct allegations and their ongoing wellbeing needs to be considered, particularly those who were close to the person subject to the allegations. Staff 'will need clear guidance on how to respond to particular requests such as acting as a witness'.[374] Staff should be reminded of the availability of supports in the weeks and months that follow, and the effect of potentially stressful events (for example, the conclusion of a trial) should be anticipated and monitored[375]
- counselling and the option of alternative placements should be considered for relatives of the accused person who are employees or enrolled students at the site or in the sector.[376]

The Debelle Inquiry's report emphasised that how counselling is offered is important. Where possible, counselling should not be offered in 'a mere letter'.[377] However, any offer of counselling should be followed up in writing.[378] The Department should also 'offer counselling as quickly as possible, if not immediately, after it learns of the allegations'.[379]

The Debelle report also emphasises the importance of ensuring the safety, health and wellbeing of other children in the wake of an allegation against a staff member. It advocates conducting a risk assessment to discover whether there might be other victim-survivors of the alleged offending.[380]

Under the South Australian guidelines, risk assessments are conducted by the Directorate 'in consultation with the site leader, drawing on information provided by South Australia Police'.[381]

In making the risk assessment, the following factors are considered:

- the nature of the offending
- the circumstances in which the alleged offending occurred
- the place or places where the alleged offending occurred
- the age and gender of the victim
- the age and gender of the accused person
- whether the accused person had regular and frequent contact with other children or a group or groups of children and the nature and circumstances of that contact
- the opportunities that were available to the accused person to offend against other children.[382]

The Debelle Inquiry also recommended that the South Australian Department for Education develops a policy that guides the communication of an allegation to the school community.[383] This communication must achieve a balance between the rights of staff, students and parents to be informed, and the right of an individual staff member not to be identified before an assessment and/or investigation of the allegation. Avoiding liability for defamation is also a consideration when communicating about an allegation of child sexual abuse.

While there are laws in South Australia forbidding the publication of an accused person's name, the Debelle Inquiry found that:

> … it is proper for those with a legitimate interest in the matter to be informed of the alleged offending. Those who have a legitimate interest in the offending are the staff at the site, the members of the governing council of the site [school association committee], and parents of children who are likely to have been in contact with the accused person.[384]

Based on the Debelle Inquiry's recommendations, the South Australian guidelines provide detailed directions for communicating an allegation based on the audience and the stage of the response. This approach is outlined in Appendix E. In summary, it outlines appropriate communications for staff, governing councils and parents when:

- there is an allegation only
- the accused person has been charged
- the court process is over.

The supporting documentation provides template letters for each stage of the process. Examples of letters from the Debelle Inquiry can be found at Appendix E.

Secretary Bullard noted the approach taken in the Debelle Inquiry to communicating with relevant parties and the considerations relevant at each stage of the process. He stated that he would go further by including guidance on communication where 'the conduct does not amount to a criminal offence, or Police do not proceed with charges, but the Department investigates a potential breach of the State Service Code of Conduct'.[385]

In his February 2023 update on the safeguarding activities the Department was undertaking, Secretary Bullard informed us that there had been amendments to the letters sent to complainants and witnesses involved in Employment Direction No. 5—Breach of Code of Conduct processes related to child sexual abuse matters. These letters, he said, are now more 'accessible and trauma-informed'.[386] While the relevant policy is still being drafted, we also understand that the Department will, where appropriate and authorised to do so, communicate information to relevant parties about a child sexual abuse incident within the Department's service areas, including schools.

6.5.3 Our observations

These developments outlined by Secretary Bullard are encouraging. We recommend that the Department develops a specific policy about responsible communication in the context of legal obligations. The policy should outline what communications the Department should make, and to whom they should make them, at particular stages of investigating a child sexual abuse matter. This should be based on the resources developed by the South Australian Department for Education for responding to allegations about staff.

Similar resources should be developed to support the response to allegations about harmful sexual behaviours (refer to Section 7).

We also recommend that the Department adopts a similar approach to that recommended by the Debelle Inquiry to the supports it provides to students, families, staff and the school community when dealing with child sexual abuse matters.

As indicated, we recommend that the Child-Related Incident Management Directorate oversees the response to allegations about staff in relation to the education, Child Safety Service, out of home care and youth justice contexts. Similarly, guidelines should be developed to assist in the response to allegations in all these institutional contexts.

Drawing on the South Australian example, the Department should also look to provide leadership to the Catholic and independent school sectors and consider ways to support a statewide approach to responding to child sexual abuse in schools.

Recommendation 6.7

1. The Department for Education, Children and Young People should develop guidelines that outline the ongoing supports that should be provided for victim-survivors, families, staff and the school community when there are allegations or incidents of child sexual abuse by staff or harmful sexual behaviours.
2. The guidelines should include policies, procedures, and templates for:
    a. Counselling and support—a counselling and support plan should be developed for victim-survivors and their parents and carers, other children or young people at the school, staff at the school, and the alleged perpetrator and their family.
    b. Risk assessment—a risk assessment should be conducted to determine whether there is any concern for the ongoing safety of other children and whether there may be other victim-survivors.
    c. Informing responsibly—the Department should develop specific policies that outline what communications should be made by the Department, and to whom they should be made, at particular stages of a child sexual abuse matter. These policies should take account of all legal obligations and the importance of informing victim-survivors, parents and the community. Communication may be needed with children and young people, staff, School Association Committees, parents, previous students and other schools.
3. Any policy outlining the communications that should be made by the Department should extend to matters where conduct does not amount to a criminal offence or where police do not proceed with charges but the matter is investigated as a possible breach of the State Service Code of Conduct, a professional conduct policy or reportable conduct under the Reportable Conduct Scheme.
4. Guidelines should also be developed for Child Safety Services, out of home care and youth justice contexts.

Recommendation 6.8

The Department for Education, Children and Young People should work with the Catholic and independent school sectors to adopt a statewide approach to responding to child sexual abuse in schools.

7 Harmful sexual behaviours in schools

Harmful sexual behaviours are sexual behaviours displayed by a child or young person:

> ... that [fall] outside what may be considered developmentally, socially, and culturally expected, may cause harm to [themselves] or others, and [occur] either face to face and/or via technology. When these behaviours involve another child or young person, they may include a lack of consent, reciprocity, mutuality, and involve the use of coercion, force, or a misuse of power.[387]

Harmful sexual behaviours are occurring in Tasmanian schools and are causing immense distress and harm to students, their families and staff. Lack of understanding about harmful sexual behaviours may mean that they are either not responded to at all, or the response is disproportionate to developmentally expected or less serious problematic sexual behaviours. Consistent with the Independent Education Inquiry, we heard that schools need better guidance and training in preventing and responding to harmful sexual behaviours.

Addressing harmful sexual behaviours requires schools to balance their duty of care to the child displaying harmful sexual behaviours and to other children. An understandable desire to respond to harmful sexual behaviours in a therapeutic and thoughtful way should not overshadow the real and very damaging experiences of victim-survivors of such behaviours. Principals may be reluctant to exclude young people displaying harmful sexual behaviours from school (with all the related impacts on their education), particularly if the child has disability or if their behaviours are a product of their own victimisation. However, failures to ensure the safety of students (particularly of victim-survivors of harmful sexual behaviours) has its own impacts on their ability to learn and thrive at school. Balancing what can sometimes be competing considerations requires tailored planning and responses to meet the unique circumstances of each situation. Schools will often need access to specialist knowledge and guidance to get this balance right.

The National Royal Commission made one specific recommendation (Recommendation 13.6) about harmful sexual behaviours in the education context:

> Consistent with the Child Safe Standards, complaint handling policies for schools ... should include effective policies and procedures for managing complaints about children with harmful sexual behaviours.[388]

The Department of Education considered that it had implemented this recommendation because it 'has existing policies/procedures/practices for managing complaints about children with harmful sexual behaviour'.[389]

However, questions around the effectiveness of the Department's policies and measures came up in the Independent Education Inquiry. That inquiry found significant uncertainties among departmental staff on how to respond appropriately to suspected or alleged harmful sexual behaviours in schools. It recommended developing protocols to respond to concerns or complaints of this nature.[390]

Leanne McLean, Commissioner for Children and Young People, acknowledged that the Department was developing a flowchart to help guide responses to harmful sexual behaviours, but she was concerned by the apparent lack of policy or procedure given that:

> … during my term as Commissioner, a number of incidents have been raised with me by members of the public related to harmful sexual behaviours in educational contexts, and in particular, the responses of Department of Education employees to such allegations.[391]

The Department told us of several initiatives to address this issue, including setting up a Harmful Sexual Behaviours Working Group, investing in staff expertise and developing clearer guidance for principals and staff. We discuss these initiatives and other changes throughout this section. However, we consider more needs to be done.

In this section, we begin by discussing the experiences of families affected by harmful sexual behaviours in schools. We outline steps taken since the Independent Education Inquiry to improve responses to harmful sexual behaviours in schools, including flowcharts developed to guide principals' responses and the role of the Prevention, Assessment, Support and Treatment program in supporting the understanding and response to harmful sexual behaviours. We then discuss continuing challenges for schools in understanding and responding to harmful sexual behaviours and review positive recent initiatives to increase specialist support to schools. Finally, we outline the recommendations we have made across our report that will continue to enhance prevention, identification and responses to harmful sexual behaviours in government schools, and which build on the positive recent developments in the Department for Education, Children and Young People. We conclude by recommending the Department develops better policies, protocols and guidance for schools responding to harmful sexual behaviours.

7.1 Experiences of families affected by harmful sexual behaviours in schools

Some families (and people working with them) told us about their experiences navigating harmful sexual behaviours in schools. These experiences included significant trauma and distress because of the incident(s), as well as the way the school and/or the Department responded. Problems included:

- incidents of harmful sexual behaviours being downplayed or minimised by teachers, principals or others, including failures by schools to appropriately acknowledge and apologise for the harm caused[392]
- principals having too much discretion to determine whether an incident constitutes harmful sexual behaviours and the steps taken (or not) to manage it[393]
- the movements and actions of a victim-survivor being controlled or restricted to manage their safety, rather than the behaviour of the child or young person who had engaged in harmful sexual behaviours being managed or closely supervised[394]
- victim-survivors having to continue to encounter the young person who harmed them at school in ways that affected their sense of safety and exacerbated trauma[395]
- poor communication to affected parties (particularly parents and carers) about steps being taken following a complaint or incident, with confidentiality often cited as justification[396]
- inadequate information sharing and record keeping by schools and the Department, which can make it difficult to determine patterns of harmful sexual behaviours (particularly where a young person engaging in such behaviour moves schools)[397]
- inadequate access to appropriate psychological and support services for victim-survivors and young people engaging in harmful sexual behaviours.[398]

Some of these issues have been described to us in incidents as recent as 2021 (refer to the case study of 'Andy' in Chapter 5).

Parents and caregivers of children who had experienced harmful sexual behaviours from other children came forward to share their and their children's experience with us. For example, the parents of one young child who was subjected to harmful sexual behaviours told us:

> Post care for us was so minimal. The Department of Education just said, 'I'm so sorry [redacted] I can't believe that's happened, would you like a call from Learning Support?' … I never got an apology from the Department of Education I never got any acknowledgement, I just got the principal telling me [they were] sorry, and that they did the best they could and that they really couldn't tell anybody about it.[399]

Parents of another young child said:

> If this had [have] been dealt with a little bit more … a little bit more personally, a little bit more listening right from the beginning, well, we wouldn't be in this situation. We just have no trust left.[400]

We also heard from parents who told us that the only reason their child got support was because they 'yelled very loudly' and because of their connections. They said, 'if we didn't have those … connections it would have been swept under the carpet'.[401]

Parents of victim-survivors of harmful sexual behaviours often expressed empathy for the child or young person engaging in the behaviours, recognising its complex drivers and the vulnerability of all the children and young people involved. These parents told us:

> We believe the system failed both our child and the offending child as well as us as a family. The long-term damage that has occurred to our daughter and our families' wellbeing has been a direct result of the education department not following protocol or having protocols in situ.[402]

Ignatius Kim, Clinical Lead, Child and Adolescent Mental Health Service, described his experience helping a 15-year-old girl who was sexually abused by another student on school grounds. He told us that he attended a meeting of the young woman and her parents with the school:

> I came away just really angry myself about what this family was met with, the response that they were met with, which was quite officious, two senior members of the school staff, and my clear impression was that it was clearly planned and rehearsed with a view to managing the meeting, perhaps with a sort of view focused on the reputational aspects.[403]

Mr Kim said that the young woman commented after the meeting that she had just wanted the school to apologise. Mr Kim reflected:

> You know, I think, if an apology had been forthcoming and a really authentic, you know, really compassionate approach had been taken in that meeting, I do think it could have gone some way.[404]

He noted that the student did not feel protected and continued to have inadvertent contact with the older male student who assaulted her. She was eventually forced to change schools.[405]

7.2 Challenges for schools in preventing and responding to harmful sexual behaviours

We heard about several challenges for schools in preventing and responding to harmful sexual behaviours, including practical challenges of maintaining safety for victim-survivors and staff while providing support for students who have displayed harmful sexual behaviours, a lack of staff confidence, and challenges with accessing professional support.

7.2.1 Difficulties maintaining safety for students and supporting staff

Understandably, principals can be reluctant to exclude students from schools, or to isolate or stigmatise them, recognising the importance of education and social connection. But this can make it difficult to maintain the safety of victim-survivors or other students and it can contribute to victim-survivors feeling unsafe at school and disengaging from their studies.

Renae Pepper from the Sexual Assault Support Service told us that the challenge of keeping children safe may be particularly acute in rural schools, where it can be difficult to effectively separate students—for example, if there is only one class for each year level, or limited space, facilities and staff.[406] She said that sometimes victim-survivors at rural schools would have to attend school feeling unsafe or anxious, or would disengage from school.[407]

Poor responses to harmful sexual behaviours can also affect staff involved.[408] Mr Russell told us:

> The lack of support offered by the Department following this [harmful sexual behaviour] incident made it hard for me to trust that the classroom would be a safe place for me or my students. My health has suffered because of this lack of support. I have had to seek my own support, and this has affected my ability to teach.[409]

7.2.2 Lack of confidence in identifying and responding to harmful sexual behaviours

Teachers and principals are often not confident in identifying harmful sexual behaviours. Ms Pepper described how most queries about harmful sexual behaviours that the service receives are from educators who do not fully understand the difference between normal sexual development and inappropriate behaviour, and therefore do not know how to respond.[410] She said:

> The skills gap, in terms of lack of training on harmful sexual behaviours for teachers, principals and support staff, has a very real cost for the children or young people affected by harmful sexual behaviours.[411]

Sometimes this lack of training and understanding results in inaction despite multiple reports of inappropriate behaviour, with Ms Pepper providing a recent (2021) example of a teacher not escalating complaints:

> The disclosures all related to a single child within the class, who was alleged to have been inappropriately touching the complainants. The classroom teacher had dismissed the reports and told the children not to 'tell lies' or 'be unkind'. It was not until the reports from a number of children, made over this extended six to twelve month period, made their way to the principal that they were acknowledged and addressed.[412]

Lack of training can also contribute to harsh discipline. Ms Pepper cited, as an example of an extreme response, the case of an eight-year-old boy who was expelled from school for holding another student's hand and kissing them on the cheek.[413]

We heard that having good guidance on harmful sexual behaviours is critical and in the absence of such guidance, 'the role of teachers becomes even more complex'.[414] Professor Walsh acknowledged that teachers do not have to have the expertise to determine whether consent has occurred, but at a minimum they should understand the spectrum of typical sexual behaviours for a child's age and stage and be able to identify signs to suggest that support services may be necessary.[415]

Ms Pepper agreed, stating that without such guidance there are 'really inconsistent responses' from schools:[416]

> There needs to be clear policies and procedures within individual schools as schools vary in numbers, structure, layout and ability to safety plan and protect all students, and there needs to be clear policies and procedures more broadly across [the Department] around mandatory reporting, contacting [Sexual Assault Support Service] for consultation and how investigations are carried out in regard to incidents.[417]

Ms Pepper highlighted the need for training for all schools on harmful sexual behaviours including 'how to respond appropriately and be trauma-informed, focusing on students feeling safe and able to engage in their education'.[418]

Dale Tolliday, a clinical adviser working in this area, said that judgment and discretion are important in managing harmful sexual behaviours incidents:

> It does not require a specialist [therapeutic] response in all cases, rather there must be different layers of support where the appropriate persons are given the permission and confidence to respond.[419]

We discuss mandatory professional development in Section 5.

7.2.3 Role of professional support staff

We heard evidence about the role that social workers, in particular, play in supporting and upskilling school staff in responding to harmful sexual behaviours (and child sexual abuse more broadly). In an anonymous submission to our Inquiry, we were told that:

> School social work and psychology are often the main intervention used in [the Department of Education for harmful sexual behaviours], however both professions are woefully understaffed. Both the … Australian Association of Social Workers and the Australian Psychological Society recommend 1 full-time social worker and psychologist per 500 students. The ratio in Tasmania is currently 1 full-time worker per 1,200 students.[420]

Ms Carter highlighted the value of social workers and professional support staff, not only in providing direct support to students but also in upskilling staff:

> I mean, training in a one-off session is good, but having the people there actually supporting you through is the best sort of professional learning so that you become confident and you grow your understanding.[421]

She recommended a universal 'realistic' allocation of such staff to schools.[422]

Social worker Debra Drake acknowledged that she saw children displaying harmful sexual behaviours in schools, but 'given the high caseloads of school social workers, we do not have the capacity to provide appropriate counselling for harmful sexual behaviours'.[423] Ms Drake reflected that such support would ideally be offered by specialist services that are well trained, adequately funded and external to schools.[424] Mr Kim said that 'school psychologists and school social workers are often stretched across several schools in their work week, so their consistency of presence is lacking and I think we need more of them'.[425]

Secretary Bullard responded to calls for increased social workers and support staff by highlighting that 'there has already been a significant increase in social workers and psychologists into the system' since 2014, also pointing to the broader safeguarding responsibilities of teachers:[426]

> And not saying that every teacher is a skilled social worker, but every teacher understands the importance of child safeguarding, understands what our expectations are, knows how to deal with a report and where to refer it.[427]

The 2021–22 State Budget has allocated $3.8 million over four years from 2022–23 (and $1.68 million ongoing) to employ extra psychologists and social workers to directly support schools.[428] These professional support staff would be ideally placed to respond to inappropriate and problematic sexual behaviours if they are provided with more professional development, guidance and practice resources to build their capability to do so. However, best practice responses suggest a more intensive specialist therapeutic response is likely to be needed for persistent, abusive and violent harmful sexual behaviours, such as a referral to a specialist service like the Prevention, Assessment, Support and Treatment program, which we discuss further in the next section.

7.3 Processes to respond to harmful sexual behaviours in schools

Schools have access to some resources to support responses to harmful sexual behaviours, including specialist therapeutic supports provided externally and recent initiatives of the Department.

7.3.1 Programs and training on harmful sexual behaviours

Schools can make referrals to specialist programs for young people displaying harmful sexual behaviours and for those who have been harmed by the behaviours. They can also access training programs for school staff on identifying and responding to such conduct.

The Prevention, Assessment, Support and Treatment program, offered by the Sexual Assault Support Service, is directed at children and young people (aged 17 or younger) who have displayed harmful sexual behaviours. Secretary Bullard described the two streams of the program:

- therapeutic intervention, assessment and case management for children and young people using harmful sexual behaviours—schools, family members or agencies can refer young people to this program[429]
- a shorter training session of about three hours for school staff (teaching years 3 to 12) on how to identify and respond to harmful sexual behaviours called 'HSB: Overview for Educators'.[430] This is offered on a fee-for-service basis and schools generally contact the Sexual Assault Support Service directly for this training.[431]

The Prevention, Assessment, Support and Treatment program and our recommendation for increased specialist services are discussed in Chapter 21.

7.3.2 Departmental initiatives to improve responses to harmful sexual behaviours

Secretary Bullard described recent departmental initiatives to prevent and respond to harmful sexual behaviours in Tasmanian schools. These include:

- building the capacity of school social workers and psychologists to respond to children and young people who are victim-survivors of harmful sexual behaviours (and child sexual abuse)[432]
- the Department's Harmful Sexual Behaviours Working Group (in operation since 2020), which identifies the signs of, and improves responses to, harmful sexual behaviours and equips support staff to identify it and respond in trauma-informed ways[433]
- appointing extra staff to 'oversee the coordination, case management and follow up of the support provided to children and young people impacted'.[434]

Following up on these initiatives, Secretary Bullard told us in February 2023 that the Department had committed to employing four more full-time-equivalent senior support staff—two psychologists and two social workers—'to provide further support for children and young people affected by harmful sexual behaviours or child sexual abuse'.[435]

He told us that three of the four positions had been filled, with the remaining position being readvertised in early 2023.[436] The Department has also filled two more Student Support Response Coordinator positions to manage 'responses to incidents of child sexual abuse and harmful sexual behaviour, ensuring that the best interests of children and young people are the central consideration'.[437]

We see the opportunity for these positions to form a specialist Harmful Sexual Behaviours Support Unit to help schools (and other government institutions) correctly identify harmful sexual behaviours, respond locally to inappropriate and problematic behaviour and support a critical incident response to persistent, abusive or violent harmful sexual behaviours. We recommend a Harmful Sexual Behaviours Support Unit for education, out of home care and youth justice settings in Chapter 9 (Recommendation 9.28).

7.3.3 Steps in response to allegations of harmful sexual behaviours

Principals and 'site leaders' are guided by a departmental flowchart entitled *Responding to Incidents, Disclosures or Suspicions of Harmful Sexual Behaviour Initiated by a Child or Young Person* when responding to disclosures or concerns about harmful sexual behaviours. The Department's Harmful Sexual Behaviours Working Group informed the updated version of this document.[438]

According to this flowchart, principals must collect information about the alleged behaviour and then 'immediately' consult a student support leader, senior professional support staff, a school social worker or a psychologist to assess the situation.[439] The reference for this assessment is Hackett's continuum of harmful sexual behaviours, which 'is based on a continuum model to demonstrate the range of sexual behaviours presented by children and young people, from those that are normal, to those that are highly deviant'.[440] Secretary Bullard explained:

> The context of the behaviour is then considered as part of the overall assessment (that is; do any of the students have a disability, what is the frequency of the behaviours, is there coercion, a difference of ages, etc.?).[441]

The flowchart divides behaviours into only two categories—'harmful or problematic' or 'developmentally appropriate'—and directs a different response for each category.

On our reading of the flowchart, we understand that if the behaviour is assessed as constituting harmful or problematic sexual behaviours, the student support leader and senior professional support staff must:

- notify the Strong Families, Safe Kids Advice and Referral Line and police, and meet with parents/carers to 'inform, reassure and include in the response'
- form a care team and develop a risk assessment, safety plan and referrals for therapeutic support

- develop a 'community response/containment strategy' (where appropriate)
- store all documentation in the Student Support System.[442]

If, on the other hand, the behaviour is assessed as developmentally appropriate, the flowchart outlines the principal must notify parents/carers, provide support and 'educate regarding the nature of the incident' and 'update and consult' with relevant staff.[443] The school social worker or psychologist is to assess the needs of student(s) and provide support.[444] The principal must also ensure relevant documentation is stored in the Student Support System and turn their mind to how they can build understanding of consent and child sexual abuse prevention in their school.[445]

When considering the extent to which principals can apply discretion and depart from these requirements, Secretary Bullard was clear in stating:

> … all school principals have a mandated responsibility to follow all departmental policies and procedures, including those related to harmful sexual behaviours, and for ensuring staff are aware of and follow all relevant policies and procedures.[446]

Concerns about the flowchart

While we understand the desire for a simplified flowchart to guide principals' responses, we are concerned that reducing harmful sexual behaviours to an 'either/or' oversimplifies the issue and may give rise to inappropriate responses. The spectrum of behaviours described on Hackett's continuum requires a range of more nuanced responses than described in the flowchart. For instance, sexual behaviours that are assessed to be inappropriate or problematic on Hackett's continuum may not require statutory or specialist treatment responses, but will still require some form of local school response. We consider the guidance for developmentally appropriate behaviours to be more consistent with what would be expected for locally managed inappropriate or concerning sexual behaviours. We are concerned that the guidance in the flowchart for developmentally appropriate behaviours is not a proportionate or appropriate response to healthy sexual development. We are not clear as to why parents would be notified or records created for developmentally appropriate behaviours. As we outline below, the Department needs a more tailored response to the children and families involved, rather than an 'either/or' approach.

Also, any care plan and risk assessment should not be viewed as static. In any safety planning, the least intrusive actions necessary to secure the safety of all children and young people involved should be implemented. The plan should also recognise that risk is likely to change—for example, in response to effective treatment. Finally, we note that, where required, arrangements should be made for any background information, risk assessment and care plan to follow a child or young person (or children or young people) if they change schools in the aftermath of a harmful sexual behaviours incident, as is often the case.

While the flowchart covers the basics of an appropriate response, the policy should ensure attention is given to the child displaying the behaviours and any child (or children) and young people who were harmed by or witness to those behaviours, and their families. The flowchart also needs to be clearer about who takes particular actions. In Section 7.5, we recommend improved guidance on responding to harmful sexual behaviours. This guidance should align with and be complemented by the holistic across government approach to harmful sexual behaviours we recommend throughout our report, and which we summarise in relation to schools in Section 7.4.

7.4 A holistic approach to preventing, identifying and responding to harmful sexual behaviours

Given the challenges and complexities in balancing the needs of all children affected when a child displays harmful sexual behaviours, a holistic whole of government, whole of Department approach is needed. We have made recommendations across our report that will help improve the prevention and identification of, and responses to, harmful sexual behaviours in Tasmanian government schools:

- The Tasmanian Government should develop a statewide framework and plan for preventing, identifying and responding to harmful sexual behaviours that provides a common understanding of harmful sexual behaviours and high-level guidance on how to respond, and clearly articulates the roles and responsibilities of different government and government funded agencies in the response (refer to Chapter 21, Recommendation 21.8).
- The Department for Education, Children and Young People should establish a Harmful Sexual Behaviours Support Unit to support all child-facing areas of the Department (refer to Chapter 9, Recommendation 9.28). The role of the Unit would be to provide advice, support and guidance to local areas to facilitate consistent, best practice, proportionate approaches to responding to harmful sexual behaviours that balances the needs of victim-survivors, children who have displayed harmful sexual behaviours and other affected parties. The Unit would also lead harmful sexual behaviours policy development and build on the new positions already devoted to supporting responses to harmful sexual behaviours in schools, which were outlined above.
- The Tasmanian Government should fund and appropriately resource sexual assault and abuse therapeutic services, including for harmful sexual behaviours (refer to Chapter 21, Recommendations 21.1, 21.4 and 21.6).
- All teachers should have minimum mandatory education in child sexual abuse, grooming and harmful sexual behaviours (refer to Section 5 of this chapter, Recommendation 6.5). Our intent is that minimum mandatory education will assist teachers to develop a minimum level of knowledge and awareness of what are harmful sexual behaviours and how they should respond.

- There should be advanced professional education on responding to harmful sexual behaviours made available to employees who directly respond to harmful sexual behaviours. This would include principals, school social workers, school psychologists, child safety officers, youth workers and residential carers. This could be developed and provided by the Harmful Sexual Behaviours Support Unit or outsourced to specialist providers (refer to Chapter 9, Recommendation 9.28).
- There should be mandatory child sexual abuse prevention curriculum for students from early learning programs to year 12. We consider this education to be an important element in preventing harmful sexual behaviours (refer to Recommendation 6.1).

We also recommend detailed education-specific policies, protocols and guidance for principals and site leaders in identifying and responding to harmful sexual behaviours, which we discuss in Section 7.5.

7.5 Clear, specialised advice and support for schools responding to harmful sexual behaviours

While we consider that the revised flowchart for harmful sexual behaviours is an improvement on previous guidance, we consider it should be refined to allow for a more nuanced approach and underpinned by more comprehensive guidance that can explain in more detail how it should be applied. This includes greater guidance on:

- the recommended Harmful Sexual Behaviours Support Unit, how and when to access the Unit and its role in supporting school responses
- correctly identifying and distinguishing developmentally appropriate, inappropriate and harmful sexual behaviours
- proportionate local responses to inappropriate and problematic sexual behaviours
- how the needs of children displaying harmful sexual behaviours, victim-survivors of harmful sexual behaviours and other children and young people can be addressed through safety assessment and school participation planning (including describing key considerations and possible features of a safety and school participation plan, balancing the safety of all children with the school participation needs of the child displaying harmful sexual behaviours)
- supports and guidance that can be offered to victim-survivors of harmful sexual behaviours, their family and other affected parties (such as teachers or other students) including what departmental and external supports are available
- strategies to ensure appropriate supervision, support and referrals/reports occur in response to a child displaying harmful sexual behaviours

- what information should be recorded and the circumstances in which it should be shared with external authorities, affected parties and other schools
- guidance about communicating with families, other children and affected parties—this includes supports such as template letters (similar to the approach to allegations of child sexual abuse by adults discussed in Section 6.5 of this chapter)
- review processes for safety and participation plans, recognising that risk is not static.

We consider this guidance should become part of core school procedures and be used by principals and site leaders in conjunction with advice, support and guidance from the Harmful Sexual Behaviours Support Unit. A public version of the policy should be easily accessible to the public on the Department's website with an appropriate level of detail to help parents/carers and the broader community understand the steps that will be taken in response to incidents, to help drive accountability, and to overcome the information vacuum that exacerbates distress and gives the impression (rightly or wrongly) that no action has been taken. Being able to point to more detailed guidance can also satisfy an understandable desire from the school community for information, without compromising aspects of an incident response that need to be managed privately for the young people involved.

Guidance should direct staff on when and how to seek support from the new Harmful Sexual Behaviours Support Unit for help identifying and responding to harmful sexual behaviours in schools. The Harmful Sexual Behaviours Support Unit may provide guidance on how the students involved can be safely supported in the school, recommend involving professional support staff in schools to assist, or provide more intensive support where a child has displayed persistent, abusive and/or violent harmful sexual behaviours.

Recommendation 6.9

The Department for Education, Children and Young People should develop detailed education-specific policies, protocols and guidelines for preventing, identifying and responding to harmful sexual behaviours in schools. The development of these policies, protocols and guidelines should be:

a. led and informed by the Harmful Sexual Behaviours Support Unit (Recommendation 9.28)

b. informed by the Tasmanian Government's statewide framework and plan to address harmful sexual behaviours (Recommendation 21.8).

8 Teacher registration

In her second reading speech for the Teachers Registration Bill 2000, the then Minister for Education said:

> Parents of students are entitled to a guarantee that their children are being taught by fully and appropriately qualified teachers who will not abuse their position of trust with students. This guarantee can be best achieved by having a fully and properly regulated teaching profession.[447]

The National Royal Commission recognised that teacher registration is a key mechanism through which Australian states and territories can ensure teachers meet minimum professional standards, including suitability to work with children. The National Royal Commission observed that, common to all Australian jurisdictions, teachers must:

- satisfy requirements related to professional learning and qualifications
- be able to meet the Australian Professional Standards for Teachers, including Standard 4 that requires teachers to 'maintain student safety'[448]
- pass criminal history checks and/or have current authorisation to work with vulnerable people
- observe any code of conduct concerning 'professional and ethical standards'.[449]

In Tasmania, the Teachers Registration Board plays an important role in protecting students from abuse by teachers. It does this by vetting the applications of new teachers for teacher registration, as well as the applications of continuing teachers seeking renewal of their registration, which is required every five years. The Board has the power to refuse, suspend or cancel the registration of a teacher if they (in the Teachers Registration Board's opinion) are not of good character or are not fit to teach. The Board's authority to permit or bar a person from teaching is an essential part of child safeguarding in the education system.

The Department also requires that all departmental employees, whether or not they have direct contact with children, hold Registration to Work with Vulnerable People.[450] This registration is a prerequisite to registration as a teacher. Non-teaching staff working in educational settings—for example, administrators, contractors, sports coaches, parent volunteers and maintenance staff—must also hold Registration to Work with Vulnerable People.[451]

As we discuss in Section 8.2, we heard that the teacher registration framework is not operating as well as it could, particularly for protecting children in schools.

In her second reading speech for the Teachers Registration Bill 2000, the then Minister for Education stated that the 'introduction of the legislation will protect children in government and non-government schools from the possibility of sexual or other abuse'.[452] Yet the

Teachers Registration Act (which, among other things establishes the Teachers Registration Board), does not contain any provisions specifically requiring the Board to prevent, identify or report on child sexual abuse in schools, although it includes a good character requirement. Rather, the Act's provisions relate to teacher registration, good character and fitness to teach, and regulate how the Board should respond to complaints about teacher conduct, including about child sexual abuse.[453]

In this section, we provide an overview of the role and powers of the Teachers Registration Board. We then consider the shortcomings in the Board's operation and how these shortcomings might best be overcome.

8.1 The role of the Teachers Registration Board

All Australian states and territories require teachers to be registered (or accredited) by a statutory board or authority that is 'responsible for ensuring that registered persons have the appropriate professional qualifications and personal qualities to teach'.[454] In Tasmania, the Teachers Registration Board undertakes these functions, registering teachers to work in government, Catholic and independent schools.[455]

The Teachers Registration Board is an independent statutory authority established under the Teachers Registration Act. The Board consists of several people appointed by the Minister: a chairperson, practising teachers from schools across the independent, Catholic and government education sectors, a nominee of the University of Tasmania's Faculty of Education, a nominee of the Department, and a parent or guardian of a student attending a Tasmanian school.[456]

The Board regulates the teaching profession for the wellbeing and best interests of Tasmanian students.[457] One of its key functions is to register appropriately qualified teachers who 'have been determined to be of good character, competent, and fit to teach in Tasmanian schools'.[458]

The Board's other functions include:

- conducting investigations, inquiries and hearings to determine whether there have been breaches of the Act[459]
- taking disciplinary action, including placing conditions on, or suspending or cancelling, a teacher's registration[460]
- maintaining a code of ethics for the teaching profession.[461]

In performing its functions and in any action taken by the Board, the Board must 'consider the welfare and best interests of students to be of paramount importance'.[462]

While the Board has a much broader role than identifying, preventing or responding to child sexual abuse, the requirements of registration, along with other powers granted to the Board under the Act, mean that much of its work is 'aimed at preventing potential abusers from becoming registered as teachers'.[463]

All teachers who intend to work in a Tasmanian school or college must be a registered teacher or be granted a 'Limited Authority to Teach' by the Board.[464] A Limited Authority to Teach is designed to allow a person with specialist knowledge or skills, who is not a registered teacher, to teach in circumstances where there are no registered teachers with the requisite knowledge or skills available to fill the role.[465] It is an offence under the Act to teach without being registered or holding a Limited Authority to Teach.[466]

In determining if an applicant is of good character, the Board considers whether:

- the person has been charged with or convicted of an offence[467]
- the person holds a Registration to Work with Vulnerable People, including whether the person's Registration to Work with Vulnerable People status has ever been suspended or cancelled[468]
- the person has engaged in conduct that does not satisfy the standard generally expected of a teacher or is 'otherwise disgraceful or improper'[469]
- there are other matters the Board considers relevant such as 'employment and registration history and any previous and/or current disciplinary proceedings'.[470]

In determining whether an applicant is fit to teach, the Board may consider a person's medical or psychological conditions, their competence as a teacher and any other relevant matter.[471] The 'good character' assessment is most relevant to allegations of child sexual abuse and related concerns.

The Board requires applicants for registration to make declarations as to their character and fitness to teach and to authorise the Board to conduct a National Police Check.[472] The Board is also authorised to obtain information from a corresponding registration authority from interstate, a government department or a relevant body, and request that the applicant undergo psychiatric and/or psychological examination.[473] Registration is for up to five years, after which time a person must apply to have their registration renewed.[474]

The Board produces the resource *Professional Boundaries: Guidelines for Tasmanian Teachers* to educate applicants for registration, as well as registered teachers, about maintaining appropriate boundaries with students. The guidelines state that:

> For teachers, engaging in sexualised or romantic/sexual relationships with any student, regardless of their age, is completely inappropriate, and—depending on the age of the student—may also be a crime. It will result in disciplinary action.[475]

Teachers are advised that sexualised, romantic or sexual relationships with former students 'may breach teacher-student professional boundaries', including a 'relationship that commences within **two years** of the student completing compulsory education or turning 18 (whichever is later)' [original emphasis].[476] We discuss sexual abuse by a person in a position of authority in Chapter 16. The guidelines also define grooming and explain how to identify grooming behaviours.[477] Breaching the guidelines may result in a finding of 'misconduct, serious misconduct, and a lack of suitability/fitness to teach'.[478] Depending on the circumstances, a breach of the guidelines may also result in criminal charges.[479] The guidelines are provided to all applicants for teacher registration, who must declare on their application they have read and understood them. The guidelines are also given to all employers of teachers.[480]

Other provisions in the Teachers Registration Act regulate professional conduct and empower the Board to take action against a teacher for unprofessional conduct including sexual abuse:

- Section 18 requires registered teachers (or holders of a Limited Authority to Teach) to notify the Board if they are charged with or found guilty of a prescribed offence.[481] Prescribed offences include offences committed in Tasmania for which a sentence of imprisonment may be imposed, or an offence committed elsewhere if a sentence of imprisonment may have been imposed had the offence been committed in Tasmania.[482] The Board must notify employers and other registration authorities as soon as reasonably practicable after becoming aware that a registered teacher has been charged with or found guilty of a prescribed offence.[483] This would include a sexual offence.
- Section 19 provides that a person can complain to the Board *in writing* about the professional conduct or competence of a registered teacher (or a holder of a Limited Authority to Teach).[484] As soon as practicable after receiving a complaint, the Board must provide 'notice of the making of the complaint, the name of the complainant and the contents of the complaint' to the person who is the subject of the complaint and to the employers of that person.[485]
- Section 6A authorises the Board to investigate a complaint made under the Act.[486] When investigating the complaint, the Board will conduct a risk assessment for the alleged conduct and prepare a report for the relevant committee of the Board, which will determine an outcome.[487] In a 'high-risk situation'—for example, where the complaint alleges child sexual abuse—the investigation is expedited.[488] The Board may also recommend prosecution for offences committed against the Act, although the Registrar of the Teachers Registration Board, Ann Moxham, told us that, to the best of her knowledge, this has never happened.[489]

- Section 20 provides that the Board may inquire into any matter relating to a registered teacher (or holder of a Limited Authority to Teach), or someone who was formerly a registered teacher (or holder of a Limited Authority to Teach), including for disciplinary actions taken by an employer against a registered teacher.[490] Having completed an inquiry, the Board may impose conditions on the person's registration, suspend, revoke or cancel the person's registration, or determine that the complaint or disciplinary action is without substance.[491]
- Section 17BA, which was inserted into the Act in 2020, allows the Board to suspend or cancel a person's registration without an inquiry, if the person's Registration to Work with Vulnerable People has been suspended or revoked.[492]
- Section 24B covers 'emergency' situations and allows the Board to suspend a teacher's registration if it believes on reasonable grounds that the person may pose a risk to a student.[493] Ms Moxham told us that emergency suspensions are used when 'risk of harm to a student materialises and the [Board] is required to act expeditiously'.[494] Decisions about an 'emergency suspension [are] undertaken by reference to a risk assessment matrix procedure'.[495] Following an emergency suspension, the Board must ensure an inquiry is held as soon as possible.[496]
- Section 32A permits for the Board to share information with other relevant entities, including corresponding registration authorities in other jurisdictions, police, child protection authorities in Tasmania, and other state and national bodies such as the Australian Institute for Teaching and School Leadership.[497]

The Board can also impose conditions on a person's registration without an inquiry or investigation if it considers this to be warranted.[498] Conditions include that a teacher undertakes professional development, accesses coaching and/or mentoring, or that the teacher be monitored in-school and an assessment of their conduct provided to the Board.[499]

In 2020, there were 31 people whose registration was subject to conditions. Of these, 26 per cent had met the conditions imposed and 48 per cent were still being monitored. The other 26 per cent had their registration lapse or expire.[500]

Conditions placed on a teacher's registration are included in an online database established by the Board called Watched Registrations. This database is not publicly accessible but gives teachers' employers direct access to the Tasmanian Register of Teachers.[501] If a teacher's registration is subject to conditions, this is indicated by two asterisks against that teacher's name. However, the details of the conditions are not included in the database. School principals are advised to contact the Board's Professional Conduct Team to find out the specific nature of any conditions on a teacher's registration if the teacher appears on the Watched Registrations list.[502] The onus is on individual schools to update the list of teachers they employ on the database.[503]

8.2 Strengthening the Board's safeguarding measures

Through public hearings, witness statements, submissions and engagement with the community, as well as through information provided to us by the Department, we have identified problems with the teacher registration system. These problems undermine the Board's capacity to act in the best interests of Tasmanian students.

We heard that, as a result of advice provided by the Office of the Solicitor-General, the Department's approach to sharing information with the Teachers Registration Board about a teacher's conduct is restrictive and undermines the Board's ability to quickly assess whether a teacher should remain registered. We understand that the Government is considering solutions that will 'make it easier to share information about risks to children, including looking at whether issues of custom, practice and culture are creating unnecessary barriers'.[504] We support an approach that facilitates rather than restricts information sharing about risks to children and suggest that any changes in this regard include independent regulators such as the Teachers Registration Board. Information sharing must be supported by legislation in a way that prioritises the safety of children over privacy concerns.

We also heard that the Teachers Registration Act does not equip the Board to keep track of where teachers are employed, making it difficult for the Board to monitor teachers' conduct where concerns have been raised about the safety of children.

As reported by the National Royal Commission, a number of risks to children arise when information about child sexual abuse perpetrated by teachers (or others in educational settings) is not shared 'by and with schools (or other employers of teachers) and state and territory teacher registration authorities'.[505] A lack of information exchange can allow teachers who are or have been the subject of conduct complaints 'to move between schools, systems and jurisdictions' without conduct issues being identified or addressed.[506] We heard of situations where teachers in Tasmania, including some teachers from interstate, have continued to be registered and to teach despite concerns about their conduct at other schools.

In keeping with the National Royal Commission's finding that 'improved and consistent information on teacher registers should be considered' for inclusion on registers, we recommend that a teacher's place of employment be included on the Register of Teachers.[507]

We also heard:

- It is difficult for the Teachers Registration Board to enforce the provisions of the Teachers Registration Act, even in instances where it is aware that an unregistered teacher is teaching in a Tasmanian school.

- Changes to Commonwealth laws will mean that teachers from other jurisdictions are automatically recognised as being registered to teach in Tasmania, and this poses risks to child safety.
- The Board is not authorised to mandate training and ongoing professional development as a prerequisite to teacher registration.
- Insufficient resourcing has undermined the Board's capacity to fulfil its statutory obligations relevant to ensuring teachers comply with professional standards.

We make recommendations that address each of these issues in the following sections.

8.2.1 Information sharing

Information sharing between institutions with responsibilities for children's safety and wellbeing, and between those institutions and relevant professionals, is necessary to identify, prevent and respond to incidents and risks of child sexual abuse.[508]

The Teachers Registration Act governs what information the Board can and must share, and with whom and under what circumstances it is to be shared.

Information on the Register of Teachers that can be made publicly available is governed by section 25 of the Act, as set out in Appendix F. This information can be accessed via a search facility on the Board's website.[509] While any person can request certain information on the Register, the Act prohibits public access to information about a teacher's registration conditions or whether a registration has been previously suspended.[510] If the request for information comes from a 'teacher employing authority' (the Department, Catholic Education, the governing body of a registered school or TasTAFE), the Board may provide particulars of any conditions or suspension. The Act does not allow other information about a teacher's conduct to be released unless the teacher (or holder of a Limited Authority to Teach) gives their consent.

The Board can also share information about registered teachers, or someone who has applied to be registered, with other teacher registration authorities. This can include any information the Board comes across in performing its functions or exercising its powers in relation to registered teachers or a person who has applied to be registered.[511]

While the provisions of the Teachers Registration Act restrict what information the Board can share, Ms Moxham told us that to share information 'to prevent, identify, report on, and respond to child sexual abuse (as well as other potential and actual harms against students) in relation to teachers', the Board relies on the notification provisions in the Teachers Registration Act that allow the Board to 'do anything necessary or convenient to perform its functions'.[512]

Under the Teachers Registration Act, the Board can access police reports when considering an application for registration or renewal of registration.[513] Ms Moxham told us that, generally, police respond to these requests promptly.[514] But we were also told that in terms of criminal history checks, it would be more efficient if the Board could 'sync the entire register with Tasmania Police overnight so that information, including charges, is known in real-time'.[515] Also, the Board has no way of knowing when a registered teacher is currently charged with an offence.[516] While the Act requires that a person must notify the Board if they are charged with a prescribed offence, Ms Moxham told us is it is 'uncommon for people to provide these notifications'.[517]

Ms Moxham informed us that the Board has generally found it difficult to 'obtain primary evidence held by other agencies, bodies and employers in relation to people it regulates'.[518] This, we were told, has affected the Board's ability to conduct its own investigations with efficiency and can result in the Board not conducting investigations in a trauma-informed way.[519] Ms Moxham said that the way the Department provides information to the Board about professional conduct matters is 'patchy' and sometimes depends on who in the Department is in communication with the Board.[520]

While the Board will receive information from the Department about an allegation involving a teacher and the final decision about that allegation, it will not receive information collected during the investigation.[521] This makes it more difficult for the Board to determine if a teacher is of good character.

Ms Moxham told us that she understood limits on information sharing were due to advice from the Office of the Solicitor-General that the Department cannot disclose information collected in its investigations to a third party.[522] We understand this advice is based on an interpretation of the *Personal Information Protection Act 2004* ('Personal Information Protection Act'), which we discuss in Chapter 19. This problem exists to varying degrees across education sectors in Tasmania, with some sectors recently changing their practices at the risk of breaching their privacy obligations.[523]

Ms Moxham noted three key reasons for sharing investigative information with the Board. First, children and young people should not be subjected to multiple interviews because this has the potential to cause or exacerbate trauma. Emily Sanders, Director, Regulation, Victorian Commission for Children and Young People, noted in her evidence:

> Reducing the number of times a child or young person is asked to give their account helps to minimise the risk of exacerbating trauma through an interview. We suggest organisations check if they can gain access to an interview conducted by other investigative agencies … to reduce multiple interviews.[524]

Second, the Board has limited resources, and using those resources to conduct investigations into matters already investigated is inefficient. Third, a significant amount of time may pass before the Board can investigate a matter (because the Department's disciplinary process may take a long time), and this may affect the quality of the evidence

it can get.[525] We would add that delays in resolving a matter can also exacerbate a complainant's trauma.[526]

Secretary Bullard commented on aspects of Ms Moxham's characterisation of the Department providing information and the impact on Board investigations. He told us that the Department provides 'as much information as [it is] legally able' to the Board:[527]

> The Investigation Report into an [Employment Direction No. 5—Breach of Code of Conduct] matter is not routinely provided … [to entities including the Teachers Registration Board]. This is on the basis of legal advice from the Office of the Solicitor General, that in the absence of consent, the provisions of the Personal Information Protection Act (PIP Act) prevent the Department from disclosing the [Employment Direction No. 5] report.[528]

Secretary Bullard also said that while he understood Ms Moxham's evidence to be that the Board will wait to receive a 'full investigation file' before starting its investigative processes, he 'wanted to be very clear' that when a matter of concern is raised, the Registrar could start investigating straightaway.[529] He also asserted there was nothing preventing the Board from conducting its own investigations into matters before receiving any information from the Department.[530] We note, however, that conducting parallel investigations into the same matter is not only a waste of resources, it may also cause further trauma to victim-survivors. Secretary Bullard ultimately agreed that it was 'nonsensical' for the Board to have to expend resources investigating a matter that has (or is being) investigated by the Department:[531]

> It does seem that we end up duplicating investigations in terms of, we undertake a process, I end up with a [large] file … it would be expedient to be able to provide that through to the Teachers Registration Board in full.[532]

We also heard of problems with the Board sharing information with the Department, particularly about relief teachers 'who have had employment conditions imposed upon them'.[533] This means that the Department may not know when allegations of unprofessional conduct have been made against relief teachers who are teaching in Tasmanian schools.[534] Ms Moxham told us that the Board responds to all requests for information from the Department of Justice under section 52A of the *Registration to Work with Vulnerable People Act 2013* ('Registration to Work with Vulnerable People Act') for information about registered teachers.[535] Similar information sharing should occur with the Department.

Secretary Bullard was asked in hearings whether he would support removing any barriers to the flow of information between various regulators. He replied that he would be 'very supportive' of this.[536] Jenny Gale, Secretary, Department of Premier and Cabinet, informed us that her Department was working on a legislative reform as part of the Keeping Children Safer Actions that will enable certain information to be shared between the Department for Education, Children and Young People and entities such as the Teachers Registration Board.[537]

Ms Sanders provided evidence about how information sharing is facilitated in Victoria, with a view to avoiding the duplication of investigations. Under Victoria's Reportable Conduct Scheme, 'co-regulators' can be requested to conduct reportable conduct investigations while investigating for another purpose, such as disciplinary purposes.[538] In the Tasmanian context, this would operate, for example, to allow the Department or the Teachers Registration Board to investigate for the purposes of both an Employment Direction No. 5—Breach of Code of Conduct matter and an assessment of fitness to teach.

Ms Sanders noted that while different regulators may assess matters based on different criteria, in Victoria, the fact that there has not been a 'substantiated finding under the [Reportable Conduct] Scheme' by one co-regulator does not preclude another co-regulator, for example the Victorian Institute of Teaching (the Victorian equivalent of the Tasmanian Teachers Registration Board), from finding that professional conduct standards have been breached. Ms Sanders told us that if information sharing occurs properly, 'the co-regulators in a particular matter should all have access to the relevant information held by others that they need for their role'.[539]

In terms of information sharing across jurisdictions, the Teachers Registration Act specifies that the Board can provide limited information to corresponding teacher registration authorities.[540] The Board may also seek information from a corresponding authority about a registered teacher, on the proviso that written authorisation is provided by the teacher concerned.[541]

Secretary Bullard's view of information sharing across jurisdictions was that a 'coordinated response at the Commonwealth level to information sharing between state and territory education agencies would be useful'.[542] He noted that:

> A scoping project on national information sharing as it relates to teacher registrations is currently underway. It is being led by NSW with the involvement of all state and territory education departments, as well as all teacher registration authorities. The scope includes provision of advice on risks associated with the introduction of Automatic Mutual Recognition (AMR) for teachers.[543]

Automatic mutual recognition is discussed in Section 8.2.5.

The situation in Tasmania for sharing information between the Board and the Department—in particular, information gathered by the Department during its investigations into misconduct involving allegations or suspicions of child sexual abuse—is unsatisfactory. The situation does not prioritise the safety of children, nor meet the needs of victim-survivors.[544] The reluctance to share information between government entities, even when there would be clear benefits to children to do so, appears to be the product of an excessively risk-averse culture in the State Service, possibly influenced by narrow legal advice. Also, the focus is on the wrong risk—that of breaching a person's privacy, and not of exposing children to potential harm. As expressed by Secretary Gale, it 'almost beggars belief that people guard information as if they own it and that that would [potentially put] young children at risk'.[545]

There appears to be a clear desire on behalf of the Tasmanian Government to overcome actual and perceived barriers to sharing information about child sexual abuse in order to protect children. To help remedy the current situation, the Department of Premier and Cabinet is planning reforms for government-wide information sharing in the form of 'overarching legislation that would be superior to … all other … legislation in relation to that information'.[546] This issue is discussed in Chapters 18 and 19.

Presumably, the reforms noted by Secretary Gale will also affect how the Department shares information with entities such as the Teachers Registration Board and the Registration to Work with Vulnerable People Scheme. However, in the absence of more detail about the reforms, and irrespective of any changes to the privacy legislative framework, we recommend short- and long-term solutions to restrictions on sharing information between the Department and the Board.

There is a relatively straightforward interim solution to this issue: the Department can seek an exemption under the Personal Information Protection Act, thereby allowing it to share information about investigations into employees suspected of child sexual abuse with the Board.

Section 13 of the Personal Information Protection Act allows a 'personal information custodian' to apply for exemptions 'from compliance with any or all provisions' of the Act.[547] In determining whether or not to approve an application for an exemption, the Minister must be satisfied that 'the public benefit outweighs to a substantial degree the public benefit from compliance with the personal information protection principles'.[548] In our view, providing information to the Board in these circumstances would nearly always satisfy this requirement. We note that in a later hearing Secretary Bullard informed us there is 'work under way' towards applying for an exemption from the Act.[549]

While the longer-term measures in Recommendation 6.10 are being implemented, the Department should seek a section 13 exemption from the Personal Information Protection Act.

In the longer term, the Government should amend the Teachers Registration Act to support information sharing. An amended Act should empower the Teachers Registration Board to compel other entities to provide relevant information to the Board, including information gathered by the Department as part of an investigation into alleged misconduct by a teacher, in circumstances where child sexual abuse of a student by a registered teacher or holder of a Limited Authority to Teach is alleged or suspected. Providing such information will allow the Board to conduct investigations more efficiently, thereby reducing potential trauma to witnesses.

Part 6A of the Registration to Work with Vulnerable People Act, which allows the Registrar under that Act to compel information or documents, provides a useful model for amendments to the Teachers Registration Act.[550] We note that the Personal

Information Protection Act would not pose a barrier to sharing such information because if a provision of the Personal Information Protection Act is inconsistent with a provision in another Act, the other Act will prevail.[551] Also, the Personal Protection Principles in Schedule 1 of the Personal Information Protection Act allow personal information to be revealed if disclosure is required or authorised by another law.[552] This approach will help create consistency in the ability of independent regulators to request information relevant to child sexual abuse while limiting the personal information shared in these circumstances to that which is requested.

While allowing the Teachers Registration Board to compel information from other government entities will help improve the Board's investigative processes, the Board may still not know when to request that an entity provides such information. In other words, the Board may not be aware of child sexual abuse allegations or suspicions against a teacher. We understand the Department's policy is to notify the Board within 24 hours of receiving information about allegations of child sexual abuse by a teacher.[553] Secretary Bullard told us that the Department also notifies the Board when it starts a formal investigation into misconduct by a teacher under Employment Direction No. 5—Breach of Code of Conduct.[554]

We consider, however, that such notifications, which are vital to helping the Board safeguard children, should be legal requirements. Also, these notification requirements should apply to other entities that may have information about allegations or suspicions of child sexual abuse by a teacher. For example, other employers of teachers (such as non-government schools) the Registrar of the Registration to Work with Vulnerable People Scheme, police and the Child Safety Service should all be subject to a mandatory requirement to notify the Board. Equally, the Board should be allowed to share information relevant to matters involving alleged or suspected child sexual abuse by a teacher, with all relevant entities. We note that under the new *Child and Youth Safe Organisation Act 2023*, entities will be able to share information relevant to the Child and Youth Safe Standards and the Reportable Conduct Scheme.[555]

To facilitate more efficient information sharing and use of resources, and to reduce the possibility of investigations into child sexual abuse matters being duplicated, any investigation of allegations or suspicions of child sexual abuse by a teacher that the Department (or the Board) seeks to undertake should be done jointly, taking into account the relevant criteria of the Department and the Board.

Recommendation 6.10

The Tasmanian Government should introduce legislation to:

a. allow the Teachers Registration Board to compel relevant entities—including the Department for Education, Children and Young People, other employers of teachers, the Registrar of the Registration to Work with Vulnerable People Scheme, police, and Child Safety Services—to give the Board information or documentation that is relevant to child sexual abuse matters involving a registered teacher or a holder of a Limited Authority to Teach

b. compel these relevant entities to notify the Teachers Registration Board when they become aware of allegations or suspicions of child sexual abuse by a teacher. Such entities should also be required to notify the Board if they begin any formal investigation that involves allegations or suspicions of child sexual abuse by a teacher or a holder of a Limited Authority to Teach, and the outcome of any investigation

c. allow entities, when investigating matters involving child sexual abuse by a registered teacher or holder of a Limited Authority to Teach, to jointly appoint investigators to investigate the matter, taking into account the different criteria required for investigations by the Department and the Board.

8.2.2 Keeping track of where teachers are working

Ms Moxham told us that the Teachers Registration Board 'does not have reliable information about where a teacher is employed' because a teacher's registration is not associated with a particular school, and under the Teachers Registration Act, there is no provision requiring that a teacher's location of employment be disclosed.[556] Also, a teacher does not have to inform the Board when they change their place of employment, although they must let the Board know about a change of residential address.[557] As Ms Moxham noted:

> Teachers are not required under the Act to update us whenever they change schools, only if they change address and they don't even always do that, and there's some limitations with our Act about actually pursuing them over those matters.[558]

As discussed in Section 8.1, the Watched Registrations list helps the Board keep track of teachers with conditions on their registration.[559] But this relies on individual schools to maintain updates. Ms Moxham noted that even if schools update their lists, the whereabouts of relief teachers may remain unknown to the Board because these teachers 'commonly do not appear on Watched Registration lists'.[560] Ms Moxham told us that 'it's almost impossible' for the Board to know where a relief teacher is employed on any given day.[561]

The National Royal Commission found that:

> … including employers' details [on teacher registers] may enable registration authorities to notify them of circumstances related to allegations or incidents of child sexual abuse by a teacher employee.[562]

Including such details may be particularly useful where teachers work at more than one school or in more than one school system.[563]

Most Australian jurisdictions require details about a teacher's place of employment to be recorded on the Register of Teachers or notified to the relevant teacher registration authority. Most jurisdictions also require that the relevant teacher registration authority be notified when a teacher's place of employment changes. In some Australian jurisdictions, there are penalties for failing to notify the relevant teacher registration authority of a change to place of employment. Tasmania is the only state that does not require place of employment to be included on the Register of Teachers.

We note that although most jurisdictions require teachers to notify the relevant registration authority of their place of employment, including any changes to their place of employment, there may be gaps in compliance. Such gaps mean that a registration authority may not know the whereabouts of an unknown number of teachers for a period. Another issue is that the requirement to inform the relevant authority of place of employment does not apply to relief teachers, who may teach at different schools within short periods.

To help keep children safe in Tasmanian schools, we consider that a teacher's work-related address(es) should be included on the Register of Teachers. This requirement should also apply to holders of a Limited Authority to Teach. When a registered teacher or a holder of a Limited Authority to Teach begins teaching at a different school, a notification should be made to the Teachers Registration Board, and the Register updated accordingly. Schools should be able to capture these details electronically, which would allow notifications to occur simply and quickly, thereby providing improved visibility of where teachers, particularly relief teachers, are teaching. Also, rather than requiring teachers (or a holder of a Limited Authority to Teach) to notify the Board, a more effective approach may be to require employers to make such notifications.

To facilitate the accurate and timely recording and exchange of information about teachers, we understand that improvements may be required to be made to the Register of Teachers. The Board noted that it would require resources for an upgraded, fit-for-purpose Customer Records Management System that can support information exchange in real time with third parties, including other jurisdictions. We were told this is proving to be a resourcing challenge that is delaying efforts to keep students safe.[564]

Recommendation 6.11

The Tasmanian Government should:

a. introduce legislation to amend the *Teachers Registration Act 2000* (or regulations) to require details of the prospective or current place of employment of a teacher (or a holder of Limited Authority to Teach) to be included on the Register of Teachers

b. develop an electronic means of updating the Register of Teachers with details of the place of employment of a teacher (or a holder of Limited Authority to Teach)

c. require employers to make updates to a teacher's place of employment—including when a teacher (or a holder of Limited Authority to Teach) begins working at the school or is no longer working at the school

d. fund the Teachers Registration Board to develop an upgraded, fit-for-purpose Customer Records Management System to enable the Board to maintain a Register of Teachers which can support information exchange in real time with other bodies working with children, and other jurisdictions.

8.2.3 Improving compliance and enforcement

Under several provisions of the Teachers Registration Act, non-compliance with the provision attracts a penalty. For example, if a person who is not a registered teacher teaches in a school in Tasmania, they can be fined up to 50 penalty units (approximately $9,000 at the time of writing).[565] The Act also specifies that a person must not employ someone who is an unregistered teacher. The penalty is a fine of up to 50 penalty units for a first offence and up to 100 penalty units for a second offence (and an ongoing daily fine of 10 penalty units for each day the offence continues).[566] All other states and territories have similar provisions.[567]

We heard that:

- there are 'regular offenders who employ unregistered teachers'[568]
- although the Teachers Registration Act requires that teachers notify the Board if they are charged with a prescribed offence, teachers seldom comply with this provision[569]
- although the Act requires that employers notify the Board when they take disciplinary action or dismiss a teacher due to unacceptable behaviour, this provision is not always followed, at least by some independent schools[570]

- although the Act requires teachers to update the Board of changes to their residential address, some teachers do not do so, despite non-compliance attracting a penalty.[571]

Ms Moxham gave evidence that, despite the Act including 'enforcement' provisions for a range of 'offences', the Board has never undertaken an investigation to determine whether someone has contravened the provisions of the Act nor has it recommended prosecution against the Act.[572] Ms Moxham explained that this is largely due to the 'costly and time-consuming process of filing matters with the Administrative Division of the Magistrates Court' to have a fine issued for a contravention.[573] Regarding taking action against a school that employs an unregistered teacher, she stated:

> … the only process by which we can do that is to take the matter to the Magistrates Court, the administrative division of the Magistrates Court, and the time, energy, effort and resources to undertake that process has [worked] against the board ever taking any of those matters. So, we write letters, but you can imagine that if you've got a school that regularly offends and they've had five letters and a visit from us—no teeth. It's something that should be fixed in our Act.[574]

As with all legislation, effective enforcement is key to ensuring compliance with the Act. In turn, compliance with the Act is essential to ensuring that only qualified, fit and proper people are registered as teachers. Providing the Board with a simplified means of enforcing the provisions in the Act, particularly those that have relatively low-level sanctions attached, could help improve compliance with the Act and, in some instances, relieve the Board of costly and time-consuming enforcement processes.

As was pointed out in a submission to the Australian Law Reform Commission's Review of Federal Civil and Administrative Penalties, infringement schemes can be an appropriate means to address non-compliant behaviour, particularly in the context of a failure to provide notification or information to a regulator, which potentially reduces the effectiveness of the regulator 'in performing its regulatory functions'.[575] Such schemes have the advantage of providing a relatively quick and cost-effective means of dealing with contraventions of legislative provisions and are not uncommon in Tasmanian legislation.[576]

Under section 55 of the Registration to Work with Vulnerable People Act, an infringement notice can be issued if the Registrar 'believes that the person has committed an infringement offence'.[577] Infringement offences are listed in Schedule 2 of the *Registration to Work with Vulnerable People Regulations 2014*. Infringement offences include engaging in a regulated activity as an unregistered person and employing an unregistered person in a regulated activity. Infringement notice schemes such as that in the Registration to Work with Vulnerable People Act are not uncommon in Tasmanian legislation and have the advantage of providing a relatively quick and efficient means of dealing with contraventions of legislative provisions.[578]

While other states and territories do not have infringement notice provisions in their teacher registration legislation, some jurisdictions do specify that breaches of particular provisions are strict liability offences. For example, in the Northern Territory it is an offence (as it is in Tasmania) to teach while unregistered or without authorisation (the maximum penalty for this is 50 penalty units). The Act specifies that this is a strict liability offence.[579] Similarly, in the Australian Capital Territory a person will commit an offence under the *Teacher Quality Institute Act 2010* (ACT) if they teach in a school without being an approved teacher. This is also a strict liability offence (attracting a penalty of 50 penalty units).[580]

To enforce the Teachers Registration Act and thereby enhance the Board's ability to protect children and young people in Tasmanian schools, we recommend that the Act be amended to allow the Board to issue infringement notices for those provisions in the Act that carry penalties in the form of fines.

We understand that the Office of the Director of Public Prosecutions provides advice to, and undertakes summary prosecutions on behalf of government departments and State Service agencies.[581] The Teachers Registration Board should consider entering an agreement with the Office of the Director of Public Prosecutions to prosecute summary offences.

Recommendation 6.12

The Tasmanian Government should introduce legislation to amend the *Teachers Registration Act 2000* to allow administrative infringement notices to be issued for noncompliance with the provisions of the Act that currently carry penalties in the form of fines.

8.2.4 The emergency suspension provision

The Teachers Registration Act allows for an 'emergency suspension' of a teacher's registration if the Board believes, on reasonable grounds, that a registered teacher (or holder of a Limited Authority to Teach) poses 'a risk of harm to a student'.[582] In 2020, the Board used this provision to suspend the registration of six teachers.[583]

The emergency suspension provision has recently been subject to an appeal, which was upheld by the Magistrates Court. The Court found that if the Department has already suspended a teacher's employment, there is no 'emergency' justifying the Board to use the provision. The Court therefore ordered that the suspension of the teacher's registration be set aside, but that a condition be placed on his registration that he not be able to teach. The Registrar of the Teachers Registration Board described this as 'contrary to the function of the Board'.[584] This arose as an issue in the 'Jeremy' case study (refer to Chapter 5).

In other jurisdictions, there is no specification that the relevant registering authority must demonstrate an 'emergency' to suspend a teacher's registration. For example, in Queensland, the *Education (Queensland College of Teachers) Act 2005* (Qld) says that a teacher may be suspended if they pose an unacceptable risk to children or if they are charged with a serious offence.[585]

The Victorian Institute of Teaching may suspend a teacher's registration if it forms a reasonable belief that the teacher poses an unacceptable risk of harm to children. The Institute may also suspend a registration if a person is charged with 'a Category B offence' (these include sexual offences).[586]

Ms Moxham told us that the 'emergency suspension' provision in the Teachers Registration Act should be amended to read 'immediate suspension', which 'would provide greater clarity about the purpose of the section'.[587] We agree. Also, allowing the Board to suspend registration where a person has been charged with a serious offence (as is the case in Queensland and Victoria) would help the Board to ensure children are protected in a timely manner in such circumstances.

Recommendation 6.13

The Tasmanian Government should introduce legislation to amend section 24B of the *Teachers Registration Act 2000* to:

a. allow for the immediate rather than emergency suspension of registration or a Limited Authority to Teach when the Teachers Registration Board considers there is an unacceptable risk of harm to children

b. allow the Board to suspend a person's registration or a Limited Authority to Teach where that person has been charged with a serious offence.

8.2.5 Mutual and automatic mutual recognition for teachers

The national mutual recognition scheme allows registered and licensed professionals to work throughout Australia. Under the scheme, a registered teacher in another Australian jurisdiction can 'lodge a notice' to become a registered teacher in Tasmania. If the application is lodged correctly, within seven days the Board will provide the applicant with a notification of 'deemed registration'.[588] Once deemed registration is granted, the applicant can start teaching in Tasmania, pending the 'granting or refusal of substantive registration' within 30 days.[589] This is commonly referred to as mutual recognition.

A requirement for lodging a valid notice is that the teacher seeking mutual recognition must state whether they have been subject to any disciplinary proceedings in any other jurisdiction, including a 'preliminary investigation' or other action that could result in disciplinary proceedings.[590] Ms Moxham told us that if the notice contains any

materially false or misleading information, the application may be refused.[591] The Board can receive and share relevant information with equivalent registration boards in other jurisdictions, to inform a decision to grant or refuse substantive registration.[592]

Building on the mutual recognition scheme, national changes to mutual recognition laws in 2021 provide for automatic mutual recognition in some circumstances. In Tasmania, teaching is exempt from the automatic recognition scheme until July 2025.[593] Once automatic mutual recognition is implemented, it will dispense with the requirement for a teacher to 'lodge a notice' for recognition of their registration in another jurisdiction.[594]

The Independent Education Inquiry heard about concerns with mutual recognition:

> An example provided to us described an applicant who falsified this declaration, gained registration as a relief teacher in Tasmania and went on to allegedly offend at multiple Tasmanian Government schools. We were told that a systemic weakness of the *Mutual Recognition Act 1992* (Cth) is that a teacher's previous registration body is not obliged to disclose information about disciplinary proceedings to the teacher's new registration body. We heard that under the current processes in Tasmania, a teacher can obtain registration under the mutual recognition legislation much quicker than it takes to receive [Registration to Work with Vulnerable People]. This has the potential to result in instances where a teacher is able to begin work as a registered teacher in a school prior to being cleared to work with children.[595]

We heard similar concerns. Both Ms Moxham and Secretary Bullard expressed concerns about the mutual recognition scheme, particularly automatic mutual recognition.[596] Their primary concern was that the Board may not be notified if teachers from interstate start working in Tasmania. Without a requirement for notification, the Board cannot assess whether the person is suitable to work as a teacher in Tasmania, even if registered in their original jurisdiction.[597] The automatic mutual recognition scheme will also make it difficult for the Board to know who is working in this jurisdiction (and whether those who are working in Tasmania are registered in another jurisdiction). It may also make it difficult to validate teachers' principal place of residence and/or work, to monitor their ongoing eligibility to work under the *Mutual Recognition Act 1992* (Cth), and to identify previous places of employment to access information about their conduct.[598]

We note that the *Mutual Recognition Act 1992* (Cth) allows for an occupation to be excluded from the operation of the automatic mutual recognition scheme if automatic recognition poses a significant risk to consumer protection, environment protection, animal welfare or the health and safety of workers or the public. Exemptions from the scheme can be granted for up to five years.[599]

Given that the operation of the automatic mutual recognition scheme has been paused for teacher registration, we recommend that the Board continues to advocate at the national level that the risks posed by the scheme to the safety of children in Tasmanian schools be addressed before the exemption expires.

Recommendation 6.11 about teachers' employers being required to notify the Board of their place of employment may go some way to addressing some of the risks described above. The Board would be aware of a 'new' teacher in their jurisdiction and could conduct its own checks.

Recommendation 6.14

The Tasmanian Government, Department for Education, Children and Young People and the Teachers Registration Board should continue to advocate at the national level for an automatic mutual recognition scheme that takes into account risks to child safety and imposes measures to address these risks.

8.2.6 Professional development and training

During our hearings Ms Moxham indicated that it would be beneficial if training on mandatory reporting was part of Tasmania's teacher registration process.[600] She pointed out that in South Australia mandatory reporting training is a requirement of teacher registration; that is, teachers cannot be registered until they have successfully completed this training.[601] In Section 5, we make recommendations about compulsory and ongoing professional development on child safeguarding and related matters.

There is benefit in requiring that training for identifying, preventing and responding to child sexual abuse be completed as a prerequisite to registration. This is in keeping with the role of governments to enforce appropriate professional standards, as argued in the seminal work *The Professions*.[602] We note, however, that the Teachers Registration Board does not have the authority to set requirements for teacher registration.

We recommend that the Teachers Registration Act be amended to allow the Board to require that particular training be undertaken for the purpose of registration, renewal of registration and professional development. The content of that training should be set out in the Regulations so the Board can revise the training as required, without the need for more amendments to the principal Act.

Recommendation 6.15

1. The Tasmanian Government should introduce legislation to amend the *Teachers Registration Act 2000* to allow the Teachers Registration Board to set requirements for minimum training and ongoing professional development.
2. The Teachers Registration Board should make child safeguarding training (Recommendation 6.5) a mandatory requirement for the granting of teacher registration and as part of ongoing registration requirements.

8.2.7 Resourcing

When asked whether the current level of funding was sufficient for the Teachers Registration Board to perform all its regulatory functions, Ms Moxham told us that 'the short answer to this question is no'.[603] She added that due to lack of funding, developing policy and procedures as well as 'leveraging … technical solutions' lag behind other parts of the Board's work.[604] If the Board is to take a more active role in enforcing the provisions of the Teachers Registration Act, this may place more pressure on available resources.

Ms Moxham told us that the ability to undertake investigations was also hampered by a lack of resources in a context where the Board is 'currently inundated with matters requiring complex and, in many cases, historical investigations'.[605] The Board's 'conduct team' comprises only two full-time investigators—a person who deals with applications (checking good character and fitness to teach based on national criminal history checks and other declarations made by applicants) and a person whose role primarily involves processing right to information requests.[606] Our recommendation that investigators be jointly appointed and for increased information sharing with the Board by relevant entities may help to reduce unnecessary duplication and thereby save resources.

Ms Moxham stated while the Board's funding was once exclusively sourced through registration fees, since 2017 it has also received some funding from the Tasmanian Government.

We heard that in the past the Board has advocated for a significant increase to teacher registration fees to help meet the costs of performing its functions under the Teachers Registration Act.[607] The Department has denied this request.[608] Instead, the Department reviewed the functions and powers of the Board and determined which areas were within the Board's 'central role of registration' and which were 'other'. 'Other' included functions concerned with professional conduct. More funding was then provided for roles deemed to not be part of the core teacher registration function of the Board (including functions concerned with professional conduct).[609] We are concerned that professional conduct matters were not seen as core business of the Board.

This funding is indexed to increase each year, but it is unclear for how long this will continue.[610] Ms Moxham noted that although the Board will receive extra funding in 2023 and 2024, this funding is akin to a two-year grant, 'not a structural/recurrent funding arrangement'.[611] According to Ms Moxham, greater certainty of funds would enable the Board to 'fully address [its] regulatory remit (inclusive of educative and co-regulation processes)'.[612]

We note that the Board also has concerns about how its funding arrangements may affect its independence. Ms Moxham's view was that 'ad hoc grants on a per annum or project basis' are not enough to ensure the independence of the Board and that, for the Board to be 'truly independent', funding should be drawn from consolidated revenue rather than the departmental purse.[613]

We also note that, in response to the recent Education Regulation Review, the *Education Legislation Amendments (Education Regulation) Act 2022* has amended the *Education Act 2016* to require the Registrar of the Teachers Registration Board and the Secretary of the Department to enter into a 'Framework Agreement'.[614] The Framework Agreement will cover matters such as the Registrar's staffing, budgets and the application of departmental policies.[615] The intention of the amendment is to further safeguard the independence of education regulators (such as the Board) by providing 'greater transparency and clarity on administrative support' provided by the Department.[616]

Ms Moxham told us that this amendment 'appears to give effect to what is already achieved by the [Teachers Registration Board] and the Department via Memoranda of Understanding and … Service Level Agreements'.[617] She also stated:

> … while ever the regulator is subject to the Department for the funding it needs over and above teacher registration fees (rather than from consolidated government revenue), the Department can continue to consider the regulator as a business unit of the Department and subject [to] its strategic intent, rather than to the important reforms needed to ensure the most efficient and effective use of resources for the best outcomes for the welfare and best interests of students (vulnerable children and young people).[618]

During our hearings, Secretary Bullard commented on Ms Moxham's concerns that changes effected by the Education Regulation Review mean that the Board will become less independent. His view was that rather than bringing the Board closer to Government, the changes will have the opposite effect, in part due to introducing a skills-based Board to replace the representative Board and the 'higher level of scrutiny and regulatory oversight to the activities of the [Teachers Registration Board]' that this change will bring.[619]

Ultimately, from the perspective of keeping children safe in Tasmanian schools, the most important point is that the Board can perform its statutory functions. Given Ms Moxham's concerns and noting that one of the purposes of establishing the Board was to 'protect children in government and non-government schools from the possibility of sexual or other abuse', consideration should be given to whether the Board's funding levels are enough for it to perform *all* of its functions under its Act—whether under current funding arrangements or through the new Framework Agreement.[620]

While the registration of teachers is a core function of the Board, those functions deemed 'other' by the Department—that is, functions concerned with professional conduct, compliance and enforcement—are equally important to protecting children and fostering student wellbeing. Adequate resources should be provided to enable the Teachers Registration Board to perform these functions, without which students may be at increased risk. In this respect, we note that the Review of Education Regulation report recommended that the Department develops a methodology, with input from regulators such as the Board, to determine sustainable funding.[621]

Recommendation 6.16

The Tasmanian Government should ensure the Teachers Registration Board is funded to perform its core function of regulating the professional conduct of teachers.

9 Conclusion

Schools should always be a safe place for children and young people. Students are entitled to expect that school staff will always act in their best interests and are equipped to help them if they disclose concerns. We acknowledge that, overwhelmingly, teachers and school staff are committed to ensuring the safety, wellbeing and educational achievement of students in their care. Their actions can have an enormous impact on the lives of children and young people—many teachers will shape the lives of their students for the better.

The Department should consistently strive to prevent child sexual abuse through strong screening and registration requirements, clear and practical policies and guidance, and a commitment to ongoing training and education. The Department can make an important contribution to the knowledge and confidence of young people, and their ability to recognise and understand risks to their safety, by providing child sexual abuse prevention education to all children in Tasmanian Government schools. The Teachers Registration Board should be equipped to robustly regulate the registration and professional conduct of teachers. The Board should have access to the powers, information and funding that it needs to acquit its functions and to be responsive to the risks that teachers may pose to students.

There are instances where students are not kept safe. Sometimes they are harmed by teachers who they trusted, in other instances by fellow students who display harmful sexual behaviours. While these incidents are more common than we would like to believe, they often occur relatively infrequently in the careers of individual principals and teachers. While school staff and leadership should have foundational skills in line with their responsibilities to receive a disclosure and know what to do, there is a place for specialist roles to closely guide and support schools when concerns are raised about a teacher's conduct or a student's safety. While it is inevitable that such incidents will cause distress and concern, the impact of abuse can be greatly alleviated by an effective and supportive response.

We are greatly encouraged by the efforts of the Department in implementing the recommendations of the Independent Education Inquiry and progressing a range of other safeguarding initiatives designed to improve the safety of students. We see

great promise in these initiatives. However, we consider it is important that the Department be accountable for its commitments. We consider it appropriate that the Child Sexual Abuse Reform Implementation Monitor we recommend in Chapter 22 monitors the implementation of the Independent Education Inquiry's recommendations.

For many victim-survivors, the most pressing concern is preventing what happened to them from happening to another student. We expect the Department to share this commitment of victim-survivors and to prove this commitment through its actions.

Notes

1 Refer to, for example, Department of the Prime Minister and Cabinet, *National Strategy to Prevent and Respond to Child Sexual Abuse 2021–2030* (2021) 37–39; National Centre for Action on Child Sexual Abuse, *Here for Change: Five Year Strategy 2023*–2027 (June 2023) 22–23.

2 Tim Moore and Morag McArthur, *Take notice, believe us and act! Exploring the safety of children and young people in government run organisations* (Research Report prepared for the Commission of Inquiry into the Tasmanian Government's Responses to Child Sexual Abuse in Institutional Settings, February 2023) 65.

3 Tim Moore and Morag McArthur, *Take notice, believe us and act! Exploring the safety of children and young people in government run organisations* (Research Report prepared for the Commission of Inquiry into the Tasmanian Government's Responses to Child Sexual Abuse in Institutional Settings, February 2023) 65.

4 Transcript of Leah Sallese, 8 July 2022, 2638 [35–39].

5 Transcript of Sam Leishman, 13 May 2022, 1054 [35]–1055 [3].

6 The name 'Rachel' is a pseudonym; Order of the Commission of Inquiry, restricted publication order, 11 May 2022; Statement of 'Rachel', 14 April 2022, 8 [38].

7 Transcript of Kerri Collins, 9 May 2022, 611 [27–34].

8 Carmel Hobbs, *Young, In Love and In Danger: Teen Domestic Violence and Abuse in Tasmania* (Report, Social Action & Research Centre, Anglicare Tasmania, November 2022) 50.

9 Carmel Hobbs, *Young, In Love and In Danger: Teen Domestic Violence and Abuse in Tasmania* (Report, Social Action & Research Centre, Anglicare Tasmania, November 2022) 63.

10 Carmel Hobbs, *Young, In Love and In Danger: Teen Domestic Violence and Abuse in Tasmania* (Report, Social Action & Research Centre, Anglicare Tasmania, November 2022) 40.

11 Carmel Hobbs, *Young, In Love and In Danger: Teen Domestic Violence and Abuse in Tasmania* (Report, Social Action & Research Centre, Anglicare Tasmania, November 2022) 40.

12 Australian Government eSafety Commissioner, 'Online Porn', *Issues and Advice* (Web Page, 2023) <https://www.esafety.gov.au/parents/issues-and-advice/online-porn>.

13 Statement of Kathryn Fordyce, 3 May 2022, 15 [47]–16 [48].

14 Statement of Kathryn Fordyce, 3 May 2022, 16 [50].

15 *Royal Commission into Institutional Responses to Child Sexual Abuse* (Final Report, December 2017) vol 6, Recommendation 6.2.

16 *Royal Commission into Institutional Responses to Child Sexual Abuse* (Final Report, December 2017) vol 6, Recommendation 6.2.

17 *Royal Commission into Institutional Responses to Child Sexual Abuse* (Final Report, December 2017) vol 6, 72.

18 *Royal Commission into Institutional Responses to Child Sexual Abuse* (Final Report, December 2017) vol 6, 72.

19 *Royal Commission into Institutional Responses to Child Sexual Abuse* (Final Report, December 2017) vol 6, 73.

20 *Royal Commission into Institutional Responses to Child Sexual Abuse* (Final Report, December 2017) vol 13, 156.

21 *Royal Commission into Institutional Responses to Child Sexual Abuse* (Final Report, December 2017) vol 13, 156.

22 Statement of Kerryann Walsh, 15 April 2022, 11–12 [38].

23 Transcript of Kerryann Walsh, 13 May 2022, 1105 [14–40].

24 Transcript of Kerryann Walsh, 13 May 2022, 1106 [18–41].

25 Transcript of Kerryann Walsh, 13 May 2022, 1107 [12–45].

26 Transcript of Kerryann Walsh, 13 May 2022, 1107 [12–45].

27 Submission 067 Body Safety Australia, 2.

28 Transcript of Kerryann Walsh, 13 May 2022, 1106 [6–14].

29 Transcript of Kerryann Walsh, 13 May 2022, 1107 [28–34].

30 Submission 067 Body Safety Australia, 5.

31 Burnie consultation, 24 August 2021.

32 Statement of Kerryann Walsh, 15 April 2022, 12 [39].

33 Statement of Kerryann Walsh, 15 April 2022, 12 [39].

34 Statement of Kerryann Walsh, 15 April 2022, 12 [42].

35 Transcript of Kerryann Walsh, 13 May 2022, 1103 [17–21].

36 Statement of Timothy Bullard, 10 May 2022, 11 [63].

37 Statement of Elizabeth Jack, 29 April 2022, 7 [36].

38 Statement of Timothy Bullard, 10 May 2022, 11 [67].

39 Tasmanian Government, *Safe Homes, Families, Communities: Tasmania's Action Plan for Family and Sexual Violence 2019–2022* (2019) 9.

40 Tasmanian Government, *Survivors at the Centre: Tasmania's Third Family and Sexual Violence Action Plan 2022–2027* (November 2022) 19.

41 Tasmanian Government, *Survivors at the Centre: Tasmania's Third Family and Sexual Violence Action Plan 2022–2027* (November 2022) 19.

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47 Statement of Timothy Bullard, 10 May 2022, 11 [64].

48 Statement of Timothy Bullard, 10 May 2022, 11 [65].

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62 Statement of Elizabeth Jack in response to Questions on Notice, 3 June 2022, 3.

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76 Statement of Elizabeth Jack, 29 April 2022, Annexure 2 (Department of Education, 'Statement of Duties for Executive Director, Safeguarding Children and Young People,' July 2021) 3 [13].

77 Statement of Elizabeth Jack, 29 April 2022, 6 [28].

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84 Department for Education, Children and Young People, *Safe. Secure. Supported. Our Safeguarding Framework* (April 2023).

85 Stephen Smallbone and Tim McCormack, *Independent Inquiry into the Tasmanian Department of Education's Responses to Child Sexual Abuse* (Report, 7 June 2021) 77.

86 Statement of Timothy Bullard, 6 June 2022, 13 [53].

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88 Statement of Elizabeth Jack, 29 April 2022, 5 [26]; Stephen Smallbone and Tim McCormack, *Independent Inquiry into the Tasmanian Department of Education's Responses to Child Sexual Abuse* (Report, 7 June 2021) 77.

89 Statement of Kerryann Walsh, 15 April 2022, 13 [46].

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92 Letter from Timothy Bullard to the Commission of Inquiry, 9 February 2023, 1.

93 Letter from Timothy Bullard to the Commission of Inquiry, 9 February 2023, 1.

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98 Stephen Smallbone and Tim McCormack, *Independent Inquiry into the Tasmanian Department of Education's Responses to Child Sexual Abuse* (Report, 7 June 2021) 82.

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100 Department of Education, *Safeguarding Children and Young People – System Review Panel Report* (Report, 16 December 2021) 3.

101 Department of Education, *Safeguarding Children and Young People – System Review Panel Report* (Report, 16 December 2021) 4.

102 Department of Education, *Safeguarding Children and Young People – System Review Panel Report* (Report, 16 December 2021) 4.

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104 Department of Education, *Safeguarding Children and Young People – System Review Panel Report* (Report, 16 December 2021) 3.

105 Department of Education, *Safeguarding Children and Young People – System Review Panel Report* (Report, 16 December 2021) 8.

106 Department of Education, *Safeguarding Children and Young People – System Review Panel Report* (Report, 16 December 2021) 8.

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109 Department of Education, *Safeguarding Children and Young People – System Review Panel Report* (Report, 16 December 2021) 12.

110 Department of Education, *Safeguarding Children and Young People – System Review Panel Report* (Report, 16 December 2021) 24.

111 Department for Education, Children and Young People, *Procedural Fairness Response*, 17 March 2023, 10.

112 The Department has since told us that although its deliberations were not detailed in the review, the Review Panel did give specific consideration to whether the relevant young person and/or their family should be invited to participate in an interview. We are told that the Review Panel determined that it would be inappropriate to do so in the circumstances. We consider it important that any similar future reports detail all critical deliberations. Department for Education, Children and Young People, *Procedural Fairness Response*, 17 March 2023, 11–12.

113 Integrity Commission, 'Audit Report: MM21/0102; MM20/0141', 10 August 2022, 15 [77].

114 Integrity Commission, 'Audit Report: MM21/0102; MM20/0141', 10 August 2022, 15 [78].

115 Integrity Commission, 'Audit Report: MM21/0102; MM20/0141', 10 August 2022, 15 [74].

116 Integrity Commission, 'Audit Report: MM21/0102; MM20/0141', 10 August 2022, 16 [82].

117 Integrity Commission, 'Audit Report: MM21/0102; MM20/0141', 10 August 2022, 16 [83].

118 Integrity Commission, 'Audit Report: MM21/0102; MM20/0141', 10 August 2022, 16 [85].

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120 Transcript of Timothy Bullard, 12 September 2022, 3934 [35–37].

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122 Statement of Kerryann Walsh, 15 April 2022, 8 [24], [26].

123 Stephen Smallbone and Tim McCormack, *Independent Inquiry into the Tasmanian Department of Education's Responses to Child Sexual Abuse* (Final Report, 7 June 2021) 9, 17, 59, 70.

124 Statement of Nigel Russell, 29 April 2022, 2 [11].

125 Transcript of Kerri Collins, 9 May 2022, 636 [19–24].

126 Transcript of Debra Drake, 10 May 2022, 771 [12–46].

127 Stephen Smallbone and Tim McCormack, *Independent Inquiry into the Tasmanian Department of Education's Responses to Child Sexual Abuse* (Report, 7 June 2021) 76.

128 Stephen Smallbone and Tim McCormack, *Independent Inquiry into the Tasmanian Department of Education's Responses to Child Sexual Abuse* (Report, 7 June 2021) 78–79.

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130 Stephen Smallbone and Tim McCormack, *Independent Inquiry into the Tasmanian Department of Education's Responses to Child Sexual Abuse* (Report, 7 June 2021) 79.

131 Stephen Smallbone and Tim McCormack, *Independent Inquiry into the Tasmanian Department of Education's Responses to Child Sexual Abuse* Report, 7 June 2021) 80.

132 Stephen Smallbone and Tim McCormack, *Independent Inquiry into the Tasmanian Department of Education's Responses to Child Sexual Abuse* (Report, 7 June 2021) 81–82.

133 Statement of Stephen Smallbone, 28 April 2022, 8 [31]; Statement of Elizabeth Jack, 29 April 2022, Annexure 12 (Excel spreadsheet: 'Planned and completed implementation of DoE Inquiry Recommendations', 29 April 2022) 5.

134 Statement of Timothy Bullard, 10 May 2022, 7 [39].

135 Statement of Timothy Bullard, 10 May 2022, 43 [250].

136 Statement of Timothy Bullard, 10 May 2022, 14 [91].

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138 Statement of Timothy Bullard, 10 May 2022, 27 [169].

139 Letter from Timothy Bullard to the Commission of Inquiry, 9 February 2023, 2.

140 A URL link for the *Child Safe Code of Conduct (Interim)* can be found in Department for Education, Children and Young People, *Safe. Secure. Supported. Our Safeguarding Framework* (April 2023) 69.

141 Transcript of Kerri Collins, 9 May 2022, 636 [26–34].

142 Transcript of Monique Carter, 10 May 2022, 752 [23–27].

143 Department for Education, Children and Young People, *Safe. Secure. Supported. Our Safeguarding Framework* (April 2023).

144 Department for Education, Children and Young People, *Safe. Secure. Supported. Our Safeguarding Framework* (April 2023) 6.

145 Department for Education, Children and Young People, *Safe. Secure. Supported. Our Safeguarding Framework* (April 2023) 65.

146 Letter from Timothy Bullard to the Commission of Inquiry, 9 February 2023, 6.

147 Department for Education, Children and Young People, *Safe. Secure. Supported. Our Safeguarding Framework* (April 2023) 69.

148 Department for Education, Children and Young People, *Safe. Secure. Supported. Our Safeguarding Framework* (April 2023) 9.

149 Statement of Alana Girvin, 28 April 2022, 6 [28].

150 Statement of Alana Girvin, 28 April 2022, 4 [22].

151 Statement of Alana Girvin, 28 April 2022, 5 [26].

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153 Transcript of Alana Girvin, 11 May 2022, 862 [36–39].

154 *Royal Commission into Institutional Responses to Child Sexual Abuse* (Final Report, December 2017) vol 7, 185.

155 *Royal Commission into Institutional Responses to Child Sexual Abuse* (Final Report, December 2017) vol 7, 186.
156 Statement of Alana Girvin, 28 April 2022, 4–5 [24].
157 Statement of Alana Girvin, 28 April 2022, 4–5 [24].
158 Statement of Alana Girvin, 28 April 2022, 5 [25].
159 Statement of Alana Girvin, 28 April 2022, 5 [24].
160 Statement of Alana Girvin, 28 April 2022, 6 [29].
161 Transcript of Alana Girvin, 11 May 2022, 863 [15–17].
162 Statement of Alana Girvin, 28 April 2022, Annexure ASG-3 (Guideline: 'Protective practices for staff in their interactions with children and young people', 2019) 11.
163 Refer to *Royal Commission into Institutional Responses to Child Sexual Abuse* (Final Report, December 2017) vol 7, 186.
164 Transcript of Elizabeth Jack, 13 May 2022, 1114 [45–46].
165 Statement of Nigel Russell, 29 April 2022, 1 [8].
166 Statement of Nigel Russell, 29 April 2022, 4 [29]–5 [31].
167 Transcript of Monique Carter, 10 May 2022, 773 [28–36].
168 Statement of Kerri Collins, 11 April 2022, 9 [40].
169 Transcript of Monique Carter, 10 May 2022, 760 [9–13].
170 Transcript of Kerri Collins, 9 May 2022, 637 [9–19].
171 Transcript of Monique Carter, 10 May 2022, 759 [7–11].
172 Transcript of Monique Carter, 10 May 2022, 760 [22–35].
173 Statement of Steven Smith, 22 April 2022, 5 [35].
174 Statement of Steven Smith, 22 April 2022, 6 [36].
175 Statement of Steven Smith, 22 April 2022, 6 [37].
176 Statement of Timothy Bullard, 10 May 2022, 15 [94].
177 Statement of Monique Carter, 26 April 2022, 8 [52].
178 Statement of Timothy Bullard, 10 May 2022, 15 [94].
179 Statement of Timothy Bullard, 10 May 2022, 22–23 [142].
180 Statement of Timothy Bullard, 10 May 2022, 22 [137].
181 Statement of Timothy Bullard, 10 May 2022, 6 [33].
182 Statement of Timothy Bullard, 10 May 2022, 6 [34].
183 Statement of Timothy Bullard, 10 May 2022, 32 [189].
184 Transcript of Timothy Bullard, 12 May 2022, 987 [46]–988 [5].
185 Letter from Timothy Bullard to Commission of Inquiry, 9 February 2023, 7.
186 Letter from Timothy Bullard to Commission of Inquiry, 9 February 2023, 7.
187 Letter from Timothy Bullard to Commission of Inquiry, 9 February 2023, 6.
188 Letter from Timothy Bullard to Commission of Inquiry, 9 February 2023, 6.
189 Statement of Timothy Bullard, 6 June 2022, 13 [53].
190 Statement of Alana Girvin, 28 April 2022, Annexure ASG-2 ('Key Debelle Report Recommendations', 28 April 2022) 6 [16–17], [21]; refer to Recommendations 16, 17, 21.
191 Statement of Alana Girvin, 28 April 2022, 5–6 [26].
192 Statement of Alana Girvin, 28 April 2022, 5 [25].
193 Transcript of Alana Girvin, 11 May 2022, 868 [27–32].
194 Transcript of Monique Carter, 10 May 2022, 774 [34–46], 775 [1–12].
195 Statement of Kerryann Walsh, 15 April 2022, 6 [18].
196 Statement of Katrina Munting, 5 April 2022, 9 [45].

197 Stephen Smallbone and Tim McCormack, *Independent Inquiry into the Tasmanian Department of Education's Responses to Child Sexual Abuse* (Report, 7 June 2021) 12.

198 Statement of Elizabeth Jack, 29 April 2022, Annexure 17 (Letter from Elizabeth Jack to Dean and Head of School, Education, University of Tasmania, 21 December 2021) 1–2.

199 Stephen Smallbone and Tim McCormack, *Independent Inquiry into the Tasmanian Department of Education's Responses to Child Sexual Abuse* (Report, 7 June 2021) 12.

200 Teachers Registration Board, *Procedural Fairness Response*, 17 March 2023, 2.

201 Teachers Registration Board, *Procedural Fairness Response*, 17 March 2023, 2.

202 Stephen Smallbone and Tim McCormack, *Independent Inquiry into the Tasmanian Department of Education's Responses to Child Sexual Abuse* (Report, 7 June 2021) 12.

203 Stephen Smallbone and Tim McCormack, *Independent Inquiry into the Tasmanian Department of Education's Responses to Child Sexual Abuse* (Report, 7 June 2021) 78.

204 Statement of Kerryann Walsh, 15 April 2022, 6 [18].

205 Statement of Kerryann Walsh, 15 April 2022, 7 [23].

206 *Royal Commission into Institutional Responses to Child Sexual Abuse* (Final Report, December 2017) vol 6, 89.

207 *Royal Commission into Institutional Responses to Child Sexual Abuse* (Final Report, December 2017) vol 6, 90.

208 Statement of Elizabeth Jack, 29 April 2022, Annexure 17 (Letter from Elizabeth Jack to Dean and Head of School, Education, University of Tasmania, 21 December 2021) 1–2.

209 Statement of Kerryann Walsh, 15 April 2022, 8 [25].

210 Statement of Timothy Bullard, 10 May 2022, 6 [35].

211 Statement of Elizabeth Jack, 29 April 2022, Annexure 17 (Letter from Elizabeth Jack to Dean and Head of School, Education, University of Tasmania, 21 December 2021) 2.

212 Statement of Elizabeth Jack, 29 April 2022, Annexure 17 (Letter from Elizabeth Jack to Dean and Head of School, Education, University of Tasmania, 21 December 2021) 2.

213 We note that increases and decreases in allegations or incidents of child sexual abuse must be viewed in a broader context. A decrease in reporting does not necessarily coincide with a decrease in incidents, just as an apparent increase in incidents may reflect increased awareness and reporting. For example, we note in Chapter 5 that Secretary Bullard has attributed a recent increase in reports in the Department to 'people getting the message'. However, over time, if the measures designed to prevent child sexual abuse and their implementation are successful, we would expect there to be an overall decrease in incidents, as appears to be the case in South Australia.

214 *Child and Youth Safe Organisations Act 2023* ss 14 and 22.

215 *Child and Youth Safe Organisations Act 2023* s 34.

216 *Child and Youth Safe Organisations Act 2023* s 30.

217 For example, Department for Education, Children and Young People, *Advice for School Staff – Responding to Incidents, Disclosures and Suspicions of Child Sexual Abuse* (2022). Other flowcharts include: Department for Education, Children and Young People, *Responding to Incidents, Disclosures or Suspicions of Child Sexual Abuse by a Current Department Employee or Volunteer* (version 2.0, undated); Department for Education, Children and Young People, *Responding to Incidents, Disclosures or Suspicions of Child Sexual Abuse by a Former Department Employee* (version 2.0, undated); Department for Education, Children and Young People, *Responding to Incidents, Disclosures or Suspicions of Child Sexual Abuse by an Adult in the Family or Community, Including Visitors in Schools* (version 2.0, undated); Department for Education, Children and Young People, *Responding to Incidents, Disclosures or Suspicions of Harmful Sexual Behaviour* (version 2.0, undated); Department for Education, Children and Young People, *Online Child Sexual Abuse Material: Response Flowchart for Staff* (version 2.0, undated). In February 2023, Secretary Bullard told us that flowcharts relating to preventing, identifying and responding to child sexual abuse were updated and distributed to schools: Letter from Timothy Bullard to Commission of Inquiry, 9 February 2023, 2.

218 Refer to Department for Education, Children and Young People, *Advice for School Staff – Responding to Incidents, Disclosures and Suspicions of Child Sexual Abuse* (2022).

219 Refer to Department for Education, Children and Young People, *Advice for School Staff – Responding to Incidents, Disclosures and Suspicions of Child Sexual Abuse* (2022).

220 Department for Education, Children and Young People, *Advice for School Staff – Responding to Incidents, Disclosures and Suspicions of Child Sexual Abuse* (2022).

221 Department for Education, Children and Young People, *Advice for School Staff – Responding to Incidents, Disclosures and Suspicions of Child Sexual Abuse* (2022). The flowchart also provides contacts that should be made for matters involving harmful sexual behaviours and abuse by a family member or member of the community.

222 Department for Education, Children and Young People, *Advice for School Staff – Responding to Incidents, Disclosures and Suspicions of Child Sexual Abuse* (2022).

223 Department for Education, Children and Young People, *Advice for School Staff – Responding to Incidents, Disclosures and Suspicions of Child Sexual Abuse* (2022).

224 Department for Education, Children and Young People, *Advice for School Staff – Responding to Incidents, Disclosures and Suspicions of Child Sexual Abuse* (2022).

225 Statement of Timothy Bullard, 10 May 2022, 55 [336].

226 Department of Education, *Department of Education Process Where an Allegations(s) of Child Sexual Abuse is Made Against a Current Employee* (2021) 1. This policy is available on the Workplace Relations *Child Sexual Abuse* Intranet page.

227 Department of Education, *Department of Education Process Where an Allegations(s) of Child Sexual Abuse is Made Against a Current Employee* (2021) 1.

228 Statement of Timothy Bullard, 10 May 2022, 33 [191].

229 Statement of Timothy Bullard, 10 May 2022, 33 [191].

230 This occurs in relation to the fixed term and relief employment register: Statement of Timothy Bullard, 10 May 2022, 33 [191].

231 Statement of Timothy Bullard, 10 May 2022, 33 [191].

232 Statement of Timothy Bullard, 10 May 2022, 33 [191].

233 Department for Education, Children and Young People, *Advice for DoE Staff – Responding to Incidents, Disclosures and Suspicions of Child Sexual Abuse* (2022).

234 Department for Education, Children and Young People, *Advice for DoE Staff – Responding to Incidents, Disclosures and Suspicions of Child Sexual Abuse* (2022).

235 Statement of Timothy Bullard, 10 May 2022, 33 [192].

236 Statement of Timothy Bullard, 10 May 2022, 34 [193].

237 Statement of Timothy Bullard, 10 May 2022, 41 [244].

238 Statement of Timothy Bullard, 10 May 2022, 41 [244].

239 Transcript of Monique Carter, 10 May 2022, 765 [3–40].

240 Department of Education, *Department of Education Process Where an Allegations(s) of Child Sexual Abuse is Made Against a Current Employee* (2021) 2.

241 Statement of Timothy Bullard, 10 May 2022, 34 [194].

242 Department of Education, *Department of Education Process Where an Allegations(s) of Child Sexual Abuse is Made Against a Current Employee* (2021) 2.

243 Statement of Timothy Bullard, 10 May 2022, 34 [194].

244 Statement of Timothy Bullard, 10 May 2022, 34 [194].

245 Statement of Timothy Bullard, 10 May 2022, 34 [194].

246 *State Service Act 2000* s 10(1).

247 *State Service Act 2000* s 9(6).

248 *State Service Act 2000* s 9.

249 Statement of Timothy Bullard, 10 May 2022, 10 [60].

250 Statement of Timothy Bullard, 10 May 2022, 34 [194].

251 Statement of Timothy Bullard, 10 May 2022, 34 [194].

252 Statement of Timothy Bullard, 10 May 2022, 34 [194].

253 Statement of Timothy Bullard, 10 May 2022, 34 [194].

254 Statement of Timothy Bullard, 10 May 2022, 35 [202].

255 Statement of Timothy Bullard, 10 May 2022, 36 [217].

256 Refer to *State Service Act 2000* s 3 (definition of 'employee'), 10(1). Refer also to Statement of Timothy Bullard, 10 May 2022, 35 [202].

257 Statement of Timothy Bullard, 10 May 2022, 56 [347].

258 Statement of Timothy Bullard, 10 May 2022, 56 [348].

259 Statement of Steven Smith, 22 April 2022, 6 [39].

260 Statement of Steven Smith, 22 April 2022, 6 [39].

261 Refer to Department for Education, Children and Young People, *Advice for School Staff – Responding to Incidents, Disclosures or Suspicions of Child Sexual Abuse* (2022) 2.

262 Integrity Commission, *Guide to Managing Misconduct in the Tasmanian Public Sector* (March, 2021).

263 Transcript of Timothy Bullard, 11 May 2022, 904 [4–9].

264 Transcript of Timothy Bullard, 11 May 2022, 904 [23–30].

265 Transcript of Timothy Bullard, 11 May 2022, 904 [11–21]. Refer also to Commissioner's Direction 5/2002.

266 Department for Education, Children and Young People, *Procedural Fairness Response*, 17 March 2023, 23.

267 Department for Education, Children and Young People, *Procedural Fairness Response*, 17 March 2023, 23.

268 Transcript of Timothy Bullard, 12 May 2022, 955 [27–33].

269 Transcript of Timothy Bullard, 12 May 2022, 957 [5–29].

270 Transcript of Timothy Bullard, 12 May 2022, 960 [23–25].

271 Statement of Timothy Bullard, 10 May 2022, 57 [357].

272 *Child and Youth Safe Organisations Act 2023* s 35(3).

273 *Child and Youth Safe Organisations Act 2023* s 40(3).

274 *Teachers Registration Act 2000* s 31(3).

275 *Child and Youth Safe Organisations Act 2023* s 34.

276 We note that the State Service Management Office issued practices, procedures and standards on 8 July 2022 that enabled these breaches to be recorded: State Service Management Office, *Practices, Procedures and Standards No. 5: Register for Tasmanian State Service Code of Conduct Breaches Resulting in or that would have Resulted in Termination* (8 July 2022).

277 Transcript of 'Rachel', 11 May 2022, 811 [14–16].

278 Transcript of 'Rachel', 11 May 2022, 809 [45]–810 [3].

279 Statement of Timothy Bullard, 10 May 2022, 56 [342].

280 Statement of Timothy Bullard in response to Questions on Notice, 6 June 2022, 2 [7].

281 Statement of Timothy Bullard in response to Questions on Notice, 6 June 2022, 2 [6]–3 [10].

282 Statement of Timothy Bullard, 10 May 2022, 56 [343–346].

283 Statement of Steven Smith, 22 April 2022, 6 [39]. Refer also to Employment Direction No. 5, *Procedures for the Investigation and Determination of Whether an Employee Has Breached the Code of Conduct* (2013) cl 7.3.

284 Statement of Steven Smith, 22 April 2022, 7 [39].

285 Statement of Timothy Bullard in response to Questions on Notice, 6 June 2022, 2 [6]–3 [10].

286 Statement of Timothy Bullard, 10 May 2022, 55 [341].

287 Statement of Timothy Bullard, 10 May 2022, 3 [24].

288 Transcript of 'Rachel', 11 May 2022, 813 [17–26].

289 Statement of Timothy Bullard, 10 May 2022, 58 [361–364].

290 Transcript of Timothy Bullard, 11 May 2022, 901 [28–32].

291 Transcript of Timothy Bullard, 11 May 2022, 902 [29–35].

292 Statement of Timothy Bullard, 12 September 2022, 6 [18].

293 Statement of Timothy Bullard, 12 September 2022, 10 [32].

294 Statement of Timothy Bullard, 12 September 2022, 10 [32].

295 Statement of Timothy Bullard in response to Questions on Notice, 6 June 2022, 3 [16].

296 Statement of Timothy Bullard in response to Questions on Notice, 6 June 2022, 3 [16].

297 Statement of Timothy Bullard, 12 September 2022, 10 [32].

298 Statement of Timothy Bullard, 12 September 2022, 10 [32].

299 Statement of Timothy Bullard, 12 September 2022, 6 [19].

300 Statement of Timothy Bullard, 12 September 2022, 10 [33].

301 Statement of Timothy Bullard, 12 September 2022, 10 [33].

302 Tim Moore and Morag McArthur, *Take notice, believe us and act! Exploring the safety of children and young people in government run organisations* (Research Report prepared for the Commission of Inquiry into the Tasmanian Government's Responses to Child Sexual Abuse in Institutional Settings, February 2023) 47.

303 Statement of Katrina Munting, 5 April 2022, 5 [23]. The name 'Peter' is a pseudonym; Order of the Commission of Inquiry, restricted publication order, 10 May 2022.

304 Statement of Kerri Collins, 11 April 2022, 2 [11].

305 Statement of 'Rachel', 14 April 2022, 4 [22]–5 [23]. The name 'Wayne' is a pseudonym; Order of the Commission of Inquiry, restricted publication order, 11 May 2022.

306 Statement of Nigel Russell, 28 April 2022, 3 [22–23].

307 Transcript of Robert Boost, 12 September 2022, 3894 [34–47].

308 Transcript of Robert Boost, 12 September 2022, 3895 [10–18].

309 Transcript of Robert Boost, 12 September 2022, 3894 [45]–3895 [8].

310 Statement of Sam Leishman, 15 March 2022, 2 [11] and [15].

311 *Child and Youth Safe Organisations Act 2023*, s 42.

312 Statement of Timothy Bullard, regarding Sam Leishman, 8 April 2022, 6 [43].

313 Statement of Timothy Bullard, 10 May 2022, 58 [365].

314 Statement of Timothy Bullard, 10 May 2022, 10 [60].

315 Letter from Timothy Bullard to the Commission of Inquiry, 9 February 2023, 2.

316 Letter from Timothy Bullard to the Commission of Inquiry, 9 February 2023, 2.

317 Stephen Smallbone and Tim McCormack, *Independent Inquiry into the Tasmanian Department of Education's Responses to Child Sexual Abuse* (Report, June 2021) 50, 10.

318 Stephen Smallbone and Tim McCormack, *Independent Inquiry into the Tasmanian Department of Education's Responses to Child Sexual Abuse* (Report, June 2021) 10.

319 Refer to, for example, Transcript of Timothy Bullard, 12 May 2022, 930 [9–43].

320 Stephen Smallbone and Tim McCormack, *Independent Inquiry into the Tasmanian Department of Education's Responses to Child Sexual Abuse* (Report, June 2021) 79, Recommendation 12.

321 Transcript of Timothy Bullard, 12 September 2022, 3938 [26–30].

322 Statement of Alana Girvin, 28 April 2022, 2 [11].

323 Statement of Alana Girvin, 28 April 2022, 2 [14].

324 Department for Education, *Protective Practices for Staff in Their Interactions with Children and Young People* (2nd ed, Government of South Australia, 2019) 7.

325 Department for Education, *Managing Allegations of Sexual Misconduct in SA Education and Care Settings* (Government of South Australia, 2019) 3.

326 Statement of Alana Girvin, 28 April 2022, 20 [86].

327 Statement of Alana Girvin, 28 April 2022, 20 [87].

328 Statement of Alana Girvin, 28 April 2022, 21 [88–90].

329 Conversation with Alana Girvin, former Director of the Incident Management Directorate in the South Australian Department for Education (staff, Commission of Inquiry, 3 March 2022).

330 Statement of Alana Girvin, 28 April 2022, 2 [12].

331 The current Incident Report Management System is to be replaced from 2022 with a new system based on a new technology platform. Refer to Department for Education, *Annual Report 2021* (Report, Government of South Australia, 2021) 37.

332 Statement of Alana Girvin, 28 April 2022, 3 [15].

333 Statement of Alana Girvin, 28 April 2022, 11 [43].

334 Statement of Alana Girvin, 28 April 2022, 11 [43].

335 Statement of Alana Girvin, 28 April 2022, 11 [43].

336 Department for Education, *Management of Complaints, Incidents and Non-Compliance in Family Day Care and Respite Care Program Procedure* (Government of South Australia, 2022) 6.

337 Statement of Alana Girvin, 28 April 2022, 11 [43].

338 Statement of Alana Girvin, 28 April 2022, 12 [44–45].

339 Statement of Alana Girvin, 28 April 2022, 12 [46].

340 Statement of Alana Girvin, 28 April 2022, 12 [46].

341 Statement of Alana Girvin, 28 April 2022, 12 [49].

342 Statement of Alana Girvin, 28 April 2022, 13 [50].

343 Statement of Alana Girvin, 28 April 2022, 13 [51].

344 Statement of Alana Girvin, 28 April 2022, 13 [53].

345 Statement of Alana Girvin, 28 April 2022, 13 [54].

346 Statement of Alana Girvin, 28 April 2022, 13 [56].

347 Transcript of Alana Girvin, 11 May 2022, 868 [41]–869 [4]; Statement of Alana Girvin, 28 April 2022, 16 [70].

348 Statement of Alana Girvin, 28 April 2022, 14 [57].

349 Statement of Alana Girvin, 28 April 2022, 15 [64].

350 Statement of Alana Girvin, 28 April 2022, 15 [66].

351 Statement of Alana Girvin, 28 April 2022, 16–17 [70].

352 Transcript of Alan Girvin, 11 May 2022, 855 [6–11].

353 *Royal Commission into Institutional Responses to Child Sexual Abuse* (Final Report, December 2017) vol 7, 206.

354 *Royal Commission into Institutional Responses to Child Sexual Abuse* (Final Report, December 2017) vol 7, 206.

355 *Royal Commission into Institutional Responses to Child Sexual Abuse* (Final Report, December 2017) vol 7, 193.

356 *Royal Commission into Institutional Responses to Child Sexual Abuse* (Final Report, December 2017) vol 7, 211.

357 *Royal Commission into Institutional Responses to Child Sexual Abuse* (Final Report, December 2017) vol 7, 211

358 *Royal Commission into Institutional Responses to Child Sexual Abuse* (Final Report, December 2017) vol 7, 213.

359 *Royal Commission into Institutional Responses to Child Sexual Abuse* (Final Report, December 2017) vol 7, 211.

360 Transcript of Timothy Bullard, 13 May 2022, 1092 [4–23].

361 Department of Premier and Cabinet, *'Keeping Children Safer Implementation Status Report', Keeping Children Safer (Policy Document, 31 May 2023) 6, Action 21 <https://www.dpac.tas.gov.au/keepingchildrensafer>.*

362 Department for Education, *Managing Allegations of Sexual Misconduct in SA Education and Care Settings* (Government of South Australia, 2019) 3.

363 Department for Education, *Managing Allegations of Sexual Misconduct in SA Education and Care Settings* (Government of South Australia, 2019) 3.

364 Government of South Australia, *Report of the Independent Education Inquiry* (Report, 2013) 231 [695]; Department for Education, *Managing Allegations of Sexual Misconduct in SA Education and Care Settings* (Government of South Australia, 2019) 11 [3.1].

365 Department for Education, *Managing Allegations of Sexual Misconduct in SA Education and Care Settings* (Government of South Australia, 2019) 11 [3.1].

366 There are other actions that should be taken by the 'sector office': Statement of Alana Girvin, 28 April 2022, 8 [36].

367 Refer to Department for Education, Children and Young People, *Advice for DoE Staff – Responding to Incidents, Disclosures and Suspicions of Child Sexual Abuse* (2022).

368 Department for Education, *Managing Allegations of Sexual Misconduct in SA Education and Care Settings* (Government of South Australia, 2019) 14 [3.3]; Government of South Australia, *Report of the Independent Education Inquiry* (Report, 2013) 252 [3.3].

369 Department for Education, *Managing Allegations of Sexual Misconduct in SA Education and Care Settings* (Government of South Australia, 2019) 14 [3.3.1]; Government of South Australia, *Report of the Independent Education Inquiry* (Report, 2013) 252 [3.3.1].

370 Government of South Australia, *Report of the Independent Education Inquiry* (Report, 2013) 200 [610].

371 Government of South Australia, *Report of the Independent Education Inquiry* (Report, 2013) 230 [692]–231 [693], 252 [3.3.2], 280 [12].

372 Department for Education, *Managing Allegations of Sexual Misconduct in SA Education and Care Settings* (Government of South Australia, 2019) 14 [3.3.2].

373 Department for Education, *Managing Allegations of Sexual Misconduct in SA Education and Care Settings* (Government of South Australia, 2019) 14 [3.3.2].

374 Department for Education, *Managing Allegations of Sexual Misconduct in SA Education and Care Settings* (Government of South Australia, 2019) 15 [3.3.2].

375 Department for Education, *Managing Allegations of Sexual Misconduct in SA Education and Care Settings* (Government of South Australia, 2019) 15 [3.3.2].

376 Department for Education, *Managing Allegations of Sexual Misconduct in SA Education and Care Settings* (Government of South Australia, 2019) 14 [3.3.2]; Government of South Australia, *Report of the Independent Education Inquiry* (Report, 2013) 252 [3.3.2].

377 Government of South Australia, *Report of the Independent Education Inquiry* (Report, 2013) 231 [693].

378 Government of South Australia, *Report of the Independent Education Inquiry* (Report, 2013) 231 [693], 252 [3.3.2], 280 [12].

379 Government of South Australia, *Report of the Independent Education Inquiry* (Report, 2013) 231 [693].

380 Government of South Australia, *Report of the Independent Education Inquiry* (Report, 2013) 183 [555], 252 [3.3.2], 253 [3.3.3].

381 Department for Education, *Managing Allegations of Sexual Misconduct in SA Education and Care Settings* (Government of South Australia, 2019) 15 [3.3.3].

382 Government of South Australia, *Report of the Independent Education Inquiry* (Report, 2013) 194 [592], 253 [3.3.3]. Refer also to Department for Education, *Managing Allegations of Sexual Misconduct in SA Education and Care Settings* (Government of South Australia, 2019) 15 [3.3.3].

383 Government of South Australia, *Report of the Independent Education Inquiry* (Report, 2013) 277 [1–2].

384 Government of South Australia, *Report of the Independent Education Inquiry* (Report, 2013) 253–254 [3.3.4].

385 Statement of Timothy Bullard, 31 October 2022, 3 [13].

386 Letter from Timothy Bullard to the Commission of Inquiry, 9 February 2023, 8.

387 National Office for Child Safety, 'Discussion Paper from the National Clinical Reference Group – Language and Terminology' (Discussion Paper, December 2022); Statement of Dale Tolliday, 29 April 2022, 3 [14]. Harmful sexual behaviours are also discussed in the out of home care setting in Chapter 9, Ashley Youth Detention Centre in Chapter 12, and therapeutic interventions in Chapter 21. For more information about harmful sexual behaviours in institutional contexts, refer to the National Royal Commission's final report, which outlines important research and understanding of this form of child sexual abuse: *Royal Commission into Institutional Responses to Child Sexual Abuse* (Final Report, December 2017) vol 10.

388 *Royal Commission into Institutional Responses to Child Sexual Abuse* (Final Report, December 2017) vol 13, 29.

389 Department of Justice, 'Summary Table of Tasmanian Government Progress Towards Implementing the National Royal Commission Recommendations', 22 September 2021, 49 [13.6], produced by the Tasmanian Government in response to a Commission notice to produce.

390 Stephen Smallbone and Tim McCormack, *Independent Inquiry into the Tasmanian Department of Education's Responses to Child Sexual Abuse* (Report, 7 June 2021) 80.

391 Statement of Leanne McLean, 12 April 2022, 32 [111].

392 Anonymous session, 12 October 2022; Anonymous session, 16 August 2022; Anonymous session, 17 February 2022.

393 Submission 093 Anonymous, 1; Statement of Nigel Russell, 29 April 2022, 2–3 [15]; Transcript of Ignatius Kim, 9 May 2022, 689 [12–13].

394 Submission 093 Anonymous, 1; Submission 086 Angela Sdrinis Legal, 78; Statement of Ignatius Kim, 20 April 2022, 7 [45].

395 Anonymous session, 16 August 2022; Anonymous session, 12 October 2022; Anonymous session, 17 February 2022; Submission 086 Angela Sdrinis Legal, 78; Burnie consultation, 24 August 2021; Hobart consultation, 13 August 2021.

396 Submission 086 Angela Sdrinis Legal, 78; Anonymous session, 16 August 2022; Anonymous session, 12 October 2022; Anonymous session, 17 February 2022.

397 Consultation with Tasmania Police (Hobart), 25 August 2021; Anonymous session, 12 October 2022.

398 Burnie consultation, 24 August 2021; Hobart consultation, 13 August 2021.

399 Anonymous session, 12 October 2022.

400 Anonymous session, 17 February 2022.

401 Anonymous session, 13 October 2021.

402 Submission 093 Anonymous, 1.

403 Transcript of Ignatius Kim, 9 May 2022, 684 [39–45].

404 Transcript of Ignatius Kim, 9 May 2022, 686 [41–45].

405 Statement of Ignatius Kim, 20 April 2022, 7 [45]; Transcript of Ignatius Kim, 9 May 2022, 687 [1–6].

406 Statement of Renae Pepper, 30 April 2022, 12 [51].

407 Statement of Renae Pepper, 30 April 2022, 12 [51].

408 Statement of Nigel Russell, 28 April 2022, 3 [22–23].

409 Statement of Nigel Russell, 28 April 2022, 3 [22].

410 Statement of Renae Pepper, 30 April 2022, 6 [25].

411 Statement of Renae Pepper, 30 April 2022, 12 [50].

412 Statement of Renae Pepper, 30 April 2022, 6 [26].

413 Statement of Renae Pepper, 30 April 2022, 11 [46].

414 Statement of Kerryann Walsh, 15 April 2022, 6 [19].

415 Statement of Kerryann Walsh, 15 April 2022, 6 [19].

416 Transcript of Renae Pepper, 10 May 2022, 733 [4–5].

417 Statement of Renae Pepper, 30 April 2022, 13 [51].

418 Statement of Renae Pepper, 30 April 2022, 13 [51].

419 Statement of Dale Tolliday, 29 April 2022, 17 [71].

420 Submission 078 Anonymous, 3.

421 Transcript of Monique Carter, 10 May 2022, 774 [28–32].

422 Transcript of Monique Carter, 10 May 2022, 773 [22–24].

423 Statement of Debra Drake, 6 May 2022, 7 [45].

424 Statement of Debra Drake, 6 May 2022, 7 [44].

425 Transcript of Ignatius Kim, 9 May 2022, 688 [32–36].

426 Transcript of Timothy Bullard, 12 May 2022, 988 [21–24].

427 Transcript of Timothy Bullard, 12 May 2022, 988 [39–43].

428 Statement of Timothy Bullard, 6 June 2022, 13 [53].

429 Statement of Timothy Bullard, 10 May 2022, 30 [19(d)].

430 Statement of Timothy Bullard, 10 May 2022, 30 [19(d)]; Statement of Renae Pepper, 30 April 2022, 3 [14].

431 Statement of Timothy Bullard, 10 May 2022, 30 [19(d)].

432 Statement of Timothy Bullard, 10 May 2022, 12 [72].

433 Statement of Timothy Bullard, 10 May 2022, 12 [73], 39 [236].

434 Statement of Timothy Bullard, 10 May 2022, 12 [73].

435 Letter from Timothy Bullard to Commission of Inquiry, 9 February 2023, 2.

436 Letter from Timothy Bullard to Commission of Inquiry, 9 February 2023, 2.

437 Letter from Timothy Bullard to Commission of Inquiry, 9 February 2023, 2.

438 Statement of Timothy Bullard, 10 May 2022, 37 [226]–39 [235]; Department for Education, Children and Young People, 'Responding to Incidents, Disclosures or Suspicions of Harmful Sexual Behaviour Initiated by a Child or Young Person (Flowchart)', undated, produced by the Tasmanian Government in response to a Commission notice to produce.

439 Statement of Elizabeth Jack, 29 April 2022, Annexure 8 (Flowchart: 'Responding to Incidents, Disclosures or Suspicions of Child Sexual Abuse by a Current or Former DoE Employee', undated).

440 Statement of Timothy Bullard, 10 May 2022, 38 [229]; Statement of Elizabeth Jack, 29 April 2022, Annexure 8 (Flowchart: 'Responding to Incidents, Disclosures or Suspicions of Child Sexual Abuse by a Current or Former DoE Employee', undated).

441 Statement of Timothy Bullard, 10 May 2022, 38 [230].

442 Department for Education, Children and Young People, 'Responding to Incidents, Disclosures or Suspicions of Harmful Sexual Behaviour Initiated by a Child or Young Person (Flowchart)', undated, produced by the Tasmanian Government in response to a Commission notice to produce.

443 Department for Education, Children and Young People, 'Responding to Incidents, Disclosures or Suspicions of Harmful Sexual Behaviour Initiated by a Child or Young Person (Flowchart)', undated, produced by the Tasmanian Government in response to a Commission notice to produce.

444 Department for Education, Children and Young People, 'Responding to Incidents, Disclosures or Suspicions of Harmful Sexual Behaviour Initiated by a Child or Young Person (Flowchart)', undated, produced by the Tasmanian Government in response to a Commission notice to produce.

445 Statement of Elizabeth Jack, 29 April 2022, Annexure 8 (Flowchart: 'Responding to Incidents, Disclosures or Suspicions of Child Sexual Abuse by a Current or Former DoE Employee', undated).

446 Statement of Timothy Bullard, 10 May 2022, 40 [240].

447 Tasmania, *Parliamentary Debates*, House of Assembly, 14 November 2000, 43 (Paula Wriedt, Minister for Education).

448 Refer to *Australian Professional Standards for Teachers*, Standard 4, Focus area 4.4.

449 *Royal Commission into Institutional Responses to Child Sexual Abuse* (Final Report, December 2017) vol 13, 60.

450 Refer to Department for Education, Children and Young People, *Registration to Work with Vulnerable People Policy* (2021).

451 *Royal Commission into Institutional Responses to Child Sexual Abuse* (Final Report, December 2017) vol 13, 168.

452 Tasmania, *Parliamentary Debates*, House of Assembly, 14 November 2000, 40 (Paula Wriedt, Minister for Education).

453 In relation to applications for registration, refer to *Teachers Registration Act 2000* pt 3. In relation to discipline and inquiries, refer to *Teachers Registration Act 2000* pt 4.

454 Ben Mathews, *Oversight and Regulatory Mechanisms Aimed at Protecting Children from Sexual Abuse: Understanding Current Evidence of Efficacy* (Report prepared for the Royal Commission into Institutional Responses to Child Sexual Abuse, 2017) 88 [2.7.4.4.1].

455 Refer to *Teachers Registration Act 2000* s 6A; Teachers Registration Board, *Employing Teachers in Tasmania* (Web Page, 2022) <https://www.trb.tas.gov.au/employing-teachers-in-tasmania/>.

456 *Teachers Registration Act 2000* s 6.

457 *Teachers Registration Act 2000* s 7A.

458 Teachers Registration Board, *About Us* (Web Page, 2022) <https://www.trb.tas.gov.au/about-us/>.

459 *Teachers Registration Act 2000* s 6A(d)–(e).

460 *Teachers Registration Act 2000* s 6A(f) s 24.

461 *Teachers Registration Act 2000* s 6A(i).

462 *Teachers Registration Act 2000* s 7A.

463 Statement of Ann Moxham, 27 April 2022, 2 [1.5].

464 Under the *Teachers Registration Act 2000* s 11, it is an offence to teach in these institutions without registration or a Limited Authority to Teach.

465 *Teachers Registration Act 2000* pt 3, div 3.

466 *Teachers Registration Act 2000* s 11.

467 *Teachers Registration Act 2000* s 17J(a).

468 *Teachers Registration Act 2000* s 17J(a)(b).

469 *Teachers Registration Act 2000* s 17J(b); Teachers Registration Board, *Determining Good Character and Fitness to Teach: Board Policy July 2020* (Version 1.2, 8 October 2022). The Teachers Registration Board may also take into account any other matter it considers relevant: *Teachers Registration Act 2000* s 17J.

470 *Teachers Registration Act 2000* ss 7A, 17J(c); Teachers Registration Board, *Annual Report 2020* (Report, 2021) 30.

471 *Teachers Registration Act 2000* s 17K; Teachers Registration Board, *Determining Good Character and Fitness to Teach: Board Policy July 2020* (Version 1.2, 8 October 2022).

472 Teachers Registration Board, *Determining Good Character and Fitness to Teach: Board Policy July 2020* (Version 1.2, 8 October 2022).

473 Teachers Registration Board, *Determining Good Character and Fitness to Teach: Board Policy July 2020* (Version 1.2, 8 October 2022).

474 *Teachers Registration Act 2000* ss 16, 17A. Provisionally registered teachers should become fully registered within five years. Limited Authorities to Teach are granted for a period of up to two years.

475 Teachers Registration Board, *Professional Boundaries: Guidelines for Tasmanian Teachers* (2021) 8.

476 Teachers Registration Board, *Professional Boundaries: Guidelines for Tasmanian Teachers* (2021) 8.

477 Teachers Registration Board, *Professional Boundaries: Guidelines for Tasmanian Teachers* (2021) 7–8.

478 Teachers Registration Board, *Professional Boundaries: Guidelines for Tasmanian Teachers* (2021) 9.

479 Teachers Registration Board, *Professional Boundaries: Guidelines for Tasmanian Teachers* (2021) 9. Teachers must also abide by the Code of Professional Ethics, which is a statement about 'the ethical commitments, practices and aspirations that underpins the identity of the teaching profession in Tasmania'. Refer to Statement of Ann Moxham, 27 April 2022, 9 [6.3].

480 Statement of Ann Moxham, 27 April 2022, 9 [6.2].

481 *Teachers Registration Act 2000* s 18.

482 *Teachers Registration Act 2000* s 3 (definition of 'prescribed offence').

483 *Teachers Registration Act 2000* s 27A(3)–(4).

484 *Teachers Registration Act 2000* s 19.

485 *Teachers Registration Act 2000* s 19(3)(a)(i)–(ii). Section 19(2) of the *Teachers Registration Act 2000* requires complaints to be in writing and disclose the name and address of the complainant.

486 *Teachers Registration Act 2000* s 6A(d).

487 Statement of Ann Moxham, 27 April 2022, 21 [13.2].

488 Statement of Ann Moxham, 27 April 2022, 21 [13.4].

489 Statement of Ann Moxham, 27 April 2022, 8 [5.13].

490 *Teachers Registration Act 2000* ss 20(1)(a), 20(1)(c), 31.

491 *Teachers Registration Act 2000* s 24. This also applies in respect of a Limited Authority to Teach.

492 *Teachers Registration Act 2000* s 17BA(2)–(3).

493 *Teachers Registration Act 2000* s 24B.

494 Statement of Ann Moxham, 27 April 2022, 17 [10.23].

495 Statement of Ann Moxham, 27 April 2022, 17 [10.23].

496 *Teachers Registration Act 2000* s 24B(2)(b).

497 *Teachers Registration Act 2000* s 26A; Teachers Registration Regulations 2021 reg 5(1).

498 *Teachers Registration Act 2000* s 17(a).

499 Statement of Ann Moxham, 27 April 2022, 18 [11.5].

500 Teachers Registration Board, *Annual Report 2020* (Report, 2021) 43.

501 Watched Registrations contains a person's Teachers Registration Board number, their registration type, the expiry date of their registration and the cycle expiry date (end of five-year cycle registration). Refer to Teachers Registration Board, *Watched Registrations* (Web Page) <https://www.trb.tas.gov.au/watched-registrations>.

502 Teachers Registration Board, *Watched Registrations* (Web Page) <https://www.trb.tas.gov.au/watched-registrations>.

503 Statement of Ann Moxham, 27 April 2022, 3 [3.4].

504 Statement of Jenny Gale, 23 November 2022, Annexure 3 (Keeping Children Safer – Implementation Status Report – as at 16 November 2022, Ref 18); refer to Department of Premier and Cabinet, 'Keeping Children Safer Implementation Status Report', *Keeping Children Safer* (Policy Document, 31 May 2023) 5, Action 18 <https://www.dpac.tas.gov.au/keepingchildrensafer>.

505 *Royal Commission into Institutional Responses to Child Sexual Abuse* (Final Report, December 2017) vol 13, 248.

506 *Royal Commission into Institutional Responses to Child Sexual Abuse* (Final Report, December 2017) vol 13, 248. Refer also to vol 8, 283.

507 *Royal Commission into Institutional Responses to Child Sexual Abuse* (Final Report, December 2017) vol 8, 292.

508 *Royal Commission into Institutional Responses to Child Sexual Abuse* (Final Report, December 2017) vol 8, 30.

509 Refer to Teachers Registration Board, 'Teacher Search', *TRB Online* (Web Page) <https://trbonline.trb.tas.gov.au/Home/Search>. Information provided includes registration number, name, type of registration and date until which the person is registered.

510 *Teachers Registration Act 2000* s 25(4)(a).

511 *Teachers Registration Act 2000* s 32A.

512 Statement of Ann Moxham, 27 April 2022, 13 [9.10].

513 *Teachers Registration Act 2000* s 17L.

514 Statement of Ann Moxham, 27 April 2022, 13 [9.10].

515 Statement of Ann Moxham, 27 April 2022, 13 [9.23].

516 Statement of Ann Moxham, 27 April 2022, 13 [9.25].

517 Statement of Ann Moxham, 27 April 2022, 13 [9.25].

518 Statement of Ann Moxham, 10 June 2022, 2 [2][A].

519 Statement of Ann Moxham, 10 June 2022, 2 [2][A]. Note that under the *Teachers Registration Act 2000* s 12(3), the Board can request information relating to an applicant from any registration authority or any other person or government department. However, this only applies in respect of an application for registration and the applicant must authorise the Board to obtain the information.

520 Transcript of Ann Moxham, 12 May 2022, 995 [11–15].

521 Transcript of Ann Moxham, 12 May 2022, 995 [14–24].

522 Transcript of Ann Moxham, 12 May 2022, 995 [16–20]. Note that this would be subject to any other applicable exceptions to the application of the Act's principles as set out in sch 1 cl 2 of the *Personal Information Protection Act 2004*: sch 1 cl 2(1)(b).

523 Transcript of Ann Moxham, 12 May 2022, 995 [1–7], 1011 [35–36].

524 Statement of Emily Sanders, 5 May 2022, 22 [91].

525 Transcript of Ann Moxham, 12 May 2022, 998 [5–16].

526 Transcript of Ann Moxham, 12 May 2022, 997 [39–44].

527 Transcript of Timothy Bullard, 13 May 2022, 1081 [3–4].

528 Statement of Timothy Bullard, 6 June 2022, 3–4 [10].

529 Transcript of Timothy Bullard, 13 May 2022, 1091 [20–24].

530 Refer to Transcript of Timothy Bullard, 13 May 2022, 1091 [9–12]; Transcript of Timothy Bullard, 12 September 2022, 3941 [37–44].

531 Transcript of Timothy Bullard, 13 May 2022, 1083 [34–42].

532 Transcript of Timothy Bullard, 13 May 2022, 1081 [39–44].

533 Stephen Smallbone and Tim McCormack, *Independent Inquiry into the Tasmanian Department of Education's Responses to Child Sexual Abuse* (Report, 7 June 2021) 14.

534 Stephen Smallbone and Tim McCormack, *Independent Inquiry into the Tasmanian Department of Education's Responses to Child Sexual Abuse* (Report, 7 June 2021) 14.

535 Statement of Ann Moxham, 27 April 2022, 12 [9.16].

536 Transcript of Timothy Bullard, 13 May 2022, 1084 [10–14].

537 Transcript of Jenny Gale, 13 September 2022, 4021 [9–22].

538 Statement of Emily Sanders, 5 May 2022, 11 [46].

539 Statement of Emily Sanders, 5 May 2022, 11 [48].

540 *Teachers Registration Act 2000* s 32A(1).

541 *Teachers Registration Act 2000* s 32A(2).

542 Statement of Timothy Bullard, 'Brad', 4 April 2022, 17 [65].

543 Statement of Timothy Bullard, 'Brad', 4 April 2022, 17 [66].

544 It should also be noted that the *Personal Information Act 2004* is also currently a barrier to keeping complainants informed about their complaints.

545 Transcript of Jenny Gale, 13 September 2022, 4022 [34–36].

546 Transcript of Jenny Gale, 13 September 2022, 4021 [17–21].

547 *Personal Information Protection Act 2004* s 13.

548 *Personal Information Protection Act 2004* s 14(1)(a).

549 Transcript of Timothy Bullard, 12 September 2022, 3941 [12–15].

550 Refer to *Registration to Work with Vulnerable People Act 2013* s 52A.

551 *Personal Information Protection Act 2004* s 4.

552 *Personal Information Protection Act 2004* sch 1 cl 2(1)(f).

553 Statement of Timothy Bullard, 6 June 2022, 2 [6]. The notification is made by Workplace Relations. Refer to Department for Education, Children and Young People, *Advice for DoE Staff – Responding to Incidents, Disclosures and Suspicions of Child Sexual Abuse* (2022) 1.

554 Statement of Timothy Bullard, 6 June 2022, 2 [7].

555 *Child and Youth Safe Organisation Act 2023* s 42.

556 Statement of Ann Moxham, 27 April 2022, 3 [3.2]; Transcript of Ann Moxham, 12 May 2022, 1008 [12–20].

557 Transcript of Ann Moxham, 12 May 2022, 1008 [11–21].

558 Transcript of Ann Moxham, 12 May 2022, 1008 [14–20].

559 Transcript of Ann Moxham, 12 May 2022, 1008 [22–26].

560 Statement of Ann Moxham, 27 April 2022, 3 [3.6].

561 Transcript of Ann Moxham, 12 May 2022, 1008 [8–11].

562 *Royal Commission into Institutional Responses to Child Sexual Abuse* (Final Report, December 2017) vol 13, 249.

563 *Royal Commission into Institutional Responses to Child Sexual Abuse* (Final Report, December 2017) vol 13, 249.

564 Statement of Ann Moxham, 27 April 2022, 8 [5.15]–9 [5.21].

565 *Teachers Registration Act 2000* s 11(1). A penalty unit is the base amount from which a monetary penalty is calculated. The base amount is adjusted each year according to movements in the consumer price index (for Hobart) in the previous year and notice of the amount is published in the Gazette: refer to *Penalty Units and Other Penalties Act 1987*. The penalty unit amount for 1 July 2022 to 30 June 2023 is $181.

566 *Teachers Registration Act 2000* s 27(1).

567 *ACT Teacher Quality Institute Act 2010* (ACT) ss 28–29; *Teacher Accreditation Act 2004* (NSW) s 28; *Teacher Registration (Northern Territory) Act 2004* (NT) s 73; *Education (Queensland College of Teachers) Act 2005* (Qld) ss 82–83; *Teachers Registration and Standards Act 2004* (SA) s 20; *Education and Training Reform Act 2006* (Vic) ss 2.6.56–2.6.56B; *Teacher Registration Act 2012* (WA) ss 6–7.

568 Transcript of Ann Moxham, 12 May 2022, 1012 [30–31].

569 Statement of Ann Moxham, 27 April 2022, 13 [9.25]; *Teachers Registration Act 2000* s 18. Section 3 of the *Teachers Registration Act 2000* defines prescribed offences as offences for which a sentence of imprisonment may be imposed.

570 Transcript of Ann Moxham, 12 May 2022, 1011 [44]–1012 [6].

571 Transcript of Ann Moxham, 12 May 2022, 1008 [14–21].

572 Statement of Ann Moxham, 27 April 2022, 8 [5.13]; refer to *Teachers Registration Act 2000* ss 6A(e), 6A(l).

573 Statement of Ann Moxham, 10 June 2022, 3.

574 Transcript of Ann Moxham, 12 May 2022, 1012 [19–29].

575 Australian Law Reform Commission, *Principled Regulation: Federal Civil and Administrative Penalties in Australia* (Report No 95, March 2003) 445.

576 Refer generally to *Monetary Penalties Enforcement Act 2005*. There are over 70 Tasmanian Acts that allow for infringement notices to be issued.

577 *Registration to Work with Vulnerable People Act 2013* s 55(2).

578 Infringement notices are governed by the *Monetary Penalties Enforcement Act 2005*.

579 *Teacher Registration (Northern Territory) Act 2004* (NT) s 73(1)–(2).

580 *ACT Teacher Quality Institute Act 2010* (ACT) s 28.

581 Government of Tasmania, Director of Public Prosecutions, *Prosecution Policy and Guidelines* (2022) 121.

582 *Teachers Registration Act 2000* s 24B.

583 Teachers Registration Board, *Annual Report 2020* (Report, 2021) 45.

584 Statement of Ann Moxham, 27 April 2022, 22 [21.2].

585 *Education (Queensland College of Teachers) Act 2005* (Qld) ss 48 and 49. 'Harm' is defined in s 7.

586 Refer to Victorian Institute of Teaching, *Immediate Action* (Web Page, 2021) <https://www.vit.vic.edu.au/conduct/immediate-action>.

587 Statement of Ann Moxham, 14 June 2022, 3 [2(C)].

588 Transcript of Ann Moxham, 12 May 2022, 1004 [23–30]. Commonwealth legislation adopted in 1992 sets out the scheme (refer to *Mutual Recognition Act 1992* (Cth)). All states and territories have implemented the scheme in their respective jurisdictions – for example, *Mutual Recognition (Tasmania) Act 1993*; *Mutual Recognition (New South Wales) Act 1992* (NSW); *Mutual Recognition (Victoria) Act 1998* (Vic); *Mutual Recognition (Queensland) Act 1992* (Qld); *Mutual Recognition (South Australia) Act 1993* (SA); *Mutual Recognition (Western Australia) Act 2020* (WA); *Mutual Recognition (Australian Capital Territory) Act 1992* (ACT); *Mutual Recognition (Northern Territory) Act 1992* (NT). A similar scheme exists with New Zealand: refer to *Trans-Tasman Mutual Recognition Act 1997* (Cth).

589 Transcript of Ann Moxham, 12 May 2022, 1004 [23–30]; Teachers Registration Board, *Mutual Recognition Policy* (9 March 2022) 3.

590 Teachers Registration Board, *Mutual Recognition Policy* (9 March 2022) 2.

591 Statement of Ann Moxham, 27 April 2022, 17 [10.28].

592 *Teachers Registration Act 2000* s 32A.

593 Department of Treasury and Finance, 'Automatic mutual recognition for occupational licences', *Economy* (Web Page, 2022) <https://www.treasury.tas.gov.au/economy/economic-policy-and-reform/automatic-mutual-recognition>.

594 Refer to, for example, Department of Treasury and Finance, 'Automatic Mutual Recognition for Occupational Licences', *Economy* (Web Page, 2022) <https://www.treasury.tas.gov.au/economy/economic-policy-and-reform/automatic-mutual-recognition>; refer generally to Department of the Prime Minister and Cabinet, *Improving Occupational Mobility* (Web Page) <https://deregulation.pmc.gov.au/priorities/improving-occupational-mobility>.

595 Stephen Smallbone and Tim McCormack, *Independent Inquiry into the Tasmanian Department of Education's Responses to Child Sexual Abuse* (Report, 7 June 2021) 11.

596 Statement of Ann Moxham, 14 June 2022, 5; Transcript of Timothy Bullard, 12 May 2022, 977 [14–34].

597 Statement of Ann Moxham, 14 June 2022, 5.

598 Statement of Ann Moxham, 14 June 2022, 5.

599 *Mutual Recognition Act 1992* (Cth) s 42S.

600 Transcript of Ann Moxham, 12 May 2022, 1013 [9–18]. Mandatory reporting requirements are set out in the *Children, Young Persons and Their Families Act 1997.*

601 Transcript of Ann Moxham, 12 May 2022, 1013 [9–18].

602 Alexander Morris Carr-Saunders and Paul Alexander Wilson, *The Professions* (Frank Cass & Co., 1964).

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604 Transcript of Ann Moxham, 12 May 2022, 1006 [32–37].

605 Statement of Ann Moxham, 27 April 2022, 8 [5.18].

606 Transcript of Ann Moxham, 12 May 2022, 999 [14–43].

607 Transcript of Ann Moxham, 12 May 2022, 1007 [22–37].

608 Transcript of Ann Moxham, 12 May 2022, 1007 [20–29].

609 Transcript of Ann Moxham, 12 May 2022, 1007 [22–37].

610 Transcript of Ann Moxham, 12 May 2022, 1007 [37–40].

611 Statement of Ann Moxham, 10 June 2022, 4 [2(G)].

612 Statement of Ann Moxham, 10 June 2022, 5.

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614 *Education Legislation Amendments (Education Regulation) Act 2022* s 13.

615 Clause Notes, Education Legislation Amendments (Education Regulation) Bill 2021, cl 150, s 10C.

616 Refer to Review of Education Regulation Steering Committee, *Review of Education Regulation – Steering Committee Report* (Report, December 2020) 42, Recommendation 18.

617 Teachers Registration Board, *Education Regulation Review – Draft Legislation: Response from the Board of the TRB, its Registrar and Staff* (Web Page, undated) 10 <https://publicdocumentcentre.education.tas.gov.au/library/Shared Documents/Submission-7-Teachers-Registration-Board.pdf>.

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619 Transcript of Timothy Bullard, 13 May 2022, 1091 [26–43].

620 Tasmania, *Parliamentary Debates*, House of Assembly, 14 November 2000, 40 (Paula Wriedt, Minister for Education).

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Commission of Inquiry into the Tasmanian Government's Responses to Child Sexual Abuse in Institutional Settings

Who was looking after me? Prioritising the safety of Tasmanian children

Volume 4: Children in out of home care

August 2023

Commission of Inquiry into the Tasmanian Government's Responses to Child Sexual Abuse in Institutional Settings Report

Volume 4
Children in out of home care

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President and Commissioner

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August 2023

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Introduction to Volume 4

This volume considers the care of children who the Tasmanian Government have removed from their families of origin and placed in out of home care since 2000. This is in line with the Order establishing our Commission of Inquiry. Where we refer to children who were in care before 2000, their experiences are relevant to informing the present system.

Out of home care is provided when children cannot live with their families because of safety concerns. In most cases, these children are placed with kinship or foster carers. Placements in residential care settings are far less common.

The Government is obligated to protect children in out of home care from abuse, including sexual abuse. This is enshrined in the *Children, Young Persons and Their Families Act 1997* ('Children, Young Persons and Their Families Act'). When a child is taken into care, the Secretary for the relevant department (currently the Department for Education, Children and Young People) applies to the Magistrates Court for guardianship and/or custody to be assigned to someone who is not the child's parent—either the Secretary of the Department or a third party—for the period of the order.[1] In exercising functions and powers under the Children, Young Persons and Their Families Act, the Secretary and their delegated officers must give 'paramount consideration' to the 'best interests of the child'. The State is obligated to protect these children from further harm, as well as provide them with opportunities to heal and support them to flourish.[2]

Unlike other groups of children receiving support from the Government, those in care live within the system and rely on government or government funded services and workers for their welfare. Children in care do not always have an advocate external to the Government (a role normally assumed by parents) who can supervise, support and protect them. Therefore, there is a heavy burden of responsibility on a statutory authority that has used the powers of the State to legally remove a child from their family of origin. Any failure to protect children from abuse in care is a significant betrayal of the trust conferred upon the State by such powers.

Children in care often, if not inevitably, have unresolved trauma from experiences of abuse or neglect that gave rise to them being taken into care. Tragically, children in care are much more likely to experience further maltreatment and exploitation, including sexual abuse, than children who are not in out of home care, and they find it more difficult to talk about their abuse and to get support for their healing and growth.

The Government has been alerted to the risk of sexual abuse for children in care several times through the findings of previous reviews of the Tasmanian statutory child protection and out of home care systems. The National Royal Commission also examined this. Throughout this volume we consider the progress that the Department

for Education, Children and Young People has made towards implementing the recommendations from these reports that relate to improving the safety of children in care from sexual abuse.

A note on language

Unless otherwise stated, references to ‘the Department’ in this volume are to the Tasmanian government department responsible for out of home care. During the period under examination by our Commission of Inquiry (that is, responses to reports of child sexual abuse since 1 January 2000), this Department has been called the Department of Health and Human Services, the Department of Communities (also referred to as Communities Tasmania) and the Department for Education, Children and Young People. In October 2022, departmental responsibility for out of home care transitioned from the Department of Communities to the newly formed Department for Education, Children and Young People. When we specifically refer to the previous Department of Communities or the new Department for Education, Children and Young People, we use the full name.

As described in the glossary, the terms ‘the Child Safety Service’ or 'Child Safety Services' are used generically across our report to describe the child protection functions of the Department, including its Strong Families, Safe Kids, Advice and Referral Line.

As well as assessing and investigating notifications about children in the community, the Child Safety Service (and specifically Child Safety Officers) perform case management functions for children in out of home care.

The Child Safety Service, including out of home care services and the Strong Families, Safe Kids Advice and Referral Line, are positioned within a Directorate, which has been variously named ‘Child and Youth Services’, ‘Children and Family Services’ and, currently, ‘Services for Children and Families’. We generally refer to the variously named Directorates as Services for Children and Families.

Our Inquiry into out of home care, laid out in this volume, has shown there is much more to be done. It has concluded that Tasmania’s out of home care system lacks many of the safeguards that help protect children from sexual abuse. We heard that few mechanisms are in place to engage Aboriginal communities in decision making about their children; there are no consistently applied standards for out of home care providers; professional development and other support for staff and carers is inconsistent; and monitoring and oversight of the system, internally and externally, is inadequate. Each of these problems, alone and together, increases the risk of child sexual abuse for children in care.

We also heard that the structures and processes to respond to reports of suspected child sexual abuse (as well as other abuses of children in care)—such as the care concern process and Serious Events Review Team—have been in transition, without a clear replacement. This means there has been no guarantee that the response to child sexual abuse has been consistent or appropriate. This failure of the State is deeply concerning and must be addressed as a matter of urgency.

We have concluded that problems in protecting children from, and responding to, child sexual abuse in out of home care partly stem from a lack of strategic, expert and active executive leadership. Fundamentally, however, these failings are the result of consecutive governments' chronic underfunding of, and failure to prioritise, out of home care and the statutory child protection system more generally

When approaching the issue of child sexual abuse in out of home care, we faced a dilemma: how to shine a light on an important issue for the safety of Tasmanian children in out of home care at the same time as acknowledging the challenging environment of child protection and the difficulties dedicated child protection workers face in any jurisdiction.

Soon after our hearings on out of home care in June 2022, a series of media articles highlighted problems in statutory child protection in every Australian jurisdiction.[3] Tasmania is not alone in facing the challenge of safeguarding children in care. However, the magnitude of the challenge should not deter those involved from continuing to try to improve the systems charged with protecting Tasmania's most vulnerable children, who have the right to be shielded from harm and given every opportunity to grow and thrive.

As former Child Safety Service staff told us, not only are many of the children who have been taken into care traumatised by their experiences of abuse and neglect, so too can the staff tasked with protecting them. We acknowledge that in scrutinising a traumatised system, people in that system may perceive our Inquiry as threatening.

We were reluctant to add to the stress that overburdened staff already feel. We consider most staff in the system are working to the best of their ability under difficult conditions and are often underappreciated. We acknowledge the skill and dedication required to work in child protection. To do their jobs well, Child Safety Service staff need to be enormously resourceful, particularly those on the 'frontline'. As a former Department employee noted in her statement:

> Many children and young people heal and thrive, due in no small part to their own extraordinary resilience and determination, and the commitment of those who care for them. This includes staff working in [the Child Safety Service], our service providers, our foster and kinship carers, and those supporting the [out of home care] system.[4]

We consider there should be greater accountability for Tasmania's out of home care system. Increased accountability for Government would motivate it to prioritise and assign the necessary resources to ensure the system works for the benefit of children in care. Increased accountability for executive staff would help to establish priorities, maintain the necessary structures and processes, and provide the leadership required to enable the out of home care system to operate safely for children in care.

We are also conscious that, because of our Inquiry, there will be families of children in care who become concerned about whether their children have been sexually abused. Family members may reasonably ask questions of the Child Safety Officer who is responsible for their child in care. We hope they will receive honest and transparent answers to their questions and be reassured that any known risks have been addressed.

While the scrutiny brought by our Inquiry may be unwelcome for some, there are many others who have bravely come forward because they believe, as we do, that the most vulnerable children in Tasmania—those who experience hurt, damage and shame, and are often forgotten—deserve the best possible protection from abuse, or further victimisation, when in out of home care. We have strived to be direct and honest in our assessment of the current system and of what needs to occur in future

This volume has three chapters. In Chapter 7, we cover the background and context for our Inquiry, describing Tasmania's out of home care system, discussing the risk factors and sources of risk for the sexual abuse of children in out of home care. We summarise the numerous reviews of the out of home care and child protection systems in Tasmania.

In Chapter 8, we outline our approach to inquiring into the out of home care system in Tasmania, including the scope of our Inquiry, the evidence we drew on and the picture we formed of the scale and nature of child sexual abuse in the system.

In Chapter 9, we analyse the systemic problems of out of home care in Tasmania that expose children to greater risk of sexual abuse. We make recommendations to change the system to measurably improve the safety and wellbeing of children in care.

7 Background and context: Children in out of home care

1 Introduction

In this chapter, we lay the foundation for our later analysis by understanding the Tasmanian out of home care system as it currently functions.

In Section 2, we describe the current arrangements for out of home care provision in Tasmania. We outline the legislative basis for the State removing a child into out of home care and the responsibilities of the statutory guardian of children in care—the Secretary of the Department. We detail the number of children in the various types of out of home care provided in Tasmania. Last, we describe the Department's organisational structure in relation to out of home care.

In Section 3, we briefly outline the risks and protective factors for sexual abuse of children in care identified by the National Royal Commission. Sources of risk include adults in the out of home care system, other children with whom children have contact while in care, and adults from outside the system who sexually exploit children in care. We identify the increased risk that some children face by virtue of their Aboriginality or disability.

Section 4 summarises the findings of the National Royal Commission, as well as those of the many reviews and reports into the out of home care and child protection systems in Tasmania that have been published since the early 2000s. We briefly consider the large number of recommendations that were made by these reviews but were too often not actioned.

2 Tasmania's out of home care system

In this section, we have attempted to describe the out of home care system in Tasmania. This was not an easy task. Our understanding of the system was derived from multiple sources and we have highlighted any contradictory information.

2.1 Defining 'out of home care'

The Department defines out of home care as:

> ... the system that provides formal care to children and young people who are assessed as unable to live safely at home. Where the Child Safety Service assesses that a child or young person is at risk in their home, they will seek a court application for the short or longer term care for those children and young people and an out of home care arrangement will be made for their day to day care. The Secretary of the Department of Communities Tasmania then becomes responsible for the care and protection of those children and young people.[5]

The Department's definition is broadly consistent with the nationally agreed definition of out of home care, namely: 'overnight care for children aged under 18 who are unable to live with their families due to child safety concerns', including 'placements approved by the relevant department for which there is ongoing case management and financial payment'.[6] Since 2018, for data collection purposes, the nationally agreed definition of out of home care has not formally included children on third-party guardianship orders. However, we consider that the Department still owes these children protection from abuse in care because the Department is the entity that statutorily intervened to remove the child from their family of origin and assigned guardianship or custody to a third party.[7] We explore this issue in more detail in Chapter 9.

In recent decades, Tasmania has followed other Australian jurisdictions in changing the way out of home care is provided. The out of home care model has moved from primarily housing children in large institutions to placing children in home-based settings with kinship or foster carers. Some children are still cared for in residential care settings, but these usually aim to be home-like and are small in scale.[8] Decreasing numbers of carers and increasing numbers of children in care have created, by necessity, new care types such as 'emergency care', which has paid rotational carers looking after children in temporary accommodation such as hotel rooms.[9] Different categories of out of home care are discussed in more detail in Section 2.5.

In Tasmania, the out of home care system primarily comprises the Department and non-government services that provide support to children on the Department's behalf. A range of government and non-government agencies also support 'the system'. These agencies are responsible for meeting the broad needs of children (including health, education and disability) and should play a part in protecting children.[10]

In this chapter, a reference to a child who is 'in out of home care', 'in care' or 'in the care of the Department' means a child who has been placed under the guardianship or custody of the Secretary—this includes children under a third-party guardianship order (their guardian is not the Secretary) following statutory removal by the Department, as the State retains obligations to protect such children.

2.2 A child's pathway through the system

2.2.1 Entering care

The Department typically becomes aware of a child who is at risk of abuse or neglect when someone who is concerned about the child contacts the Department's Strong Families, Safe Kids Advice and Referral Line ('Advice and Referral Line'). If staff on the Advice and Referral Line believe there is sufficient concern to warrant an assessment, they refer the matter to the Child Safety Service, whereupon a Child Safety Officer assesses the situation.[11]

If the assessment determines that the child needs care and protection, the Secretary can apply to the Magistrates Court (Children's Division) for a care and protection order for the child.[12] If the Court is satisfied that the child is at risk and that a care and protection order is necessary, it may make an order placing the child under the guardianship of the Secretary (among other possible orders).[13] Placing a child under the guardianship of the Secretary is a last resort, when a child cannot be properly protected from risk by any other means, and no other order would be in the child's best interests.[14] A child may be placed in care for a short time (for example, six months) or for a long time—sometimes until the child turns 18 years old.

Once a child has been placed under the Secretary's guardianship, the Secretary is responsible for deciding where the child should live, making arrangements for the child's education and medical treatment, and making any other arrangements for the child's care (these responsibilities are discussed in Chapter 9).[15] Increasingly, child protection departments across Australia are recognising that their obligations to support and care for children in care do not end when the child turns 18, with several states announcing extensions of support to the age of 21.[16]

When a Child Safety Officer collects the child to take them into care, they need to find somewhere for the child to stay until a longer-term arrangement can be made. Sometimes the Child Safety Officer can place the child with a family member (kinship care), but often the Child Safety Officer needs to find a temporary non-familial 'placement'. Respite carers or foster carers might look after the child until a decision is made about where the child should ultimately live.

The Child Safety Officer will try to find a foster family that is suitable for the child in the longer term. Often children will live with several foster carers throughout their time in care. For some children, their time in care is short-lived, but others 'grow up in care', living with carers or workers for more than a decade. Where possible, the number of placements is kept to a minimum, but many children live in multiple homes or settings, which can be unsettling and reinforce their sense of instability and rejection.

Some children cannot be placed with a foster family and are therefore placed in 'residential care', which is usually a house where the child lives on their own or with other children, under the supervision of youth workers or other paid carers. Although considered an option of 'last resort', many children are placed in residential care due to a lack of available foster or kinship carers, particularly a lack of carers who can meet the needs of children who are older, children with behavioural and mental health issues or those with disability. For some, residential care is the best placement option, but for many, residential care can be marked by an ongoing sense of a lack of safety and can lead to poorer outcomes.

The Department funds non-government organisations to provide some foster care and all residential care. The child's allocated Child Safety Officer supports the child on behalf of the Secretary, including by enrolling the child in school and ensuring they stay connected with their family of origin. Foster, kinship or paid residential carers provide the child with day-to-day physical, emotional and cultural support. Where a non-government service provider is contracted, it supports the carers to carry out their role.

At the time of writing, the Department had a team of Child Safety Officers who support the Department's own foster and kinship carers. These officers are separate to the Child Safety Officers who support children.

2.2.2 While in care

Children do best when they are surrounded by a network of supportive adults who understand and respond to their needs. While in care, it is the Department's policy that a child has a care team around them, coordinated by a Child Safety Officer.[17] This team should include important adults in the child's life—such as their carer, teacher, counsellor and paediatrician or doctor—and a representative from their cultural community (this is particularly important for Aboriginal children).[18]

The Department's policy is that the care team should meet regularly to develop and monitor the child's care plan. The plan should outline the child's needs and who is responsible for meeting those needs, and be updated to reflect the child's changing needs. Depending on the child's age, they may have a say in the plan through attending care team meetings.[19]

Members of the care team are jointly responsible for keeping the child safe from sexual abuse. They develop trusting relationships with the child, so if a child wants to disclose a concern about sexual abuse, they may feel comfortable to talk to a trusted adult in their

care team. The Child Advocate can also help a child raise a concern or get help if they are not feeling heard. When a child (or anyone else) raises a safety concern or discloses abuse, the Department uses its 'care concern process' to investigate the matter (discussed in Chapter 9).

2.3 The Secretary's responsibilities as guardian

Under the Children, Young Persons and Their Families Act, the Secretary is conferred 'the same rights, powers, duties, obligations and liabilities as a natural parent of the child' when assigned guardianship.[20] These duties include:

- deciding where the child will live, being mindful of securing a stable home[21]
- arranging education and medical care, and providing anything else that is necessary (including financial assistance)[22]
- providing for the physical, intellectual, psychological and emotional development of the child[23]
- reviewing the child's care and protection order to ensure it is still in the child's best interests.[24]

In carrying out the duties and responsibilities of a guardian, the Secretary must consider the best interests of the child to be paramount.[25] This is one of the objects of the Children, Young Persons and Their Families Act, and the guiding principle that underpins all decisions the Department makes in relation to children.[26] The Secretary relies on a detailed instrument of delegation to exercise these duties and responsibilities through departmental staff.[27]

Section 10E of the Act sets out a range of matters that must be considered in determining the best interests of a child. These matters are directly relevant to reducing the risk of child sexual abuse for children in out of home care.

Section 10E of the Children, Young Persons and Their Families Act

1. In performing functions or exercising powers under this Act, the best interests of the child must be the paramount consideration.
2. Without limiting the matters that may be taken into account in determining the best interests of a child, the following matters are to be taken into account for that purpose:
    a. the need to protect the child from physical, psychological and other harm and from exploitation;

b. the views of the child, having regard to the maturity and understanding of the child;

c. the capacity and willingness of the child's parents or other family members to care for the child;

d. the nature of the child's relationships with his or her parents, other family members and other persons who are significant in the child's life, including siblings;

e. the child's need for stable and nurturing relationships with his or her parents, other family members, other persons who are significant in the child's life and the community;

f. the child's need for stability in living arrangements;

g. the child's physical, emotional, intellectual, spiritual, developmental and educational needs;

h. the attitude to the child, and to the responsibilities of parenthood, demonstrated by each of the child's guardians;

i. the need to provide opportunities for the child to achieve his or her full potential;

j. the child's age, maturity, sex, sexuality and cultural, ethnic and religious backgrounds;

k. any other special characteristics of the child;

l. the likely effect on the child of any changes in the child's circumstances;

m. the least intrusive intervention possible in all the circumstances;

n. the opportunities available for assisting the child to recover from any trauma experienced—

   i. in relation to being separated from his or her parents, family and community; or

   ii. as a result of abuse or neglect;

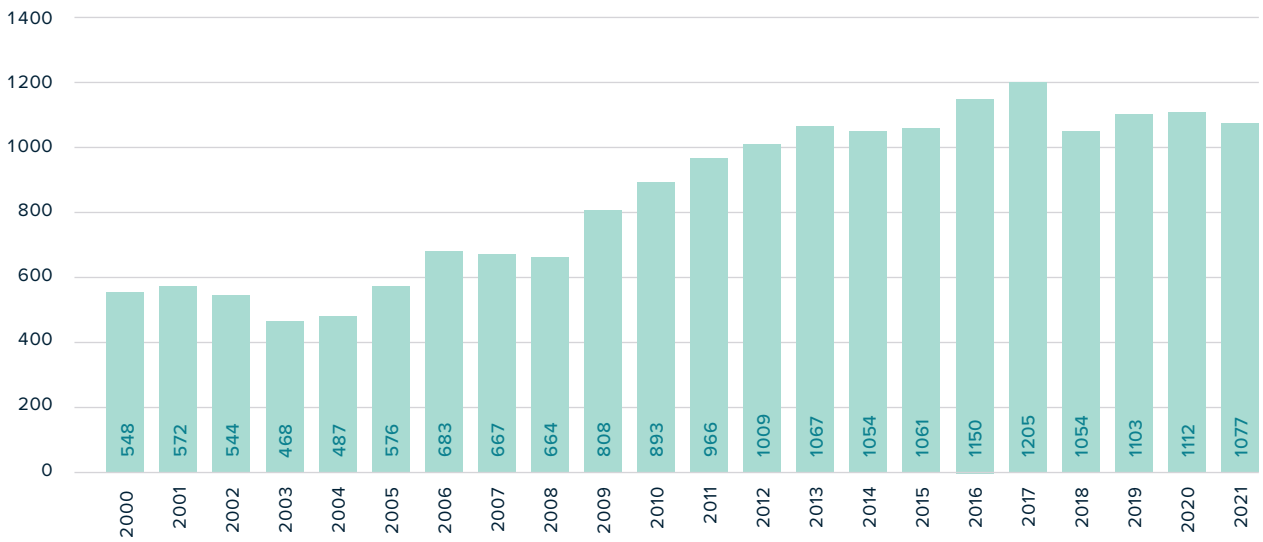
o. any persuasive reports of the child being harmed or at risk of harm and the cumulative effects of such harm or risk.

2.4 The number of children in care

The number of children in out of home care in Tasmania is reported monthly on the Department's website.[28] In April 2022, the website stated that 1,256 children were in out of home care in Tasmania; however, Michael Pervan, then Secretary, Department of Communities, reported that 1,034 children were in out of home care in the same period.[29] Secretary Pervan explained that the figures reported on the website include children on third-party guardianship orders.[30] For the sake of clarity, we will state whether data includes children on third-party guardianship orders where it is relevant to do so.

Since 2007, the number of children in out of home care in Tasmania in any given year has fluctuated, although the trend has been an increase (refer to Figure 7.1).

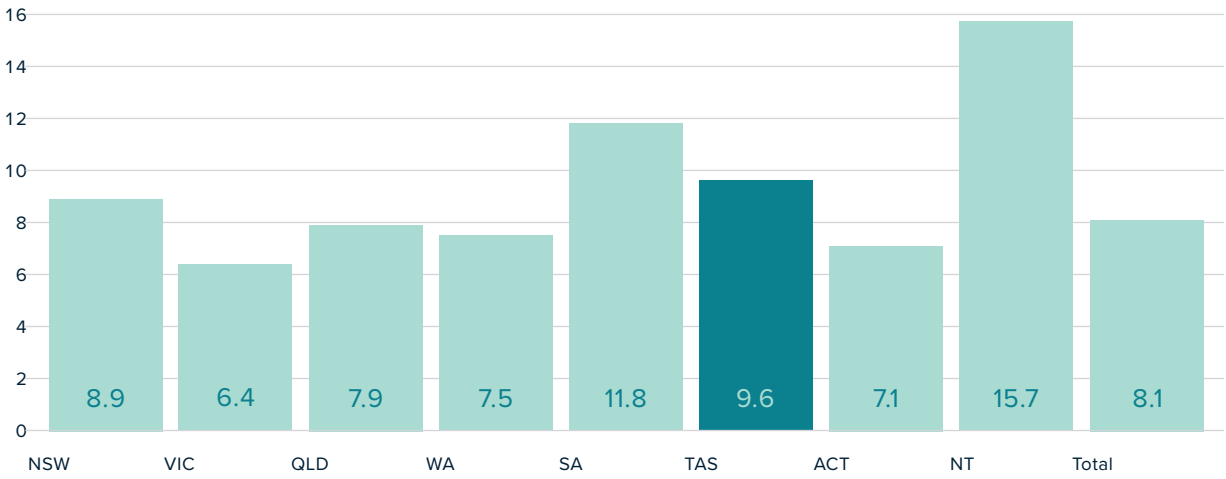
Figure 7.1: Number of children in out of home care in Tasmania, excluding third-party guardianship orders, from 30 June 2000 to 30 June 2021[31]



Source: Australian Institute of Health and Welfare, *Child Protection Australia* reports 2000–01 to 2020–21.

Given Tasmania's small population, it is also worth considering the relative number of children in care in Tasmania compared with other Australian jurisdictions. At 9.6 per 1,000 children in out of home care, Tasmania sits above the national average of 8.1 per 1,000 children (Figure 7.2).[32]

Figure 7.2: Rate of children per 1,000 in out of home care by state and territory[33]



Source: Australian Institute of Health and Welfare, *Child Protection Australia 2020–21.*

2.5 Types of out of home care

In her first Monitoring Report, covering 2018–19, Leanne McLean, Commissioner for Children and Young People, outlined the characteristics of the different forms of out of home care provided in Tasmania as follows:

> **Foster care**: A form of [out of home care] where the caregiver is authorised and provided a contribution for the cost of care by the state/territory for the care of the child. (This category excludes relatives/kin who are provided a contribution for the cost of care).
>
> **Kinship care**: A form of [out of home care] where the caregiver is either:
>
> - a relative (other than parents); or
> - considered to be a family member or a close friend; or
> - a member of the child or young person's community (in accordance with their culture); and
> - who is provided a contribution for the cost of care by the state/territory for the care of the child.
>
> For Aboriginal and Torres Strait Islander children, a kinship carer may be another Indigenous person who is a member of their community or a compatible community or from the same language group.
>
> ...
>
> **Residential care**: Where the placement is in a residential building whose purpose is to provide placements for children where there are paid staff. It appears through monitoring activities that the term 'residential care' is used by [out of home care] providers to describe [out of home care] arrangements provided to children and

young people by paid staff on a rostered 24/7 basis. Within this broad definition, arrangements of this sort ranged from a single child or young person living in a house with paid staff to two or more children and young people (who may or may not be related) living in a house with paid staff.

Respite care: A form of [out of home care] used to provide short-term accommodation for children and young people, where the intention is for the child to return to their prior home. In family-based [out of home care], this may be planned and regular to give the child's usual carers, parents or guardians a break.

...

Third-party guardianship: Transfer of guardianship to a third party is where a person other than the Secretary may be granted guardianship for a child or young person under a care and protection order. Under such an order, the guardian has the same rights, power, duties, obligations and liabilities as a natural parent of the child or young person would have.[34]

The Department describes sibling group care as 'a placement option for groups of three or more connected children who cannot be placed together in foster or kinship care'.[35]

More recently, the Department has funded children in residential care under 'special care packages', which were intended to enable 'a specific child's extraordinary level of need for care to be matched to care options including therapeutic, medical, disability or similar support'.[36] We discuss concerns about the Department's Special Care Package funding in Chapter 9.

Commissioner McLean reported that some children have 'independent living' arrangements.[37] Such arrangements presumably involve older children in care living independently, either in private or supported rental accommodation.

Table 7.1 sets out the most recent figures for the number of children in out of home care in Tasmania by the form of care (or type of placement). The table does not include children on third-party guardianship orders. National figures are included for comparison. The data indicates that:

- Like other jurisdictions, most children in out of home care in Tasmania live in a home-based environment.
- Within home-based care types, Tasmania has a higher proportion of children in foster care than in kinship care arrangements.
- Tasmania has a slightly lower proportion of children in residential care environments.

Table 7.1: Children in out of home care in Tasmania by type of placement, 2020–21[38]

Type of placement	Number of Tasmanian children	Placement type, Tasmania (%)	Placement type, national (%)
Foster care	556	51.6	36.1
Relative/kinship care	449	41.7	53.7
Other home-based care	0	0.0	1.3
Total home-based care	*1,005*	*93.3*	*91.1*
Family group homes	0	0.0	0.3
Residential care	64	5.9	7.3
Independent living	Not published due to small numbers	Not published due to small numbers	0.5
Other/unknown	Not published due to small numbers	Not published due to small numbers	0.8
Total	**1,077**	**100.0**	**100.0**

Source: Australian Institute of Health and Welfare, *Child protection Australia 2020–21*.

2.6 Government and non-government providers

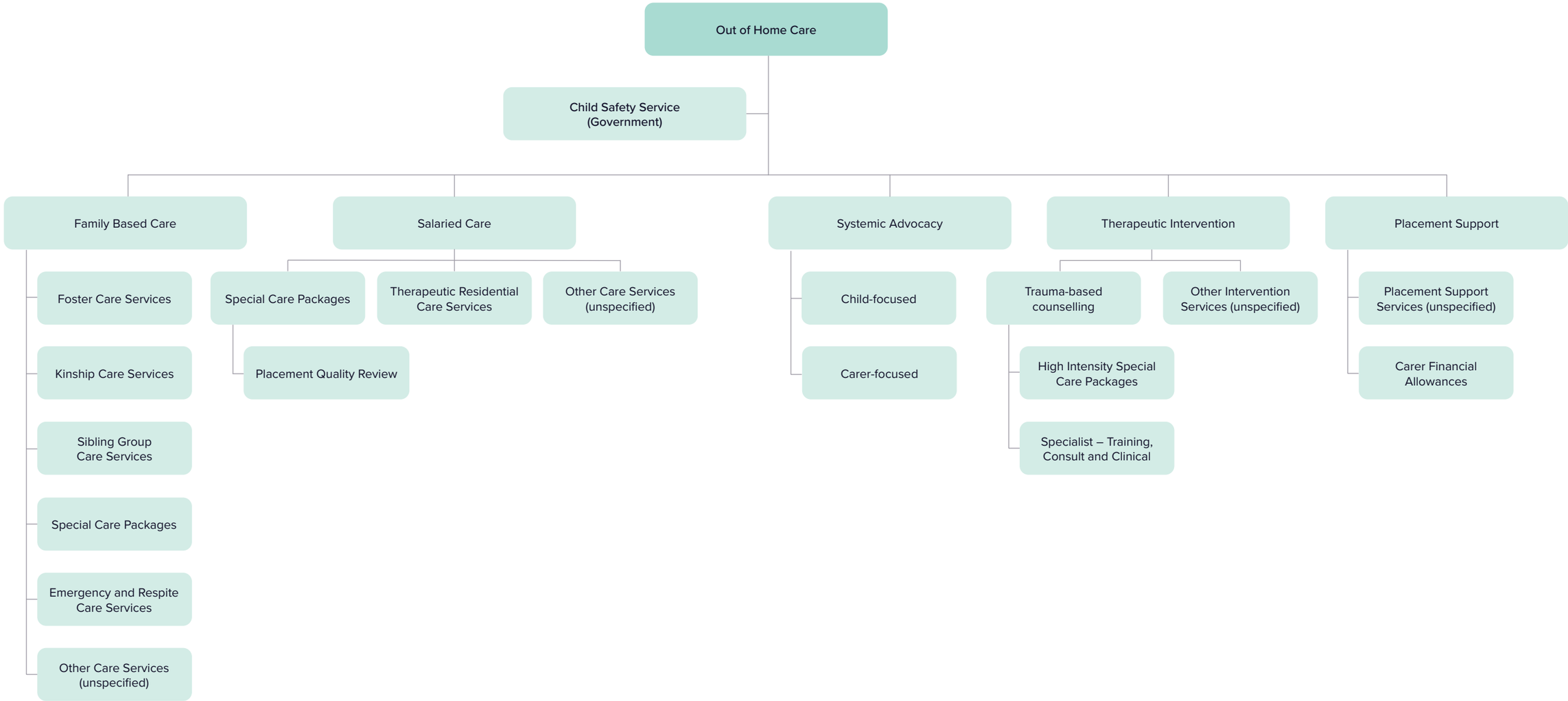
Out of home care in Tasmania is a 'hybrid system', where the Department directly provides some out of home care services and others are provided by Department funded non-government providers.[39]

The Department's out of home care 'service directory' maps the funded services available for children in out of home care under the categories of 'family-based care' (foster and kinship care) and 'salaried care' (residential care). Available funded support services are also independently listed in the directory.[40] This directory is reproduced at Figure 7.3.

Figure 7.3: Out of home care service directory provided by the Secretary[41]

On foldout →

Figure 7.3: Out of home care service directory provided by the Secretary[41]



Source: Statement of Michael Pervan, 6 June 2022.

We heard that the Department directly provides kinship care, foster care and respite care. It also supports children who are in independent living arrangements or on third-party guardianships.[42] The Department is the only facilitator of kinship care, but there are plans for a non-government organisation to share support for kinship care in the future.[43]

Of 968 children in family-based out of home care on 22 April 2022, the Department directly facilitated the care of 700 children (72 per cent), while the remaining 268 children (28 per cent) were living in foster care arrangements overseen and supported by non-government providers.[44] In 2020–21, 449 of the 1,005 children in departmental family-based care were living in kinship care.[45]

The non-government organisations the Department funded to provide out of home care services, or support for children in out of home care or their carers, in 2021–22 are listed in Table 7.2 (up to 22 April 2022). Several non-government providers—including Mosaic Support Services, Oak Tasmania and St Giles Society—are specialist disability support agencies.

Table 7.2: Non-government organisations the Department funded to provide out of home care services by type of service and number of children in the service, 1 July 2021 – 22 April 2022[46]

Organisation	Service provided	Number of children who received the service on 22 April 2022
Anglicare	Special care packages	1
Australian Childhood Foundation	Special care packages and Australian Childhood Foundation-only packages	Not reported
Australian Childhood Foundation	Therapeutic assessment and review	Not reported
Australian Childhood Foundation	Therapeutic services for children in out of home care	Not reported
Australian Childhood Foundation	Therapeutic operating model for the Many Colours One Direction program	Not reported
Baptcare	Family-based foster care	15
Caring Hearts	Special care packages	1
Catholic Care	Capability – salaried care	0
Catholic Care	A team for special care packages and Bringing Baby Home program	0
Catholic Care	Special care packages	5
Choice Supports Tasmania	Special care packages	1
CREATE Foundation Ltd	Advocacy (Connect, Empower and Change program)	Not reported
Devonfield	Special care packages	0
Eskleigh	Special care packages	2
Foster and Kinship Carers Association of Tasmania	Advocacy	Not reported

Organisation	Service provided	Number of children who received the service on 22 April 2022
Glenhaven Family Care Inc.	Emergency and respite care	3,000 (bed nights block-funded)
Glenhaven Family Care Inc.	A team for special care packages and Bringing Baby Home program	0
Glenhaven Family Care Inc.	Family-based foster care	21
Glenhaven Family Care Inc.	Special care packages	19
iCare	Special care packages	1
Inglis Support Services	Special care packages	1
Kennerley Children's Home Inc.	Emergency and respite care	2,158 (bed nights block-funded)
Kennerley Children's Home Inc.	Moving On Program (transition from care)	Not reported
Kennerley Children's Home Inc.	Family-based foster care	105
Key Assets	Sibling group care	59 (bed nights block-funded)
Life Without Barriers	Family-based foster care	66
Life Without Barriers	Special care packages	7
Langford	Special care packages	3
Many Colours One Direction (Northern Territory)	Special care packages	0
Mosaic Support Services	Special care packages	5
MSJ Aust	Special care packages	Not reported
Nexus	Special care packages	0
Oak Tasmania	Special care packages	0
St Giles Society	Special care packages	1

Source: Statement of Michael Pervan, 7 June 2022.

The Foster and Kinship Carers Association of Tasmania advised us that Baptcare also provides statewide support for kinship carers.[47]

2.7 Number of foster and kinship carers

The Foster and Kinship Carers Association of Tasmania believes there are about 1,200 foster and kinship carers in Tasmania. Of these, the Department directly engaged about half, and non-government out of home care providers engaged the other half.[48]

According to the Australian Institute of Health and Welfare, on 30 June 2021 there were 566 Tasmanian households that were officially caring for at least one child in out of home care as foster carers or kinship carers.[49] Table 7.3 lists the number of Tasmanian households, type of placement and number of children in each home. It shows that foster care households are more likely to have larger numbers of children in care living with them than kinship care households.

Table 7.3: Tasmanian carer households by number of children in the placement and type of placement, 2020–21[50]

Number of children in placement	Number of foster care households	Number of kinship care households
1	112 (41.6%)	196 (66.0%)
2	80 (29.7%)	68 (22.9%)
3+	77 (28.7%)	33 (11.1%)[51]
Total	**269 (100%)**	**297 (100%)**

Source: Derived from Australian Institute of Health and Welfare, *Child Protection Australia 2020–21.*

In addition to these figures, the Foster and Kinship Carers Association informed us of 'thousands' of informal kinship carers in Tasmania who are not included in official statistics and who do not have access to the same supports as formal carers.[52] While we acknowledge the incredible commitment of these informal kinship carers, their situations fall outside the scope of our Inquiry because the children they care for are not in 'institutional' care.

2.8 Department structure

In October 2022, the Department of Communities' child protection and out of home care functions transferred to the new Department for Education, Children and Young People.[53] In the new Department, the child protection and out of home care systems sit under an Executive Director who reports to a Deputy Secretary for Keeping Children Safe (refer to Appendix G for the organisational structure of the new Department). The Child Advocate, whose role is described in detail in Chapter 9, reports directly to the Secretary, as was the case in the Department of Communities. The current Secretary of the Department for Education, Children and Young People is Timothy Bullard.

Given that the Department of Communities was responsible for statutory child protection and out of home care for most of our Inquiry, it is also important to understand the structure of that Department, particularly the mechanisms that were in place to protect children from sexual abuse in out of home care and to respond when they had been harmed.[54]

Michael Pervan was the Secretary of the Department of Communities (and its predecessor, the Department of Health and Human Services), from May 2014 to October 2022, with a gap between July 2018 and September 2019, when Ginna Webster filled the role. Before this, between 2000 and May 2014, seven people held the position at different times.[55]

In the Department of Communities, the Children, Youth and Families division was one of four large service divisions that each sat under a Deputy Secretary. Within this division, an Executive Director headed Children and Family Services. The Child Advocate sat outside Children, Youth and Families and reported directly to the Secretary.

Secretary Pervan described Children and Family Services as follows:

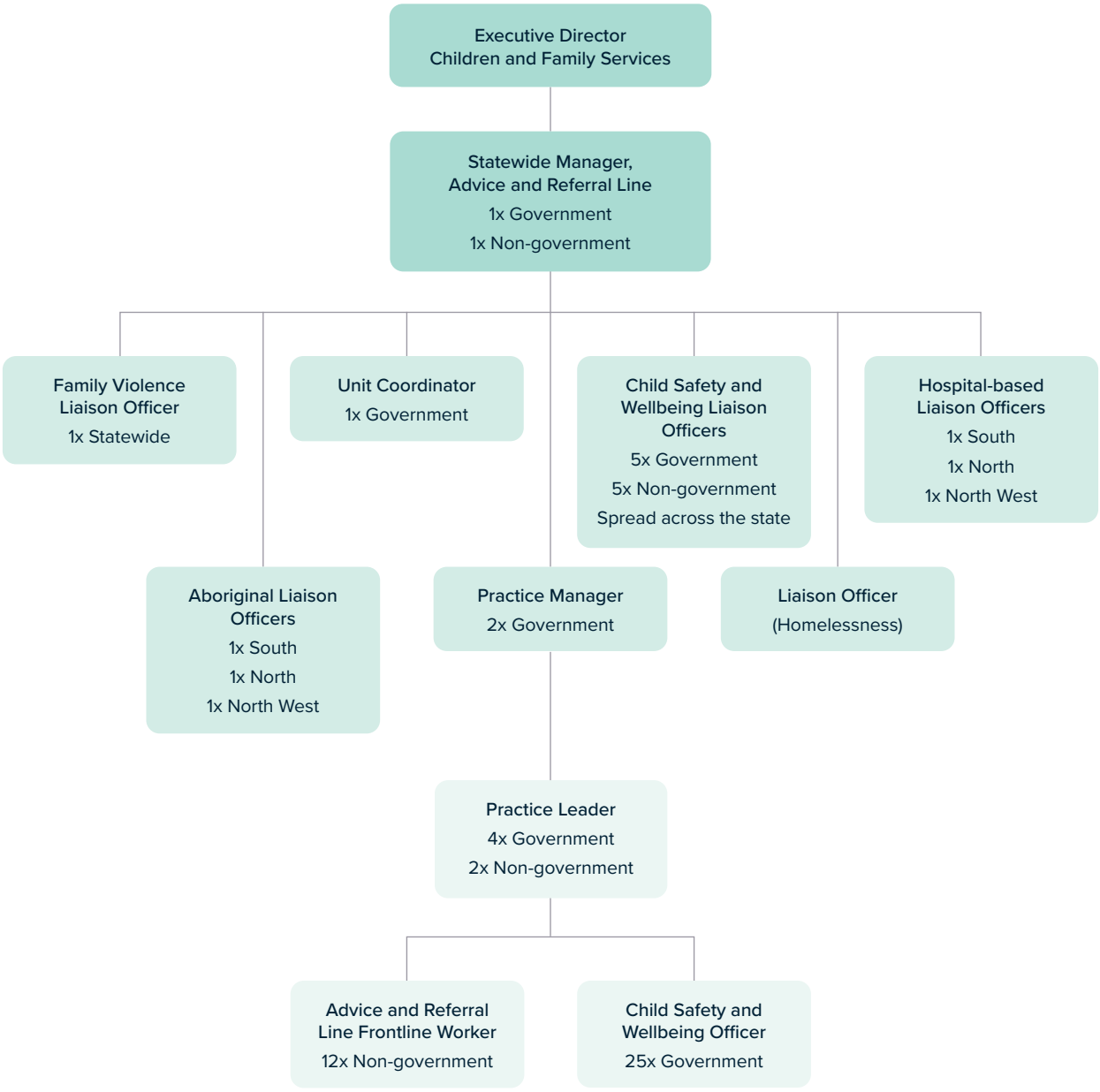
> Children and Family Services … includes the Strong Families Safe Kids Advice and Referral Line, the Child Safety Service, Out of Home Care; Adoptions, Permanency and After Care Support, Intensive Family Engagement Services, and the Child Safety After-Hours Emergency Service, and is currently holding Community Youth Justice.[56]

We asked Secretary Pervan to describe the internal organisational structure of the Strong Families, Safe Kids Advice and Referral Line, the Child Safety Service and Out of Home Care services (which exist in the current and older organisational structures), and the ways in which these service components relate to one another on a day-to-day basis.[57] He indicated the following:

- The Advice and Referral Line receives concerns about the wellbeing of a child. A brief assessment decides if the concern requires advice and referral to support services, or referral to the Child Safety Service for support or investigation.[58]
- Child Safety Service staff are in regional offices and receive notifications of child abuse and neglect. Child Safety Officers provide case management for children who are being assessed for risk of harm or neglect, or who are already in out of home care.[59]
- Out of Home Care services recruit and assess prospective foster or kinship carers, provide support to carers, monitor compliance of foster carers with requirements, and facilitate placements for children with foster carers.[60]

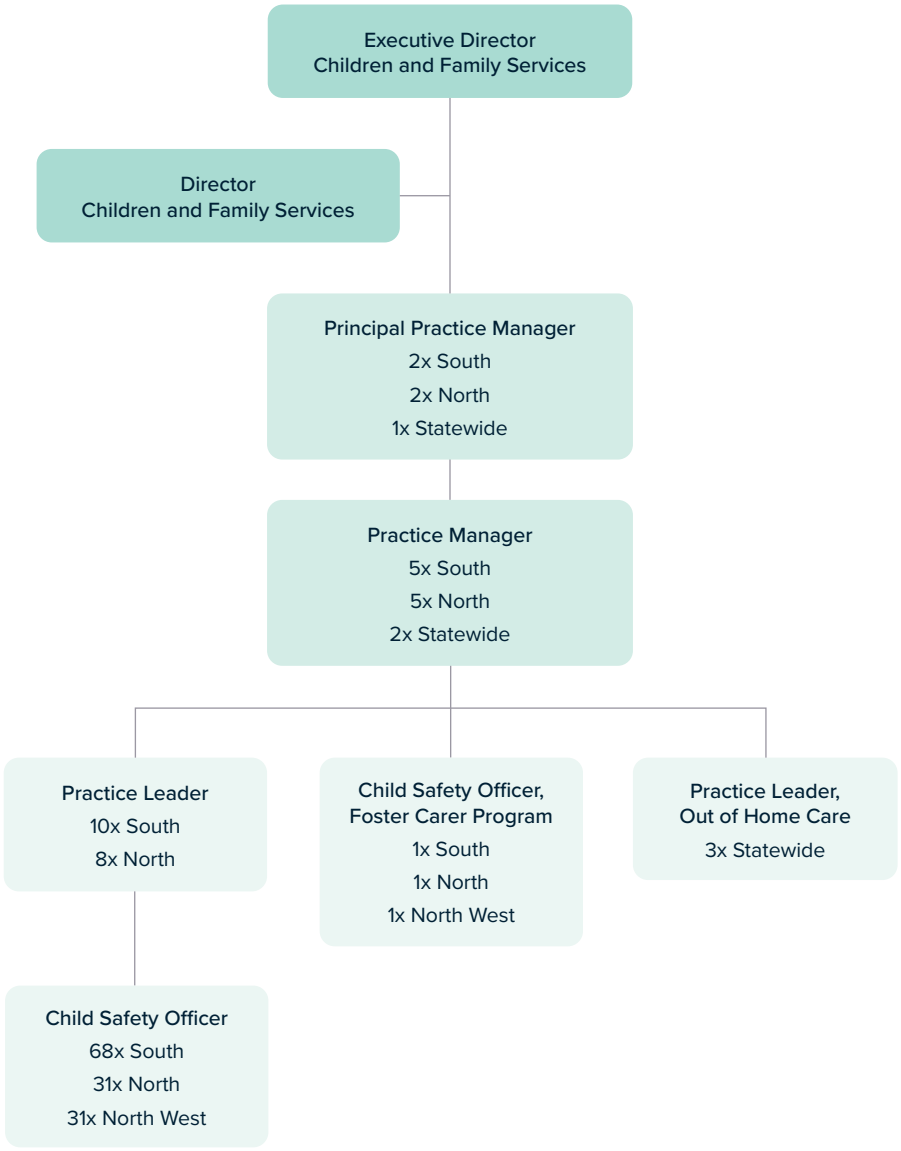
Secretary Pervan provided information on the reporting lines of staff on the Advice and Referral Line and in the Child Safety Service, as well as the full-time-equivalent staff allocation for each role (refer to Figure 7.4 and Figure 7.5). He advised us that the Child Safety Service receives more than $19.6 million in funding each year and employs 204.85 permanent full-time-equivalent staff.[61] Secretary Pervan also described the Out of Home Care services staffing complement and structure, which is shown at Figure 7.6. We understand these arrangements have been augmented in the new Department by additional funding for 10 new Child Safety Officer positions and 13 new administrative roles.[62] In the absence of any evidence to the contrary, we have assumed this reflects the current internal organisation of the Advice and Referral Line and the Child Safety Service.

Figure 7.4: Staffing structure of the Advice and Referral Line[63]



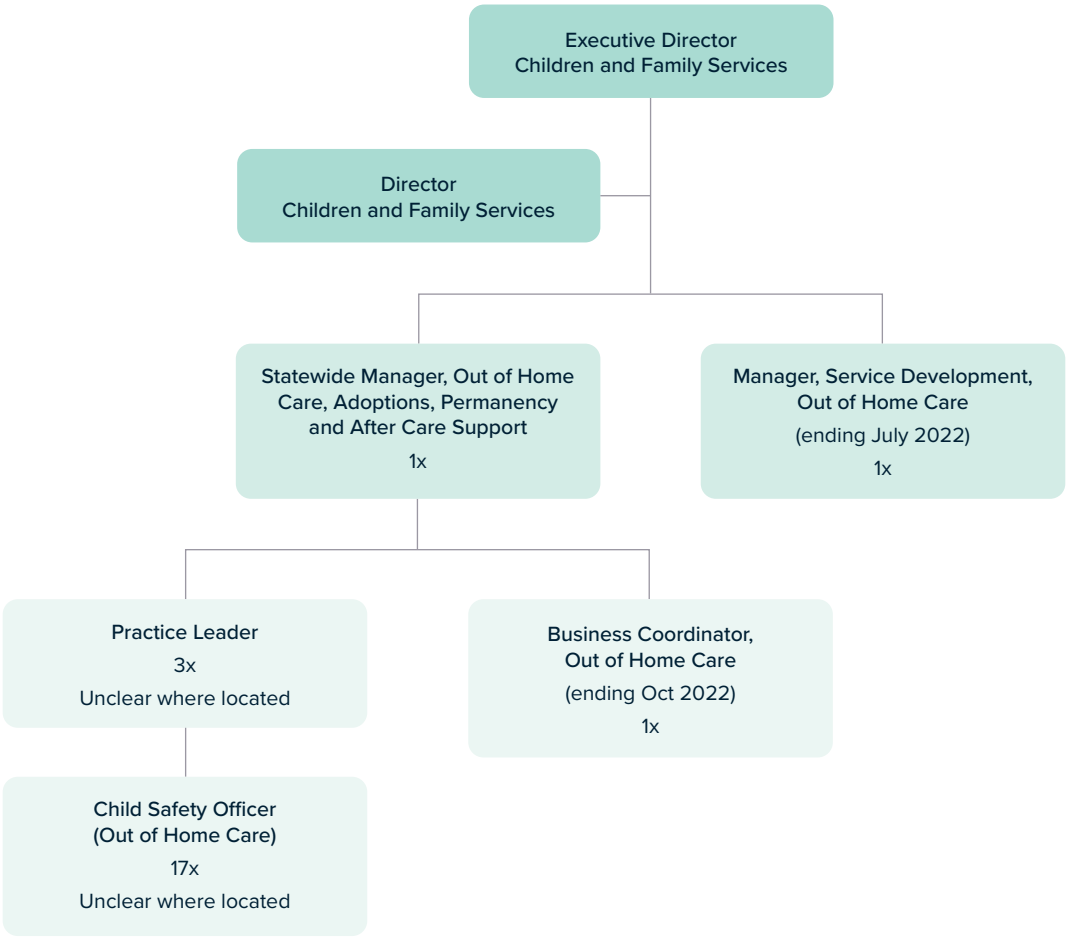
Source: Compiled from statement of Michel Pervan, 7 June 2022.

Figure 7.5: Staffing structure of Child Safety Services[64]



Source: Compiled from statement of Michael Pervan, 7 June 2022.

Figure 7.6: Staffing structure of Out of Home Care services[65]



Source: Compiled from statement of Michael Pervan, 6 June 2022.

When comparing the structure of the Out of Home Care services and the Child Safety Service, some information provided about some positions is unclear:

- the Practice Leader (Out of Home Care) positions appear in both structures but report to different managers
- the Child Safety Officer (Foster Carer Program) positions are in the Child Safety Service but would seem to sit more naturally in Out of Home Care services.

We heard that the Department's Out of Home Care team supports departmental carers, while the Child Safety Service provides case management for a child for the length of their contact with the Department, from their referral by the Strong Families, Safe Kids Advice and Referral Line to their transition out of care.[66]

Claire Lovell, Executive Director, Children and Family Services, explained that the Out of Home Care teams work from three locations across the State (South, North and North West) and sit alongside the Child Safety Service teams, which provide assessment and case management for children in contact with the service or in out of home care.[67]

Ms Lovell told us that in June 2022 there were between 26 and 30 vacant positions across the Advice and Referral Line, Child Safety Service and Out of Home Care services.[68]

We heard that frontline practitioners may receive clinical supervision from senior practitioners who sit outside their direct line management; for example, staff in Out of Home Care services access clinical supervision from a Practice Manager (location unspecified) who has no line management responsibility for them.[69] Secretary Pervan also told us that an unspecified number of Clinical Practice Consultants and Educators were assigned to case management and out of home care teams in the Child Safety Service statewide to support clinical practice.[70] However, these roles were not included in the organisational charts or descriptions we received, so we have no other information about them.

Ms Lovell also told us that, in addition to the out of home care staffing contingent outlined above, the Manager of Strategic Commissioning, who sits outside the Children and Family Services portfolio, is responsible for engaging and contracting non-government organisations to provide out of home care services (among other commissioning activities for the Children, Youth and Families division).[71] She advised that this single role has limited capacity to oversee non-government organisations' compliance with contractual obligations.[72] Instead, oversight of contractual obligations is 'spread to different positions in different ways' between Child Safety Officers, reviews by the Australian Childhood Foundation and reports received from non-government agencies.[73] We discuss the need to improve commissioning in Chapter 9.

3 Child sexual abuse in care: risks and protective factors

The National Royal Commission heard horrific accounts of abuse in 'old-fashioned' care institutions. It also found that many children were still experiencing sexual abuse in contemporary out of home care:

> Despite reforms in every jurisdiction, there are weaknesses and systemic failures that continue to place children in care at risk of sexual abuse. Abuse by carers, family members, visitors and workers still occurs, and sexual exploitation, especially of children in residential care, is an emerging concern. Frequent placement changes, poor information sharing, gaps in training and supports, especially to kinship carers, still exist. Given the increasing number of children in care and the inherent vulnerability of children in care, such weaknesses need to be addressed.[74]

Despite the National Royal Commission having reported over five years ago, we heard that similar problems still exist in Tasmania. These problems are discussed throughout this chapter.

3.1 Factors that increase risk

As mentioned in Chapter 3, the National Royal Commission identified several factors that increase the risk of child sexual abuse.[75] Characteristics specific to the out of home care context that increase risk of child sexual abuse include:

- situational factors, such as aspects of the physical environment; the dislocation from culture that can occur when Aboriginal children are placed with non-Aboriginal families; a lack of culturally sensitive supports for children from culturally diverse backgrounds; and the absence of trusted adults created through disconnection from family and placement instability, including frequent placement moves[76]
- vulnerability factors, such as children lacking an understanding that particular behaviour is sexual abuse, prior maltreatment, being younger, having disability, or having a history of trauma or mental illness, which are disproportionately more likely in out of home care populations than the broader community[77]
- propensity factors, such as the risk of abusers targeting children in residential care settings for the purposes of child sexual exploitation[78]
- institutional factors, some of which are particularly associated with residential care, including:
    - placement of vulnerable children with other children or within families where they are at greater risk of harm (due to poor assessment, placement matching and monitoring)[79]
    - inadequate professional development and supervision of staff, lack of role clarity for staff and unclear expectations of relationships between staff and young people[80]
    - the absence of policies and procedures that protect children in care from sexual abuse, and an organisational culture that does not actively promote child welfare[81]
    - inconsistent data collection and reporting among service providers, making it difficult to monitor incidents and responses[82]
    - large caseloads that overwhelm child protection staff, reducing their ability to respond and their frequency of visits to children in care[83]
    - low remuneration, work stress and public criticism of child protection staff, making it difficult to attract and retain highly skilled staff.[84]

We identified that most of the institutional risk factors are present in Tasmania's statutory child protection system. In Chapter 9, we explore the policies and practices that the Department should adopt to reduce these and other risk factors as they relate to out of home care.

The National Royal Commission, Australian and international research has shown that children and young people in residential care are more likely to experience child sexual abuse, peer sexual victimisation and sexual exploitation than their peers in kinship and foster care (who are still at greater risk than those who do not live in care). This is often because children in residential care are more likely to have behavioural and mental health issues, have disabilities and be older than children in other placement types. They tend to lack a stable and secure relationship with a trusted adult and are also more likely to be placed with peers who engage in harmful sexual behaviours.[85]

3.2 Sources of risk

The main sources of risk for children in out of home care are the adults working in the statutory child protection system or other adults in their lives. Another source of risk is other children in the out of home care system.

3.2.1 Adults working in the child protection system

We recognise that most adults in the out of home care system are hard-working and committed people who are trying to provide children with the supports they need. Despite these positive contributions, the nature of out of home care—whereby foster carers and their family members, Child Safety Officers and staff from non-government organisations contracted by the Department have opportunities to be alone with children outside of public view—means that children are exposed to a greater risk of child sexual abuse.

Research commissioned by the National Royal Commission found the following:

- adults who sexually abuse children in out of home care settings are more likely to be male, charismatic, controlling and in positions of power[86]
- such abuse is often accompanied by grooming so children will trust the abuser and believe they have consented to the abuse[87]
- such abusers can engage in 'institutional grooming' where they manipulate systems and communities into trusting them and setting them outside the usual safety nets that exist to prevent child sexual abuse, and so can abuse multiple children over long periods.[88]

The National Royal Commission noted that it can be difficult to distinguish grooming from legitimate caring activities, particularly where the abuser is a carer. A key aspect of grooming is creating a trusting relationship with the child and making them feel special and cared for—the same behaviours we want from carers. Grooming is often associated with boundary breaches, such as taking a child on an unauthorised shopping trip or supplying them with alcohol, drugs or cigarettes.[89]

We heard of several instances of departmental staff having engaged in grooming behaviours and boundary violations. We identified many more allegations of sexual abuse of children by foster carers and adults associated with foster families. These issues are discussed in Chapter 8.

We address measures that can, reduce the risk to children in care from adults in the out of home care system in Chapter 9.

3.2.2 Adults outside the child protection system: child sexual exploitation

The National Royal Commission defined child sexual exploitation as arising when 'children are coerced or manipulated into engaging in sexual activity in return for something (such as alcohol, money or gifts)'.[90] It can take different forms, including the child perceiving it as a 'loving relationship' and the adult manipulating the child into sex work. It can also include the production, consumption, dissemination and exchange of child sexual exploitation material.[91] The abuser may meet the child in the community but often initially grooms a child online. In the context of out of home care, the relationship with the abuser is sometimes initiated by other children in care.[92]

In addition to unknown adults from the community, children in care may be at risk of child sexual abuse from adults and other family members from within their families of origin while on unsupervised contact visits. We heard of only a few instances of this form of harm.

We focus on the risk of child sexual exploitation and measures that are necessary to reduce the risk and respond more appropriately in Chapter 9.

3.2.3 Other children in the out of home care system: harmful sexual behaviours

The National Royal Commission noted that the out of home care sector has been aware of risks to children in out of home care from harmful sexual behaviours for some time; however, policies, procedures and professional development that address these risks was lacking in all Australian jurisdictions.[93] The National Royal Commission also noted that therapeutic treatment programs for young people who engage in harmful sexual behaviours were under-resourced and limited in their availability.[94]

We also identified that a high proportion of concerns about the sexual abuse of children in care in Tasmania related to the harmful sexual behaviours of other children (refer to Chapter 8). As we discuss in Chapter 9, the Department does not have a policy for preventing, identifying or responding to harmful sexual behaviours in out of home care and has only recently funded limited specialist support for children engaging in such behaviour. Chapter 21 discusses the broader need for a coordinated approach to harmful sexual behaviours in children across Tasmanian institutional settings.

3.3 Over-representation of particular groups of children

In addition to specific vulnerabilities referred to above, Aboriginal children and children with disability are at increased risk of experiencing sexual abuse in out of home care due to their over-representation in the system.

3.3.1 Aboriginal children

On 30 June 2021, there were 403 Aboriginal children in Tasmanian out of home care, which is 37.4 per cent of the number of children in out of home care.[95] The proportion of Aboriginal children in out of home care in Tasmania was 34.4 per 1,000 children compared with 6.5 per 1,000 non-Aboriginal children.[96] This means that Aboriginal children in Tasmania are a little over five times more likely to be in out of home care than non-Aboriginal children. However, because there are high numbers of children in care whose Aboriginal status is recorded as 'unknown', it is likely that the number is higher than reported.[97]

Australia-wide, the proportion of Aboriginal children in out of home care has increased over the past five years from 57.8 per 1,000 children in 2017 to 65.7 per 1,000 children in 2021.[98] Without urgent action to reverse this trend, the number of Aboriginal children in out of home care in Australia is predicted to increase by 54 per cent (to just over one in 10 children) by 2030.[99]

Aboriginal children are more likely to experience abuse and maltreatment in out of home care because they are over-represented and therefore 'have more contact with high risk institutional settings' such as 'residential and contemporary out of home care'.[100] The ongoing impacts of colonisation, the treatment of Aboriginal children in the past and subsequent intergenerational trauma continues to place them at risk.[101] There is also a range of culturally specific barriers to Aboriginal children disclosing abuse.[102] In Chapter 9, we examine the steps the Department is taking to address the over-representation of Aboriginal children in out of home care, and we make recommendations for more significant reforms.

3.3.2 Children with disability

The Australian Bureau of Statistics reports that 10.2 per cent of children aged 0–14 years in Tasmania have disability, which is higher than the national average of 7.7 per cent.[103] When compared with the general population, Tasmanian statistics indicate that children and young people with known disability are over-represented in out of home care: 21.0 per cent have known disability, 47.2 per cent are recorded as having no disability and the disability status of the remaining 31.8 per cent of children in care is unknown.[104]

Research commissioned by the National Royal Commission noted that, in general, children with disability are about three times more likely to experience sexual abuse than children who do not have disability.[105] There is little Australian data to understand the reasons for this increased risk, although it is likely that multiple interacting factors are at play.[106]

The National Royal Commission observed that children with disability in out of home care face unique challenges because services and supports are not tailored to their individual needs.[107] Research commissioned by the National Royal Commission found that children with disability are more vulnerable to child sexual abuse in out of home care where:

- their disability means they need help with intimate care activities[108]
- they have an intellectual disability, behavioural disorder or communication disorder[109]
- the child and carers have little control over daily activities[110]
- the child is expected to be compliant[111]
- the child has difficulty communicating to others that child sexual abuse is occurring.[112]

Our examination of 22 departmental files, discussed in Chapter 8, confirmed these observations. As we explore in Chapter 9, there are several steps that the Department must take to reduce the risk of sexual abuse for children with disability in out of home care.

3.4 Protective factors

According to the National Royal Commission, maintaining positive connections with family, community and culture may be protective factors against sexual abuse for children in out of home care.[113]

The National Royal Commission heard that placing a child in kinship care increases the likelihood that he or she 'will grow up and know that they're loved, they're claimed, they belong'.[114] The National Royal Commission also heard that:

> Children who are part of a broader community with an interest in their wellbeing are more likely to be noticed when they are in danger and have networks of support to draw upon when they feel unsafe.[115]

For these reasons, kinship care may offset some of the 'psychic trauma' for a child caused by being removed from parents, provide the child with a familiar environment with known carers and maintain 'the perceived warmth and safety of a family during the placement process'.[116] Kinship care can also provide 'a strong parent/child relationship, family cohesion and positive social connection and support', which are all important protective factors for children in care.[117]

For Aboriginal children, connection to culture can increase protective factors by 'helping them to develop their identities, fostering high self-esteem, emotional strength and resilience', while positive relationships with their family and communities of origin can also increase protective factors against the risk of sexual abuse.[118] This is discussed in Chapter 9.

Associate Professor Tim Moore, Deputy Director, Institute of Child Protection Studies, Australian Catholic University, told us that healthy relationships with 'trustworthy adults' were 'more protective than risky':

> Inquiries and research has demonstrated that children and young people who are socially isolated are more at risk of experiencing abuse than their peers who are not, while those who are surrounded by trustworthy adults who will protect them, watch out for them and intervene and be available when they have safety concerns are safer than those who are not.[119]

The National Royal Commission also found that children in care who had regular visits from their Child Safety Officer were less likely to be sexually abused than children who were not visited regularly.[120] We explore the barriers to regular visitation in Chapter 9.

4 Previous reviews and reforms

In this section, we consider the Tasmanian Government's progress on implementing the numerous recommendations that have been made to improve the out of home care system in Tasmania since 2000, including the National Royal Commission's recommendations for contemporary out of home care.

4.1 National Royal Commission

The National Royal Commission made 22 recommendations aimed at improving the safety of children in contemporary out of home care. These recommendations encompassed:

- strengthening data collection and reporting (Recommendations 12.1–12.3)
- accrediting out of home care service providers (Recommendations 12.4 and 12.5)
- improving processes for authorising carers (Recommendations 12.6–12.8)
- developing a child sexual abuse prevention strategy (Recommendation 12.9)
- creating a culture that supports disclosure and identifying child sexual abuse (Recommendation 12.10)
- measures to strengthen the capacity of carers, residential care staff and child protection workers to understand trauma and abuse and its impact on children (Recommendation 12.11)
- measures to address the known risks of children in out of home care engaging in harmful sexual behaviours (Recommendations 12.12 and 12.13)
- measures to reduce the risk of child sexual exploitation in out of home care (Recommendations 12.14 and 12.15)
- strategies to increase placement stability to protect children in out of home care against the risk of sexual abuse (Recommendation 12.16)
- measures to support kinship carers and for children in care to maintain relationships with their birth families (Recommendation 12.17)
- developing an 'intensive therapeutic model of care framework' for residential care to meet the complex needs of children with histories of abuse and trauma, and regular professional development and supervision for residential care staff (Recommendations 12.18 and 12.19)
- measures to reduce the over-representation of Aboriginal children in out of home care, including full implementation of the Aboriginal and Torres Strait Islander Child Placement Principle (Recommendation 12.20)
- measures to improve out of home care systems' responses to children with disability, including adequate assessment, and developing and implementing care plans that identify specific risk management and safety strategies for the child (Recommendation 12.21)
- supporting care leavers who experienced sexual abuse while in care (Recommendation 12.22).[121]

The National Royal Commission also made seven recommendations for setting up and maintaining a carers' register (Recommendations 8.17–8.23).[122]

The Tasmanian Government has reported on its progress towards implementing the recommendations of the National Royal Commission in annual reports and action plans since 2018, most recently in December 2022 ('Fifth Progress Report').[123] In response to our notice to produce, the Department provided information that essentially replicated the Fifth Progress Report, with some minor additional details.[124] We note that in relation to the recommendations relevant for this chapter, the main updates in the Fifth Progress Report relate to the Government's release of the Tasmanian Out of Home Care Standards during 2022 (discussed in Chapter 9), a current review of the Children, Young Persons and Their Families Act, plans for a Carer Register to be completed by 2024 and an Out of Home Care Accreditation Framework to be completed by 2026.[125]

Following is an overview of the Government's responses to the National Royal Commission recommendations. Throughout Chapter 9, we examine in detail the Government's progress on implementing relevant National Royal Commission recommendations where they relate to specific issues identified in the Tasmanian out of home care system.

4.2 Tasmanian reviews and reports into out of home care

Tasmanian out of home care is a highly examined system. We identified 22 reviews or reports on out of home care or statutory child protection in Tasmania since 2003, which, in total, contained several hundred recommendations. Of the 22 reviews or reports, 13 were either planned or responses to known general challenges facing the sector and nine were prompted by public reporting of specific adverse care situations. The reports were prepared by various entities, including the Commissioner for Children and Young People, the Tasmanian Auditor-General and the Tasmanian Government.

While most of the reports did not consider the issue of child sexual abuse in out of home care in detail, all raised important issues about out of home care in Tasmania and features of the system that increase the risks of child sexual abuse in that setting. The reports repeatedly highlighted that the systems in place to protect children from abuse and neglect, including child sexual abuse, had not performed in the way intended.

The remaining nine reports were strategic documents about out of home care or child protection in Tasmania that outlined the various attempts at reform in response to the recommendations made in the various reviews.

The Department has initiated three main reforms to out of home care since 2003: the *Out of Home Care Strategic Framework* (2007), *Out of Home Care Reform in Tasmania* (2014) and the *Strategic Plan for Out of Home Care in Tasmania* (2017). All reforms were ambitious and aimed to improve the experience of children in out of home care. Alongside these reforms, the Department has attempted two main reforms of the child protection system, the most recent being the 'Strong Families, Safe Kids' redesign. These reforms are discussed in Section 4.2.

However, despite attempts to reform Tasmania's child protection and out of home care systems, reviews continue to identify similar problems that directly affect the experience of children in care and increase their risk of child sexual abuse. These include:

- insufficient support for carers
- poor recruitment practices and insufficient support and professional development for staff
- inappropriate placements for children
- inadequate monitoring of children in care
- poor record keeping
- too few out of home care placements compared with the number of children in need
- poor monitoring of non-government out of home care providers and governance of funding agreements
- inadequate complaints processes
- over-representation of Aboriginal children in out of home care and low compliance with the Aboriginal and Torres Strait Islander Child Placement Principle
- over-representation of children with disability in out of home care
- poor support for children taking part in decision making
- variable understanding of and compliance with the *National Standards for Out-of-Home Care*, and poor monitoring of compliance
- no accreditation, registration or licensing system for out of home care providers
- poor information sharing between non-government providers and the Department.

Unfortunately, these themes have changed little over time and were echoed in the evidence we heard, which we explore in Chapter 9.

Some internal changes have been achieved over the past 19 years, such as appointing the Child Advocate and the incremental implementation of the Strong Families, Safe Kids redesign. However, out of home care is not a priority in that reform, and little apparent progress has been made on implementing the 2014 reform agenda *Out of Home Care Reform in Tasmania.* The various reports highlight that previous reform recommendations have not always been implemented in a timely manner, have been under-resourced or, when implemented, have not been subject to appropriate monitoring and oversight to ensure the intended outcomes are achieved.

Importantly, underfunding of statutory child protection was raised with us repeatedly as a fundamental contributing factor to the lack of implementation of recommendations over time. According to Sonya Enkelmann, a former Department employee:

> There seems to be a long tradition of undertaking reviews into Child Protection/Child Safety and [out of home care] which then quietly drop from sight. Understanding what sustains this systemic inertia is difficult and I will leave that to others – but a history of chronic underfunding in the Department to build its capacity and infrastructure cannot be overlooked. I am not referring to services (although they are too often underfunded) so much as capacity – having the right people and sufficient number of people in the right jobs to manage and implement change over the long term. A system in crisis is not well placed to manage change.[126]

Secretary Pervan described how:

> … budgetary pressure [from an expenditure overrun on special care packages] … resulted in an immediate loss of impetus for, and opportunity to, resource significant operational reforms in Family Based Care, which were suspended.[127]

He added that 'the Government has been consistent in not providing funds to the Department … to implement change', citing this factor as fundamental to the slow progress towards improving systems in the Department.[128]

In her statement, the Child Advocate also noted the pattern of repeated reviews and little change, commenting that 'Tasmania is guilty of partial reform' and needs 'doers not reviewers'.[129] She attributed this inertia to 'significant leadership churn' in the executive, underfunding of reforms, the lack of a focused change management team in the corporate structure and distraction caused by the demands of external scrutiny.[130] Other former senior departmental employees expressed similar views.[131]

Ms Lovell acknowledged that the Child Safety Service struggles to 'keep up with reasonable community expectation around the services that we deliver and the safety and quality of those services', as well as the demand on the service. She stated that efforts to reform the service have been repeatedly interrupted by new concerns demanding their focus:

> … we acknowledge that we're not doing well in relation to one aspect; we commit to doing better, we have a strategy around how to do that, but it's immediately superseded by the next area where it's determined that we're failing, and so on and so on.[132]

When providing evidence to our Inquiry, Ms Lovell's frustration was clear:

> We can't do everything at once, so the expectation on us—we certainly agree that we need to improve in all of those areas. That's what continuous improvement is about. But we can only do so much at once, and the more things we try and do simultaneously, it seems, the more that our efforts are diluted and we don't do anything as perfectly as we would aspire to.[133]

We imagine this sense of not being able to 'catch up' on reforms has affected the morale and culture of the Child Safety Service and those working in the out of home care sector.

Inertia in implementing recommendations of inquiries and reviews is not unique to Tasmania. Analyses of previous inquiries for the National Royal Commission highlighted factors that enable and constrain reforms in the child protection and out of home care systems. Central to successfully implementing reforms are effective leadership, adequate resourcing and sufficient internal and external accountability.[134] We explore these factors in relation to the Department in Chapter 9.

We are aware that our Commission of Inquiry is yet another review, with the potential to cause harm if our scrutiny does not translate into change. With this in mind, we aspire to recommendations that will help create a system that can sustain a journey of continuous improvement. Dr Samantha Crompvoets, an expert on organisational change processes, told us that sustainable organisational change can be achieved, but it can take a long time. She recommended regularly evaluating the impact of the change to track progress, breaking it down into manageable steps.[135] We recognise that even with the best leadership and systems of accountability, the reforms we recommend will not lead to meaningful improvements for children without the commitment of the Tasmanian Government to provide the infrastructure and resources to enable the Department to drive and sustain change.

We recognise that the Department has been undergoing change for many years and may well be fatigued by the partial reforms. While we have compassion for the people within an overwhelmed and underfunded system, it is our view that little meaningful change has been sustained for children and their families or carers. Improved experiences for children in care must be the benchmark for success, and a system that is enabled to create and sustain change is urgently required to achieve this outcome. We outline our recommendations for reform in Chapter 9.

Notes

1 *Children, Young Persons and Their Families Act 1997* ss 5, 6. Before October 2022, the Department of Communities (also referred to as Communities Tasmania) was responsible for the out of home care system.

2 *Children, Young Persons and Their Families Act 1997* s 10B

3 'Attorney-General "Deeply Concerned" about Child Protection System', ABC News (online 21 June 2022) <https://www.abc.net.au/news/2022-06-21/attorney-general-deeply-concerned-about-child/13938526>; 'Veteran Child Protection Worker Calls Out Inadequate Staff Training', ABC NewsRadio (online 20 June 2022) <https://www.abc.net.au/news/2022-06-20/veteran-child-protection-worker-calls-out/13936804>; 'Calls for Overhaul of Australia's Child Protection System', ABC News (online 20 June 2022) <https://www.abc.net.au/news/2022-06-20/calls-for-overhaul-of-australias-child-protection/13936456>; 'National Children's Commissioner Critical of Government Inaction on Child Protection', ABC NewsRadio (online 20 June 2022) <https://www.abc.net.au/news/2022-06-20/national-childrens-commissioner-criticises/13936774>; 'The Forgotten Children Subjected to Abuse in State Care', ABC News (online 19 June 2022) <https://www.abc.net.au/news/2022-06-19/the-forgotten-children-subjected-to-abuse-in-state/13936094>; Katri Uibu, 'Bad Parent', ABC News (online, 20 June 2022) <https://www.abc.net.au/news/2022-06-20/hundreds-of-people-speak-out-against-child-protection-system/101094220>.

4 Statement of Sonya Enkelmann, 26 April 2022, 2–3 [11].

5 Department for Education, Children and Young People, *'Out of Home Care in Tasmania', Children, Youth and Families* (Web Page, 2023) <https://www.decyp.tas.gov.au/children/out-of-home-care-in-tasmania/>.

6 Australian Institute of Health and Welfare, *Child Protection Australia* 2018–19 (Report, Child Welfare Series No 72, 18 March 2020) 44–45.

7 Australian Institute of Health and Welfare, 'Out-of-home care', *Child Protection Australia* 2020–21 (Web Page, 26 May 2022) 5.1 <https://www.aihw.gov.au/reports/child-protection/child-protection-australia-2020-21/contents/out-of-home-care>.

8 *Royal Commission into Institutional Responses to Child Sexual Abuse* (Final Report, December 2017) Preface and Executive Summary, 39.

9 For example, The Hon Margaret Nyland AM Commissioner, *The Life They Deserve: Child Protection Systems Royal Commission Report* (Summary and Report, August 2016) vol 1, 309, 312.

10 The Court can assign guardianship to any appropriate person, who may come from the child's family or community: refer to *Children, Young Persons and Their Families Act 1997* s 42(4).

11 Transcript of Zaharenia Galanos, Jurek Stopczynski, Emily Churches and Rachel Hales, 4 May 2022, 315 [35–41].

12 *Children, Young Persons and Their Families Act 1997* s 42(2).

13 *Children, Young Persons and Their Families Act 1997* ss 42(3), 42(4)(c)(i). Other orders that the Court can make include a supervision order (where the child remains with their natural guardian/s but the Secretary is responsible for supervising the welfare of the child), an order granting custody to the Secretary or another person, or an order granting guardianship to a person other than the Secretary (a third-party guardianship order): *Children, Young Persons and Their Families Act 1997* ss 42(4), 42A.

14 *Children, Young Persons and Their Families Act 1997* s 42(6).

15 *Children, Young Persons and Their Families Act 1997* s 69(1).

16 Refer to Department of Families, Fairness and Housing Victoria, 'Home Stretch', *Young People* (Web Page, 2021) <https://services.dffh.vic.gov.au/home-stretch#:~:text=Home%20Stretch%2C%20part%20of%20the,from%20a%20Better%20Futures%20worker>; Leanne Linard, Minister for Children and Youth Justice, 'Support for Young People Leaving Care Makes History (Media Release 18 June 2022) <https://statements.qld.gov.au/statements/95435>.

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18 Child Safety Service, 'Care Teams and Care Planning Practice Advice', 8 December 2020, 3, produced by the Tasmanian Government in response to a Commission notice to produce.

19 Child Safety Service, 'Care Teams and Care Planning Practice Advice', 8 December 2020, 2, produced by the Tasmanian Government in response to a Commission notice to produce.

20 *Children, Young Persons and Their Families Act 1997* s 5.

21 *Children, Young Persons and Their Families Act 1997* s 69(1)(a)–(c), (2)(d).

22 *Children, Young Persons and Their Families Act 1997* s 69(1)(d)–(f).

23 *Children, Young Persons and Their Families Act 1997* s 69(2)(c).

24 *Children, Young Persons and Their Families Act 1997* s 71(1)–(2).

25 *Children, Young Persons and Their Families Act 1997* s 69(2)(a).

26 *Children, Young Persons and Their Families Act 1997* ss 7(1)(a), 10E.

27 Department of Communities, '*Children, Young Persons and Their Families Act 1997*: Instrument of Delegation', 8 July 2022.

28 Department for Education, Children and Young People, *Human Services Dashboard* (Web Page, 2022) <https://www.decyp.tas.gov.au/about-us/department-data/human-services-dashboard/>.

29 Department for Education, Children and Young People, *Human Services Dashboard* (Web Page, 2022) <https://www.decyp.tas.gov.au/about-us/department-data/human-services-dashboard/>; Statement of Michael Pervan, 6 June 2022, Annexure 36.

30 Statement of Michael Pervan, 4 August 2022, 1 [4–6].

31 Figures compiled from several Australian Institute of Health and Welfare *Child Protection Australia* reports 2000–01 to 2020–21 to cover the period. Source materials contain cautions about variations between years in how the total number was calculated. Reports can be found at Australian Institute of Health and Welfare, 'Report Editions', *Child Protection* (Web Page, 2023) <https://www.aihw.gov.au/reports/child-protection/child-protection-australia-2021-22/report-editions>.

32 Australian Institute of Health and Welfare, 'Data Tables', *Child Protection Australia 2020–21* (Web Page 15 June 2022), Table 5.1 <https://www.aihw.gov.au/reports/child-protection/child-protection-australia-2020-21/data>.

33 Australian Institute of Health and Welfare 'Data Tables', *Child Protection Australia 2020–21* (Web Page 15 June 2022) Table 5.1 <https://www.aihw.gov.au/reports/child-protection/child-protection-australia-2020-21/data>.

34 Commissioner for Children and Young People Tasmania, *The Tasmanian Out-of-Home Care System and 'Being Healthy', Out-of-Home Care Monitoring Program 2018–19* (Monitoring Report No. 1, October 2019) 2–3.

35 Department for Education, Children and Young People, *Out of Home Care in Tasmania* (Web Page, 2023) <https://www.decyp.tas.gov.au/children/out-of-home-care-in-tasmania/>.

36 Statement of Michael Pervan, 6 June 2022, 2 [10]–5 [18].

37 Commissioner for Children and Young People Tasmania, *The Tasmanian Out-of-Home Care System and 'Being Healthy', Out-of-Home Care Monitoring Program 2018–19* (Monitoring Report No. 1, October 2019) 22–23.

38 Australian Institute of Health and Welfare, 'Data Tables', *Child Protection Australia 2020–21* (Web Page, 15 June 2022) Table S5.3 <https://www.aihw.gov.au/reports/child-protection/child-protection-australia-2020-21/data>. Note that Tasmanian data has some limitations that can be viewed in the source document.

39 Statement of Sonya Enkelmann, 26 April 2022, 8–9 [25].

40 Statement of Michael Pervan, 6 June 2022, Annexure 26 (Diagram: 'Child and Family Services out of home care service directory', undated).

41 Statement of Michael Pervan, 6 June 2022, Annexure 26 (Diagram: 'Child and Family Services Out of Home Care Service Directory', undated).

42 Commissioner for Children and Young People Tasmania, *The Tasmanian Out-of-Home Care System and 'Being Healthy', Out-of-Home Care Monitoring Program 2018–19* (Monitoring Report No. 1, October 2019) 23.

43 Statement of Michael Pervan, 6 June 2022, 23 [91].

44 Statement of Michael Pervan, 6 June 2022, 23 [92].

45 Australian Institute of Health and Welfare, 'Data Tables', *Child Protection Australia 2020–21* (Web Page 15 June 2022) Table S5.3 <https://www.aihw.gov.au/reports/child-protection/child-protection-australia-2020-21/data>.

46 Statement of Michael Pervan, 7 June 2022, Annexure 83 (Table: 'Funding for out of home care services') 1–5.

47 Statement of Kim Backhouse, 8 June 2022, 10–11 [52].

48 Statement of Julian Watchorn, 8 June 2022, 2 [13].

49 Australian Institute of Health and Welfare, 'Data Tables', *Child Protection Australia 2020–21* (Web Page, 15 June 2022) Table S7.1 <https://www.aihw.gov.au/reports/child-protection/child-protection-australia-2020-21/data>.

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51 Tasmanian data for kinship care households with three or more children was 'unpublished', but it was possible to calculate the difference between total households and numbers in the other two categories.

52 Statement of Julian Watchorn, 8 June 2022, 3 [14].

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55 Determined from annual reports, websites, media releases, Hansard and news articles.

56 Statement of Michael Pervan, 7 June 2022, 3 [22].

57 Requests for statement served on Michael Pervan, 11, 22 and 26 April 2022.

58 Statement of Michael Pervan, 7 June 2022, 7 [45].

59 Statement of Michael Pervan, 7 June 2022, 7 [47].

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62 Roger Jaensch, Minister for Education, Children and Youth, 'New Positions to Bolster Child Safety Workforce' (Media Release, 4 November 2022) <https://www.premier.tas.gov.au/site_resources_2015/additional_releases/new-positions-to-bolster-child-safety-workforce>; Roger Jaensch, Minister for Education, Children and Youth, 'New Initiatives Help Bolster Child Safety Workforce' (Media Release, 15 August 2022) <http://www.rogerjaensch.com.au/new-initiatives-help-bolster-child-safety-workforce/>.

63 Compiled from statement of Michael Pervan, 7 June 2022, Annexure 7 (Table: Staffing of the Advice and Referral Line).

64 Compiled from statement of Michael Pervan, 7 June 2022, Annexure 18 (Table: Staffing for Child Safety Services, undated).

65 Compiled from statement of Michael Pervan, 6 June 2022, 22 [81], 23 [88].

66 Statement of Michael Pervan, 6 June 2022, 24 [97].

67 Transcript of Claire Lovell, 14 June 2022, 1187 [11–17].

68 Transcript of Claire Lovell, 14 June 2022, 1205 [9–17].

69 Statement of Michael Pervan, 6 June 2022, 22 [82].

70 Statement of Michael Pervan, 6 June 2022, 8 [24].

71 Transcript of Claire Lovell, 14 June 2022, 1185 [35–41].

72 Transcript of Claire Lovell, 14 June 2022, 1185 [46]–1186 [6].

73 Transcript of Claire Lovell, 14 June 2022, 1186 [18–27].

74 *Royal Commission into Institutional Responses to Child Sexual Abuse* (Final Report, December 2017) Preface and Executive Summary, 40.

75 *Royal Commission into Institutional Responses to Child Sexual Abuse* (Final Report, December 2017) vol 12, 90.

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79 *Royal Commission into Institutional Responses to Child Sexual Abuse* (Final Report, December 2017) vol 12, 122–127, 207.

80 Keith Kaufman et al, *Risk Profiles for Institutional Child Sexual Abuse: A Literature Review* (Report prepared for the Royal Commission into Institutional Responses to Child Sexual Abuse, October 2016) 10, 38.

81 Keith Kaufman et al, *Risk Profiles for Institutional Child Sexual Abuse: A Literature Review* (Report prepared for the Royal Commission into Institutional Responses to Child Sexual Abuse, October 2016) 9–10.

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83 Keith Kaufman et al, *Risk Profiles for Institutional Child Sexual Abuse: A Literature Review* (Report prepared for the Royal Commission into Institutional Responses to Child Sexual Abuse, October 2016) 73.

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90 *Royal Commission into Institutional Responses to Child Sexual Abuse,* 'Institutional Responses to Child Sexual Abuse in Out-of-Home Care' (Consultation Paper, March 2016) 5.

91 Statement of Hilda Sirec, 28 April 2022, 4 [2–24].

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8 Case examples and our approach: Children in out of home care

Content warning

Please be aware that the content in this report includes descriptions of child sexual abuse and may be distressing or raise issues of concern for some readers.

We encourage readers to exercise discretion in their engagement with this content and to seek support and care if required.

1 Introduction

In this chapter we outline our approach to inquiring into the out of home care system in Tasmania. This includes the scope of our Commission of Inquiry, the evidence we drew on and the picture we formed of the scale and nature of child sexual abuse in this system.

2 Interpreting our scope

When considering the issue of sexual abuse of children in out of home care, we needed to establish the scope of our Inquiry.

First, the out of home care system sits within the broader statutory child protection system. For reasons discussed below, we have focused on out of home care specifically, and only include those aspects of the wider statutory child protection system that relate to the risk of sexual abuse for children in care.

Second, we decided to consider all aspects of out of home care in Tasmania that might affect the risk of sexual abuse to children. We explain our rationale later in this section.

2.1 Focusing on out of home care, not the whole of child protection

As discussed in Chapter 7, out of home care in Tasmania is part of the wider child protection system and sits alongside the Child Safety Service and Strong Families Safe Kids Advice and Referral Line ('Advice and Referral Line') functions in the Department.

Had we interpreted our terms of reference broadly, we might have inquired into the child protection system as a whole, on the basis that preventing children from entering out of home care would protect them from experiencing child sexual abuse while in care. With the exception of our discussion of the Aboriginal and Torres Strait Islander Child Placement Principle in Chapter 9, we have not adopted this interpretation, because the core business of the child protection system is to respond to abuse and neglect in a familial, rather than institutional, setting. Moreover, the time and resources allocated to our Inquiry do not allow us to do justice to a review of the entire child protection system in addition to our inquiries into the health, education and youth detention systems. We note that the National Royal Commission did not examine the child protection system as a whole but similarly limited its inquiry to the out of home care system.

For these reasons, we have limited our Inquiry to those aspects of the Advice and Referral Line and Child Safety Service functions that relate directly to children who have been taken into the Department's care. For example, Child Safety Service decisions about where a child will live once a guardianship order has been made are within the scope of our Inquiry, whereas the actions of Child Safety Service staff in relation to children who are not yet in the care of the Department are outside the scope. Our decision to consider these aspects of the Department as out of scope should not be interpreted as an endorsement of these functions in Tasmania. In hearings and sessions with Commissioners, we heard evidence of problems in the statutory child protection system's responses to sexual abuse in and out of family settings. These included failings of the Advice and Referral Line and the Child Safety Service more broadly.[1] What we heard, while outside the scope of our Inquiry, was concerning.

Between 2000 and 2021, the rate of children in out of home care in Tasmania rose substantially from 548 children on 30 June 2000 (4.6 per 1,000 children living in Tasmania) to 1,077 children on 30 June 2021 (9.6 per 1,000 children).[2] During the same period the number of children living in Tasmania decreased.[3] Even more concerning, for every 1,000 Aboriginal children living in Tasmania in June 2021, 34.4 were in out of home care. This over-representation is a direct and continuing effect of colonisation.[4]

These figures show that the system is not preventing children from entering out of home care. The most effective strategy to prevent child sexual abuse in out of home care is for families and communities to be supported to keep children safe in their families of origin. This requires an appropriate child safety system.

We heard evidence about the importance of early intervention and prevention in an effective child safety system.[5] However, we caution against using the term 'early intervention' without being specific about the context and purpose of that intervention, particularly as the new Department brings together a broad range of children's services. For example, early intervention could be used to refer to intervention with:

- children in the early years
- families in need of support
- families with multiple and complex needs who are known to statutory child protection
- adolescents at risk of entry into youth justice, school disengagement or early parenting.

During our hearings, we heard from multiple witnesses about the significant number of children and their families in need, and the complexity of those needs that stem from a range of circumstances and experiences.[6]

There is also growing evidence of intergenerational contact with the statutory child protection system; that is, the children likely to end up in the system are often those born to parents with complex needs who themselves have had contact (perhaps for multiple generations) with the system. This research shows that most families known to the child protection system have multiple profound impacts that accumulate over time and need intensive therapeutic responses.[7] Concerns have been raised about whether the dominant governmental model of providing general family support is effectively meeting such multiple and complex needs.[8] Unmanaged mental illness, substance addiction, domestic violence and housing instability are common features in families known to statutory child protection.[9] A whole of government response is required to prevent these problems and treat children and adults for their impacts as well as the effects—often intergenerational—of abuse and neglect.

We note the results of the Australian Child Maltreatment Study, which showed that 62.2 per cent of the Australian population had experienced at least one form of child abuse, maltreatment or neglect.[10] The study also showed that this is not merely a historical problem: 40.2 per cent of young people aged 16–24 had experienced two or more forms of child maltreatment.[11] The study further showed that Australians who have experienced abuse and neglect are likely to experience profound mental health impacts.[12]

Given this context, we do not suggest a review of the statutory child protection system in Tasmania. Such a review would fail to address the factors that result in children and families becoming known to the Advice and Referral Line and the Child Safety Service.

Instead, we urge the Tasmanian Government to focus its efforts and resources on ensuring that it has a whole of government response to meeting the health and human service needs of children and adults who have experienced abuse or neglect. To break the intergenerational cycle of involvement in statutory child protection, the Government should provide coordinated responses that address the support and specialist intervention needs of:

- first-time parents with childhood histories of abuse and neglect
- families who have complex needs in which children have experienced abuse and neglect
- children and young people in out of home care and youth detention who are struggling to overcome the impacts of violence, abuse and neglect.

Using the language of a public health model, we see these as tertiary therapeutic needs that require an appropriate response (in addition to primary and secondary child abuse prevention and family support services) to serve the volume of families in this situation.

2.2 A broad understanding of out of home care

Within the out of home care system itself, we have taken a broad approach to our Inquiry to fully appreciate the risks and potential sources of protection for children in care.

While the sexual abuse of children in care remained central, many victim-survivors shared with us other experiences they had of violence, abuse and neglect in care. For some, these other experiences of abuse and neglect occurred alongside the sexual abuse; for others, their maltreatment increased their vulnerability to sexual victimisation and harm.[13]

In addition, the structures and processes to protect children from harm in out of home care are often the same as those needed to maintain children's wellbeing and care generally. Effective structures and processes provide children with trusted and responsible adult supervision and care, give children a voice, meet children's needs, and establish clear and supported avenues for raising and addressing concerns.

3 Evidence we have drawn on

Our understanding of the Tasmanian Government's responsibility for children in care is based on the extensive research from the National Royal Commission about the risks of child sexual abuse for children in out of home care.

We received information from numerous sources about the experiences of children in out of home care. These included submissions, community consultations, written and oral evidence at our hearings, and documents produced by the Tasmanian Government. We received targeted information about out of home care from the following sources:

- a stakeholder consultation session for non-government providers of out of home care held in Hobart on 25 October 2021
- the relevant sections of Child Safety Service files for 22 children who were in care between 2000 and 2021 and were recorded as having been at risk of child sexual abuse while in care[14]
- evidence provided in the out of home care hearings held in Hobart from 14 to 17 June 2022
- statements from local and interstate experts on preventing and responding to sexual abuse of children in out of home care
- material that was publicly available on the websites of the Department of Communities and the Department for Education, Children and Young People
- internal material available to staff on the Department of Communities and the Department for Education, Children and Young People's intranet
- strategic documents and reports, some of which were publicly available and some of which the Tasmanian Government provided in response to our notice to produce
- previous reviews and reform agendas for out of home care in Tasmania.

3.1 Evidence from children in care and victim-survivors

We considered it essential to understand the experience of out of home care from those people who spent time in care because they can best identify how the out of home care system has affected them.

We heard from children who live in out of home care about their experiences of the system as it is today. Many children, including those currently in out of home care, shared their experiences through a research project we commissioned from Associate Professor Tim Moore and Emeritus Professor Morag McArthur (refer to Chapter 1).[15]

In sessions with a Commissioner and through oral evidence at hearings, we heard directly from victim-survivors who recalled being sexually abused in out of home care as children. We also heard from their carers and family members.

We closely tracked the journey of some children in the 22 files we received from the Department (refer to Section 4).

The following case examples illustrate common experiences.

Case example: Azra

The alleged abuse

Azra told us that she does not know why she came to be in out of home care but that she was very young at the time.[16] In the 1990s, Azra recalled being placed in a foster home where she experienced physical and emotional abuse from her foster mother.[17] She said that once, when she was about five years old, her foster mother broke her arm and then slapped her for crying in pain.[18] Azra described her foster father as 'loving but passive' and said that he did not protect her from her foster mother's abuse.[19]

Azra felt unloved and unwanted, so when a person associated with the foster family started paying her attention, she said she experienced this attention as love.[20] When this man began to sexually abuse her, she did not identify what he was doing as wrong and even sought out his company to escape her foster mother's cruelty.[21] When one of her foster father's work colleagues also started sexually abusing her, Azra told us that she also did not recognise this as wrong.[22] In Azra's words, she only realised much later in life, when she had children of her own, that she had not recognised 'wrong love'.[23]

Azra said she recalls very few visits from her departmental case worker and reflected that she may have been able to tell her case worker about the physical and sexual abuse if she had seen her more often.[24] She thinks that the Department trusted the carers because of their standing in the community.[25] Later in life, friends of her foster parents admitted to Azra that they knew about her abuse and apologised for not doing or saying something.[26]

After Azra's sibling told someone about their foster mother's physical and emotional abuse, a representative of the Department interviewed Azra at school.[27] However, Azra's foster mother was present at this interview, so Azra was too frightened to tell the truth.[28] Azra told us that she remained in the same family until her behaviour became too extreme for them to manage, and they sent her away.[29]

The impact

Azra described the impact of the abuse she recalls: 'I'm not sure I can even begin to recover and learn to live like a normal person. I'm completely ruined'.[30] She said that all her romantic relationships have been violent, which she links to her 'skewed love maps', and she believes her childhood experiences have negatively affected her parenting, with her children suffering as a result.[31] Azra said she has been diagnosed with complex post-traumatic stress disorder and has flashbacks of the alleged abuse.[32] She has tried medication, therapy and illicit drugs in her attempts to cope.[33] She attributes still being alive to her children and pets.[34]

Reflections

Azra is concerned that abuse like what she recalls experiencing is continuing to happen to other children. She is aware of children currently in foster care who she believes are being sexually exploited or neglected, and that the care provider and the Department are aware of this but are not acting to protect the children.[35] She stated: 'It's too late for me, but it shouldn't be too late for them'.[36]

Azra proposed several ways that out of home care could be made safer for children, such as listening to the voices of adults who grew up in out of home care and developing strategies to help break the intergenerational cycle of out of home care:

> Now, more than ever, we need to have the mentality of it takes a village to raise a child, and frankly it takes a whole lot more to heal a traumatized child. Most parents with traumatic childhoods similar to mine want to do better, want to be better, but simply lack the resources and know-how to do so. We can help them and we can certainly better support current carers who take in these children who often come with more issues than *Vogue*. We need to stop relying on that one social worker. Each child and family needs that village of support. This will prevent future children from falling through the cracks.[37]

Azra noted her experience of feeling devalued as a person, both in out of home care and when she sought recourse for the abuse against her. Her view is that the Government should take responsibility for past failures to protect children:

> As an ex-ward of the state there has always been this stigma attached to me and to the many others like me. We are unfairly judged and completely dismissed because we are deemed 'trouble' and 'liars'. This shame should never have been mine to bear, nor any other victim of past sexual abuse whilst under government care. That should be on the Government's head. They should be ashamed and disgusted that they have sat back and allowed this to happen throughout the years knowing full well the damage it's done.[38]

What we can learn

While Azra's experiences in out of home care occurred before 2000, they have continuing relevance for understanding how we can better protect children from child sexual abuse in out of home care, including:

- the importance of adequately monitoring the safety of a child in out of home care and having other adults such as case workers who visit the child and with whom they can develop a relationship
- the vulnerability of children, particularly those who have no positive and appropriate relationships, to grooming and sexual abuse
- the need to ensure children in care receive sexuality and respectful relationship education, so they can recognise abuse for what it is
- the need for appropriate interviewing techniques following a disclosure, such as not interviewing children in the presence of the person who has had a complaint made about them
- the importance of ongoing support, including mental health and parenting support, for adults traumatised by their childhood experiences in out of home care.

Case example: Hudson[39]

Hudson (a pseudonym) was a small child when they came into Cassandra's (a pseudonym) care in the late 2010s, following a number of previous foster care placements.[40] Three years after entering her care, Cassandra discovered by chance that Hudson was Aboriginal.[41]

Cassandra told us that, at the time, there was a requirement for children to demonstrate Aboriginal heritage via specific documentation. She understood that although it was well known that Hudson was Aboriginal, Hudson's parents had not been able to provide the necessary documents. The outcome was Hudson did not receive cultural support in care.[42] Cassandra, herself an Aboriginal woman, described how she felt Hudson missed out on taking part in cultural programs due to this situation. She saw this as 'systemic racism' and a denial of Hudson's right to 'develop a positive sense of culture and identity'.[43]

Reflecting on the Child Safety Service, Cassandra referred to a 'broken system' and in her view, Hudson's case:

> … raises significant questions that must be answered, such as … how the failings of an individual Child Safety case worker can make or break a child's ability to not just heal but to learn and engage and be supported and appropriately resourced to do so.[44]

What we can learn

Hudson's case illustrates the importance of cultural identification for children in care and the importance of providing cultural supports.

Case example: Faye

The alleged abuse

Faye (a pseudonym) was placed into foster care with her sibling in the mid-1990s, when she was in late primary school.[45] Faye recalled that her foster parents provided food and material comforts, and although they were strict, she experienced a stability and security she had not experienced before.[46]

After one of the foster parents' adult sons moved back into the family home, Faye remembers case workers from the Department visiting and speaking with Faye and her sibling in the presence of their foster mother. She remembers these case workers asked if they wanted to stay in the home (which they did), although she does not remember them saying why they were asking. Faye told us she later found out that the son had been fired from his job for having a relationship with an underage person.[47] In retrospect, Faye thinks the case workers likely visited in response to the allegation. She told us:

> We hadn't been told what had happened with [the son] and didn't understand the implications or risk of him coming to live in the house with us. We were children. We should have been removed from the house by Children and Youth Services, at least until the allegation in relation to [the son] had been resolved.[48]

Faye said she and her sibling were left in the foster home, and case workers promised to visit regularly, but Faye said this didn't happen.[49]

Faye explained that she was in early high school when the foster parents' adult son gained Faye's and her sibling's trust by acting 'cool', bending the rules for them and taking their side. Faye now realises he was grooming them.[50] Faye told us that his sexual abuse of her started with him pressing his genitals against her during play wrestling and trying to kiss her.[51] Faye's bedroom was located away from her foster parents' bedroom, which she said made it possible for their son to sexually abuse her at night.[52]

Disclosure of the alleged abuse

Eventually, Faye said she told her sibling about the abuse and each agreed to never leave the other alone with their foster parent's son.[53] Faye said her sibling told their foster mother about the abuse. Faye said her foster mother laughed when Faye told her that the son had touched her on the vagina, and dismissed Faye's experience, asking: 'Is that all?' Faye remembers that her foster father, however, seemed to believe Faye and her sibling, saying words to the effect of: 'This has happened too many times. It can't be a coincidence; they must be telling the truth'.[54]

Faye recalled being quickly removed by the Department after she disclosed the alleged abuse, but she was heartbroken to be separated from her sibling, who was left with the family. She was also distraught when many of her few possessions were lost in the move. Faye believed her foster mother withheld these possessions as punishment for alleging abuse by the son.[55] Still, Faye missed her foster mother and wanted to see her again, but her foster mother did not attend an arranged meeting, and she never saw her again.[56]

The Department supported Faye to make a statement to police, but Faye did not feel able to proceed with charges at that time because of her sense of loyalty to her foster mother.[57] She said she received specialist sexual assault counselling but did not feel comfortable and found it hard to open up.[58]

Reflections

Faye believes the Department failed to protect her from a known risk of sexual abuse, stating:

> If there is any risk to a vulnerable child, that child should be removed from the environment. I accept that it would have been traumatising for them to remove me and my sibling from the home, but it would have been far less traumatising than the abuse I endured.
>
> They had the opportunity to protect me, but they didn't. They also failed to visit us more frequently, which they said they would. If they had have followed up I may have disclosed the abuse earlier.[59]

Although Faye was removed from the foster family, she said her sibling was left there, other children were placed there, and the family requested only girls be placed with them, despite their adult son being a known risk.[60]

What we can learn

We recognise that Faye was in care before 2000. However, Faye's case highlights important issues of continuing relevance in out of home care which, if not followed, may expose children to an increased risk of sexual abuse:

- placing children's safety at the centre of decision making—while it is important to take into account the wishes of a child, adults need to ensure they are taking responsibility for decisions about risks to safety
- ensuring all children in a placement are protected from risk of harm
- case workers regularly visiting children in care, to swiftly identify risks, build trust and enable disclosures[61]
- facilitating the security and support that children can gain from sibling relationships and having their own possessions.

Case example: Lucas[62]

Respite care

Lucas (a pseudonym), an Aboriginal man, and his partner Eleanor (a pseudonym), had a number of children in their care, including kinship care of several grandchildren.[63] The family occasionally accessed weekend respite care to cope with the complex needs of the children in their care.

On one occasion, Lucas told us he could not meet the respite carers at their home before his grandchildren went there for respite care. But he recalled being told that Child Safety Service staff had inspected the respite carers' home and assessed it as safe. Lucas said when he collected the children at the end of the weekend, he discovered an unsafe and filthy house. Lucas recalled that the children had not been adequately fed. When he arrived, Lucas said he saw an unknown man run away from the house and jump over the back fence. Lucas told us that it later transpired that neither Child Safety Service staff nor the non-government provider involved had inspected the house. Lucas stated that 'you think they're being cared for, and obviously they're not'.[64]

Once home, Lucas said his granddaughter, Matilda (a pseudonym), who was under the age of five, started talking about being kicked by the respite carer as well as a man putting his penis in her vagina.[65] Lucas told us that he and Eleanor eventually pieced together that several older male children had touched Matilda's genitals, and the carer had become aware of this. Lucas said a forensic hospital examination confirmed that male DNA was found on a vaginal swab. Following the abuse, Lucas recalled that Matilda began having nightmares and exhibiting behavioural changes.[66]

Reflections

Lucas told us he was very concerned about the out of home care system: 'The reality is, they've got no foster carers, they've got no emergency respite providers, they've got no respite providers'.[67] He was concerned that respite carers may not be 'doing it for the right reasons' and that they were not sufficiently remunerated for the hard work performed: 'If it were increased, I'm sure a lot more people would do it'.[68]

What we can learn

In addition to Lucas' concerns about the system's monitoring and support of respite carers, Lucas' experience illustrates the importance of:

- processes and resources for assessing, training and monitoring out of home care providers—this includes ensuring respite carers have the capacity to provide the care required
- increasing the number of carers available to meet demand, particularly within suitable timeframes
- ensuring clarity of roles when both non-government agencies and the Department are involved in providing out of home care.

Case example: Orson and Ivan

Early experiences in care

Orson (a pseudonym) was taken into care while under the age of five and made subject to an order granting guardianship to the State until he turned 18.[69] A few years later, concerns were raised that Orson had displayed aggression and sexualised behaviours towards other children. It was then decided that Orson should be placed with a foster family where he would be 'the only child or the youngest child'.[70]

The alleged abuse

Orson's new foster family already had an older child, Ivan (a pseudonym), in their care.[71] The foster carers expressed concern that they might not be able to keep Orson safe because Ivan had previously displayed sexualised behaviours towards other children. The Child Safety Service decided this risk could be adequately managed.[72]

Almost three years later, the foster carers again told the Child Safety Service they were worried that Ivan might abuse Orson. Around a year later, Orson told his carers that Ivan had sexually abused him and then punched him in the face when he told other children.[73] At this point, Orson's carers began monitoring Ivan at night and attempting to keep both children safe by the children 'never being unsupervised and not being permitted in the other's bedroom'.[74]

The response

The foster carers immediately reported Orson's allegations to his Child Safety Officer. The Department did not take any action. A later internal report noted that 'this matter should have been notified and addressed when the concerns were [first] reported'.[75]

The foster carers took various measures to keep Orson safe, including taking him with them everywhere they went.[76]

Several months later, Orson also reported the alleged abuse to his teacher, who notified the Child Safety Service.[77] Tasmania Police was informed and interviewed both children. Orson said that Ivan had raped him on multiple occasions since the start of the placement. The police did not pursue the matter due to insufficient evidence.[78]

The Child Safety Service referred the case to their Senior Quality Practice Advisor.[79] A safety plan developed at this time stipulated that Orson and Ivan could stay in the same placement provided they were not left alone together.[80] Orson's service provider expressed concern that he 'may be at risk' under this arrangement, given that it relied heavily on the carers' ongoing ability to provide 'a very high level of supervision'.[81] A Severe Abuse and Neglect report was finalised three months later. The report recommended an evaluation 'to ensure the service is effectively meeting the identified need' and noted that the current level of caregiver supervision was not sustainable.[82] There is no record that any protective actions followed this report.

New allegations

Six months later, Orson said that Ivan had sexually abused him again when they had been left alone together for a short period.[83] On this occasion, Tasmania Police sent the file to the Director of Public Prosecutions, and Ivan was charged with one count of rape.[84] Ivan was temporarily and then permanently removed from the home following 'grave concerns' expressed by Orson's service provider that he may be returned:

> [Orson] now needs those responsible for his care to prioritise his need for safety and recovery … To place him in a position of needing to be exposed to [Ivan] in any way will diminish his ability to feel safe in his home and will further retraumatise him.[85]

What we can learn

Orson and Ivan's case highlights the importance of the following in preventing sexual abuse and supporting children to heal:

- taking a preventative approach to placement decisions where known risks exist
- taking action to alleviate risk of harmful sexual behaviours in an out of home care placement when concerns are raised
- recognising that persistent and severe harmful sexual behaviour cannot be effectively managed by carer supervision and requires specialist treatment
- responding appropriately to disclosures of harmful sexual behaviours, addressing risks to all children and ensuring carers have the capacity to carry out the response
- the need to follow through on implementing recommendations when cases have been reviewed (such as those made in a Severe Abuse and Neglect report)
- providing trauma-informed responses and prioritising the safety and healing needs of a child who has experienced sexual violence.

Case example: Linda

Early experiences in care

Linda (a pseudonym) came into care at a young age with a 'highly significant trauma history' due to chronic abuse and neglect by her parents.[86] Linda was placed in kinship care for a number of years, during which several notifications were made to the Child Safety Service about the carers' tendency to perpetuate 'trauma due to inadequate and inappropriate parenting responses'.[87] The Child Safety Service sent a letter to the family outlining these issues but assessed that the risk did 'not meet a threshold' for intervention.[88]

When Linda was in her early teens, she began to self-harm and experience suicidal ideation.[89] She was admitted to hospital several times.[90] Linda's relationship with her carers ultimately broke down and the Child Safety Service applied for guardianship of Linda until she was 18.[91] Linda was placed with a residential care provider.[92]

The alleged abuse

In her mid-teens, Linda reported she had been taking nude photos of herself and sending them to men online who had requested them. In a statement to police, she disclosed she had also sent nude photos and videos to an older teenager who had expressed specific plans to 'lure little kids home' and 'engage in sexual activities with them'.[93] The Child Safety Service developed a safety plan for Linda that included extra monitoring, noting there was 'some potential for [Linda] to engage in these activities again as monitoring adolescent behaviour online in a residential care placement is problematic'.[94]

Linda was receiving treatment for mental health issues at this time and was later referred to the Child and Adolescent Mental Health Service for further support.[95]

Sometime later, Linda attempted suicide and was admitted to hospital.[96] She said she had been regularly leaving her placement to have unprotected sex with adult men she had met on social media, in exchange for illicit substances.[97] The Child Safety Service made a referral to Tasmania Police and deemed the probability of further harm to Linda 'highly likely'.[98]

Leaving care

Soon after, the residential care provider advised the Child Safety Service they could no longer adequately care for Linda because she was not supervised overnight and could leave the facility at any time.[99] The following day, a healthcare provider told the Child Safety Service that Linda intended to run away.[100] Child Safety Service staff asked Linda's care provider to speak with her about this, and Linda 'denied' this was her intention.[101] Five days later, Linda ran away.[102]

The residential care provider expressed feeling they had received 'little' or 'no response regarding their concerned call' to police about Linda going missing, prompting a meeting between Tasmania Police, the Child Safety Service and the provider.[103] At the meeting, police first advised that this type of concern 'would not be considered a priority' and that they could not return Linda to her placement if she was unwilling to go, had not committed a crime and was not in immediate danger.[104] But upon reflection, police agreed to start looking for Linda due to 'significant concerns' for her welfare and located her.[105] The Child Safety Service referred Linda to another child welfare service 'for assessment and case work to assist in building a safety network'.[106]

What we can learn

Linda's case involved a number of missed opportunities to protect her from risks of harm. Her experience highlights the importance of:

- providing a traumatised child with a safe, supportive placement where their needs can be addressed therapeutically
- a residential care provider having the resources and capacity to protect the physical and online safety of a young person in their care
- the Child Safety Service taking a leadership role in protecting vulnerable young people at significant risk
- the need to identify probable future harm based on previous risk-taking behaviour, abuse and mental health issues
- Tasmania Police playing a role in intervening early when presented with concerns about a vulnerable young person and illegal acts occurring (including sexual abuse and providing illicit drugs to a child)—they can play a role in preventing or disrupting perpetration or holding abusers accountable.

Case example: Brett

Coming into care

Brett was taken into the care of the Child Safety Service when he was in his first year of high school in the late 2000s.[107] At the time, he had moved from interstate to live with his father in Tasmania. He told us he generally felt loved and safe with his father.[108] Brett said he and his father had been diagnosed with mental health conditions and had been having loud arguments for about two weeks when the Child Safety Service arrived at their house and took Brett into the care of the Department.[109] Brett thought it would only be for a week, but the Child Safety Service applied for a six-month order.[110]

Once in out of home care, Brett lived in several different placements, including a rostered care house where one of the other residents had recently come out of youth detention and another was openly using illicit drugs.[111] When he was taken into care, Brett told us he stopped going to school and never returned.[112]

Brett recalled being confused and upset about being taken away from his father, so he tried to run home whenever he was able.[113]

The alleged abuse

During weekend respite from his foster placement, Brett said he was sexually abused by an older boy who was also in care.[114] The older boy told Brett not to tell anyone, but eventually Brett told his foster carer.[115] Brett told us his foster carer did not believe him.[116] Brett recalled he then told his father during a visit to his family. It was Brett's father who contacted police.[117] Brett explained that he tried to provide a statement to police about the sexual abuse, but he was too emotionally overwhelmed to finish it, so no further action was taken.[118]

Brett said he has accessed his Child Safety Service file, which included a record of his allegation of abuse by the older boy. Brett told us that the file indicated:

> They didn't believe I was sincere and it was just me trying to get out of another foster home. It said there would be an investigation but I was never spoken to.[119]

After the alleged abuse

As Brett was moved around placements, he continued to try to return to his father's care, even when he was moved to the other end of the state.[120] He said his desire to return to his father's care to feel safe only increased after the alleged abuse: 'That's where I wanted to be, you know, I mean, that's where—that's where I felt safe, you know what I mean, that's where I needed to be'.[121]

He said he also often slept rough because of the care he received in his placements, stating:

> … at that time anywhere was better than the care houses, so occasionally I would just sleep on the street or occasionally I'd—occasionally I'd break into a car and just sleep in the back of it …[122]

Because he had no income, Brett turned to stealing to provide for himself and eventually decided to engage in a robbery to pay for an aeroplane ticket to the mainland.[123] He was arrested and, within six months of being taken into care, he found himself remanded at Ashley Youth Detention Centre, where Brett said he was further abused.[124] We discuss Brett's experience in Ashley Youth Detention Centre in Chapter 11.

What we can learn

Brett's experience highlights the importance of:

- the out of home care system providing a stable, safe, consistent placement—Brett found himself at greater risk on a number of levels once he entered care, leading him to stop formal education and eventually engage in criminal behaviour to try to ensure his own safety

- carers having the capacity to identify risks and believe children when they disclose child sexual abuse, and reporting such disclosures
- the Child Safety Service investigating an allegation of child sexual abuse of a child in care.

Case example: Addison[125]

My entire life … no one has ever been there to protect me.[126]

Coming into care

Before 2000, the mother of Addison (a pseudonym) was raised in out of home care and sexually abused in one of her foster homes.[127] To her great distress, her children's experiences mirrored her own: Addison and her siblings were exposed to family violence, neglect and emotional abuse from a young age, and were ultimately taken into out of home care in the mid-2010s. Addison had also been sexually abused by a family member.[128]

The alleged abuse

Addison's experiences of sexual abuse did not end once she entered care. In one foster home she was abused by a 'foster uncle'.[129] In another, the abuse was perpetrated by her foster parents, Vanessa (a pseudonym) and Edmund (a pseudonym), and it was this abuse that most affected her.[130] Before this placement, Addison was never taught about personal hygiene and did not know she could shower alone. Addison told us Vanessa and Edmund exploited this lack of knowledge to abuse Addison, 'touching' her and eventually raping her in the shower, describing this as 'cleaning [her] insides'.[131] Addison was unaware that this was not normal: 'I was 12, I really didn't know what that meant, I didn't know that [Edmund] was having sex with me'.[132] The abuse continued for more than two years. Addison recalled that Vanessa also regularly physically abused her.

Addison said she also experienced neglect and suffered the trauma of witnessing other children being sexually and physically abused in foster homes and 'not knowing what to do'.[133]

The response

Addison tried to get help. She said she disclosed the abuse to a teacher at her school who immediately confronted Vanessa. This resulted in more severe physical punishments from Vanessa, 'sometimes using knives'.[134] Addison remembered also telling Department case workers of the abuse but said, time and time again, she was not believed: 'They didn't do anything about it'.[135] She said one case worker witnessed her being physically abused by Vanessa but chose to ignore it. It was not until Addison and her sister 'weren't taking no for an answer' that they were finally moved to other foster homes.[136]

When Addison said she was being abused by her 'foster uncle', Department staff told her to not worry about it because the abuser was already being investigated for another matter.[137] Addison felt her concerns were not heard. She told us she felt the response of police was similarly dismissive; Addison reported the abuse two years ago but heard nothing afterwards. She told us that she believed these institutions were uninterested in taking action because she had a history of mental health problems and her family was well known to the Department 'for all the wrong reasons'.[138] Addison feared for her younger siblings who were still under the guardianship of the Department: 'It's like they're blatantly ignoring us'.[139]

Journey in out of home care

The alleged abuse drastically affected Addison's subsequent experiences in care. Finally, presented with a 'good, loving family', Addison recalled that she could not regulate her behaviours and the placement broke down.[140] Addison remembered being moved to a group home where she felt her suicidal ideation was not managed in a trauma-informed way. For instance, Addison recalled that carers insisted on checking on her while she was showering, despite her abuse history and her requests for this not to occur. She said 'it wasn't until I didn't just put myself but other people at risk' that this ended.[141]

At 17, Addison said she was 'thrown into the world' by the Department without support or life skills for living independently.[142] She continued to struggle with mental health issues and developed an addiction to alcohol as a result.

> Everything that has happened has deteriorated my mental health to the point where it's a struggle just being alive … [The age of] Ten is the first time I can remember trying to take my own life.[143]

Reflecting on the impact of the abuse and the lack of support afterwards, Addison noted that her worries were not those of a typical teenager. She emphasised that her life could have been different and much of the abuse prevented had someone listened to and supported her:

> My worry should be college … I didn't want my life to end up at this point, but due to everything and the fact that I never got any support, I ended up here with fears that someone much older should have … As soon as someone reports, do something … You don't know how long that has been going on, or what point it can get to … People need to start taking kids seriously.[144]

What we can learn

Addison's case demonstrates the importance of:

- preventative education to help children to identify what is normal behaviour and what is abuse
- Department staff listening to, believing and acting on disclosures of child sexual abuse and physical abuse
- recognising the increased risk of subsequent abuse (even by other offenders) once sexual abuse has occurred
- understanding the risks of an 'informal' approach, such as speaking to the foster carers and not making an appropriate report
- providing adequate mental health support after disclosures of child sexual abuse where psychological difficulties are a factor
- ensuring carers have the resources and capacity to manage children's behaviours in the context of a history of trauma
- supporting care leavers, ensuring they are prepared for living independently, particularly given a trauma history (contributed to through child sexual abuse while in care)
- police ensuring they follow up with a person reporting child sexual abuse.

3.2 Evidence from those with inside knowledge

We received numerous submissions about problems with the out of home care system from people who have worked in the Department or with non-government service providers. They expressed strikingly similar concerns about how the Department has structured, funded and operated out of home care in Tasmania. Many of these former employees had also worked in child protection interstate or overseas, allowing them to compare Tasmania's out of home care system with systems elsewhere.

Most of the former employees, or those who had previous contact with the Department, who contacted us were willing to make a formal statement to our Inquiry, and some provided evidence at our hearings. However, a number expressed concern about the possibility of experiencing negative consequences from the Department for expressing critical views, including impacting any future engagement with the Department.[145]

One former senior employee described the Department as follows:

> My sense is that the [out of home care] system is at best dysfunctional. It can also be an abusive system, capable of causing harm and trauma in its own right. Situated in the broader child safety system, it is perceived by many within the sector as a closed, defensive system, its approach crisis-driven and reactive. It is extremely difficult for those outside of the Department to gain information on how [the Child Safety Service] and [the out of home care service] operate or even its structure. I found there existed a culture of distrust by many children and young people, carers and its own workers towards the Department.[146]

3.3 Evidence from the Department

Publicly available information about the out of home care system and its measures to reduce and respond to child sexual abuse within out of home care has lacked detail. In keeping with our approach to all the institutions we inquired into, we relied heavily on the former Secretary of the Department of Communities, Michael Pervan, to speak about the Department's operations. We also heard from the Executive Director of Children and Family Services, Claire Lovell, to assist our understanding of day-to-day decision making. Other members of the Department Executive, such as former Deputy Secretary for Children, Youth and Families, Mandy Clarke, were not asked by our Commission of Inquiry, nor offered by the State, to give evidence in relation to out of home care.

Despite the evidence we received about the evolution of the Department and areas that were under review, we remained unclear about key aspects of the Department's functioning in the present. We drew on Secretary Pervan's and Ms Lovell's evidence as well as material from the Department's Practice Manual, which guided staff practices and decision making relevant to out of home care. We outline our best understanding of the system in Chapter 7.

The challenges we confronted reflect the assertion of the former departmental employee quoted above—it is extremely difficult for those outside the Department to understand how the out of home care system is structured or operates.[147] We further observed difficulties among those *inside* the Department to explain the system's structures and operations.

4 The scale and nature of child sexual abuse in out of home care

There is little published information about the scale and nature of child sexual abuse in out of home care in Tasmania.

It is difficult to quantify the incidence of child sexual abuse in out of home care because such abuse appears to be under-reported.[148] The best publicly available data

is produced by the Australian Institute of Health and Welfare, which reports annually on the safety of Australian children in out of home care. Nationally, in 2020–21, 20.6 per cent of substantiated notifications of abuse or neglect of children in care related to child sexual abuse.[149]

Data on the Victorian Reportable Conduct Scheme published by that state's Commission for Children and Young People indicated that, in 2020–21, 1,877 allegations of misconduct were made across all sectors that involved working with children (including out of home care), 396 (or 21 per cent) related to 'sexual misconduct' and 137 (or 7 per cent) related to 'sexual offences'.[150] In 2020–21, there were 49 allegations of sexual misconduct and 32 allegations of sexual offences in the out of home care sector.[151] 'Physical violence' and 'significant neglect of a child' were reported more than any other type of abuse in out of home care in the same period.[152]

The 2014 final report of the Tasmanian Claims of Abuse in State Care Program provided some data about sexual abuse of children in care. This program operated in Tasmania from 2004 to 2013.[153] Of a total of 541 claimants between 2011 and 2013, 394 were assessed as having experienced abuse (not limited to sexual abuse) while in care, and therefore, eligible for an ex gratia payment.[154] Two hundred 'accepted' claims of sexual abuse while in care were made by 167 claimants (98 male and 69 female), which accounted for 21.4 per cent of overall accepted claims.[155] Foster care was the setting of 128 (or 26.6 per cent) of all claims, although the period and nature of the abuse were not reported.[156] Chapter 12 contains our recommendations about the Tasmanian Government's response to allegations against out of home care staff and carers identified in the Tasmanian Claims of Abuse in State Care Program.

4.1 Risk notifications of child sexual abuse in out of home care

To help us get a comprehensive picture of the risk of child sexual abuse in care during the period of our Inquiry, we asked the Department to provide the following information:

- the number of children in out of home care who had risk notifications raised about possible sexual abuse while in care
- information on complaints, investigations or disciplinary action in relation to any allegations or incidents of sexual abuse that related to children in out of home care
- the number of departmental staff who had been stood down (had their employment suspended) over allegations against them in relation to sexual abuse of children in the out of home care system.[157]

In each case, we asked the Department to indicate, where records provided such information, what the Department's response had been and the outcome of the concern or allegation. This information is discussed below.

Terminology regarding 'concerns'

The Department uses several different terms relating to concerns about the sexual abuse of children in care. Some are used in a general sense, but others have a specific meaning in the context of out of home care. The following definitions explain how we use these terms in this volume.

Allegation or concern—we use these terms interchangeably to describe the situation where the Department has been made aware that a child in care may have been, or was at risk of being, sexually abused.

Care concern—a field in the Child Protection Information System that staff can select when recording an allegation or concern about a child in care being abused or neglected (refer to Chapter 9 for more about the care concern process).[158]

Notification or risk notification—a field in the Child Protection Information System that a Child Safety Officer can select when recording an allegation or concern about a child who may or may not already be in care.[159]

Incident—a field in the Child Protection Information System that a Child Safety Officer can select when recording an allegation or concern about a child, who may or may not already be in care.[160]

Investigation—in the context of the sexual abuse of children in care, we use this term primarily to refer to the care concern process applicable to serious or severe allegations of abuse or neglect. The Department sometimes uses the term as part of its response to a notification. We make it clear if the term is being used in this way.

Assessment—following a risk notification or an incident, the Child Safety Service uses this term to describe the process of seeking information about the risk to a child who may or may not already be in care.[161]

Initially, the Department provided a list of 439 instances where children in out of home care were the subject of a risk notification relating to child sexual abuse between 1 July 2013 and 30 June 2021.[162] These risk notifications included concerns about children with harmful sexual behaviours. We understand the data was obtained from a broad search of the Child Protection Information System. It included a search of the system's records of all children under a care and protection order or in out of home care and where the record mentioned the word 'sexual' in an 'abuse type' field or in the abuse type field of the person believed responsible.[163] We understand this data reflects the number of concerns raised in relation to sexual abuse of children in out of home care—not the actual incidence of child sexual abuse in out of home care.

The Department reported the following information for each instance:

- the date of the notification
- the child's date of birth
- the child's age at the time of the notification
- the child's gender
- the child's Aboriginal status
- whether or not the child was identified as having disability
- the child's postcode at the time of the alleged incident
- the date of the alleged incident
- the alleged abuser's relationship to the child (for example, 'Carer: Foster or Parents')
- the alleged abuser's gender, date of birth, whether or not they were identified as having a disability, and their Aboriginal status.

The Department cautioned that its dataset was missing some information and the incidence of concerns about sexual abuse for children in care may be under-reported.[164] The Department also noted some limitations in the process of extracting this data from its Child Protection Information System, which may have adversely affected the quality of the data. In particular:

- The term 'care concern' was used as a search term but had not been consistently recorded by users when entering a risk notification into the system—a 'care concern' is a risk notification that a child in care is not being properly cared for and includes possible abuse or neglect of a child by a carer or someone associated with the household.
- The system allowed only one alleged person believed responsible to be recorded per incident, resulting in an undercounting of those believed responsible.
- The person believed responsible for many risk notifications was not recorded because the risk notification did not progress to assessment.[165]

4.1.1 Our analysis

Our analysis of the 439 risk notifications revealed the following:

- The risk notifications related to 299 children. Most children (68.6 per cent) were the subject of only one risk notification, but in a substantial number of cases (31.4 per cent), two or more risk notifications were made in relation to the same child.

In one case, the Department had recorded eight separate instances of alleged abuse of the same female child.

- Numbers of risk notifications per year ranged from 35 to 81, with an average of 50, which equates to about one risk notification of possible sexual abuse against a child in care per week.
- While the ratio of female to male children in out of home care is about equal, 65.8 per cent of risk notifications were about the possible sexual abuse of a girl in care.[166]
- While 21 per cent of children in out of home care were identified as having disability, 27.3 per cent of risk notifications were about the possible sexual abuse of a child with disability.[167]
- Of children in out of home care, 37.4 per cent were identified as Aboriginal, although it is likely that the Aboriginal status of a child was not always accurately recorded (refer to Chapter 9). Just over one-quarter (27.8 per cent) of risk notifications concerned the possible sexual abuse of an Aboriginal child.[168]
- The relationship of most people believed responsible (64.5 per cent) to the child concerned was recorded as 'not stated', although in some cases a deeper reading of the material identified the relationship.
- Of the alleged abusers whose relationship with the child was stated:
    - 17.1 per cent were adults in the role of a foster, kinship or residential carer
    - 16.2 per cent were identified as a parent or relative of the child
    - 2.3 per cent were identified as other children in care.

The low proportion of alleged abuse from other children contrasts with expert evidence indicating that children in out of home care are more likely to experience sexual harm from other children, rather than an adult carer.[169] It is possible this type of abuse is significantly under-reported or poorly recorded due to a lack of guidance to standardise identification and response (refer to Chapter 9). It is also possible some of the alleged abusers whose connection with the child was not recorded were other children or adults outside the care or family system who were engaged in child sexual exploitation.

Disputed figures

Secretary Pervan and Ms Lovell raised concerns about our analysis of the frequency of child sexual abuse risk notifications in out of home care.[170]

Ms Lovell told us the Department handled only 'small numbers' of care concerns—for instance, in 2021–22, she said the Department recorded 172 care concerns for children in care, which covered a broad range of concerns.[171] Ms Lovell warned that these figures should be 'interpreted with caution' due to 'inconsistent recording practices'.[172] It is not clear whether the inconsistent recording practices were perceived to have inflated or under-estimated the actual extent of suspected child sexual abuse in care. Secretary Pervan explained that a manual review by Practice Managers identified that, in the 2020–21 year, 24 of the care concerns related to the possible sexual abuse of a child in care, nine of which were substantiated.[173] And for the partial year from July 2021 to March 2022, Secretary Pervan stated there had been 13 notifications about the possible sexual abuse of children in care, five of which were substantiated.[174]

We understand that the data originally provided by the Department related to risk notifications in out of home care and not only those allegations categorised as care concerns in the Child Protection Information System. Ms Lovell explained that allegations that relate to carers, including in relation to child sexual abuse, are treated as care concerns. In contrast, allegations about abuse of children in care by people who are not carers are responded to using the standard 'Child Safety assessment'.[175] Therefore, we suspect the differences in figures have most likely arisen from the terms or categories used when recording concerns about children in care and during searches of the Department's databases.

Secretary Pervan was concerned our Inquiry had misinterpreted the initial data the Department had provided to us, and had consequently overestimated the number of children who had been sexually abused in care.[176] He said:

> … it would seem that numbers relating to potential child sexual abuse in multiple contexts were reported by Counsel Assisting [during the out of home care hearing] as being the number of incidents of child sexual abuse in out of home care.[177]

We have considered Secretary Pervan's concerns and conclude that our analysis of the data is sound for the following reasons.

Counsel Assisting used the term '439 allegations' each time she referred to these numbers.[178] In doing so, Counsel Assisting was pointing out that the Department was alerted to the possibility of sexual abuse of a child in care at the frequency of about one allegation per week, rather than one substantiated incident each week.[179] Each of those 439 allegations required a response from the Department, even

if in the end they were not all substantiated. Failure to substantiate an allegation does not necessarily mean the alleged incident did not occur, but could mean that evidence was not sufficient to substantiate it or investigate it further.

As noted above, when the Department provided the original data on allegations, it cautioned that its dataset was missing some information due to limitations in its process for extracting data from the Child Protection Information System, and therefore, may under-report the true incidence of sexual abuse for children in care.[180]

As described in Section 4.1.2, we sampled 22 children's cases, which involved 55 allegations from the 439 allegations provided (12.5 per cent of the allegations reported). The sample was deliberately selected to illustrate a diversity of child sexual abuse risks and characteristics of children in care in Tasmania.[181] If the dataset contained irrelevant or false inclusions, we would have expected to see this reflected in our sample, but we did not. All 22 cases contained allegations of sexual abuse or concerns about the risk of sexual abuse for a child in care. We agree with Secretary Pervan's subsequent decision to address problems in recording child sexual abuse by widening the scope of the type of concerns recorded as a notification on the Child Protection Information System to include:

- generating notifications for observations of behaviour that may indicate abuse that would previously have been embedded in case notes and incident reports
- raising separate notifications for any children who have been exposed to a person believed responsible, even when the allegation does not relate directly to those children
- maintaining a very low bar for substantiation not linked to the evidentiary threshold used by police or courts, which we take to be the balance of probabilities
- substantiating for children who were at risk of abuse, or even future abuse, due to being exposed to an unsafe person
- initiating new notifications and new assessments if the first assessment is called into question after receiving new information or a review.[182]

We consider that this broader view of child sexual abuse more accurately reflects contemporary understanding of the variety and complexity of risk concerns involving the sexual abuse of children in care.

Secretary Pervan was conscious that making these changes would increase the data on concerns about the sexual abuse of children in care:

> Although the intentions of these changes is to improve safety for children, it will result in data indicating a higher number of notifications and substantiations. This may be misinterpreted as more children being at risk, or having experienced child sexual abuse.
>
> Unintended consequences can include [an] incorrect narrative being published and discussed publicly, stigmatisation of children in out of home care and difficulty in recruiting staff and carers to a service which is viewed negatively.[183]

In our view, broadening the data collected to include all risks of sexual abuse would improve safety for children in care by revealing a more accurate picture of concerns. Reputational issues may be managed by ensuring the public narrative is correctly informed of the reason behind the change in data collection—to improve the safety and wellbeing of children in care.

4.1.2 Detailed analysis of 22 cases

To better understand the nature of the 439 allegations and the Government's responses to them, we selected 20 children from the 299 children who were the subject of a concern about sexual abuse while in out of home care. Some of these were recorded as care concerns on the Child Protection Information System; others were recorded as notifications and some as incidents.[184]

The 20 children were selected to ensure our analysis included the experiences of children with a range of genders, Aboriginal status, disability status, geographical area, relationship of the alleged abuser to the child, and age of the child at the time of notification. We added the files of the two children who had the highest number of reported risk notifications—six and eight risk notifications respectively. The files we included were for children who were in care during the period from 2013 to 2021.

The Department provided 592 documents from the 22 children's files relevant to the concerns, including notification records of care concerns, placement summaries, file notes of telephone conversations, emails, correspondence between departmental staff and carers or specialist therapy providers, Tasmania Police referrals, minutes of care team meetings, 'investigation of serious abuse and neglect' reports and file notes of home visits. We did not examine the child's whole file. The Department produced a cover sheet for each child's file that summarised the risk notifications identified and the Department's process for selecting documents from the child's file.

A review of the files revealed the following:

- All the children in the sample were either known, or strongly suspected, to have a history of sexual abuse before coming into the Department's care. This is consistent with the known increased risk of sexual abuse for children in out of home care when they already have that history.[185]
- Multiple risk notifications of abuse or neglect in relation to a child in care was the norm in our sample. Across the 22 files reviewed, there were 55 risk notifications and most cases involved risk notifications of more than one form of child sexual abuse while in out of home care. The most common presentation was a combination of risk notifications relating to harmful sexual behaviours and abuse by an adult, or adults, whether a carer or a person outside the care environment.
- Risk notifications about harmful sexual behaviours were common. Eleven children were alleged to have either engaged in harmful sexual behaviours themselves, or experienced such behaviour from another child or children in care. Most of these children were alleged to have engaged in multiple instances of harmful sexual behaviours and/or been subject to more than one incident.
- Risk notifications about child sexual exploitation were represented. Four children in the sample were alleged to have been groomed or sexually exploited by multiple adults outside the care or family system, although some of the 'persons believed responsible' were recorded in the initial dataset as 'unstated'. All four of these children were female and three had a known intellectual disability. One of the risk notifications involved producing online child exploitation material and attempts to enlist the child to recruit other, very young children to be similarly exploited.
- Risk notifications of abuse by carers or residential care workers were also common. The files of 11 children contained risk notifications about a current or previous foster, residential or kinship carer.
- Sometimes risk notifications were recorded for a child when there was concern about possible exposure to risk, rather than a direct allegation. Three of the children had a risk notification recorded as a result of alleged sexual abuse of a sibling or another child in the same placement, but no allegation had been made a that time about the child in question.
- Children in out of home care were at risk of sexual abuse from a variety of sources. One risk notification involved a teacher allegedly grooming a child in care, another involved boundary breaches by a departmental employee, four risk notifications related to biological family members sexually abusing or grooming children during visitation, and one involved the alleged sexual assault of a girl by her same-aged boyfriend.

- The rate of criminal conviction was low. Of the 55 risk notifications recorded in the files, only two risk notifications were recorded as resulting in a criminal conviction. While police were involved in investigating many of the risk notifications and took statements, it was common for matters not to proceed to charges because the child did not want to give evidence.

These themes are similar to those identified by the National Royal Commission. They also reflect anecdotal evidence we heard at our targeted consultation with out of home care providers.

The Department's responses

Some aspects of the Department's responses to risk notifications of sexual abuse concerning children in out of home care appeared reasonable. Although it was not always clear what care concern process was followed (refer to Chapter 9 for more about care concern processes), overall there was evidence that departmental and out of home care staff undertook some form of investigation or assessment of each concern.

Positively, there was consistent evidence across the files that Tasmania Police were involved in investigating risk notifications of sexual abuse of children in out of home care. This evidence included formal referrals to and from police, and ongoing liaison about risk notifications in emails and file notes.

While there was evidence of some departmental staff and police describing children who were allegedly being sexually exploited outside the placement as engaging in 'risk taking behaviours', the Department and non-government out of home care providers appeared to regularly approach Tasmania Police for support with these concerns.[186] In addition to trying to educate the children involved about self-protective behaviours, staff had documented some proactive attempts to intervene, such as taking out a restraining order against an alleged abuser, police attending premises to retrieve a child, and staying in contact with the child.[187] We discuss the Department's response to child sexual exploitation in Chapter 9.

System and practice failures

The file reviews also revealed system and practice failures that may have adversely affected the Department's capacity to predict an increased risk of sexual abuse for a child in out of home care and therefore, to act protectively. These included the following:

- We observed inconsistent recording of Aboriginal status between documents within children's records, leading to uncertainty about a child's Aboriginal status. Without clarity of Aboriginal status, it would be difficult to know if cultural support was needed for a child.

- For those children who were identified as Aboriginal, we saw limited evidence in the records of the presence of cultural support plans or engagement in cultural support activities. Refer to Chapter 9 for a discussion of the need for cultural engagement for Aboriginal children in care and its centrality in protecting children from sexual abuse and facilitating disclosure.
- It was difficult to identify children with disability unless we read each file note in detail and again, this information was recorded inconsistently. Rarely did a child's disability feature as a vulnerability factor in the risk assessment section of a notification or assessment record. Our impression was that it would be difficult for staff accessing these records to identify the nature of the child's disability (and consequently, the support they might need) and to consider that information when assessing risk to a child, specifically in relation to the risk of child sexual abuse. In Chapter 9, we outline the importance of a clear understanding of each child's individual needs, including their disability support needs, to acting protectively.
- The review identified very few case and care plans among the documents provided. It is possible these documents were omitted during the Department's process of compiling the files for us. However, the absence of these plans is also consistent with concerns raised by witnesses such as Andrea Sturges from Kennerley Children's Services, who reported that less than 5 per cent of the 105 children in Kennerley's care had current case and care plans.[188] (Refer to Chapter 9 for a discussion of care plans.)
- The notes made by departmental staff often referred to following the 'care concern process', but it was not always clear which process was being followed: the 'quality of care concern' process or the more serious 'investigation of serious abuse and neglect' process. On occasion, notes referred to risk notifications being managed through other processes such as 'case consultation' or an 'incident response review' or a matter being 'handled in Assessment'. This use of different and unclear language made it difficult to assess what had occurred. We examine the care concern process in Chapter 9.
- The risk assessment section of the notification record was frequently not updated with current information to support the risk assessment and decision made, and often appeared to have been cut and pasted from previous notification records. In one instance, the risk assessment section content referred to the child being seven years of age and living with her parents, when she was in fact aged 17 and living in a residential care setting, and had been in care since she was seven.
- Staff regularly used the term 'self-selected' in their notes to describe why children and young people in care were not living in their placement. This confirmed concerns raised by others who work regularly with the Department of a pervasive practice among departmental staff of deferring responsibility to children to

decide where they live rather than viewing them as missing from placement (refer to Chapter 9). This is particularly concerning in light of the National Royal Commission's observations on groomed compliance of children experiencing sexual exploitation.

Harmful sexual behaviours

In relation to risk notifications about harmful sexual behaviours between children in out of home care, we observed the following from the files:

- The nature of alleged harmful sexual behaviours ranged from developmentally inappropriate to coercive or violent sexual behaviours (refer to Chapter 21 for more on the continuum of harmful sexual behaviours).
- Positively, there was strong evidence of departmental staff appropriately referring children involved in alleged incidents to specialist support and intervention agencies, such as the Australian Childhood Foundation, Laurel House or the Sexual Assault Support Service.
- All children who were believed to have displayed or been subject to harmful sexual behaviours, were known to have been involved in sexualised or harmful sexual behaviours before being moved to the placement where the alleged incidents took place. We were concerned the Department may not have sufficiently considered the known risk factor of a history of harmful sexual behaviours when making placement decisions.
- 'Adult supervision' was a strategy departmental staff relied on regularly to manage the risk of harmful sexual behaviours between children in out of home care. We are concerned this approach is not practically achievable in a home or residential care setting (refer to Chapter 9 for a discussion of managing harmful sexual behaviours in out of home care).
- There was no evidence that departmental staff referred to any harmful sexual behaviours framework or policy documents when assessing and managing the risk of harmful sexual behaviours for a child.
- The Department's response to alleged incidents of harmful sexual behaviours was varied—in some instances, the Department immediately removed one of the children involved from the placement, and in others, it left the children in the placement with increased supervision from the carers. It was not apparent that the different responses were determined by the nature of the behaviour.
- Many of the children involved in an incident of harmful sexual behaviour had an intellectual disability. There was evidence on the files that when the child who displayed the harmful sexual behaviour had an intellectual disability, some departmental staff downplayed the impact of the behaviour on the other child.

4.2 The Department's response to incidents and allegations

We asked the Department to provide information about 'complaints made, or investigations, or disciplinary action' in response to any allegations or incidents of child sexual abuse in out of home care, from 1 January 2000 to 9 March 2022. We asked for:

- the names of the person reporting the incident, the alleged victim-survivor and the alleged abuser
- the dates of the alleged incident and when the allegation was raised
- a summary of the allegation
- who in the Department was involved in responding to the allegation or incident
- any actions taken by the Department such as reporting the incident to police or regulatory agencies
- the outcome of the allegation.[189]

We expected some overlap between the data already provided for 2013 to 2021, but this request differed from the initial data request in that we were asking primarily about the alleged abusers and the Department's response to them. The data the Department provided reflected this focus. It drew from the Children's Advice and Referral Line Digital Interface, the Child Protection Information System (from 2008 onwards), a manual review of documents produced for the Joint Review Team (a recent cross-jurisdictional document review led by Tasmania Police; refer to Chapter 16) and the Abuse in State Care Support Service (refer to Chapter 11). We understand the search of the documents focused on alleged abusers (the Department records these as 'persons believed responsible') and the Department's response to alleged abusers.

The Department told us minimal information was recorded for cases before the Child Protection Information System was introduced in 2008, and staff have only recently begun recording the persons believed responsible more consistently in the database.[190] The Department acknowledged a limitation of its data system for this purpose is that it is naturally 'child-centric', which means that relatively little information about other people in a child's life is captured on the child's record.[191]

Given this context, we expect the records the Department provided to us are not comprehensive in identifying those believed responsible for abuse in out of home care and that the data extracted underestimates the number of allegations of sexual abuse in out of home care.

Consequently, the Department listed 284 allegations, considerably fewer than the 439 instances they identified when the focus was on children's records rather than persons believed responsible.[192]

Acknowledging the data limitations, we reviewed this second list to understand how the Department responded to alleged sexual abuse of a child in care by an adult. After removing allegations of harmful sexual behaviours, we focused on 106 allegations concerning adults believed responsible and observed that:

- most allegations were against foster or kinship carers, or an associate of the carers
- very few allegations related to child sexual exploitation
- allegations were recorded for 72 different persons believed responsible
- concerningly, very few outcomes and actions resulting from the allegations were provided
- eighteen of the persons believed responsible had multiple allegations against them
- the care concern process was reported as having been initiated in 25–30 per cent of cases
- police referrals were recorded in about 40 per cent of cases.[193]

4.3 Staff suspensions and terminations following allegations of abuse

The Department has provided us with a list of suspensions between January 2000 and 2023 in relation to out of home care—this includes reference to four suspensions.[194] We received information from Secretary Pervan about one other suspension that was not included in the Department's list.[195] The four cases about which we received information from the Department are described in deidentified form below.

4.3.1 Suspension 1

In the late 2000s, a male child protection worker was suspended for alleged breaches of sections 9(2) and (14) of the *State Service Act 2000*. It was alleged he had sent 'inappropriate texts' to one of the teenagers he was case-managing and to a 'vulnerable young woman' over the age of 18. The terms of his suspension are unknown, but an Employment Direction No. 5—Breach of Code of Conduct investigation determined he had breached sections 9(1), (3) and (14) of the Act. The Department referred the matter to Tasmania Police, but no charges were laid. The man's employment was terminated.[196]

The Department could not identify the date it was notified of the allegations attached to this suspension. The Department's records indicated two dates of suspension, six months apart. The Department therefore, could not say how long it had taken to suspend the employee after receiving the allegations. The man's employment was terminated five months after the Employment Direction No. 5—Breach of Code of Conduct investigation started.[197]

We received additional information that the man had been accused of sending inappropriate or sexualised texts to other children in care during his employment with the Department. The Department had conducted two previous Employment Direction No. 5—Breach of Code of Conduct investigations, but it was not clear if the employee was suspended during these investigations. In these instances, the Department had issued 'lawful and reasonable directives' to desist after conducting investigations.[198]

4.3.2 Suspension 2

In the early 2000s, the Department became aware of allegations about a male departmental employee who worked as a carer. The allegations were that he was 'having a sexual relationship with a [child aged less than 18 years] under the guardianship of the Secretary'. Tasmania Police charged him with sexual abuse charges, including four counts of 'sexual intercourse with a young person'. According to the Department, 'at least 166 days' elapsed between the date police charged the man—when the Department became aware of the allegations—and the date he was suspended. The Department did not provide an explanation for the delay in suspending the man, nor did it describe the terms of his suspension or the outcome of the matter.[199]

4.3.3 Suspension 3

A long-serving male Child Safety Officer was suspended after the start of our Commission of Inquiry. The Department instigated an Employment Direction No. 5—Breach of Code of Conduct investigation in relation to a longstanding pattern of boundary breaches involving children in the care of the Department. It was alleged the employee accessed the files of children in out of home care who were no longer under his management, interviewed children under his management at his home, and transported children in care in his personal vehicle. The Department advised that he had been given 'lawful and reasonable directives' and reminder letters of these directives, but his behaviour continued.[200] At the time of writing, we are unaware of the outcome of this matter.

4.3.4 Suspension 4

A male support worker employed by the Department was stood down after the start of our Commission of Inquiry. The Department instigated an Employment Direction No. 5—Breach of Code of Conduct investigation into alleged unsafe practices by this worker, namely transporting children in care in an unsafe manner. The Department acknowledged it was aware of other concerns about the worker over a longer period, which had not resulted in an investigation. These concerns were:

- the worker being charged in the early 2000s with possession of child exploitation material that did not proceed to a conviction

- a conflict of interest arising from a personal relationship with a foster carer
- taking longer than was necessary to transport children in care, raising concerns about his activities with those children
- the negative response of a child in care to being transported by the worker.[201]

The Department advised us it had notified the Registrar of the Registration to Work with Vulnerable People Scheme of these concerns. Subsequently we received documentation indicating that the worker's registration to work with vulnerable people had been cancelled.[202]

These four cases constitute very few staff being suspended or terminated over more than 20 years. Because of poor record keeping, it is difficult to determine whether there has been more disciplinary action than that reported to us, or whether the Department has been slow to take action against staff for concerning behaviour.

5 Overview of systemic problems

Through our review of the information received by us—from children in care, case file reviews, from those working within and with the out of home care system, previous reviews and inquiries, and the documents and policies we have reviewed—we have identified a number of systemic problems with Tasmania's out of home care system that should be addressed to better protect children in care from the risks of child sexual abuse, and improve the response when abuse does occur. We elaborate on these problems in more detail in Chapter 9, where we discuss our reasoning for our recommendations for the way forward. However, in summary, these problems include:

- challenges in adopting measures to prevent child sexual abuse, including ensuring appropriate placements of children
- difficulties consistently putting in place risk mitigation strategies when risks are identified, such as providing early treatment for serious and concerning harmful sexual behaviours
- not consistently addressing the trauma children have experienced before or during their out of home care experience, increasing their risk of child sexual abuse or reducing their confidence in disclosing such abuse
- not consistently addressing the cultural needs of Aboriginal children, increasing their risk of child sexual abuse or reducing their confidence in disclosing such abuse
- insufficient supports for staff and carers to manage risks of child sexual abuse, or respond appropriately when it occurs

- inconsistent and uneven responses when children disclose child sexual abuse while in care.

We consider that these problems are, at least partially, a result of a system under pressure. They need to be addressed through changes to the systems and processes of out of home care generally, rather than tweaks to the system. In Chapter 9, we consider in detail various aspects of the out of home care system, and explain our recommendations for keeping children in care safe and for improving departmental responses to child sexual abuse.

Notes

1 For example, we heard that some professionals in the community experience 'pushback' from the Advice and Referral Line (Transcript of Claire Lovell, 14 June 2022, 1189 [38]–1191 [22]) and that the Advice and Referral Line was understaffed, poorly administered and characterised by inconsistent timeframes in responding to child safety concerns (Statement of Jack Davenport, 3 June 2022, 4 [30]). We also heard that the Child Safety Service took a 'very binary view' of decision making, whereby children were either left with their family or removed and placed under statutory orders (Statement of Andrea Sturges, 16 June 2022, 19 [73]).

2 Australian Institute of Health and Welfare, 'Summary', *Child Protection Australia 1999–00* (Web Page, 10 May 2001) 2, 39 <https://www.aihw.gov.au/reports/child-protection/child-protection-australia-1999-00/contents/summary>; Australian Institute of Health and Welfare, 'Table 5.1. Children in out of home care, by state or territory 30 June 2021', *Child Protection Australia 2020–21* (Web Page, 15 June 2022) <https://www.aihw.gov.au/reports/child-protection/child-protection-australia-2020-21/contents/out-of-home-care/how-many-children-were-in-out-of-home-care>.

3 Children 14 years of age and under: refer to Australian Bureau of Statistics, 'Demographics and Education', *Tasmania 2001 Census All Persons QuickStats* (Web Page, 7 August 2001) <https://www.abs.gov.au/census/find-census-data/quickstats/2001/6>; Australian Bureau of Statistics, 'People and Population', *Tasmania 2021 Census All persons QuickStats* (Web Page, 2021) <https://www.abs.gov.au/census/find-census-data/quickstats/2021/6>.

4 Australian Institute of Health and Welfare, 'Data Tables: Child Protection Australia 2020–21', *Child Protection Australia 2020–21* (Web Page, 15 June 2022) Table S5.5 <https://www.aihw.gov.au/reports/child-protection/child-protection-australia-2020-21/data>.

5 Transcript of Robyn Miller, 14 June 2022, 1253 [5–33]; Transcript of Jack Davenport, 15 June 2022, 1371 [5–15]; Transcript of Jodie Stokes, 15 June 2022, 1295 [40]–1296 [29]; Transcript of Heather Sculthorpe, 15 June 2022, 1303 [3–19]; Transcript of Catia Malvaso, 3 May 2022, 173 [10–24]; Transcript of Helen Milroy, 4 May 2022, 237 [37–43].

6 Transcript of Anne Hollonds, 2 May 2022, 58 [3–5]; Transcript of Brett McDermott, 3 May 2022, 170 [24–28], 170 [43]–171 [1], 177 [11–15]; Transcript of Sally Robinson, 4 May 2022, 251 [23–26], 262 [11–16]; Transcript of Ignatius Kim, 9 May 2022, 682 [32–33]; Transcript of Timothy Bullard, 12 May 2022, 988 [27–32]; Transcript of Claire Lovell, 14 June 2022, 1192 [9–19]; Transcript of Muriel Bamblett, 15 June 2022, 1332 [7–12]; Transcript of Elena Campbell, 7 July 2022, 2566 [26–41]; Transcript of Alison Grace, 26 August 2022, 3478 [26–35]; Transcript of Cathy Taylor, 12 September 2022, 3915 [6–18].

7 Refer generally to Olivia Octoman et al, 'Tailoring Service and System Design for Families Known to Child Protection: A Rapid Exploratory Analysis of the Characteristics of Families' (2022) 31(5) *Child Abuse Review*; Olivia Octoman et al, 'Subsequent Child Protection Contact for a Cohort of Children Reported to Child Protection Prenatally in One Australian Jurisdiction' (2023) 32(1) *Child Abuse Review*; Miriam Jennifer Maclean, Scott Anthony Sims and Melissa O'Donnell, 'Role of Pre-existing Adversity and Child Maltreatment on Mental Health Outcomes for Children Involved in Child Protection: Population-based Data Linkage Study' (2019) 9(7) *BMJ Open*; Jason M Armfield et al, 'Intergenerational Transmission of Child Maltreatment in South Australia, 1986–2017: A Retrospective Cohort Study' (2021) 6(7) *Lancet Public Health*.

8 Refer to Jenna Meiksans et al, 'Risk Factors Identified in Prenatal Child Protection Reports' (2021) 122 *Children and Youth Services Review*; Sarah Louise Cox et al, 'Opportunities to Strengthen Child Abuse Prevention Service Systems: A Jurisdictional Assessment of Child Welfare Interventions', *Journal for the Society for Social Work and Research* (forthcoming).

9 Leah Bromfield et al, *Issues for the Safety and Wellbeing of Children in Families with Multiple and Complex Problems: The Co-occurrence of Domestic Violence, Parental Substance Misuse, and Mental Health Problems* (NCPC Issues No 33, Australian Institute of Family Studies, December 2020) 1.

10 Australian Child Maltreatment Study, Queensland University of Technology, *The Prevalence and Impact of Child Maltreatment in Australia: Findings from the Australian Child Maltreatment Study: Brief Report* (Report, 2023) 14.

11 Australian Child Maltreatment Study, Queensland University of Technology, *The Prevalence and Impact of Child Maltreatment in Australia: Findings from the Australian Child Maltreatment Study: Brief Report* (Report, 2023) 3.

12 Australian Child Maltreatment Study, Queensland University of Technology, *The Prevalence and Impact of Child Maltreatment in Australia: Findings from the Australian Child Maltreatment Study: Brief Report* (Report, 2023) 24–27.

13 For example, Transcript of Azra Beach, 16 June 2022, 1443 [21–23]; Transcript of 'Faye', 14 June 2022, 1173 [33–45]; Anonymous session, 29 October 2022. The name 'Faye' is a pseudonym; Order of the Commission of Inquiry, restricted publication order, 14 June 2022.

14 This was a sample of a much larger cohort of children identified by the Department; refer to Section 4.1.2 for methodology.

15 Tim Moore and Morag McArthur, *Take notice, believe us and act! Exploring the safety of children and young people in government run organisations* (Research Report prepared for the Commission of Inquiry into the Tasmanian Government's Responses to Child Sexual Abuse in Institutional Settings, February 2023).

16 Transcript of Azra Beach, 16 June 2022, 1442 [36–41].

17 Transcript of Azra Beach, 16 June 2022, 1443 [3–9].

18 Transcript of Azra Beach, 16 June 2022, 1443 [21–24].

19 Transcript of Azra Beach, 16 June 2022, 1443 [13].

20 Transcript of Azra Beach, 16 June 2022, 1444 [2–24].

21 Transcript of Azra Beach, 16 June 2022, 1444 [26–31].

22 Transcript of Azra Beach, 16 June 2022, 1444 [33–39].

23 Transcript of Azra Beach, 16 June 2022, 1444 [41–45], 1445 [5–11].

24 Transcript of Azra Beach, 16 June 2022, 1443 [37–39]; Statement of Azra Beach, 14 June 2022, 3–4 [20].

25 Transcript of Azra Beach, 16 June 2022, 1449 [21–22].

26 Statement of Azra Beach, 14 June 2022, 5 [33]–6 [34].

27 Transcript of Azra Beach, 16 June 2022, 1445 [13-22]; Statement of Azra Beach, 14 June 2022, 4 [26]–5 [27].

28 Transcript of Azra Beach, 16 June 2022, 1445 [20–29].

29 Transcript of Azra Beach, 16 June 2022, 1446 [16–30].

30 Statement of Azra Beach, 14 June 2022, 10 [59].

31 Transcript of Azra Beach, 16 June 2022, 1448 [25–46]; Statement of Azra Beach, 14 June 2022, 10 [60].

32 Statement of Azra Beach, 14 June 2022, 10 [62].

33 Statement of Azra Beach, 14 June 2022, 10 [61].

34 Statement of Azra Beach, 14 June 2022, 10 [61].

35 Transcript of Azra Beach, 16 June 2022, 1449 [27–47].

36 Statement of Azra Beach, 14 June 2022, 10 [58].

37 Statement of Azra Beach, 14 June 2022, 11–12 [70].

38 Statement of Azra Beach, 14 June 2022, 13 [77].

39 In relation to this case study, the Commission of Inquiry received the information on the basis that those providing it would remain anonymous. Consequently, the State has not been provided with identifying information in relation to the case study and has not had the opportunity to fully consider or respond to the details of the case study.

40 The names 'Hudson' and 'Cassandra' are pseudonyms; Order of the Commission of Inquiry, restricted publication order, 30 August 2023.

41 Letter from 'Cassandra' to Child Safety Team Leader, 2020, 3.

42 Conversation with 'Cassandra' (staff, Commission of Inquiry into the Tasmanian Government's Responses to Child Sexual Abuse in Institutional Settings, 18 October 2022).

43 Conversation with 'Cassandra' (staff, Commission of Inquiry into the Tasmanian Government's Responses to Child Sexual Abuse in Institutional Settings, 18 October 2022); Letter from 'Cassandra' to Child Safety Team Leader, 2020, 3–4.

44 Letter from 'Cassandra' to Child Safety Team Leader, 2020, 7.

45 Transcript of 'Faye', 14 June 2022, 1169 [44–47].

46 Transcript of 'Faye', 14 June 2022, 1170 [5–15].

47 Transcript of 'Faye', 14 June 2022, 1170 [26]–1171 [1].

48 Transcript of 'Faye', 14 June 2022, 1171 [5–13].

49 Transcript of 'Faye', 14 June 2022, 1171 [15–17].

50 Transcript of 'Faye', 14 June 2022, 1171 [19–27].

51 Transcript of 'Faye', 14 June 2022, 1171 [29–35].

52 Transcript of 'Faye', 14 June 2022, 1171 [37]–1172 [5].

53 Transcript of 'Faye', 14 June 2022, 1172 [38–44].

54 Transcript of 'Faye', 14 June 2022, 1172 [46]–1173 [28].

55 Transcript of 'Faye', 14 June 2022, 1173 [33–45].

56 Transcript of 'Faye', 14 June 2022, 1175 [7–10].

57 Transcript of 'Faye', 14 June 2022, 1175 [3–7].

58 Transcript of 'Faye', 14 June 2022, 1175 [12–25].

59 Transcript of 'Faye', 14 June 2022, 1178 [33–45].

60 Transcript of 'Faye', 14 June 2022, 1173 [30–32], 1174 [6–7] [26–35].

61 Statement of 'Faye', 7 June 2022, 8 [40]; Transcript of 'Faye', 14 June 2022, 1178 [42–45].

62 Session with 'Lucas' (a pseudonym), 24 June 2022. The name 'Lucas' is a pseudonym; Order of the Commission of Inquiry, restricted publication order, 30 August 2023.

63 The name 'Eleanor' is a pseudonym; Order of the Commission of Inquiry, restricted publication order, 30 August 2023.

64 Session with 'Lucas', 24 June 2022.

65 The name 'Matilda' is a pseudonym; Order of the Commission of Inquiry, restricted publication order, 30 August 2023.

66 Session with 'Lucas', 24 June 2022.

67 Session with 'Lucas', 24 June 2022.

68 Session with 'Lucas', 24 June 2022.

69 Order of the Commission of Inquiry, restricted publication order, 17 June 2022; Department of Communities, 'Child Safety History', 4 April 2022, 2, produced by the Tasmanian Government in response to a Commission notice to produce.

70 Department of Communities, 'Investigation of Severe Abuse and Neglect Report', 12 February 2021, 1, produced by the Tasmanian Government in response to a Commission notice to produce.

71 Order of the Commission of Inquiry, restricted publication order, 17 June 2022.

72 Department of Communities, 'Investigation of Severe Abuse and Neglect Report', 12 February 2021, 2, produced by the Tasmanian Government in response to a Commission notice to produce.

73 Department of Communities, 'Investigation of Severe Abuse and Neglect Report', 12 February 2021, 2, produced by the Tasmanian Government in response to a Commission notice to produce.

74 Department of Communities, 'Investigation of Severe Abuse and Neglect Report', 12 February 2021, 4, produced by the Tasmanian Government in response to a Commission notice to produce.

75 Department of Communities, 'Investigation of Severe Abuse and Neglect Report', 12 February 2021, 4, produced by the Tasmanian Government in response to a Commission notice to produce.

76 Department of Communities, 'Investigation of Severe Abuse and Neglect Report', 12 February 2021, 6, produced by the Tasmanian Government in response to a Commission notice to produce.

77 Department of Communities, 'Assessment Report', 3 March 2021, 2, produced by the Tasmanian Government in response to a Commission notice to produce.

78 Department of Communities, 'Investigation of Severe Abuse and Neglect Report', 12 February 2021, 5, produced by the Tasmanian Government in response to a Commission notice to produce.

79 Department of Communities, 'Referral to a Senior Quality and Practice Advisor (SQPA)', 25 November 2020, 4, produced by the Tasmanian Government in response to a Commission notice to produce.

80 Email from SQPA investigator to her manager, 22 December 2020, 1, produced by the Tasmanian Government in response to a Commission notice to produce.

81 Email from service provider to SQPA investigator, 18 January 2021, 1, produced by the Tasmanian Government in response to a Commission notice to produce.

82 Department of Communities, 'Investigation of Severe Abuse and Neglect Report', 12 February 2021, 7–8, produced by the Tasmanian Government in response to a Commission notice to produce.

83 Notification Report to the Child Safety Service, 11 August 2021, 2, produced by the Tasmanian Government in response to a Commission notice to produce.

84 Department of Communities, 'Responding to Quality of Care Concerns Relating to Children in Out of Home Care: Coordination Meeting – Agenda/Minutes', 12 August 2021, 3, produced by the Tasmanian Government in response to a Commission notice to produce; Letter from Tasmania Police to the Commission of Inquiry, 1 March 2023, 2.

85 Letter from service provider to Child Safety Officer, 17 August 2021, 1, produced by the Tasmanian Government in response to a Commission notice to produce.

86 Order of the Commission of Inquiry, restricted publication order, 17 June 2022; Department of Communities, 'Child Safety History', 4 April 2022, 5, produced by the Tasmanian Government in response to a Commission notice to produce.

87 Department of Communities, 'Child Safety History', 4 April 2022, 5–6, produced by the Tasmanian Government in response to a Commission notice to produce.

88 Department of Communities, 'Child Safety History', 4 April 2022, 5, produced by the Tasmanian Government in response to a Commission notice to produce.

89 Affidavit of Child Safety Officer, Magistrates Court of Tasmania, 5 June 2019, 3 [12(b)], produced by the Tasmanian Government in response to a Commission notice to produce.

90 Affidavit of Child Safety Officer, Magistrates Court of Tasmania, 5 June 2019, 3 [12(b)], produced by the Tasmanian Government in response to a Commission notice to produce.

91 Affidavit of Child Safety Officer, Magistrates Court of Tasmania, 5 June 2019, 2 [5], 4 [15]–5 [19], produced by the Tasmanian Government in response to a Commission notice to produce.

92 Department of Communities, 'Child Safety History', 4 April 2022, 2, produced by the Tasmanian Government in response to a Commission notice to produce.

93 Department of Communities, 'Case note record of statement to Tasmania Police', 28 April 2020, produced by the Tasmanian Government in response to a Commission notice to produce.

94 Department of Communities, 'Child Safety History', 4 April 2022, 3, produced by the Tasmanian Government in response to a Commission notice to produce.

95 Department of Communities, 'Child Safety History', 4 April 2022, 2, produced by the Tasmanian Government in response to a Commission notice to produce.

96 Department of Communities, 'Notification Report', 27 April 2021, 2, produced by the Tasmanian Government in response to a Commission notice to produce.

97 Department of Communities, 'Notification Report', 27 April 2021, 4–5, produced by the Tasmanian Government in response to a Commission notice to produce.

98 Department of Communities, 'Notification Report', 27 April 2021, 10, produced by the Tasmanian Government in response to a Commission notice to produce.

99 Department of Communities, 'Case Notes Report', April 2021, 1, 3, produced by the Tasmanian Government in response to a Commission notice to produce.

100 Department of Communities, 'Notification Report', 27 April 2021, 6, produced by the Tasmanian Government in response to a Commission notice to produce.

101 Department of Communities, 'Case Notes Report', April 2021, 7, produced by the Tasmanian Government in response to a Commission notice to produce.

102 Department of Communities, 'Notification Report', 27 April 2021, 8, produced by the Tasmanian Government in response to a Commission notice to produce.

103 Department of Communities, 'Case Notes Report', April 2021, 11, produced by the Tasmanian Government in response to a Commission notice to produce.

104 Department of Communities, 'Case Notes Report', April 2021, 11, produced by the Tasmanian Government in response to a Commission notice to produce.

105 Department of Communities, 'Case Notes Report', April 2021, 12, produced by the Tasmanian Government in response to a Commission notice to produce.

106 Department of Communities, 'Notification Report', 27 April 2021, 8, produced by the Tasmanian Government in response to a Commission notice to produce.

107 Transcript of Brett Robinson, 17 June 2022, 1536 [8–37].

108 Transcript of Brett Robinson, 17 June 2022, 1535 [3–13].

109 Transcript of Brett Robinson, 17 June 2022, 1535 [27–41].

110 Transcript of Brett Robinson, 17 June 2022, 1537 [25–38].

111 Transcript of Brett Robinson, 17 June 2022, 1537 [13–23].

112 Transcript of Brett Robinson, 17 June 2022, 1538 [27–38].

113 Transcript of Brett Robinson, 17 June 2022, 1538 [1–11].

114 Transcript of Brett Robinson, 17 June 2022, 1539 [22]–1540 [3].

115 Transcript of Brett Robinson, 17 June 2022, 1540 [5–9].

116 Transcript of Brett Robinson, 17 June 2022, 1540 [12-14].

117 Transcript of Brett Robinson, 17 June 2022, 1540 [15–17].

118 Transcript of Brett Robinson, 17 June 2022, 1540 [19–35].

119 Statement of Brett Robinson, 2 June 2022, 3 [16].

120 Transcript of Brett Robinson, 17 June 2022, 1540 [40–45].

121 Transcript of Brett Robinson, 17 June 2022, 1541 [14–16].

122 Transcript of Brett Robinson, 17 June 2022, 1541 [25–28].

123 Transcript of Brett Robinson, 17 June 2022, 1541 [44]–1542 [9].

124 Transcript of Brett Robinson, 17 June 2022, 1542 [12–25].

125 Anonymous session, 29 September 2022. In relation to this case study, the Commission of Inquiry received the information on the basis that those providing it would remain anonymous. Consequently, the State and Tasmania Police have not been provided with identifying information in relation to the case study and have not had the opportunity to fully consider or respond to the details of the case study.

126 Anonymous session, 29 September 2022.

127 The name 'Addison' is a pseudonym; Order of the Commission of Inquiry, restricted publication order, 30 August 2023.

128 Conversation with mother of 'Addison' (staff, Commission of Inquiry into the Tasmanian Government's Responses to Child Sexual Abuse in Institutional Settings, 26 August 2022).

129 Anonymous session, 29 September 2022.

130 The names 'Vanessa' and 'Edmund' are pseudonyms; Order of the Commission of Inquiry, restricted publication order, 30 August 2023.

131 Anonymous session, 29 September 2022.

132 Anonymous session, 29 September 2022.

133 Anonymous session, 29 September 2022.

134 Anonymous session, 29 September 2022.

135 Anonymous session, 29 September 2022.

136 Anonymous session, 29 September 2022.

137 Anonymous session, 29 September 2022.

138 Anonymous session, 29 September 2022.

139 Anonymous session, 29 September 2022.

140 Anonymous session, 29 September 2022.

141 Anonymous session, 29 September 2022.

142 Anonymous session, 29 September 2022.

143 Anonymous session, 29 September 2022.

144 Anonymous session, 29 September 2022.

145 Refer to Letter from Thirza White to the Commission of Inquiry, 15 July 2022, 1; Staff survey results indicate that only 45 per cent of respondents were confident they would be protected from reprisals if they spoke out: refer to Transcript of Michael Pervan, 17 June 2022, 1612 [3]–1613 [6]); Anonymous session, 21 October 2022.

146 Statement of Sonya Enkelmann, 26 April 2022, 3 [12].

147 Statement of Sonya Enkelmann, 26 April 2022, 3 [12].

148 *Royal Commission into Institutional Responses to Child Sexual Abuse* (Final Report, December 2017) vol 12, 99.

149 Australian Institute of Health and Welfare, 'Data Tables: Safety of Children in Care 2020–21', *Safety of Children in Care 2020–21* (Web Page, 10 December 2021) Table 3 <https://www.aihw.gov.au/reports/child-protection/safety-of-children-in-care-2020-21/data>. We note the definition used to collect this data limits 'abuse in care' to *substantiated* instances of abuse by someone living with the child in care, or where the carer failed to prevent the abuse. For the purposes of this report, we have adopted a broader definition to include all forms and sources of child sexual abuse of children while they are in care, without any limitation to the involvement of people in the child's household. The Australian Institute of Health and Welfare's definition of 'substantiation' is: 'where it was concluded that there was reasonable cause to believe that the child had been, was being, or was likely to be, abused … [and] does not necessarily require sufficient evidence for a successful prosecution'—refer to Australian Institute of Health and Welfare, 'Glossary', *Child Protection* (Web Page, 13 June 2023) <https://www.aihw.gov.au/reports-data/health-welfare-services/child-protection/glossary>.

150 Commission for Children and Young People (Victoria), *Annual Report 2020–21* (Report, October 2021) 79.

151 Commission for Children and Young People (Victoria), *Annual Report 2020–21* (Report, October 2021) 80.

152 Commission for Children and Young People (Victoria), *Annual Report 2020–21* (Report, October 2021) 80.

153 Eligibility required claimants to be aged 18 or over on 11 July 2003: Department of Health and Human Services, *Review of Claims of Abuse of Children in State Care: Final Report – Round 4* (Report, November 2014) 3–4.

154 Department of Health and Human Services, *Review of Claims of Abuse of Children in State Care: Final Report – Round 4* (Report, November 2014) 3, 18.

155 'Accepted' meant deemed eligible for a claim: Department of Health and Human Services, *Review of Claims of Abuse of Children in State Care: Final Report – Round 4* (Report, November 2014) 13.

156 Department of Health and Human Services, *Review of Claims of Abuse of Children in State Care: Final Report – Round 4* (Report, November 2014) 10, 12.

157 Notice to produce served on the State of Tasmania, 20 July 2021.

158 Refer to Transcript of Claire Lovell, 14 June 2022, 1213 [4–17].

159 Refer to Transcript of Claire Lovell, 14 June 2022, 1213 [25–30].

160 Department of Communities, 'Cover Sheet', 9 September 2021, 1, produced by the Tasmanian Government in response to a Commission notice to produce.

161 Refer to Transcript of Claire Lovell, 14 June 2022, 1213 [4–45].

162 Department of Communities, 'Excel Spreadsheet of Allegations Relating to Child Sexual Abuse of Children in Out of Home Care', August 2021, produced by the Tasmanian Government in response to a Commission notice to produce.

163 Department of Communities, 'Cover Sheet', August 2021, 1, produced by the Tasmanian Government in response to a Commission notice to produce.

164 Department of Communities, 'Cover Sheet', 9 September 2021, 2, produced by the Tasmanian Government in response to a Commission notice to produce.

165 Department of Communities, 'Cover Sheet', 9 September 2021, 2, produced by the Tasmanian Government in response to a Commission notice to produce.

166 Gender ratio of children in out of home care in Tasmania taken from Australian Institute of Health and Welfare, 'Data Tables: Child Protection Australia 2020–21', *Child Protection Australia 2020–21* (Web Page, 15 June 2022) Table S5.6 <https://www.aihw.gov.au/reports/child-protection/child-protection-australia-2021-22/data>.

167 Australian Institute of Health and Welfare, 'Data Tables: Child Protection Australia 2020–21', *Child Protection Australia 2020–21* (Web Page, 15 June 2022) table S5.8 <https://www.aihw.gov.au/reports/child-protection/child-protection-australia-2021-22/data>.

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9 The way forward: Children in out of home care

1 Introduction

Out of home care environments should be safe for children and young people. A child in care is entitled to expect the Government, departmental staff, out of home care service providers and carers will always act to keep them safe. A child in care should also expect that if they disclose sexual abuse, the adults around them will have the knowledge to recognise the disclosure and to put in place supports to respond immediately and appropriately, and to ensure they are protected from further harm.

In Chapters 7 and 8, we outline the background and context of the out of home care system, discuss the risks of child sexual abuse in out of home care, describe how we approached our inquiry into out of home care and provide a series of case examples to highlight areas where the out of home care system can be strengthened. In this chapter—Chapter 9—we outline our recommendations for better preventing child sexual abuse in the out of home care context, and better addressing it when such abuse occurs.

The key principle underpinning our recommendations is that a high-quality and well-functioning out of home care sector is the best way to protect children from child sexual abuse and to respond appropriately when it occurs. As discussed in Chapter 7, there are factors of a child protection system that increase the risk of children and young people experiencing sexual abuse in out of home care. If addressed, these risk factors can be transformed into protective factors; that is, the likelihood that children and young people will experience sexual abuse in out of home care decreases when:

- an out of home care system has structures and processes in place to identify and respond proactively to risks of abuse
- leadership oversees and is accountable for delivering care services that are trauma-informed
- children are empowered through active inclusion in decision making, individually and systemically
- staff are set up for success by providing a supportive work culture and conditions, including an organisational commitment to supervision, ongoing professional development and serviceable caseloads.

While we consider that many carers, out of home care providers and departmental staff are dedicated to ensuring the safety and wellbeing of children in their care, the out of home care system requires urgent attention and resourcing to rebuild and, consequently, enable them to succeed.

1.1 Structure of this chapter

In this chapter, we make recommendations to improve the out of home care system. These recommendations will strengthen the systems and structures that can decrease the risk of sexual abuse for children in care, as well as improve how the Department responds when abuse occurs. We also make recommendations to improve the independent oversight of the out of home care system.

This chapter is structured in the following way.

Section 2 considers the damage done to the out of home care system by chronic underfunding and the need to inject resources into the Department to ensure the full range of reforms can be achieved for children in care.

Section 3 examines the role of the Department in the out of home care system and recommends that the Government completes its outsourcing of all out of home care services to non-government providers while retaining responsibility for setting the strategic framework for out of home care, for case management and for monitoring and supporting quality care.

Section 4 considers the 'foundational pillars' required within the Child Safety Service to support staff to work with confidence and to make complex decisions about the safety of children in out of home care. We consider these foundational pillars of an out of home care system to be:

- expert and active leadership
- strong governance structures with internal accountability

- a clear strategic direction for the out of home care sector
- public and transparent policies
- a process for continuous improvement
- a strong and capable workforce.

We make recommendations around each of these pillars.

Section 5 discusses the experiences of Aboriginal children in out of home care and makes recommendations for fully implementing the Aboriginal and Torres Strait Islander Child Placement Principle. The Placement Principle is Australia's national policy framework for preventing Aboriginal children from entering the out of home care system, promoting the self-determination of Aboriginal communities in relation to child safe decision making, and ensuring Aboriginal children who enter out of home care stay connected to family, community and culture, and are ultimately returned to their families.

Section 6 focuses on the key mechanisms the Department needs to support quality out of home care, with a view to enabling staff to protect children in care from sexual abuse and other harm, and to respond appropriately when harm occurs. We focus on clinical supervision, case management, providing trauma-informed therapeutic care, expectations of adults in the out of home care system, record keeping and risk assessments.

Section 7 considers assessment and training of, and support for, carers. We discuss problems with record keeping and carer screening and recommend setting up a Carer Register. We consider carers in all types of out of home care, including kinship carers, respite carers and third-party guardianship.

In Section 8, we discuss the specific needs of individual children in care, including ensuring suitable and stable placements and regular contact with safety officers. Section 9 considers the specific needs of children, known as 'crossover children', who live in out of home care and spend time in youth detention. We recommend that Child Safety Officers be responsible for specific case management tasks while such children are in detention.

Section 10 assesses the current high risk of children in care experiencing harmful sexual behaviours and sexual exploitation. We recommend measures so the Department can address these risks.

Section 11 examines the Department's response to complaints and concerns about sexual abuse of children in care. We recommend changes to the Department's response process, including its handling of allegations against current employees and its policies and procedures for managing and reviewing complaints more generally.

In Section 12, we discuss the oversight of the out of home care system and advocacy for children in that system.

1.2 Our recommendations

Our recommendations in this chapter outline an ambitious reform agenda to establish a strong out of home care system equipped to better protect children from harm, including sexual harm. Key recommendations include:

- increased funding in every area of out of home care to meet the needs of children in care and fully implement this reform agenda
- outsourcing care to non-government providers, with obligations to comply with the National Standards for Out of Home Care and Child Safe Standards, and for reporting incidents and complaints
- developing an empowerment and participation strategy for children and young people in out of home care to strengthen children's say in their own care and in the way the out of home care system works
- strengthening executive leadership, including establishing an executive role specifically for out of home care, an Office of the Chief Practitioner and an Office of Aboriginal Policy and Practice
- strong internal functions, governance and accountability measures including a Quality and Risk Committee and a harmful sexual behaviours unit
- an out of home care strategic plan to set a strong vision for out of home care and to guide policy and resource allocation
- developing a reporting framework for out of home care to inform quality assurance and continuous improvement processes
- a workforce strategy to increase recruitment and build capacity across the Child Safety Service and out of home care
- implementing all elements of the Aboriginal and Torres Strait Islander Child Placement Principle, including increasing self-determination by promoting and supporting recognised Aboriginal organisations
- a Carer Register to ensure carers meet minimum standards and departmental expectations
- more clinical supervision, assessments, case management and therapeutic care to meet the unique needs of all children
- developing policies in key areas including professional conduct, mandatory reporting, harmful sexual behaviours, child sexual exploitation, and complaints and care concerns

- establishing key oversight roles, including setting up a Tasmanian Commissioner for Aboriginal Children and Young People, enhanced functions for the new Commission for Children and Young People in relation to out of home care, establishing the Child Advocate as an independent Deputy Commissioner and a community visitor scheme.

2 Chronic underfunding

Appropriate funding is a key pillar of a quality out of home care system. During our Commission of Inquiry, stakeholders frequently raised underfunding of child protection as a major contributing factor to poor implementation of reform recommendations over time. A former senior departmental employee, Sonya Enkelmann, observed:

> There seems to be a long tradition of undertaking reviews into Child Protection/ Child Safety and [out of home care] which then quietly drop from sight. Understanding what sustains this systemic inertia is difficult … but a history of chronic underfunding in the Department to build its capacity and infrastructure cannot be overlooked.[1]

In a statement to us, Michael Pervan, former Secretary of the Department of Communities, repeatedly noted budget constraints, including the redirection of resources to other departmental priorities, as hindering the reform agenda.[2] He stressed that funding for out of home care was the responsibility of the government of the day, and not his as Secretary.[3] Secretary Pervan advised that he:

> … was not given the resources he needed to run the Department in the manner that the Commission [of Inquiry] has concluded that it needed to be run, despite asking for them at every opportunity [from the Government].[4]

In fact, he told us that the Government effectively cut funding to the Department by requiring an 'efficiency dividend' from the Department that equated to a significant sum over several years.[5]

We consider that chronic underfunding of the Services for Children and Families section of the Department has adversely affected the Department's capacity to perform many of its functions. For example, the Child Advocate said in June 2022 that Services for Children and Families had only recently received dedicated human resources support from the Department to address the chronic workforce issues in the Child Safety Service.[6] She said that 'there is simply not the resource[s] for the breadth of roles in the portfolio to perform all corporate functions'.[7] Therefore, the task of responding to extra demands, such as external scrutiny, falls to key operational leadership positions.[8]

We consider that chronic under-resourcing has been at the expense of maintaining up-to-date and clear policies and procedures. It has stalled continuous improvement and strategic direction for the Department. It is particularly hard to understand how the amount spent per placement night could be decreasing over recent years when

the cost of living has increased.[9] It raises questions about whether placements are adequately resourced to meet children's needs. At times, under-resourcing has hindered measures to protect the safety of children in care. Children in out of home care deserve better. They should be seen as the urgent priority, even in a context where there are limited resources.

Appropriate funding will be essential considering the significant reform agenda we outline in our recommendations in this chapter.

Recommendation 9.1

The Tasmanian Government should provide one-off funding to help implement the Commission of Inquiry's recommended out of home care reforms and significantly increase ongoing funding of out of home care, including out of home care services provided by Child Safety Services (such as out of home care governance and case management).

3 The Department's role

The Department is both a purchaser and a provider of out of home care services in Tasmania. The Department provides almost all kinship care and a significant amount of foster care for children in Tasmania. In 2007, the Department committed to outsourcing all forms of out of home care to non-government organisations by 2012.[10] This has not occurred.

Outsourcing out of home care services has the benefit of clarifying the Department's role as system manager and overseer and facilitator of quality service provision, and not as service provider. We heard consistent evidence that the non-government sector in Tasmania had, in general, made much more progress in implementing systems to protect the safety of children in care than the Department.

In this section, we consider how the Department can effectively distinguish its role by:

- outsourcing all forms of out of home care services to non-government providers, including kinship and emergency care arrangements
- retaining and developing its unique and necessary role in setting the strategic framework, monitoring and supporting quality care, and ensuring public accountability
- embedding active contract management and oversight for care services.

During the period of transition to a clearer role of purchaser and administrator, the Department should ensure there are arrangements in place to track the quality of care provided by carers the Department directly supports.

3.1 Outsourcing care to non-government providers

The 2007 *Out of Home Care Strategic Framework* outlined a five-year plan to outsource all out of home care in Tasmania to the non-government sector.[11] The framework indicated that the Department would support out of home care delivery by:

- providing strategic planning and policy and by overseeing continuous quality improvement, data collection and ICT infrastructure
- budgeting and purchasing out of home care services from the non-government sector and managing workforce development
- responding to complaints about out of home care
- maintaining a Carer Register and collaborating with the community sector.[12]

Departmental child protection teams were to work alongside non-government out of home care services and be responsible for case planning, case management, placement coordination and placement decision making.[13]

In our Inquiry, non-government organisations generally perceived an inherent conflict of interest in the Department being a provider of out of home care services and having a regulatory role over those services.[14] For example, Caroline Brown, a previous employee of the Department, suggested the Department should 'hold its statutory role only and be strong in the assessment of statutory risk and the legal processes that follow'.[15] Dr Julian Watchorn, clinical psychologist, Foster and Kinship Carers Association of Tasmania, expressed concern about the Department 'effectively assessing themselves on their own standards and protocols'.[16]

Evidence suggests that some non-government providers can offer better quality out of home care than their Government counterpart. We were told that non-government providers can offer more frequent and regular support to carers because their staff-to-carer ratios are much lower.[17] The Department said that it was struggling to find enough Child Safety Officers to support departmental carers, which was one of the reasons it stopped recruiting its own carers.[18]

Several out of home care providers said that non-government care providers apply higher standards and safeguarding principles to their services than does the Department.[19] They told us they created and implemented their own quality frameworks and conducted their own internal audits.[20] In particular, we observed that many of the non-government providers with a national footprint comply with the much higher standards set in other jurisdictions. For example, several non-government providers had arranged Child Safe accreditation for their services.[21] In contrast, the Department has not yet implemented the National Standards for Out-of-Home Care ('national out of home care standards') for itself. [22]

We consider that by the Department stepping away from directly providing out of home care but retaining its obligations for ensuring the safety and wellbeing of children under the guardianship of the Secretary, Tasmania may benefit from progress made nationally and keep Tasmanian children safer. Secretary Pervan told us that this proposal was the subject of a budget bid in January 2021, however it was not adopted.[23]

The Department should develop a plan with timeframes for achieving full transition, and the Government should allocate enough resources to complete it in full. Transition may take some time to implement because it requires the Department to improve the commissioning of new providers and for each carer household to be transitioned to a non-government provider. The process of developing a transition plan should begin immediately. The transition should be orderly, staged, and trauma-informed for carers and children currently in government care.[24] It should be guided by the following principles:

- children are supported throughout the process
- minimum disruption to the placements of children in care so children transition with their carers wherever possible
- minimum disruption to sibling placements
- consideration is given to the Aboriginal and Torres Strait Islander Child Placement Principle
- capacity is developed concurrently in Aboriginal community organisations to assume care of Aboriginal children (refer to Recommendation 9.15)
- transition priorities are developed, and timeframes established
- open and clear communication with all parties about the process, roles and expectations.

The Department should develop a minimum dataset to support transition.[25]

Recommendation 9.2

1. The Department for Education, Children and Young People should outsource the provision of all forms of out of home care to the non-government sector.
2. The Department should maintain and improve its role in:
    a. the budgeting and purchasing of out of home care services from the non-government sector
    b. establishing and leading the strategic plan and policy framework for out of home care

c. monitoring the quality of out of home care

d. providing case management and leadership in out of home care

e. ensuring carers and staff receive adequate education and skill development

f. responding to complaints and safety and wellbeing concerns about children in out of home care

g. cross-sector (government and non-government) data collection, ICT infrastructure and public reporting

h. carer registration and monitoring.

3. The outsourcing of the provision of out of home care should be achieved through an orderly, staged and trauma-informed transition process and commissioning strategy.

4. The Department should establish a minimum out of home care dataset and a plan for two-way data sharing between the Department and non-government out of home care providers.

3.2 Contract management and auditing

As 'the system owner', the Department is responsible for ensuring the out of home care services it contracts to non-government providers are achieving the right outcomes for children.[26]

As outlined below, the Department does not have the systems in place to ensure non-government providers comply with any contractual requirements specific to out of home care services. In particular:

- the Department does not appear to routinely include performance measures in its funding agreements with non-government out of home care providers that relate to outcomes for children in care
- the Department, at least until recently, lacked the capacity to audit non-government providers' compliance with contract obligations
- the Department appears to only require non-government providers to regularly report on basic statistics and financial acquittals.

We encourage the new Department for Education, Children and Young People, which has installed a specific 'Commissioning' section in the Services for Children and Families portfolio, to address the issues we identify.

3.2.1 Funding agreements

The new Department's Secretary, Timothy Bullard, told us that the previous department had a 'commissioning framework'.[27] In a statement to our Inquiry, former Secretary Pervan said the Department procured services as follows:

> Funding agreements are time-limited and Departmental processes that consider renewal of agreements provide a risk management control for service need, demand and capacity, and for financial, service performance and value for money considerations. This process requires a robust and defensible business case that includes outcome considerations of what providers do, how well did they do it, and if anyone is better off. The Departmental Procurement Review Committee is the governance structure that approves business cases for renewal. Through the commissioning process, Children, Youth and Families can continuously improve services and ensure they meet the contemporary needs of Child Safety Service as Service Users and children, young people and families.[28]

We received no other details about this approach.

The funding agreement template provided to us appears to be outdated.[29] It is a generic template to purchase any number of different human services and does not have standard inclusions that are specific to out of home care providers. It only includes generalist statements under the heading 'Service Provider's Obligations'.[30]

The funding agreement template has space to include individualised 'Key Performance Indicators' and 'Service Specialist Standards' but does not specify any standard indicators or standards that all providers might need to show.[31] The template refers generically to service providers supplying 'evidence of continuous quality improvement against recognised international, national or state standards relevant to the services being funded through this Agreement'.[32] The national out of home care standards and Child Safe Standards were not specifically mentioned.

3.2.2 Compliance with standards, a therapeutic approach and preventing child sexual abuse

The two key sets of standards that apply to the safety of children in care are the national out of home care standards and the National Child Safe Standards (now adopted as the Child and Youth Safe Standards by Tasmania in the *Child and Youth Safe Organisations Act 2023*—'Child and Youth Safe Organisations Act'—therefore generally referred to in this report as the 'Child and Youth Safe Standards').[33]

It has been more than a decade since the then Commonwealth Department of Families, Housing, Community Services and Indigenous Affairs released the national out of home care standards in 2011 as a priority of the *National Framework for Protecting Australia's Children 2009–2020*.[34] Tasmania committed to the national out of home care standards under the *National Framework for Protecting Australia's Children 2009–2020 First*

Action Plan.[35] The Tasmanian Government is already required to report on a number of measures derived from the national out of home care standards to the Australian Institute of Health and Welfare each year for its Safety in Care reports.[36]

We understand the Department has not adopted the national out of home care standards for out of home care providers. Instead, the Department engaged in a process to develop Tasmanian standards for out of home care, which Secretary Pervan said had 'evolved … too slowly'.[37] After two lengthy, detailed consultation processes between 2018 and 2021, the Department released the *Tasmanian Out of Home Care Standards* on 17 August 2022.[38] In the end, the *Tasmanian Out of Home Care Standards* aligned with the six domains of wellbeing in the existing *Tasmanian Child and Youth Wellbeing Framework*.[39] As indicated above, no standards were included in the contract templates we reviewed.

We consider that out of home care providers should be made to comply with the national out of home care standards and the Child and Youth Safe Standards at a minimum. As we discuss in Sections 3.2.3 and 4.5, these standards should also form a basis for an outcomes and performance reporting framework for children in care, with which the Department can evaluate the out of home care system and the wellbeing of children in care (refer to Recommendation 9.9). As we outline in Section 7, there is also a need for statewide expectations for carer assessment and registration.

In reforming Tasmania's out of home care sector, the Department has an opportunity to embed a shared understanding of trauma and the impact it has on children's learning, behaviour, relationships and feelings. In Section 6.3, we recommend that the Department leads the sector by identifying the components of a trauma-informed therapeutic model of care for the out of home care system (refer to Recommendation 9.18). The Department should require non-government out of home care providers to provide trauma-informed therapeutic care for children in care and report on how it is provided.

The Department should also require non-government providers to implement preventative measures for children in their care to reduce their risk of engaging in, or being subject to, harmful sexual behaviours (refer to Recommendation 9.28) or being sexually exploited (Recommendation 9.29). Providers should report to the Department on their delivery of these preventative measures. We explore the rationale for such specific interventions in Section 10, along with several examples of prevention initiatives that have been reported to be effective.

3.2.3 Monitoring compliance

A non-government out of home care provider told us that the Department has requested regular financial acquittals and statistical reports from providers but has not conducted regular audits or reviews.[40]

Ms Enkelmann, a former departmental employee, reported that the Department has a long history of being under-resourced to properly oversee and manage contracted services, referring to instances of providers not having contracts for Special Care Packages 'because they would not be monitored anyway'.[41]

Claire Lovell, Executive Director, Services for Children and Families, told us in June 2022 that there was one person in Children, Youth and Families who was responsible for engaging and contracting with non-government out of home care providers, the Manager of Strategic Commissioning.[42] She stated that this role was 'very busy' undertaking commissioning work for multiple areas in addition to the Child Safety Service and out of home care—custodial services, youth justice and new strategic project work.[43] The Child Advocate said the Department had repeatedly requested resourcing for a team of staff to effectively coordinate outsourcing and strategic commissioning without success.[44]

When asked how oversight and quality assurance of non-government providers was achieved given the limited resource of one role for commissioning, Ms Lovell explained that this responsibility was diffused across positions in the division. She gave the examples of Child Safety Officers making observations about a child's care and monthly reports from the non-government providers being useful forms of feedback.[45]

Encouragingly, after assuming responsibility for out of home care, Secretary Bullard agreed that one position across several work areas was inadequate and told us that he would be 'bolstering' the Strategic Commissioning function.[46]

3.2.4 New funding agreements

Strategic and effective contract management is essential in a system that outsources out of home care services. The Department should develop funding agreements that are specific to out of home care providers, with standard inclusions and unambiguous language. As well as reporting on agreed outcomes for children in care, the funding agreements must cover compliance with the national out of home care standards, the Child and Youth Safe Standards and reporting on trauma-informed and preventative care.

The Department should monitor reporting and compliance with funding agreements and ideally, provide government-developed best practice policies and resources to guide providers. Similarly, increased reporting requirements will come at a cost to non-government providers, and the Department should fund providers to cover these expenses.

The Department should require non-government providers to report on the outcomes and performance reporting framework to the Department and the Quality and Risk Committee (refer to Recommendation 9.5). The Department should use the outcomes and performance reporting framework for its periodic auditing of non-government providers (refer to Recommendations 9.3 and 9.9).

The Department should also require non-government providers to comply with the other relevant recommendations we outline in this report, including having registered carers and staff and carer compliance with minimum professional development obligations.

Recommendation 9.3

1. The Department for Education, Children and Young People should develop new funding agreements with non-government out of home care providers that set quality and accountability requirements, including:
    a. compliance with the National Standards for Out-of-Home Care
    b. compliance with the Child and Youth Safe Standards
    c. provision of trauma-informed, therapeutic models of care (Recommendation 9.18)
    d. adoption of preventive measures for harmful sexual behaviours and child sexual exploitation
    e. only using carers who are registered on the Carer Register (Recommendation 9.20)
    f. governance and organisational structures to support monitoring and responding to child sexual abuse including grooming, harmful sexual behaviours and child sexual exploitation
    g. sharing relevant information about carers and children in their care
    h. quarterly reporting to the Department on these requirements
    i. periodic reporting of data against the outcomes framework (Recommendation 9.9).
2. All funding agreements between the Department and non-government out of home care providers should require the Department to give providers:
    a. relevant information about carers and children in their care
    b. information about the provider's performance against the data outcomes framework and compliance with standards.
3. The Department should monitor and audit non-government out of home care providers' compliance with contracts.
4. The Tasmanian Government should resource non-government out of home care providers appropriately.

4 Establishing the pillars of reform

The Secretary—and hence their Department—is ultimately responsible for children in out of home care.[47] To discharge this heavy responsibility, the Department needs strong systems in place to understand what is happening for children in care and how the out of home care system needs to operate to best protect them.

In this section, we consider the foundational pillars required to support the Department to operate with confidence and to make complex decisions for the safety of children in out of home care. These foundational pillars should include:

- adequate funding (discussed above)
- expert and active executive leadership
- fit-for-purpose governance structures and processes
- a strategic plan for the out of home care system
- clear, accessible policies and procedures that set standards for ensuring the safety of children in care
- continuous improvement processes
- a workforce strategy for recruiting and retaining staff and carers, ensuring they are well equipped and supported to safeguard children in care
- establishing an Aboriginal policy leadership role in the Department.

These foundations will support an informed executive leadership to oversee the safety and wellbeing of children in out of home care, including processes to identify risks to children and to address incidents of abuse at the earliest opportunity.

4.1 Expert and active leadership

The Department should ensure leaders have the knowledge, skills, aptitude and core capability requirements to effectively manage people and to lead a child safe organisation. Leadership can ensure child safeguarding is valued and practised throughout the out of home care system through good governance, strategic planning, workforce development and clear policies and procedures, as well as cultivating an organisational culture that is safe, innovative and accountable.[48]

4.1.1 Addressing organisational culture

The National Royal Commission found that institutions with a 'closed' organisational culture and that resist change can make child sexual abuse more likely to occur and less likely to be dealt with properly when disclosed.[49] Leaders should instil a culture

that ‘inhibits the perpetration of child sexual abuse, speeds the detection of abuse, and enhances the response to abuse’.[50] Professor Donald Palmer, an organisational misconduct researcher, stated that leaders ‘telegraph cultural content’ in several ways—by the people they hire and fire; the behaviour they reward and punish; the matters they focus on; the way they respond to crises; and the attitudes and behaviours they display.[51]

Several people who have worked across the Department and the non-government sector described the Department’s culture as ‘insular’.[52] For example, Ms Brown stated that the Department responds to external criticism by becoming defensive and developing an ‘us against them’ attitude so the service is resistant to change, particularly when that change is proposed by those external to the Department.[53] As a result, she said the Department struggles to partner with non-government providers, instead adopting a ‘command-and-control’ model of relationship. Similarly, Andrea Sturges, another former departmental employee who now works in the non-government sector, observed ‘the culture internally within Child Safety Services is very reactive and insular’.[54]

Ms Sturges further commented that the out of home care system is ‘very adversarial’.[55] She stated that this is reflected at the operational level by Child Safety Officers often not consulting the broader care team, which affects the quality of their decisions.[56] Ms Sturges reported that even some senior departmental staff seemed resistant at times to her attempts to raise concerns about the wellbeing of children in care.[57]

Ms Lovell spoke of a culture of hostility and conflict between stakeholders and the Child Safety Service, creating a barrier to well-functioning care teams. She said Child Safety Officers have had to put in extra effort to overcome this hostility.[58]

We acknowledge that working within the heavily criticised field of child protection can give rise to a defensive culture. For example, the Commissioner for Children and Young People said:

> … if departments are constantly receiving negative scrutiny through the media or through independent oversight bodies, it creates a culture of defensiveness, and I think I have experienced the culture of defensiveness …[59]

A department survey of staff from 2020 confirmed that staff also perceived cultural issues within the Department. Only 26 per cent of respondents thought that change was well managed within the Department, 55 per cent agreed that senior management modelled the values of the organisation and 45 per cent felt confident they would be protected from reprisals if they spoke out.[60] Fear of reprisal and a belief that an organisation may not respond could discourage staff from raising concerns about how child sexual abuse is being handled.

Secretary Pervan acknowledged that the Department had cultural problems.[61] At the time of our hearings, when responsibility for the statutory child protection and out of home care systems was about to move from the former Department of Communities to the new Department for Education, Children and Young People, Secretary Pervan expressed hope that the move would help improve the culture in the Child Safety Service:

> … they're moving to a new agency where a lot of those things are really well understood, and the safeguarding function is already well ahead in its thinking about how you move that culture.[62]

We, too, hope for a new culture in the Child Safety Service and consider this as, ultimately, the responsibility of the Department's executive leadership. Cultural change should form part of their key performance measures.

4.1.2 Leadership roles in out of home care

As mentioned, in October 2022, responsibility for the statutory child protection and out of home care systems moved to the newly created Department for Education, Children and Young People. Since this restructure, responsibility for the Strong Families, Safe Kids Advice and Referral Line ('Advice and Referral Line'), the Child Safety Service and out of home care services are held by the Executive Director, Services for Children and Families (currently Ms Lovell).[63] The youth justice service area is the responsibility of the newly created Executive Director for Services for Youth Justice. Originally, these two Executive Directors reported directly to the Secretary, while responsibility for education was divided between two Deputy Secretaries, who reported to the Secretary.[64]

Under a June 2023 organisational restructure, the Executive Director, Services for Children and Families, now reports to a Deputy Secretary for 'Keeping Children Safe'.[65] This role reports directly to the Secretary, while an Associate Secretary leads the education and youth justice portfolios.

The Deputy Secretary for Keeping Children Safe is responsible for, among other things, Services for Children and Families and the Office of Safeguarding Children and Young People. Services for Children and Families includes out of home care, the Child Safety Service, the Advice and Referral Line and family support services.

4.1.3 Strengthening leadership

Child protection, including out of home care, has unique and interrelated features that require the Department to have a high level of expertise and an active and engaged executive leadership, including:

- responsibility for the most vulnerable cohorts of children in the State who, along with their families of origin, exhibit challenging and complex behaviours

- being statutory guardian of children in out of home care, with a responsibility to be a 'good parent'
- carrying a high degree of risk for the safety and wellbeing of children in out of home care.

Although only a comparatively small percentage of Tasmanian children are in out of home care, other service divisions within the Department, while having responsibility for more children, do not carry this level of responsibility and risk.

More generally, the Secretary faces great challenges in managing what have been two large organisations with very different cultures, challenges and problems. We foresee risks for the quality of out of home care linked to the Department's relatively recent reconfiguration into a larger department, due to the new Department's substantial size and scope.

We recognise that some economies of scale can be achieved by child protection and out of home care being subsumed within a larger department. However, wherever responsibility for out of home care lies—in a separate department or one joined with education and other children's services—leadership must be resourced in a way that acknowledges the level of responsibility and risk.

Catherine Taylor, former Chief Executive of the Department for Child Protection in South Australia, told us about the challenges associated with child protection and out of home care being included in a 'mega-department' such as the Department for Education, Children and Young People.[66] She explained that when she joined the South Australian department it had recently been separated out from a much bigger department, which included education and child protection services, following recommendations made by the 2016 South Australian Child Protection Systems Royal Commission.[67] A key rationale for this separation was the belief that child protection needed a 'dedicated focus' and should be 'led by experience in child protection'.[68]

We consider this dedicated focus can be achieved in a larger department provided there is enough executive presence to set an operational and strategic direction and interpret advice with expertise. Based on her experience in South Australia and Queensland child protection and community services, Ms Taylor said that in any child protection service, expertise needs to be 'reflected across as much of the Executive leadership as possible'.[69] Importantly, she said key decision-makers who know the business of child protection and out of home care can advocate within a larger department to retain the required focus on the most vulnerable children.[70] She highlighted that all elements of the new Department (such as work health and safety, finance and human resources) must be informed by child protection expertise, so the services they deliver to child protection are appropriate.[71]

Considering this evidence, we welcome the addition of an Associate Secretary with responsibility for the education portfolio. This will allow the Secretary to focus on child protection, including out of home care, given the strategic, operational and reform responsibilities within the service area and the level of risk associated with the portfolio. We are also pleased that since the June 2023 restructure, there is a Deputy Secretary role to assist the Secretary. We recommend that a prerequisite for the key role of Deputy Secretary for Keeping Children Safe is knowledge and experience in child protection and out of home care.

We are concerned that the Deputy Secretary for Keeping Children Safe has a large task, including responsibility for both Services for Children and Families and the Office of Safeguarding Children and Young People. The Office of Safeguarding Children and Young People was a key reform in response to the Independent Inquiry into the Tasmanian Department of Education's Responses to Child Sexual Abuse ('Independent Education Inquiry').[72] We discuss the role of the Office of Safeguarding Children and Young People in Chapter 6. In short, we recommend in that chapter that the office focuses on prevention, risk identification, policy development and related workforce development for safeguarding children in the education context. We consider that the safeguarding needs of children in education are distinct from the safeguarding needs of children in out of home care. We question whether the same role holder should be responsible for both. We note the view expressed by Kathy Baker, Deputy Secretary, People and Culture in the former Department of Communities, about the then Deputy Secretary, Children, Youth and Families role, who said 'the volume of work that the Deputy Secretary … was undertaking at the time was significant. I consider the load on that role to be unsustainable'.[73]

We also note with some concern the scope of responsibility for the Executive Director for Services for Children and Families, which we understand includes the strategic, operational and critical incident leadership of the Child Safety Service, including commissioned non-government child abuse prevention, family support, child protection and out of home care. Evidence we heard indicated that even in the previous, smaller Department, out of home care reforms became overshadowed by the larger child protection reform agenda.[74]

We propose a significant out of home care reform agenda in this chapter that will need high-level executive support. Ensuring there is executive leadership specifically for out of home care, which we recommend below, will protect this reform agenda and ensure children in out of home care get the support they need. Funding this level of executive support will prove the Government's commitment to child safety in out of home care.

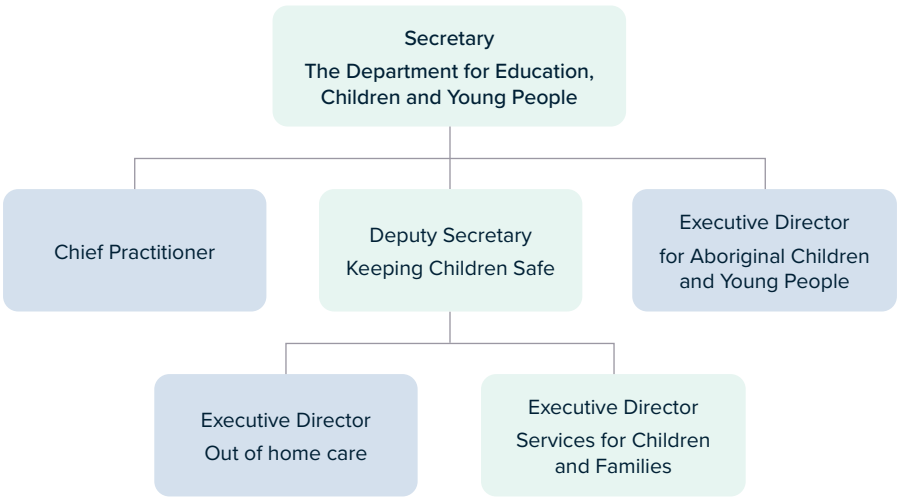
The executive position should be responsible for out of home care policy and operations.

In addition to the executive role for out of home care, we recommend that the Department establishes two more roles in its executive—a Chief Practitioner to oversee the clinical policy and practice for out of home care, the Child Safety Service and youth justice (refer to Recommendation 9.17), and an Executive Director for Aboriginal Children and Young People (refer to Recommendation 9.7). We describe the location of these positions in the organisational structure in picture form in Figure 9.1

Finally, we consider it fundamental that centralised functions within the new Department, such as human resources, procurement and staff learning and development, reflect the different needs of the Child Safety Service and out of home care. This principle is reflected in recommendations we make in other sections of this chapter.

It is self-evident that relevant executive roles should require knowledge and understanding in child protection and out of home care, as well as experience in providing strategic direction and leadership. As already foreshadowed by the Premier, key performance measures should be built into these Head of Agency and leadership roles and include a specific focus on preventing sexual abuse in out of home care.[75]

Figure 9.1 New executive positions (shown in blue) in relation to relevant existing Department for Education, Children and Young People organisational structures.



Recommendation 9.4

1. The Tasmanian Government should fund and restructure the Department for Education, Children and Young People to ensure (in addition to the current roles of Deputy Secretary for Keeping Children Safe, and the Executive Director for Youth Justice):

    a. there is separate executive-level responsibility for out of home care services

    b. there is separate executive-level responsibility for the combined areas of Child Safety Services, the Strong Families, Safe Kids Advice and Referral Line and family support services

    c. the classification level of these executive roles reflects the level of risk and responsibility carried by the positions

    d. the holders of these executive roles have knowledge and understanding in the area of child protection or out of home care and experience in providing strategic direction and leadership

    e. executive responsibility for child safeguarding in the education context is not combined with responsibility for child safeguarding in the children and family services context

    f. the role of Executive Director for Aboriginal Children and Young People is established and supported by an Office of Aboriginal Policy and Practice (Recommendation 9.7)

    g. the role of the Chief Practitioner is established and supported by an Office of the Chief Practitioner (Recommendation 9.17)

    h. expertise among members of the Department's executive is evenly balanced across the areas of education, Child Safety Services, out of home care, and youth justice

    i. the relevant specialist for out of home care and youth justice in the executive leads policy and practice development for those areas

    j. relevant centralised functions within the Department, such as human resources, procurement, and staff learning and development, address the distinct needs of schools, Child Safety Services, out of home care and youth detention.

2. The Tasmanian Government should ensure that:

    a. the Secretary of the Department demonstrates active efforts to inform themselves about child protection and out of home care through individual professional development

    b. the Deputy Secretary for Keeping Children Safe has knowledge and understanding of the area of child protection or out of home care and experience in providing strategic direction and leadership

    c. the Secretary and Deputy Secretary, and the holders of the new executive roles, have key performance measures that include culture change in Child Safety Services and out of home care

    d. the Secretary and Deputy Secretary, and the holder of the new executive role responsible for out of home care, have key performance measures that include preventing sexual abuse in out of home care

    e. the Department has appropriate processes in place to ensure leaders have the knowledge, skills, aptitude and core capability requirements to effectively manage people and to lead a child safe organisation.

4.2 Governance

The National Royal Commission defined governance in the following way:

> Governance encompasses the systems, structures and policies that control the way an institution operates, and the mechanism by which the institution, and its people, can be held to account. Governance strongly influences an institution's practices and decision-making processes. It is embedded in the good behaviour and the good judgment of those responsible for running an institution.[76]

In talking about out of home care, we use the term 'governance' to describe systems that assist leadership to understand what is happening for children in care and that keep leadership accountable for addressing risks to these children. Good governance also requires structures and systems that provide clarity and direction and enable monitoring and evaluation of progress towards clear goals.[77] In the out of home care context, it is essential that executive leadership understands the experiences of children in care, including the quality of care they are receiving and any risks to children, including any risks of child sexual abuse. This involves monitoring trends and patterns in the out of home care sector, including through reviews of the handling of care concerns, serious events, harmful sexual behaviours or child deaths, and systemic issues.

Dr Kim Backhouse, Chief Executive Officer, Foster and Kinship Carers Association of Tasmania, called for every allegation of child sexual abuse in care to be reported to an agency's board of directors (or equivalent) because:

> At the end of the day, this is a contingent liability for the Board of directors, who have a duty of care to the organisation. If the agency has vulnerable children in their care and these kinds of allegations are being made within the organisation, then the Board needs to know about them.[78]

4.2.1 Challenges in monitoring out of home care

We struggled to identify a clear articulation of the out of home care sector, let alone trends and patterns.

In her first monitoring report in 2019, the Commissioner for Children and Young People, Leanne McLean, noted that the Department could not answer many of her questions about the welfare of children in care. She stated that for the Secretary to exercise the responsibility of guardian, the Department 'needs to have a base level of knowledge about the wellbeing of each child and young person in [out of home care]' and the data systems in place to support reporting and oversight.[79] This had not improved by the Commissioner's second report in 2023, with key information about children in care still difficult to find.[80]

In a similar vein, we found it difficult to obtain a definitive list of out of home care providers from the Department. The Department's first list omitted several providers published in the Commissioner for Children and Young People's monitoring report and which were supplied in a second list provided by the Department.[81]

Through our inquiries, we identified mechanisms that may have monitored the quality and safety aspects of out of home care, including:

- the Care Concerns Monitoring Group, which included the Commissioner for Children and Young People, and was set up to monitor the response to concerns about the care of children in out of home care[82]
- the Serious Events Review Committee, which comprised representatives internal and external to the Department, and oversaw the reports of the Serious Events Review Team.[83] The Serious Events Review Team investigated when a child or young person known to the Child Safety Service had experienced a 'serious event, such as death, serious injury or "near miss"'.[84]

These groups appear to have been disbanded or, at least, are not ongoing.[85] We are unclear as to whether the Care Concerns Monitoring Group ever met.[86] We discuss these groups in Section 11.

4.2.2 Departmental oversight of out of home care

Since establishing our Commission of Inquiry, the Department has convened several committees to oversee the Child Safety Service and out of home care.[87]

First convened in July 2021, the Practice Performance and Governance Committee meets monthly and was described as leading continuous quality improvement of professional practice for the Directorate of Children and Family Services. It is chaired by the Principal Practice Manager, and membership includes managerial staff across out of home care and the Child Safety Service.[88] Standing agenda items include:

- leadership, learning and culture, including practice framework and professional development planning and progress
- accessibility, flexibility and responsiveness of the Child Safety Service
- progress on new service initiatives
- risk management for emerging risks and case reviews of adverse incidents
- communication and information management.[89]

The Child Safety Statewide Service Development Committee was also formed in July 2021.[90] The purpose of this committee was described as providing statewide 'oversight and leadership of service development matters for the Child Safety Service'.[91] The terms of reference outlined the committee's focus as including:

- reviewing and designing services for children and families and related processes
- operational process and procedure review and development
- overseeing working arrangements with other agencies and stakeholders
- workforce planning and management
- continuous improvement.[92]

We were told that a Senior Managers Operations Group Practice and the Executive Leadership Group also met regularly.[93] Our impression was that the Department relies on these meetings for governance. While we welcome these reporting processes, we struggled to identify the extent to which key aspects of out of home care are monitored or strategic direction set through these committees, including reviews of the handling of care concerns, serious events, harmful sexual behaviours or child deaths, as well as systemic issues. The committees would also be hindered by the lack of data and reporting systems the Commissioner for Children and Young People identified. We discuss an outcomes and performance reporting framework in Section 4.5.

4.2.3 Lessons from other jurisdictions

In other jurisdictions, the departments and agencies responsible for out of home care ensure they have a 'line of sight' into the activities of carers. In particular, we heard that other jurisdictions and agencies report all allegations of abuse of children in care to their most senior managers to prevent claims of 'plausible deniability' by those in leadership positions.[94]

Ms Taylor, former Chief Executive of South Australia's Department of Child Protection, acknowledged it was not practical for every issue to be escalated to the Chief Executive or the relevant minister. Instead, she provided deidentified information about care concerns to her minister each month. In her view, however, good governance includes clear guidelines about what information should be escalated to whom and in what circumstances.[95] South Australia's Department for Child Protection also provides details of all serious sexual abuse in care concerns to the Guardian for Children and Young People in Out-of-Home Care.[96]

Dr Robyn Miller, Chief Executive Officer, MacKillop Family Services, and former Chief Practitioner for the Department of Human Services in Victoria, told us that her organisation had established a Residential Care Governance Group, which 'greatly improved oversight over residential care and has led to a targeted and data driven focus on issues' and 'enabled higher level planning and commitment to continuous improvement'.[97] She said similar monitoring could be implemented in Tasmania but requires the analysis of data such as 'Work Health and Safety, Stability of staff in homes, Incident reports, Work Cover'.[98]

4.2.4 Quality improvement and safety

Purposeful systems and structures to monitor and improve safety and to drive continuous improvement are an essential aspect of good governance. Ms Taylor emphasised the need to have roles in the Department that can oversee various quality assurance and continuous improvement approaches, such as 'deep dive[s]' into files to get real data to inform child protection policy and to drive better practice.[99]

We were unclear, based on the evidence we received, as to whether such a function exists.[100]

Secretary Pervan referred to a continuous improvement plan for safeguarding children:

> The Department has had a broader focus on Safeguarding Children, with a Continuous Improvement Plan being developed with specific actions. Some actions have been completed, and others are being progressed or paused due to the transition. The Continuous Improvement Plan included training with Child Wise for managers and directors. Professional learning for employees has now been put on hold, pending the transition [to the new Department].[101]

However, we did not receive a copy of this plan during our Inquiry, nor were its contents or timeframes described, beyond referring to the Child Wise training.[102] We could not locate a current quality and safety framework or quality improvement plan that applied specifically to the Department.

The Department's Practice Manual has a *Transparency and Accountability* policy and a *Service Review and Continuous Improvement* policy, both of which were created in 2015. These policies outline the Department's endorsement, at that time, for measuring performance and improving accountability and performance.[103] As with many of the Department's policy documents, these policies have not been reviewed and may not be actively followed in the present, given neither were significantly mentioned in evidence before us.[104]

Secretary Pervan referred to an intention to adopt the 'Signs of Safety Quality Assurance System'.[105] While he provided information about the Signs of Safety approach to child protection (a series of assessment and safety planning tools and approaches used to help determine whether a child living with their family of origin should be removed or can safely remain at home), we did not receive any information during our Inquiry about how it is being used as part of the quality assurance system, and we could not locate such material on the Department's intranet.[106] Its relevance to out of home care was not clear to us.

To the extent the continuous improvement plan for safeguarding children, *Transparency and Accountability* policy and *Service Review and Continuous Improvement* policy were driving action within the Department, it was not clear what governance structures there were for monitoring and reviewing this information to drive strategy development and continuous improvement.

We consider the Department could learn from the jurisdictions we discussed above and establish a clear governance structure for monitoring key aspects of out of home care. It should ensure it has a committee (whether already existing or newly established) that monitors the system performance of out of home care, oversees children's safety and wellbeing in out of home care, including child sexual abuse, and monitors progress on implementing the Child and Youth Safe Standards and the national out of home care standards. In other words, it should have the functions of a traditional quality and risk committee. In Section 4.5, we discuss developing an out of home care outcomes and performance reporting framework, which would help this committee monitor the performance of the out of home care system, including case management of children in care.

Given the level of responsibility and risk associated with children in out of home care and the Secretary's role as statutory guardian, we consider the Secretary should chair this committee.

The Department may elect to include relevant external parties, particularly given that, in the future, all providers of out of home care will be non-government organisations.

The functions of the Quality and Risk Committee would complement the oversight and external accountability role of the Commission for Children and Young People and provide greater operational support within the Department. We envisage the committee would also monitor quality and risk issues in the Youth Justice and the Child Safety Service directorates.

Recommendation 9.5

1. The Department for Education, Children and Young People should establish a Quality and Risk Committee for Child Safety Services, out of home care, and youth justice.
2. The Secretary of the Department should chair the committee.
3. The functions of the committee should include monitoring:
    a. the system performance of the out of home care sector
    b. the performance against the outcomes and reporting framework (Recommendation 9.9)
    c. children's safety and wellbeing in out of home care, including from child sexual abuse
    d. progress on implementing the Child and Youth Safe Standards and the National Standards for Out-of-Home care
    e. practices in youth detention, including in relation to searches, isolation and the use of force (Recommendations 12.31, 12.32 and 12.33).
4. The committee should report routinely to the Commission for Children and Young People.

4.2.5 Giving children a voice

Governance structures for out of home care should promote the voices of children in care to ensure their views are being heard. Professor Palmer who researches organisational misconduct, stated that children should be explicitly involved in designing child safety measures and have the same status, in terms of rights and obligations, as adults, particularly the right to be believed.[107]

Children's participation and empowerment will allow adult decision-makers, including the executive, to better understand how children in care experience their lives, and how they can better protect children from sexual abuse. Associate Professor Tim Moore, Deputy Director, Institute of Child Protection Studies at the Australian Catholic University, observed:

> Children and young people want to play a part in their own protection and, in building alliances with adults to develop strategies to meet their safety needs they can build confidence, awareness and an ability to turn to adults if they are being harmed. These 'participatory' strategies need to empower individual children and young people through child-friendly and proactive means as well as through collective activities such as youth advisory groups.[108]

The Department must listen to children. Standard 2 of the Child and Youth Safe Standards requires that 'Children and young people are informed about their rights, participate in decisions affecting them and are taken seriously'.[109] In addition, Standard 2 of the national out of home care standards requires 'children and young people participate in decisions that have an impact on their lives'.[110]

At the individual level, Part 1A of the *Children, Young Persons and Their Families Act 1997* ('Children, Young Persons and Their Families Act') requires certain principles to be followed when dealing with children, many of which relate to children's rights to participate and be heard:

- treating a child 'with respect' including 'as far as practicable, the informed participation of the child'[111]
- taking the views of the child into account when determining the best interests of a child, 'having regard to the maturity and understanding of the child'[112]
- the child should be able to participate in any decisions that are made under the Act.[113]

It is essential the Department continues to work to make children's participation in decisions that affect them 'practice as usual' in its interactions with children in out of home care. In this section, we discuss children and young people's participation in systemic processes or decision making in out of home care. Children's participation in individual decision-making processes such as their care placement, care plans and case management is a guiding principle in our discussion of these matters below. Also, child-focused frontline practice needs to be reinformed through governance and monitoring that demonstrates the importance the Department places on children's voices in both the decisions that affect them directly as individuals and in the systems and governance of the Department.

In Chapter 19, we further discuss how children can be empowered by providing opportunities for them to participate in decisions that affect them, and in the design or review of systems that relate to them.

A key responsibility of the Child Advocate, whose role in the Department we discuss in detail later in this chapter, is to increase children's participation in decision making in out of home care, at the individual and systemic levels.[114]

The Child Advocate told us: 'systems working with children have a way to go to effectively embed the principle of child participation in practice and uphold children's rights to participate'.[115] She said she convened a time-limited youth consultation forum of children in care to get their input into several systemic improvements. She also developed an online questionnaire for children in care, called Viewpoint, which unfortunately has not been implemented.[116]

We encourage the Department to build on the Child Advocate's previous efforts to empower children in care, so their voices are routinely reflected in the Department's decisions. The Department needs to build child feedback and consultation into its systems and processes, including its quality assurance and improvement system. It should develop an empowerment and participation strategy for children and young people in out of home care, keeping in mind best practice principles for children's participation in organisations.[117] This should include implementing the Viewpoint online questionnaire, or equivalent, without delay.[118] It should also include establishing a permanent youth advisory group to provide continual input into departmental improvements.

Recommendation 9.6

1. The Department for Education, Children and Young People should, in consultation with the Commission for Children and Young People (Recommendation 18.6), develop an empowerment and participation strategy for children and young people in out of home care. This strategy should have regard to best practice principles for children's participation in organisations at the individual and systemic levels.
2. The empowerment and participation strategy should include:
    a. establishing a permanent out of home care advisory group to be involved in developing the out of home care strategic plan (Recommendation 9.8) and have ongoing input into the out of home care system
    b. building engagement with children into the Department's quality assurance and continuous improvement activities under the strategic plan (Recommendation 9.8)
    c. implementing the Viewpoint online questionnaire without delay
    d. regular monitoring and evaluation of the effectiveness of the empowerment and participation strategy.

3. The out of home care permanent advisory group should:

    a. include children, young people and young adults up to the age of 25 years with current or previous experience of out of home care in Tasmania, including Aboriginal people and people with disability

    b. have clear terms of reference developed in consultation with children, young people and young adults with experience of out of home care

    c. enable its members to participate in a safe and meaningful way and express their views on measures to empower children and young people in out of home care

    d. meet regularly, be chaired by a person independent of the Department and be attended by a senior departmental leader

    e. be adequately funded and resourced.

4.2.6 Aboriginal policy leadership

Aboriginal leadership in the Department is another key pillar in improving the quality of out of home care.

The organisational structure of the new Department does not include an area or role whose specific focus is the safety of Aboriginal children in the child protection, out of home care or youth justice systems. In our view, such a role is essential.

In Section 5, we discuss the growing over-representation of Aboriginal children in out of home care in Tasmania, which places them at increased risk of sexual abuse in this system. We also describe the Government's efforts to address over-representation. Significant reforms are required in Tasmania to reduce the number of Aboriginal children in out of home care and to protect Aboriginal children in care from sexual abuse. Effectively implementing the reforms we recommend in Section 5 will require carefully building relationships and partnerships with Aboriginal communities and establishing recognised Aboriginal organisations.

The Office of Aboriginal Affairs in the Department of Premier and Cabinet oversees and coordinates the Government's 'significant Aboriginal Affairs agenda', including Closing the Gap.[119] While this presumably includes efforts to achieve Target 12 of the *National Agreement on Closing the Gap*—to reduce the over-representation of Aboriginal and Torres Strait Islander children in out of home care by 45 per cent by 2031[120]—we consider that the significant work required to achieve this goal in Tasmania should be led by the department with portfolio responsibility for the child safety and out of home care systems.

In South Australia, the Department for Child Protection includes an Aboriginal Practice Directorate whose role is to ensure the department's practice and services are culturally safe and respond to the needs of Aboriginal children and young people, and their families and communities.[121] The Director of Aboriginal Practice reports to the Deputy Chief Executive and is jointly responsible, with the Deputy Chief Executive, for implementing the department's annual Aboriginal action plans to improve child protection outcomes for Aboriginal children and families.[122] As well as establishing the Aboriginal Practice Directorate, the department has appointed 10 'Principal Aboriginal Consultants' and an 'Aboriginal Lead Practitioner'.[123]

We recommend establishing an Office of Aboriginal Policy and Practice in the Department for Education, Children and Young People. This office should be headed by an Executive Director for Aboriginal Children and Young People, who reports directly to the Secretary. They should work closely with the Office of Aboriginal Affairs in the Department of Premier and Cabinet. The Executive Director for Aboriginal Children and Young People should be an identified position.

The Executive Director for Aboriginal Children and Young People should be responsible for:

- overseeing and reporting on the implementation of Recommendation 9.15 (our recommendation for implementing the Aboriginal and Torres Strait Islander Child Placement Principle)
- facilitating departmental engagement and building partnerships with Aboriginal communities
- promoting and facilitating the approval of recognised Aboriginal organisations and their involvement in child safety decision making
- ensuring Aboriginal culture, views and interests are represented in the Department's activities
- promoting cultural safety for Aboriginal staff and Aboriginal children and families who encounter the Department
- increasing recruitment of Aboriginal staff in the Department
- implementing policies and procedures to ensure Aboriginal children in care are connected to culture, including through appropriate cultural support plans
- participating in the Quality and Risk Committee's monitoring of metrics concerning Aboriginal children in out of home care.

While this recommendation is driven specifically by our concern for the safety of Aboriginal children in out of home care and their exposure to the risks of sexual abuse while in care, it may also be appropriate for the role of Executive Director for Aboriginal Children and Young People to include responsibilities for Aboriginal children in youth

detention and in educational settings. As discussed in Chapter 10, Aboriginal children are grossly over-represented in youth detention in Tasmania and there is a need for specialised responses to Aboriginal children in custodial settings. The Executive Director for Aboriginal Children and Young People could also oversee the implementation of these responses. There may be further benefits for this role to have a holistic focus on Aboriginal children and young people's engagement with services across the Department for Education, Children and Young People.

We are mindful of potential overlap with existing roles. In particular, the Office of Safeguarding Children and Young People is responsible for implementing the recommendations of the Independent Education Inquiry.[124] In Chapter 6, we recommend that this office restrict its focus to schools; a significant task in itself. However, consistent with the principle of self-determination, Aboriginal communities should lead Aboriginal strategy and reform.

In our view, the Department needs a position whose focus is the safety and wellbeing of Aboriginal children in out of home care and that there would be benefit in including youth justice and education in this role. The growing over-representation of Aboriginal children in out of home care and the serious risks this poses to those children requires urgent, dedicated and sustained attention.

Recommendation 9.7

The Department for Education, Children and Young People should appoint an Executive Director for Aboriginal Children and Young People for the whole of the Department. The office holder should:

a. report directly to the Secretary

b. be supported by a sufficiently resourced Office of Aboriginal Policy and Practice

c. oversee and report on the implementation of the Aboriginal and Torres Strait Islander Child Placement Principle (Recommendation 9.15)

d. facilitate departmental engagement and build partnerships with Aboriginal communities

e. promote and help establish recognised Aboriginal organisations (Recommendation 9.15)

f. ensure Aboriginal culture, views and interests are represented in all departmental activities

g. promote cultural safety for Aboriginal staff and Aboriginal children and families who come into contact with the Department

h. increase recruitment of Aboriginal staff in the Department

i. participate in the Quality and Risk Committee at least every six months in discussions about the number of Aboriginal children in out of home care, the proportion of Aboriginal children placed with Aboriginal carers, the proportion of Aboriginal children in out of home care with a cultural support plan, reunification rates for Aboriginal children and other key performance indicators to be agreed with the Quality and Risk Committee.

4.3 Strategic planning for out of home care

A key pillar of the out of home care system is having a strategic direction for out of home care, including a goal of increasing the safety and wellbeing of children. The Department does not have a strategic plan in place for out of home care.

4.3.1 The state of strategic planning

Since 2007, there have been three main strategic frameworks relevant to out of home care:

- 2007—*Out of Home Care Strategic Framework* (Department of Health and Human Services)[125]
- 2014—*Out of Home Care Reform in Tasmania,* which outlined the Government's reform agenda for providing out of home care services[126]
- 2017—*Strategic Plan for Out of Home Care in Tasmania* (Department of Health and Human Services), which expired in 2019.[127]

These strategic plans were responses to previous reviews and inquiries, but none were fully implemented. They included reforms that, if implemented, would likely have made a significant difference to the safety of children in care.

We examined the most recent *Strong Families Safe Kids: Next Steps Action Plan 2021–2023* to see what strategic direction it might provide specifically for out of home care.[128] We understand that the Department had previously directed considerable focus and resources to the original Strong Families, Safe Kids redesign, which had taken precedence over out of home care strategic reform.[129]

The 2021–2023 action plan has a list of priorities for out of home care that appear reasonable, such as improving data collection and developing an out of home care therapeutic framework and standards. However, these priorities are not coordinated under a strategic framework nor directed towards a strategic goal.

The Government described many of the actions under the plan as dependent on the review of the Children, Young Persons and Their Families Act (which is in progress), the passing of the Child and Youth Safe Organisations Act, developing a Carer Register and adopting out of home care standards for Tasmania. The out of home care standards have since been released and the Child and Youth Safe Organisations Act has been passed. The Department was not expecting to complete other actions until 2024.[130]

4.3.2 The need for a strategic plan for out of home care

We consider that out of home care is not prioritised enough in the current child protection reform agenda. Steps need to be taken to ensure the Department can continue to manage the Strong Families, Safe Kids redesign, as well as to develop and maintain a strategic plan for out of home care and good governance.

Our review of previous strategic plans and policy documents revealed a time when the Department had established systems of governance, quality improvement and oversight. However, over time, the Department lost its focus on embedding these important systems and they are no longer supported.

We recommend that the Department develops a strategic plan for out of home care by July 2024. The strategic plan needs to promote a range of goals and objectives essential to ensuring the safety and wellbeing of children in care. As set out in the recommendations below, these should include goals and objectives discussed in detail elsewhere in this chapter, including:

- completing the transition of out of home care services to the non-government sector (refer to Recommendation 9.2)
- developing and implementing an Aboriginal out of home care model in Tasmania (refer to Recommendation 9.15)
- a process for ongoing carer registration and monitoring (refer to Recommendation 9.20)
- adopting the national out of home care standards and the Child and Youth Safe Standards, and developing an outcomes and performance reporting framework for out of home care (refer to Recommendation 9.3 and Recommendation 9.9)
- a therapeutic model for out of home care (refer to Recommendation 9.18)
- a workforce capacity-building strategy (refer to Recommendation 9.10)
- a comprehensive series of up-to-date policies and procedures (refer to Recommendation 9.8).

Recommendation 9.8

1. The Department for Education, Children and Young People should develop a strategic plan for the out of home care system. The plan should include:
    a. a vision for future models of out of home care in Tasmania
    b. the transition plan and commissioning strategy for outsourcing the provision of out of home care to the non-government sector (Recommendation 9.2)
    c. the empowerment and participation strategy for children and young people in out of home care (Recommendation 9.6)
    d. implementation of the Aboriginal and Torres Strait Islander Child Placement Principle (Recommendation 9.15)
    e. a commitment to trauma-informed, therapeutic models of care (Recommendation 9.18)
    f. a commitment to the National Standards for Out-of-Home Care and the Child and Youth Safe Standards
    g. a workforce capacity building strategy (Recommendation 9.10)
    h. developing a carer recruitment, support and retention strategy, in consultation with the non-government sector
    i. a process for ongoing carer accreditation, registration and monitoring (Recommendation 9.20)
    j. establishing the outcomes and performance reporting framework (Recommendation 9.9)
    k. building quality assurance and improvement into all activities
    l. an updated framework of policies for the safety and wellbeing of children in care, including updating key policies relating to
        i. complaints handling
        ii. harmful sexual behaviours
        iii. mandatory education for staff in child sexual abuse
        iv. care concern and critical incident reporting and management
        v. child sexual exploitation
        vi. how decisions can be appealed and reviewed

vii. professional conduct

viii. implementing the Child and Youth Safe Standards.

2. All policy documents should be published on the Department's website.
3. Each element of the strategic plan for the out of home care system should have a timeframe attached, with staggered implementation, and the plan should be fully implemented within five years.
4. The Secretary's key performance indicators should require the implementation of the strategic plan for the out of home care system within allocated timeframes.

4.4 Clear policies and procedures

Clear policies and procedures are another key pillar of a well-functioning out of home care system. The National Royal Commission found that children are at increased risk of being sexually abused when the organisation responsible for their care lacks a clear commitment and statement of intent that is reinforced through policies and procedures that promote child welfare and safety.[131] Consequently, the Child Safe Principles, now embedded in the Child and Youth Safe Organisations Act, recognise the importance of organisational policies and procedures in keeping children safe.[132]

Our review of the Department's policy documents most relevant to out of home care identified several areas for improvement, which we discuss below. It is especially difficult for frontline staff, children in care and stakeholders engaged with the Department when policies are inaccessible, out of date or inconsistent, or do not address key areas of providing out of home care.

4.4.1 Lack of accessibility

We reviewed 46 of the Department's policy documents, which included protocols, guidelines, practice directions, fact sheets and flow charts.[133] Overall, we observed that, while most policy documents were available to departmental staff on the Department's intranet, most were not publicly available on the Department's website, nor did foster and kinship carers have access to them.[134]

Similarly, children interviewed for our commissioned research into children's perceptions of safety often reported that they were not aware of their rights, what was expected of the adults who were responsible for their care or what safeguards were in place to ensure they were being protected from harm. They were more likely to identify people outside of the system to whom they would turn if they had concerns or had been harmed, indicating that they were unaware of the mechanisms through which they could disclose abuse or seek help.[135]

The inaccessibility of policy documents in Tasmania is not in keeping with the practices of other Australian child protection jurisdictions. For example, full practice manuals are freely accessible on the Queensland, South Australian, Australian Capital Territory and Victorian departments' websites.[136]

The Child Advocate told us that having policies and procedures publicly available online 'will go a long way in helping to demystify the service and considerably help people to navigate it'.[137] It would also provide greater understanding, accountability and oversight of the Department's actions.

4.4.2 Out of date and incomplete policies

Many policy documents on the Department's intranet are out of date, incomplete or missing. Consequently, even staff who had access to the online Practice Manual may not have located what they needed.

We heard that the Department prefers a more reflective approach to child safety practice that relies less on procedures and is guided more by principles.[138] While this approach may guide the decision making of Child Safety Officers, there are circumstances for which staff need specific policies and procedures to provide clear guidance and support best practice and ethical conduct in their work with children in out of home care. Where a principle-based approach is best practice, those principles and how they can be enacted should be outlined in policies and practice guidance.

Secretary Pervan acknowledged that key policies, such as those relating to care concerns for children in care, were out of date and confusing.[139] The Child Advocate said that the Department's leadership acknowledged there is 'ambiguity and conflict within procedural advice guiding practice' and indicated that progress on addressing this was interrupted by the redesign of the Department in 2021.[140]

Of the 46 policy documents we reviewed, 10 were current (updated within the past two years) and another three had been updated since the National Royal Commission released its recommendations in 2017.[141] Unfortunately, most policy documents we reviewed (the remaining 33) were undated or out of date.[142] Many referred to structures and positions that no longer exist or contained links that no longer work.[143]

4.4.3 Absent policies

Our review identified that the Department does not have a policy position in several key areas relevant to the safety of children in care. We list these key areas here, and explore each issue in more detail in later sections:

- harmful sexual behaviours (refer to Section 10.1)
- mandatory education for staff about child sexual abuse (refer to Section 4.6)

- how decisions can be reviewed or appealed by carers (refer to Section 12.4)
- professional conduct (refer to Section 6.4)[144]
- child sexual exploitation (refer to Section 10.2)
- how the Child and Youth Safe Standards are implemented in the Department.

We also identified a lack of clear policy guidance on quality improvement and safety, and on the reporting framework. We discuss these in the following section.

The absence of policies relevant to these issues places children in care at greater risk of sexual abuse.

4.4.4 Our observations

Overall, the Department's policy framework appears to have been neglected. The Department has reviewed some policies and procedures, but the progress of these reviews has been slow and, in some cases, may have been prompted by announcing our Commission of Inquiry.

Policies should be updated where they are out of date or no longer relevant, and developed where they do not exist. The Department's policies should be publicly accessible and become the reference for service quality benchmarks against which the Department should report to the Government to improve the Department's accountability and transparency. Publicly available policies and procedures will also enable those involved in the out of home care sector—children and young people, families of origin, carers, non-government providers and oversight bodies—to understand their rights and responsibilities, and what to expect from out of home care.

Above, we recommend that the Department's out of home care strategy includes key policies and that these are published on the Department's website.

The Tasmanian Government should enhance its financial and human resources investment in the Department to ensure appropriate policies and procedures can be put in place to protect children in out of home care.

4.5 Outcomes and performance reporting

A quality out of home care system needs strong quality assurance processes and monitoring against key performance measures. In Section 4.2, we recommend a Quality and Risk Committee. In this section, we discuss the need for outcomes and performance reporting.

The National Royal Commission found that the capacity to report on key performance indicators is important for protecting children from sexual abuse.[145] We are concerned about the Department's capacity to do this.

The Department's annual report contains very little information about children in care, their wellbeing or the quality of care they receive.[146] On the Department's website, the 'Services for children youth and families data' ('data dashboard') contains slightly more information than the annual report, reporting seven indicators on a monthly basis: the number of contacts received by the Advice and Referral Line and how many the Line resolved; the number of notifications to the Advice and Referral Line referred to the Child Safety Service for investigation; the 'average daily cases pending child safety assessment' (defined as 'the average number [of] cases referred for a child safety assessment which had not been allocated a case worker within priority timeframes'); the number of children in out of home care; the number of children restored to families; and the number of children transferred to third-party guardianship.[147]

Importantly, neither the Department's annual reports nor the data dashboard have information about performance measures that relate to the quality of care being provided, such as numbers and types of care concerns or complaints, or the number of children who have a current care plan.

In contrast to this level of reporting, the Department of Child Safety, Seniors and Disability Services in Queensland reports quarterly on multiple measures about its performance in out of home care, including allegations of harm for children in care.[148] The department also reports on, among other things, average Child Safety Officer caseloads, living arrangements of children on a child protection order by Aboriginal status and age, the percentage of Aboriginal children who have a cultural support plan, and the number of foster and kinship carer families by Aboriginal status.[149]

Leanne McLean, the Commissioner for Children and Young People, raised similar concerns as we do about the Department's data. In her first monitoring report on out of home care in 2019, Commissioner McLean noted that the Department's quarterly reports to her were incomplete and advocated the need for improved data collection and reporting.[150] In her second report in 2023, she commented that she was determined to 'increase the transparency of the Tasmanian Out-of-Home Care system' by publishing the 'best available data'. However, she had been hampered in her reporting by 'lengthy delays' from the Department in releasing information to her, including previously unpublished data.[151]

We note that a previous departmental framework for monitoring the outcomes for out of home care (developed in 2018) did not progress because it was 'dependent on new data capture capability'.[152] Improved data capture capabilities are necessary for the Department and external parties to properly monitor the wellbeing of children in care.

The Department should focus on monitoring outcomes for children in care that are relevant to increased risk and protection. To do so, the Department should develop a reporting framework that describes the safety and wellbeing of children in care (including all providers) as a key goal in its strategic plan (refer to Recommendation 9.8).

The national out of home care standards provide a starting point for this outcomes and performance reporting framework. They list 13 standards directed at improving the outcomes and experiences of children in care, including ensuring they are safe.[153] The standards correspond with many of the factors that protect children from sexual abuse in care, such as stable placements and safe connections with adults. Each standard has multiple reportable measures. Tasmania has been a signatory to these standards since their release in 2011. The Child and Youth Safe Standards should also be incorporated into the outcomes and performance reporting framework, which will become a requirement of funding agreements with non-government providers. We discuss funding agreements in Section 3.2.

Within the outcomes and performance reporting framework, the Department should require non-government out of home care providers to report any allegations or concerns about actual or risks of sexual abuse of a child in care, including grooming. The Department should record information about each instance, including the following:

- the source of risk or concern—for example, harmful sexual behaviours from another child, child sexual exploitation by an adult outside the care system, or child sexual abuse or related conduct by an adult within the care system
- the type of concern—for example, if actual abuse is alleged, exposure to situational risk or grooming behaviours
- the location of concern—in out of home care (including which type), in another institution, in the family or in the community
- action taken and outcomes.

To properly monitor the welfare of children in care, the Department should ensure providers report against a broad definition of sexual abuse including all forms, sources and signs of sexual abuse and precursor activities such as grooming, boundary breaches or absences from placement.

In establishing an outcomes and performance reporting framework, the Department should also develop the data capability to enable reporting against the framework, and routinely report against the framework.

Recommendation 9.9

The Department for Education, Children and Young People should:

a. establish an outcomes and performance reporting framework against which it can measure the performance of the out of home care sector, including in relation to child safety

b. develop the data capability to enable reporting against the framework

c. routinely report against the framework.

4.6 A workforce strategy

Another key pillar of a quality out of home care system is a skilled and supported workforce.

4.6.1 A shortage of staff

The Department does not have enough staff to undertake its core functions. Ms Lovell advised that as of 19 July 2022, there were 42 per cent of Child Safety Officer positions vacant in the North, 70 per cent in the North West and 37 per cent in the South.[154] Ms Lovell said these positions were vacant for several reasons, including planned and unplanned leave and that some roles were 'under recruitment'.[155] She said that COVID-related leave had exacerbated the vacancy situation, particularly in the North of the State, leaving many children without a Child Safety Officer.[156]

Ms Lovell acknowledged that the Department is 'experiencing a challenge' in filling the roles, a problem that has 'persisted for some time' despite employing various strategies to attract staff. She thought perhaps Tasmania's limited labour market with high competition for recruitment of skilled staff might be contributing to the problem.[157] As indicated above, the Child Advocate told us that the Department more broadly has only recently released human resources support to the Child Safety Service to improve recruitment and retention.[158]

Ms Lovell told us that 'inadequate workforce planning' had also led to a structure with many senior positions and frontline staff being promoted quickly into more senior roles, increasing turnover in Child Safety Officer positions. This means that frontline positions are generally held by less experienced staff.[159]

High staff turnover affects the safety of children. We heard that 'many (if not all) children in the out of home care system in Tasmania will have multiple [Child Safety Officers] over the course of their time in care'.[160] A child in care will likely find it increasingly difficult to establish a trusting relationship with each new Child Safety Officer, thus removing a protective factor for that child.[161] Indeed, several children in care interviewed for our

commissioned research said they did not have a case worker or didn't know who they were, and often could not identify someone in 'the system' who could support them if they had safety concerns.[162]

We acknowledge that recruiting and retaining suitably skilled staff in child protection and out of home care is universally challenging for child protection services, and that the Department is undertaking planning for this.[163] A further challenge, as expressed by one out of home care provider, is that 'recruiting more case managers is unlikely to improve the situation unless there is also action to address the reasons for staff leaving and to improve staff retention'.[164]

4.6.2 Staff wellbeing

We heard that many staff in the Child Safety Service feel they have been traumatised.[165] Reflecting on the work she undertook with the Department, Ms Enkelmann said:

> I listened with great sadness to the harm experienced by children and young people in [out of home care], but also by carers and workers. People who wanted to care for these children sometimes ended up harmed themselves through burn out, vicarious trauma and overwhelming stress. There are too many good people – capable, hardworking and intelligent workers and carers – who have been harmed by the system in which they work or give their time. This harm continues. While I was prepared for frustration and anger by carers and workers, I was not prepared for the extent of trauma and harm inflicted by a system meant to prevent it.[166]

In addition to the impact on staff from the nature of the work they do, other pressures on the Child Safety Service have likely contributed to some staff members' experiences of trauma or compounded its effects, including the following:

- Departmental systems and structures do not always support staff and in some cases cause them harm.[167] One systemic issue that appeared to be causing harm was the unrealistic caseloads that frontline staff have to manage.[168]
- Staff had not been consulted about strategic decisions, which creates chaos and instability.[169] As a result, some staff feel disempowered to advocate on behalf of the children in their care.[170] As the Child Advocate stated 'children will be heard when staff are heard'.[171]
- Constant change and reprioritisation due to partial reform and 'leadership churn' has caused stress.[172]
- Some staff have experienced harassment, including death threats, and feelings of being disrespected by other professions.[173]

In her July–December 2021 biannual report to the Secretary, the Child Advocate drew on trauma theory to suggest that the Department is 'highly dysregulated' because it is a traumatised system.[174] The Child Advocate asked the question: 'How do we [the Department] achieve stability for children, when the system itself is so unstable?'[175]

The Community and Public Sector Union representing Child Safety Officers submitted to us that staff were leaving because of poor pay and unsustainable working conditions.[176] They reported one anonymous Child Safety Officer as saying:

> We keep coming to work every day because we want the best for the kids but our own system works against us. We aren't supported, we aren't resourced, and we don't have the processes we need to do good jobs. We are abused for the work we do, by other services as much as by clients, but we are powerless to improve the system. We aren't heard or listened to either.[177]

The union also said it 'holds a growing concern that there is an increasing fear among workers about raising concerns'.[178]

A former senior employee, Jack Davenport, described the Department's response to the mental health problems experienced by his colleagues due to vicarious trauma and workload pressures as, at best, 'passive and generally unresponsive'.[179] The union reported that Child Safety Officers would like 'trauma safe workplaces; improved debriefing and leave after major incidents, better mental health support'.[180]

Secretary Pervan told us that staff in the Department do not access their employee assistance service as much as needed, which is possibly the result of a culture of 'stoicism', whereby seeking help is viewed as not being able to do the job.[181] Secretary Pervan also said 'a lot more work needs to be done around … supporting the workforce's wellbeing, not just their professional capacity'.[182] He spoke highly of the Department's workplace health and safety team, who he said provide support to frontline workers, particularly when they take stress leave.[183] The main measure Secretary Pervan proposed to address stoicism was employing wellbeing officers who can 'chip away at that culture' over time.[184] He also referred to the role of Practice Managers to monitor staff wellbeing.[185]

There are staff in the Department who experience work stress as well as direct and vicarious trauma; therefore, trauma is likely embedded in the culture of the organisation. We are concerned about the impact of staff wellbeing on decisions they make, how they relate to stakeholders and how they respond to risk, which in turn may affect their ability to ensure children in care are safe. It appears that the current measures to address wellbeing in the Department, while possibly useful, are not addressing wellbeing effectively at the individual or the system level.

4.6.3 A workforce strategy

While we acknowledge the Department's recent efforts to improve workforce planning, the Department needs to develop a workforce strategy for now and into the future to recruit and retain staff who case manage children in care. This workforce strategy should form part of its out of home care strategic plan as outlined in Recommendation 9.8. The workforce strategy should identify the reasons skilled staff choose not to work for the Department or choose to leave prematurely and address these reasons in a meaningful way to improve the Department's reputation as an employer of choice.

In developing the workforce strategy, the Government may wish to consider approaches adopted by other jurisdictions to attract and retain a specialist workforce in similar areas. It should work with its national counterparts to leverage national incentives to increase staffing levels, such as immigration policies and subsidised tertiary education fees.[186]

Staff in the child and family welfare and out of home care sector move between the Department and other departments or non-government organisations. The Department's workforce strategy should take a whole of sector approach to generating long-term solutions to meeting the workforce needs of Tasmania's child and family welfare sector, while paying particular attention to the structural and systemic issues contributing to the view of the Department as an employer of choice.

If it is to improve the safety of children in care, the Department should include actions in its workforce strategy that explicitly address the wellbeing of the workforce. The measures the Department puts in place should be proportionate to what staff require to maintain their wellbeing and mitigate the risk of vicarious trauma.[187]

Recommendation 9.10

The Department for Education, Children and Young People should develop a workforce strategy for the child and family welfare sector to pursue the following objectives:

a. an increase in staff numbers and retention

b. workplace conditions that make the sector a more attractive employer, particularly in the Department

c. a reduction in unplanned staff vacancies, particularly in the Department

d. promoting staff wellbeing, at the individual and system levels, including by addressing the causes and effects of trauma and vicarious trauma

e. a workforce equipped with the knowledge and skills to respond effectively to the needs of children and families.

4.6.4 Child Safety Service staff minimum professional development

Ongoing professional development across out of home care services is critical to supporting quality of care for, and safeguarding of, children in care.[188]

At the time of writing, the mandatory professional development requirements for departmental staff are limited to inducting a staff member into a role. During their induction period, Child Safety Officers complete 12 education modules within a specified timeframe. Most of these modules cover basic child protection practice, but there are no modules specific to identifying and responding to child sexual abuse.[189] The Department 'encourages', but does not require, that staff refresh their skills and knowledge of these core topics periodically.[190]

The Department makes an extensive range of educational modules available to staff on an optional basis. These include modules on child sexual abuse and trauma-informed care, such as those on 'Working with Children with Sexualised Behaviours', 'Responding to Child Sexual Exploitation' and 'Introduction to Keeping Children Safe – how to engage with Tasmania Police when responding to allegations of child sexual abuse'.[191]

This range of educational modules provides a solid basis for professional development, assuming that the quality of these modules is high. Such education should assist staff to act in ways that help protect children in care. However, many of these modules should be mandatory for all staff. Also, staff should be expected to engage in a minimum number of professional development hours or activities per year.

4.6.5 Carer development

Capable and skilled carers can decrease the risk of sexual abuse and improve the response when it does occur.

All foster carers (but not kinship or paid residential carers) undertake the 'Shared Stories Shared Lives' educational module.[192] However, we were told there was no central record of the further education or professional development of carers.[193]

The Foster and Kinship Care Association of Tasmania is funded to provide professional development modules to carers from all agencies, but each out of home care provider also organises education for its own carers.[194] Dr Backhouse, from the Foster and Kinship Carers Association, told us that this approach to ongoing education for carers is not coordinated and results in unnecessary duplication.[195]

Some non-government out of home care providers spend a considerable amount each year on training their carers.[196] Former departmental employees told us that carers who are managed directly by the Department however, may not receive the level and breadth of ongoing education that non-government out of home care providers require of the carers they support.[197] These carers can only access the Foster and Kinship Carers Association sessions on an elective basis.[198] As a result, many carers may not engage in ongoing education.

Dr Backhouse expressed particular concern about this lack of ongoing education available to Department foster carers, who she said tended to be older carers who had been caring for children for a long time.[199]

Children interviewed for our commissioned research were often sceptical about their carers' knowledge and skills, particularly in relation to understanding and managing their trauma. The consequences of this were significant for some, who reported that their carers used disciplinary practices that caused them harm and could not give them the care and empathy they needed; this often resulted in placement breakdown.[200]

We consider that all carers should be required to attend a minimum level of professional development.

4.6.6 Understanding child sexual abuse and trauma

All staff and carers in the out of home care system need to understand child sexual abuse and respond appropriately if it does occur.[201]

We were told that specific knowledge of child sexual abuse, or experience working with children who have been sexually abused, were not requirements for the role of a Child Safety Officer. Neither was it mandatory to gain knowledge on the topic.[202]

During her time in the Victorian Department of Human Services, Dr Miller observed that Child Safety Officers often made mistakes when assessing the risk of sexual abuse because they lacked knowledge about the dynamics of sexual offending and how to gather information or evidence in relation to allegations.[203] Former employees said they had observed Child Safety Officers face similar difficulties in the Tasmanian Department.[204]

Dr Miller identified the need to specifically educate out of home care workers about sexual abuse for children in care, which she included as a key component of MacKillop Family Services' 'Power to Kids' program.[205] She said, as a result of that program, which sought to upskill workers to have 'brave conversations' with children in their care about sexual risks, workers could identify and intervene when they detect a sexual risk.[206] Dr Miller told us that consequently, there have been fewer incidences of harmful sexual behaviours, child sexual exploitation and dating violence in MacKillop's residential care homes.[207]

For Tasmanian carers, the *Foster and Kinship Carers Handbook* has a short section on responding to children who disclose sexual abuse.[208] However, Ms Enkelmann told us that there was no specific education routinely provided to carers on how to respond to disclosures of sexual abuse by children in their care.[209] Dr Backhouse suggested that carers would benefit from more information about how to support children who disclose sexual abuse.[210]

Understanding trauma is also essential to protecting children in care from sexual abuse and effectively responding when abuse happens. Other jurisdictions have adopted trauma-informed care models. For example, the Sanctuary Model is applied in MacKillop Family Services' residential care homes across Victoria and New South Wales. This model involves educating staff at all levels across the organisation in trauma and trauma-informed practice.[211] We are aware of other models of this nature; for example, some Australian out of home care providers such as Life Without Barriers use the 'Children and Residential Experiences' model developed by Martha and Jack Holden of Cornell University.[212]

While the Department offers several (mostly) elective professional development modules about trauma and trauma-informed therapeutic care, the Department's approach to trauma-informed care is not consistent.[213] We heard from Mary Dickins, a foster carer, that the Department's standard 'Shared Stories Shared Lives' sessions do not adequately prepare foster carers for the challenges of parenting a traumatised child, and that more guidance and support is needed.[214]

4.6.7 Knowledge and skill development

All departmental staff, non-government staff and volunteers in out of home care services, and residential, foster and kinship carers, should receive mandatory education specifically about child sexual abuse. Moreover, because child sexual abuse often co-occurs with other forms of child maltreatment, this education should cover identifying and responding to child sexual abuse, including grooming, harmful sexual behaviours and child sexual exploitation. Carers should also have mandatory professional development on trauma and trauma-informed care. They should keep their knowledge current through regular, mandatory refresher sessions or continuing professional development.[215] Ensuring such education is mandatory signals to staff, carers and children in care that the Department values the welfare of children in care and will not tolerate sexual abuse in any form.[216]

In our view, the Department in its role of overseeing the out of home care system, should determine the core knowledge and skills required for staff in non-government organisations providing carer assessment and support, as well as for residential, foster and kinship carers. It should also ensure non-government out of home care staff and carers have access to professional development in core knowledge and skills, recognising existing high-quality training available in Tasmania and developing or funding new training where required.

The Department will need to consider any systemic barriers to carers taking part in knowledge and skills development and consider options such as online modules, assistance with literacy difficulties or providing onsite childcare to support their participation. This will ensure a consistent high level of care is provided to

children in out of home care and reduce duplication of sessions offered between providers with associated cost efficiencies.[217]

Professional development should also include the components of a trauma-informed therapeutic model of care for out of home care (refer to Recommendation 9.18). When establishing the Carer Register (refer to Recommendation 9.20), the Department should mandate that carers are trained in these key areas before gaining registration. The Department should ensure carers' skills and knowledge are refreshed periodically to maintain their registration. Professional development and registration processes for kinship carers should consider the different (and usually unplanned) pathway into caring for kinship carers.

The Department's overall aim should be to ensure mandatory education is delivered to as many people in the sector as possible in the most cost-effective way. Given the remote locations of some carers and staff, attention will need to be given to making professional development accessible. The Department may find it more cost-efficient to centralise some aspects of professional development across all its child-facing service areas but should ensure professional development is tailored to the specific contexts of each of the service areas.

Also, there will be core knowledge, such as in the areas of child sexual abuse and trauma, required for Child Safety Officers, residential carers and foster and kinship carers. However, the depth of knowledge and skills expected for each group will differ. Some staff and carers will need more advanced skills and knowledge than others. Therefore, it would be useful to include basic and advanced level modules, with all residential care staff, foster and kinships carers and volunteers completing at least basic education modules, with regular refresher or continuous professional development sessions. Consistent with the demands of their roles, Child Safety Officers will require a more advanced level of induction, continuous upskilling and professional development.

As discussed in Section 6.4, the Department should develop professional conduct policies that outline standards of behaviour for staff, volunteers and carers when interacting with and caring for children in care (refer to Recommendation 9.19). These policies should be specific to the nature and context of their role in caring for children. The Department should mandate regular professional development relevant to the professional conduct policy to reduce 'ethical drift' away from appropriate behaviour. The *Foster and Kinship Carers Handbook* will need updating to reflect the professional conduct policy and support carers to respond appropriately to the risk of sexual abuse in out of home care.

Recommendation 9.11

1. The Department for Education, Children and Young People should establish mandatory core knowledge requirements for Child Safety Officers, which include an understanding of:
    a. child sexual abuse, including grooming, harmful sexual behaviours and child sexual exploitation
    b. the effects of trauma, trauma-informed care and therapeutic responses to trauma
    c. ethical and professional conduct.
2. The Department should ensure Child Safety Officers attain this knowledge during their induction period.
3. The Department should provide regular refresher training and continuous professional development opportunities to enable Child Safety Officers to continue to advance their knowledge and skills (advanced professional development).
4. In its role of overseeing the out of home care system, the Department should:
    a. determine the core knowledge and skills required for staff in non-government organisations providing carer assessment and support, and for residential, foster and kinship carers
    b. ensure non-government out of home care staff and carers have access to professional development in core knowledge and skills, recognising existing high-quality training available in Tasmania and developing or funding new training where required.

Recommendation 9.12

1. The Department for Education, Children and Young People should ensure the *Foster and Kinship Carers Handbook* is updated to include:
    a. information applicable to all carer types
    b. more information on child sexual abuse, including harmful sexual behaviours and child sexual exploitation
    c. mandatory reporting requirements for carers
    d. the professional conduct policy for foster and kinship carers.

2. The Department should:
    a. make the Handbook available publicly on its website
    b. ensure the Handbook is regularly updated in line with any relevant changes to policy.

4.6.8 Learning organisation

Dr Miller emphasised the importance of a 'learning culture' for teams to function effectively in out of home care:

> Well-functioning and cohesive teams can be established and maintained through regular high quality supervision, reflective practice, a clear leadership presence in the residential care that supports / reinforces expectations and maintain an environment that acknowledges successes and learns from mistakes and critical incidents.[218]

Caroline Brown, a veteran of child protection across several jurisdictions, told us that the Department would make better, more consistent decisions (and likely attract less criticism) if it adopted an 'open approach to learning and critical thinking, analysis [and] reflective practice'.[219] Mr Davenport similarly stated that in addition to developing and delivering professional development for staff, the out of home care system in Tasmania needs to become 'a learning culture' that is 'open and reflective'.[220]

Ms Taylor, from South Australia's Department of Child Protection, told us how her department has dedicated roles that integrate new lessons into strategy, reform, quality and practice, which all staff are told about during monthly professional development sessions.[221] Her department's lead practitioner has developed practice guidance papers based on emerging evidence or lessons from critical incident reviews.[222]

The Tasmanian Department should implement purposeful mechanisms and processes to support and encourage a learning culture internally. We have recommended an Office of the Chief Practitioner (refer to Recommendation 9.17) and a Quality and Risk Committee (refer to Recommendation 9.5) as two ways to support and encourage a learning culture internally. Other mechanisms may include practice reviews and the implementation of reflective practice in individual or group supervision (refer to Section 6.2).

A learning culture is also supported through external learning partnerships.

As one of the smallest Australian child protection jurisdictions, the Tasmanian Department may not have enough scale to always undertake its own research, which would require specialist research knowledge and skills. The Department could look to child protection agencies in other jurisdictions that have developed learning partnerships to reflect on strengths and limitations in their practice and to support the development of best practice policy and practice guidance.

In the South Australian context, for instance, the Department for Child Protection has developed strategic partnerships with universities.[223] Ms Taylor also told us how important it was for the Department to 'use the knowledge and skills from other jurisdictions' and that '[t]here is a great strength in the child protection network nationally'.[224] The University of South Australia had also partnered with the Western Australian Department of Communities and the Australian Centre for Child Protection to develop a framework around harmful sexual behaviours among children and young people, and to provide workforce development in trauma and harmful sexual behaviours.[225] This type of partnering was a cost-efficient approach for a small jurisdiction.

A learning organisation also takes a continuous approach to professional development to support the workforce to advance their knowledge and skills and keep up to date with evolving evidence over the life of their careers. Micro-credentialling, which certifies the learning of a defined set of skills, knowledge and attributes through short courses, is growing quickly in higher education as a way for people to 'rapidly upskill and encourage lifelong learning'.[226] Such an approach incentivises learning, and staff feel valued by the investment in their ongoing development. In partnering with a centre of learning in the field of child protection and out of home care, the Department should take the opportunity to develop a micro-credentialling pathway to incentivise staff to stay in the child and family welfare sector as a vocation and ensure they have up-to-date evidence-based knowledge and skills.[227]

The Department should prioritise the development of links with other jurisdictions and child protection and out of home care research specialists to ensure departmental staff are aware of, and able to implement, contemporary, evidence-based approaches to keeping children safe in care.

Recommendation 9.13

The Department for Education, Children and Young People should ensure staff have access to the latest out of home care practice knowledge by becoming a learning organisation, including by:

a. implementing purposeful means for critical reflection and internal review

b. establishing strategic partnerships with specialist out of home care, child maltreatment and child protection researchers

c. engaging in cross-jurisdictional partnerships where there are opportunities for shared learning

d. developing opportunities for formal recognition of ongoing learning for staff through these partnerships, such as via micro-credentialling pathways.

5 Keeping Aboriginal children safe and connected to culture

The over-representation of Aboriginal children in out of home care exposes them to the risks of experiencing sexual abuse in care at a substantially higher rate than non-Aboriginal children.

There are several other factors that place Aboriginal children at increased risk of sexual abuse in Tasmanian out of home care. These include the limited involvement of Aboriginal communities and organisations in decision making about Aboriginal children in care, inappropriate out of home care placements for Aboriginal children, and a lack of cultural support and connection for Aboriginal children in care.

As indicated above, the 2020 *National Agreement on Closing the Gap* ('Closing the Gap') aims to reduce the rate of over-representation of Aboriginal children in out of home care by 45 per cent by 2031 (Target 12).[228] The *Aboriginal and Torres Strait Islander First Action Plan 2023-2026* and Closing the Gap identify the Aboriginal and Torres Strait Islander Child Placement Principle ('Placement Principle') as a key indicator for measuring progress towards achieving Target 12.[229] Despite its name suggesting that it focuses solely on the 'placement' of Aboriginal children, the Placement Principle has five elements:

- prevention
- partnership
- placement
- participation
- connection.[230]

Full implementation of the Placement Principle is critical to reducing Aboriginal over-representation in Tasmanian out of home care, improving responses to Aboriginal children in care and protecting them against the risk of child sexual abuse.

This section:

- explains our approach to the question of Aboriginal status in Tasmania
- briefly describes the drivers of Aboriginal over-representation in Tasmanian out of home care
- examines the Tasmanian Government's recent efforts to address over-representation in out of home care and the extent to which it has embedded the Placement Principle in legislation, policy and practice
- makes recommendations for fully implementing the Placement Principle in Tasmania.

5.1 Identifying Aboriginality

Not all Aboriginal children who come into care have their Aboriginal status identified, as was the case for Hudson (a pseudonym) in the case example in Chapter 8.[231] Not only did Hudson's carer tell us Hudson experienced sexual abuse while in care, but they also said Hudson was denied the opportunity to get involved in community and for cultural support that may have assisted their healing.

In almost every meeting we had with Aboriginal communities, participants raised concerns about how Aboriginal status is determined in Tasmania and who is responsible for determining it. This issue was also raised by Heather Sculthorpe, Chief Executive Officer, Tasmanian Aboriginal Centre, in her evidence.[232] We heard differing views about this issue, many of which were also reflected in the 2021 *Pathway to Truth-Telling and Treaty* report.[233] We agree that it must be for Aboriginal people to decide who is and who is not Aboriginal in Tasmania. It is beyond the scope of our Inquiry to make recommendations on this issue. However, it is within our terms of reference to address the increased risk of sexual abuse that Aboriginal children face in Tasmanian out of home care due to their over-representation in that system. To address this risk, the out of home care system must ensure Aboriginal children stay connected to their Aboriginal community and culture. Therefore, it is important to make two points.

First, in this section we refer to 'Aboriginal children in out of home care in Tasmania', rather than 'Tasmanian Aboriginal children in out of home care'. We have adopted this terminology because our recommendations are aimed at ensuring all Aboriginal children in out of home care in Tasmania, not only those recognised as having Tasmanian Aboriginal ancestry, are responded to in keeping with the Placement Principle and receive the benefit of services that Aboriginal organisations provide.

Second, it is crucial that the Aboriginal status of children in contact with the Child Safety Service be sensitively ascertained and accurately recorded as early as possible. Services for Children and Families staff are required to determine a client's Aboriginal status every time the client 'commence[s] an involvement with' the service.[234] Until recently, it seems that Aboriginal status has not always been consistently identified or accurately recorded.[235] However, in his statement, Secretary Pervan indicated that the Department was '[i]mproving collection and completion of Aboriginal status for children at the Advice and Referral Line and Child Safety Service'.[236] The Commissioner for Children and Young People confirmed that the Department had advanced significantly in this regard. In the time between her first and second monitoring reports on out of home care in Tasmania in 2019 and 2023, the proportion of children in care with an 'unknown' Aboriginal or Torres Strait Islander status had fallen from 30 per cent to 1 per cent.[237]

5.2 Drivers of Aboriginal over-representation in out of home care

The rate of over-representation of Aboriginal children in Tasmanian out of home care has steadily increased since 2017.[238] This is an alarming trend that is not unique to Tasmania.

The 2022 *Family Matters* report identifies structural factors and service inadequacies that contribute to Aboriginal families encountering child protection systems and Aboriginal children entering out of home care at high rates.[239] These include:

- systemic racism in the child protection and other service systems[240]
- individual and collective experiences of trauma (including intergenerational trauma) resulting from colonisation[241]
- poverty and socioeconomic disadvantage stemming from colonisation[242]
- exposure to family violence[243]
- parental drug and alcohol misuse[244]
- mental health issues, including risks to children's mental health resulting from involvement with the child protection and out of home care systems[245]
- poor access to safe, affordable and quality housing[246]
- inadequate government investment in Aboriginal-led and culturally appropriate family support services.[247]

We heard evidence indicating that many of these factors are present in Tasmania.[248] In particular, we heard that systemic or institutional racism is a problem in the child safety system. According to Ms Sculthorpe:

> … every level of the child safety system has reinforced stereotypes about Aboriginal families, especially those families with previous experience of the child welfare and child protection systems … In some cases the community nature of child rearing has been misinterpreted as parental neglect of children … There has been a failure of child welfare authorities to recognise the strengths of Aboriginal family and community rather than concentrating solely on deficits.[249]

Several participants at our consultations with Aboriginal communities referred to the racism Aboriginal people continue to experience at the hands of government systems.[250] In relation to the child safety system, one community member said:

> I want to know why they look at Aboriginal people so harshly, why they judge us differently to everyone else. We're probably the most caring people in the world.[251]

Some participants referred to their lack of trust in the child protection and out of home care systems, indicating that Aboriginal children were removed from their families far too readily.[252]

Elders told us about the ongoing effects of intergenerational trauma on Aboriginal communities, including its adverse effects on the parenting skills of Aboriginal people, and the lack of support to address such trauma.[253] One participant told us:

> The internal and external bruises that come from being in foster care last for generations.[254]

The 1997 *Bringing Them Home* report highlighted the intergenerational effects of child removal and the 'direct association' between being removed as a child and later having a child removed.[255] More recently, research published in 2017 about the intergenerational links in the child protection system in New South Wales found that 60 per cent of Aboriginal children and young people in out of home care in 2014–15 had a parent who was known to the child protection system compared with 43 per cent of non-Aboriginal children and young people who were in out of home care in 2014–15.[256]

Participants in our community consultations also referred to the lack of safe and affordable housing for Aboriginal families and the absence of culturally safe support services—in particular, mental health and drug and alcohol services and support for family violence.[257] Several participants identified the need for improved mental health services for Aboriginal people, particularly children.[258]

All these factors are complex and interrelated. For the purposes of our Inquiry, they can be usefully considered through the lens of the Placement Principle.

5.3 Tasmania's efforts to implement the Placement Principle

In 2017, the National Royal Commission recommended that state and territory governments develop and execute plans to fully implement the Placement Principle.[259] The Tasmanian Government accepted this recommendation in principle.[260]

SNAICC - National Voice for Our Children ('SNAICC') undertakes an annual review of the progress of states and territories in implementing the Placement Principle. In its most recent review of Tasmania's progress, completed in 2021, SNAICC found limited implementation of the Placement Principle in Tasmania:

> Limited mechanisms to ensure Aboriginal participation in policy reform, decision-making, system and service design, or delivery has resulted in a child safety system that does not always meet the needs of Aboriginal children, their families, and communities.[261]

The *Family Matters Report 2022* identified that Tasmania spends only 0.79 per cent of its total child protection expenditure on Aboriginal community organisations, by far the lowest of all Australian states.[262] Since then, the Government has made other commitments to fully implement the Placement Principle.[263] Most recently, the Tasmanian Government became a signatory to the *Aboriginal and Torres Strait Islander First Action*

Plan 2023-2026 under *Safe and Supported: The National Framework for Protecting Australia's Children 2021-2031*, which was released on 31 January 2023.[264] 'Action 5-Active Efforts' commits the Government to:

> … implementing all 5 elements of the Aboriginal and Torres Strait Islander Child Placement Principle (ATSICPP), and improving the accountability of all governments and sectors in reducing the over-representation of Aboriginal and Torres Strait Islander children and young people in child protection systems.[265]

5.3.1 Prevention

According to the 'prevention' element of the Placement Principle, each Aboriginal child 'has the right to be brought up within their own family and community'.[266] This requires that Aboriginal families have equal access to high-quality and culturally safe social supports, including targeted and intensive supports to address issues in family functioning and parental issues such as trauma, mental ill-health and family violence, as well as adequate housing.[267] It also requires governments to address institutional racism in child protection systems and other structural drivers of Aboriginal over-representation in out of home care.[268]

It is beyond the scope of our Inquiry to undertake a comprehensive assessment of prevention and early intervention services available to Aboriginal families that contribute to preventing or limiting the entry of Aboriginal children into out of home care.

However, we note that the Tasmanian Government funds the Tasmanian Aboriginal Centre to provide intensive family engagement services to Aboriginal families whose children are at risk of being removed. Funding for this program is allocated on a per-family basis, described as a 'best practice funding model' that recognises the high level of support required for some families.[269] Packages enable the Tasmanian Aboriginal Centre to develop tailored plans that focus on the physical, mental, social and cultural health and wellbeing of the entire family.[270] An evaluation of the Intensive Family Engagement Services program, undertaken in 2019, showed that almost 70 per cent of families that completed the program continued to care for their children.[271] This is a positive prevention measure.

SNAICC has suggested that the funding for family support and intensive family support in Tasmania be increased as a proportion of spending on child protection services.[272] Also, the Tasmanian Aboriginal Centre's services are limited to Aboriginal children and families with Tasmanian Aboriginal ancestry as recognised by the centre.

We also note that, since 2020, three Aboriginal Liaison Officers have been appointed to the Department's Advice and Referral Line. These positions are located within Aboriginal organisations in each Tasmanian region. The Aboriginal Liaison Officer's role is to provide culturally focused advice and assistance to Aboriginal families. This may include referring families to Intensive Family Engagement Services, youth support or

other Aboriginal support services.[273] The appointment of Aboriginal Liaison Officers is a positive prevention initiative. However, a Tasmanian Auditor-General report published in June 2022 found that the Aboriginal Liaison Officer roles 'have wide coverage and limited capacity and are not resourced to deliver fully all aspects of their role'.[274]

The 2021 *Family Matters* report recommended that states and territories increase investment in universal and targeted early intervention and prevention services for Aboriginal families, including family support and reunification services, at a rate equivalent to the representation of Aboriginal children in child protection.[275]

While Secretary Pervan indicated that the Department delivers education and resourcing to staff 'to develop cultural competency and culturally safe practice', we understand it is not mandatory.[276]

The Tasmanian Government has committed to establishing 'a range of initiatives to directly address and eliminate racism within and across the State Service' as part of implementing Closing the Gap.[277] This should include measures to address institutional racism in the Child Safety Service that may be contributing to the over-representation of Aboriginal children in the out of home care system.

5.3.2 Partnership

The 'partnership' element of the Placement Principle focuses on self-determination—the right of Aboriginal communities to exercise autonomy in their own affairs.[278] Self-determination involves more than consultation and participation; it requires that decision-making authority is transferred from governments to Aboriginal communities.[279]

In relation to the child safety and out of home care systems, the transfer of decision-making authority from government to Aboriginal organisations could take different forms. For example, Aboriginal organisations could be authorised or delegated to:

- case manage Aboriginal children on care and protection orders
- assume the role of statutory guardian of Aboriginal children who would otherwise be under the guardianship of the Secretary
- undertake investigations where a notification is made about an Aboriginal child, and be primarily responsible for decisions about that child
- receive notifications about Aboriginal children.

In 2014, the Tasmanian Aboriginal Centre published *luwutina mana-mapali krakani waranta – Keeping Our Children With Us*. In preparing the report, the centre undertook extensive consultation with Aboriginal people and made 10 recommendations to improve the Tasmanian child protection system for Aboriginal children. The first, and principal, recommendation was:

> That the Tasmanian Government accept the wish of the Aboriginal community in Tasmania for the transfer of jurisdiction over child welfare and child protection to the Aboriginal community.[280]

This recommendation would appear to involve a complete transfer of all child safety decision-making authority and powers under the Children, Young Persons and Their Families Act, including the powers exercised by the Children's Court in relation to making care and protection orders. The report did not specify how equivalent decisions would be made after such a transfer of jurisdiction—for example, where a child needed to be removed from their family, but the family did not agree with this decision. However, the report recommended that the Act be amended to enable Aboriginal people 'to opt to have their matters dealt with under Aboriginal jurisdiction rather than under the Tasmanian legislation', suggesting that Aboriginal jurisdiction would not be exercised under the Act.[281]

Such a transfer of jurisdiction would enable full self-determination for Aboriginal communities for decisions about the care and protection of Aboriginal children. No Australian jurisdiction has yet effected such a large-scale transfer of authority to Aboriginal communities.

However, two jurisdictions—Victoria and Queensland—have taken 'essential first steps' towards implementing legislative, policy and practice changes to authorise Aboriginal organisations to make certain child protection decisions about Aboriginal children.[282]

In Victoria, the legislative framework allows the principal officer of an Aboriginal agency to 'perform specified functions and exercise specified powers conferred on the Secretary … in relation to a protection order' in respect of an Aboriginal child, or a non-Aboriginal child who is a sibling of an Aboriginal child subject to a relevant authorisation.[283] The Victorian Government has also made significant investment to transfer case management of Aboriginal children in out of home care from the Department of Families, Fairness and Housing and non-Aboriginal service providers to Aboriginal community-controlled organisations.[284] As an example of this model, Professor Muriel Bamblett, Chief Executive Officer, Victorian Aboriginal Child Care Agency, told us that she has statutory guardianship of just over 100 Aboriginal children on certain child protection orders, and her organisation provides a number of forms of case management and support for those children.[285] She reported achieving a higher rate of reunification of Aboriginal children with their families—between 22 and 25 per cent—compared with the Victorian Department's reunification rate of between 12 and 15 per cent for Aboriginal children.[286] The Victorian Aboriginal Child Care Agency is involved in the next step—a trial of Aboriginal-led child protection investigations.[287]

In Queensland, the *Child Protection Act 1999* (Qld) ('Queensland Child Protection Act') was similarly amended in 2017–18 to establish a framework for delegating the functions or powers of the Chief Executive of the Department of Children, Youth

Justice and Multicultural Affairs in relation to an Aboriginal child who needs protection or is likely to need protection.[288] These functions or powers may be delegated to an Aboriginal person who is the Chief Executive Officer of an 'appropriate Aboriginal or Torres Strait Islander entity', and who is 'suitable' and 'appropriately qualified' to perform the delegated function or exercise the delegated power in relation to the child.[289] In 2021–22, the Queensland Government partnered with two Aboriginal community-controlled organisations and the Queensland Aboriginal and Torres Strait Islander Child Protection Peak to implement delegated authority for 40 children.[290]

In Tasmania, section 10G of the Children, Young Persons and Their Families Act provides that Aboriginal families, kinship groups, communities and organisations 'have a major, self-determining role in promoting the wellbeing of Aboriginal children' and that a kinship group, Aboriginal community or Aboriginal organisation nominated by the child's family should 'be allowed to contribute to the making of a decision under this Act in relation to the child'.[291] Similarly, the Child Safety Service practice advice states that the Aboriginal community 'must have a say about Aboriginal children'.[292]

Despite these legislative and policy requirements, we heard that the Department's involvement of Aboriginal organisations in decision making about Aboriginal children was inconsistent. Ms Sculthorpe told us that the Department has:

- not always been willing to work with the Tasmanian Aboriginal Centre to identify placement options for Aboriginal children
- allowed non-Aboriginal non-government organisations to provide services to Aboriginal children in out of home care without consultation with the Aboriginal community
- on occasion failed to notify the Tasmanian Aboriginal Centre when Aboriginal children in out of home care have been moved to different placements, with some children 'lost to the community' for a period
- ignored warnings from Tasmanian Aboriginal Centre staff of suspected sexual abuse or neglect by foster carers and, where those suspicions had been confirmed, failed to explain departmental decision-making processes.[293]

Aboriginal community members told us that partnerships between the Department and Aboriginal organisations can work well, but they depend on the personalities of the people involved.[294] They told us that the Child Safety Service does not listen enough to Aboriginal families, particularly in relation to culture, and does not understand the ways in which Aboriginal communities raise their children.[295]

Participants told us that self-determination in the child safety system was critical: 'We need our own Aboriginal people involved with a system to handle our Aboriginal children'.[296]

The notions of 'promoting wellbeing', 'being allowed to contribute' and 'having a say' are inadequate expressions of Aboriginal self-determination in decisions about the care and protection of Aboriginal children. Structures should be in place to support Aboriginal self-determination in child safety decision making as committed to under the *Aboriginal and Torres Strait Islander First Action Plan 2023-2026*.[297]

As part of its implementation plan to reduce the over-representation of Aboriginal children in out of home care, the Government has committed to work with Aboriginal community-controlled organisations:

- to build their capacity to take on increased roles and responsibilities in the care and protection of Aboriginal children and to promote Aboriginal self-determination
- in relation to all planning and decision making for Aboriginal children in the child protection system
- to develop Aboriginal programs to deliver services to support Aboriginal children in the child protection system.[298]

Secretary Pervan indicated that the Tasmanian Government is making $5.3 million in funding available through the Closing the Gap Capacity Building Funding Program, which aims to build the capacity of Aboriginal organisations to co-design and deliver programs and services for Aboriginal people.[299]

These commitments are positive because they broadly focus on increasing Aboriginal self-determination for child safety. However, they lack detail, timeframes and allocated funding (apart from funding for capacity building). We did not see any specific evidence of progress on these actions.

The ad hoc approach to involving Aboriginal organisations in child safety decision making does not serve the interests of Aboriginal children in, or at risk of entering, the out of home care system. Self-determination requires that Aboriginal organisations be empowered to make decisions about the care and protection of Aboriginal children. There are different ways to achieve this.

Experience from jurisdictions where the transfer of decision-making authority has begun needs to be carefully considered. These processes require significant, long-term government investment, partnership and support.

In considering examples from other jurisdictions, we were also mindful of:

- the need to design an appropriate model or models for Tasmanian contexts
- the possibility of developing different models for different Aboriginal communities depending on the size, capacity and desire of specific Aboriginal organisations or groups to take on specific roles (refer to discussion under 'Participation')

- the need to ensure Aboriginal communities and organisations are fully resourced and their workforces fully supported to take on decision-making authority, in whatever form it is transferred
- the need for Aboriginal communities and organisations to be invested in and supported to enable them to perform functions transferred to them.

5.3.3 Placement

The 'placement' element of the Placement Principle requires that Aboriginal children who are removed from their families be placed according to the following hierarchy:

- Aboriginal relatives or extended family members, or other relatives or extended family members
- Aboriginal members of the child's community
- Aboriginal family-based carers.[300]

If none of these options is available, as a last resort the child may be placed with a non-Aboriginal carer or in a residential setting.[301] If the child is not placed with their extended Aboriginal family, the placement must be geographically close to the child's family.[302] Best practice requires child safety decision-makers to:

- exhaust all possible options at one level of the hierarchy before considering a lower-level placement
- consult with the child's family and community representatives to ensure all possible higher-level placement options have been considered.[303]

Section 10G of the Children, Young Persons and Their Families Act prioritises placement of an Aboriginal child, as far as practicable, with 'a member of the child's family'.[304] If this is not possible, then the child should be placed with an Aboriginal person in the child's community 'in accordance with local community practice' or with another Aboriginal person.[305] Last, is placement with a non-Aboriginal person who 'in the Secretary's opinion, is sensitive to the child's needs and capable of promoting the child's ongoing affiliation with the culture of the child's community and, if possible, the child's ongoing contact with his or her family'.[306]

The Act provides that, '[a]s far as is practicable, an Aboriginal child removed from his or her family and community, should be placed in close proximity to them'.[307]

In referring to 'a member of the child's family', which includes extended family (which, in turn, is broadly defined), the Act does not privilege Aboriginal members of the family over non-Aboriginal family members.[308]

Despite statutory requirements, Aboriginal children are placed with Aboriginal carers at a very low rate in Tasmania. According to the Australian Institute of Health and Welfare, of Aboriginal children in out of home care in Tasmania on 30 June 2021:

- 10.7 per cent were living with Aboriginal relatives or kin—this is by far the lowest rate in Australia
- 5 per cent were living with an Aboriginal caregiver who is not a relative or kin
- 32.3 per cent were living with non-Aboriginal relatives or kin
- most (52.1 per cent) were living with non-Aboriginal carers who are not relatives or kin, in residential care or in another arrangement.[309]

This data is subject to the following caveats:

- The high number of carers whose Aboriginal status is unknown in Tasmania may affect the identification of children placed with Aboriginal caregivers.
- The data excludes children not under care and protection orders who are placed with relatives where a financial payment was offered but declined by the carer.[310]

Secretary Pervan told us that the Department was working to improve the 'collection and completion of Aboriginal status of carers'.[311] We emphasise that identifying a carer's Aboriginal status is important to support the placement of Aboriginal children with Aboriginal carers.

Tasmania has been criticised for an absence of programs aimed at identifying, recruiting and supporting Aboriginal kinship carers.[312] According to SNAICC, without progress to prioritise placement with kin or other Aboriginal carers, the number and rate of children placed in out of home care in Tasmania in keeping with the Placement Principle is likely to remain the lowest in Australia.[313]

Participants in our consultations with Aboriginal communities told us that Aboriginal carers want to look after Aboriginal children, but they did not always receive the support they needed to do so.[314] Many participants referred to the need for a safe place, run by Aboriginal people, for Aboriginal children who cannot remain at home:

> A place where the families and children can be, a safe place, and there you work with the parents, without the welfare coming and saying they are taking the children.[315]

There were different views about the preferred features of such a place. Suggestions included the following:

- it should be on Country, for cultural connection and safety[316]
- it should be staffed by Aboriginal carers[317]

- Elders should play a key role in supporting young people there[318]
- it should focus on healing and include in-house services such as a nurse and a visiting general practitioner[319]
- families should be able to visit their children there, and staff should be able to work with the parents and families to reconnect them with their children and culture[320]
- it could be a place where Aboriginal children return when they need assistance again or to reconnect with culture[321]
- their design should be flexible because what works in one part of Tasmania might not work in another and should be able to accept all Aboriginal children.[322]

Following an investigation in 2020 into Tasmanian children taking part in the Many Colours One Direction program in the Northern Territory, the Tasmanian Government commissioned an expert panel to provide advice on setting up a Tasmanian-based residential program for children in out of home care with highly complex needs. The expert panel observed the following:

- effective therapeutic supports within out of home care placements are 'essential to ensuring sustainability of placements'
- maintaining connections with family and kin, where possible, is a primary influencer of stability in an out of home care placement, and 'more could be done' in the Tasmanian system to prioritise the importance of relationships to promote placement stability
- additional placement options and new programs that support cultural connection and the concept of being 'On Country' should be introduced to enhance offerings in the out of home care system.[323]

The expert panel recommended that the Tasmanian Government funds new therapeutic programs that incorporate the positive elements of the Many Colours One Direction program, including individualised assessment, care arrangements, education and prosocial activities.[324] Such programs should:

- enable cultural connection
- include respite and mentoring
- include short to medium-term residential placement options
- embed flexible education models linked to the Australian Curriculum and vocational pathways for young people for whom mainstream educational settings are not productive

- be delivered by multiple entities and in a range of locations to avoid the stigmatisation of children and young people who access the program, as well as their families and communities and the organisation and the people who deliver them.[325]

While the expert panel did not recommend setting up such a program specifically for Aboriginal children, it recommended that the Government invests in 'genuine partnerships with the Aboriginal community' to support self-determination and build capacity towards Aboriginal organisations providing out of home care.[326] The Tasmanian Government accepted the recommendations of the expert panel, and Secretary Bullard advised us that the panel is considering proposals that have been submitted for a 'Wellbeing, Care and Recovery Placement Program'.[327]

We see considerable benefit in developing local, Aboriginal-led, trauma-informed residential programs for Aboriginal children in out of home care for whom an appropriate family-based placement with an Aboriginal carer cannot be found. Such programs must be designed in partnership with local Aboriginal communities and young people and be embedded in culture. They should ideally be on Country and incorporate culturally safe mental health, drug and alcohol and general health supports, as well as cultural, mentoring and education programs. They must be run by child-safe organisations. They should not be seen as a substitute for strategies and support to increase recruitment and retention of Aboriginal kinship and foster carers.

5.3.4 Participation

Aboriginal children, parents and family members must be able to participate in all child protection decisions affecting them, including placement decisions.[328] According to the national 2021 *Family Matters* report, this requires practices such as Aboriginal family-led decision making and 'respect and acknowledgment of cultural authority and traditional child-rearing practices'.[329]

The 'participation' element is reflected in Standard 3 of the national out of home care standards, which requires that Aboriginal communities 'participate in decisions concerning the care and placement of their children and young people'.[330]

Queensland and Western Australia have statutory frameworks for Aboriginal children and families taking part in child safety decision-making processes. The Queensland Child Protection Act has a framework for an 'independent Aboriginal or Torres Strait Islander entity' ('independent person') to be involved in decision making about an Aboriginal child.[331] The independent person's role may also include:

- supporting the child and family during meetings with the Child Safety Service
- helping the family to share cultural information relevant to decision making for the child

- providing contextual information about Aboriginal tradition, the family group and their community
- supporting the child's and family's input
- helping the Child Safety Service understand this information.[332]

In Western Australia, amendments to the *Children and Community Services Act 2004* (WA) (made in 2021 but yet to begin operation) require the Chief Executive Officer of the Department of Communities to consult with Aboriginal family and community members before making a placement arrangement for an Aboriginal child.[333] This approach is being piloted in two locations in Western Australia.[334] In Tasmania, the Children, Young Persons and Their Families Act has a statutory framework for family group conferencing.[335] Where a family group conference is convened for an Aboriginal child, the Act requires the facilitator of the conference to consult with an appropriate 'recognised Aboriginal organisation' about who should be invited to attend the conference.[336] While the facilitator may invite a person nominated by a recognised Aboriginal organisation to the conference, there is no obligation to do so.[337]

According to SNAICC this legislative framework falls short of the necessary criteria to effectively implement the 'participation' element of the Placement Principle, particularly given there is no framework for Aboriginal family-led decision making in Tasmania.

We note that departmental practice advice for care teams and care planning states that, if a child identifies as Aboriginal, it is important that 'a representative from their culture and community' is included in the care team, but the Department cannot say how often this occurs due to data system limitations.[338]

Secretary Bullard advised us of the new 'Child Safe and Supported Policy Partnership Working Group', formed in January 2022 and involving the Tasmanian Aboriginal Centre and Services for Children and Families.[339] Secretary Bullard said:

> The aim of the working group is to give Aboriginal families and communities the opportunity and empowerment to lead in a culturally appropriate manner and to make decisions in relation to their particular circumstances.[340]

We welcome any progress that the Tasmanian Government is making to improve its implementation of the Placement Principle. We encourage the Government to honour its commitments under the *Safe and Supported Aboriginal Action Plan* to improve the safety of Aboriginal children in care.

Aboriginal organisations and communities may have divergent views and we therefore encourage the Government to engage with as many Aboriginal organisations and communities as possible to deliver on its commitment.

The existing framework for the participation of recognised Aboriginal organisations appears unused. The Children, Young Persons and Their Families Act enables the Minister to declare an organisation to be a recognised Aboriginal organisation after 'consulting with the Aboriginal community or a section of the Aboriginal community'.[341] The Act does not specify criteria that an organisation must meet to be declared a recognised Aboriginal organisation. We could not identify any organisations that have been declared as Aboriginal organisations under the Act.[342]

Once recognised, Aboriginal organisations will need more resourcing so they can participate in decision making for Aboriginal children consistent with the participation element of the Placement Principle.

In terms of Aboriginal children taking part, the Act requires that children be given the opportunity to express their views about out of home care decisions that will affect them, and that those views be considered, recognising the child's maturity and understanding.[343]

In Tasmania, the Child Advocate acts on behalf of children and young people in care (note that, in Recommendation 9.33, we recommend changes to the role of the Child Advocate to provide it with greater independence). There is no role dedicated solely to advocating for Aboriginal children and young people in out of home care in Tasmania.

Other jurisdictions have offices dedicated to protecting the interests of Aboriginal children. For example, Richard Weston, New South Wales Deputy Children's Guardian for Aboriginal Children and Young People, said that one of the objectives of his role is to ensure a 'high standard of practice is met for Aboriginal children and young people in care' by out of home care providers.[344] Victoria and South Australia each have a Commissioner for Aboriginal Children and Young People. In May 2020, Queensland appointed Natalie Lewis, a descendant of the Gamilaraay Nation, as a Commissioner for the Queensland Family and Child Commission to support the Principal Commissioner 'with a strong and renewed focus on the systemic and structural issues disproportionately affecting Aboriginal and Torres Strait Islander children' in Queensland.[345] Legislation to establish an Aboriginal and Torres Strait Islander Children and Young People Commissioner in the Australian Capital Territory was passed on 29 November 2022.[346]

The 2021 *Family Matters* report recommended that an Aboriginal children's commissioner be established in every state and territory, with legislated powers and functions to pursue better services for all Aboriginal children within their jurisdiction.[347] At the national level, the *Safe and Supported Action Plan* has committed the Commonwealth to establishing a National Advocate for Aboriginal and Torres Strait Islander Children.[348]

The 2014 *luwutina mana-mapali krakani waranta* report recommended that the Tasmanian Government investigates setting up an Aboriginal children's commissioner based on the Victorian model, to oversee the implementation of child welfare and child protection services for Aboriginal children.[349]

In our view, establishing an independent Tasmanian Commissioner for Aboriginal Children and Young People, with legislated powers and functions to monitor the experiences of Aboriginal children in out of home care and youth detention, and to promote the safety and wellbeing of Aboriginal children more broadly, would provide an effective way to promote the voices of Aboriginal children. The Commissioner for Aboriginal Children and Young People should work in partnership with the Commissioner for Children and Young People as part of a new Tasmanian Commission for Children and Young People, which has broader oversight functions than those of the current Commissioner for Children and Young People (refer to Chapter 18 for a discussion of the new Commission and to Section 12.6 of this chapter for a discussion of the new Commission's recommended oversight functions for out of home care).

The Western Australian or Queensland models for ensuring Aboriginal children, parents and family members participate in placement decisions may work well in Tasmania. Both models allow Aboriginal community organisations to play a role in facilitating participation and have the benefit of enabling existing Aboriginal community organisations or groups with local cultural knowledge of children and families within specific regions or areas to participate in child safety decision making for Aboriginal children in their communities. These organisations do not have to be direct service providers. The focus should be on receiving input from local Aboriginal communities. Given that the Act already includes the notion of 'recognised Aboriginal organisations', we recommend that this mechanism be used to implement the Western Australian model in Tasmania.[350]

In our view, there should be a legislative framework for recognised Aboriginal organisations to participate in child safety decision making, as in Western Australia. In particular, the Secretary should be required to consult a recognised Aboriginal organisation, nominated by an Aboriginal child (or sometimes their family of origin), before making any significant child safety decision for the child. At a minimum, consultation should occur before a decision is made to remove an Aboriginal child, and before any decision about placement. This should limit the number of Aboriginal children removed from their families of origin and allow more Aboriginal children to be placed with Aboriginal carers in keeping with the Placement Principle. Connection with family, community and culture are critical protective factors to protect Aboriginal children from child sexual abuse.

The Office of Aboriginal Policy and Practice (refer to Recommendation 9.7) should help establish recognised Aboriginal organisations, including promoting their role, encouraging organisations to apply for approval, and building their capacity to participate in child safety decision making.

Establishing recognised Aboriginal organisations in different regions of Tasmania could also provide a way to support the future delegation or transfer of child safety functions and powers in respect of Aboriginal children (referred to above under 'Partnership').

5.3.5 Connection

The 'connection' element of the Placement Principle is concerned with ensuring Aboriginal children in out of home care—particularly those placed with non-Aboriginal carers—are supported to stay connected to their family, community, culture and Country.[351]

Connection to culture plays an important role in protecting Aboriginal children in out of home care against sexual abuse.[352] The National Royal Commission found that the disconnection from culture that can occur when an Aboriginal child is placed with a non-Aboriginal family is a factor that increases the risk that victim-survivors of child sexual abuse in out of home care will be unable to disclose that abuse.[353]

The 'connection' element requires cultural support plans to be developed, resourced, implemented and regularly reviewed for every Aboriginal child in out of home care.[354] This is consistent with Standard 10 of the national out of home care standards, which requires that children in care be supported to develop their identity through contact with their families, friends, culture, spiritual sources and communities.[355] It also aligns with Standard 4, which requires that each child in care has an individualised plan that details their health, education and other needs.[356]

The 'connection' element also requires a focus on family reunification, with reunification planning starting early and measures put in place to support reunification where it is possible.[357]

We heard from many Aboriginal community members about the loss of cultural connection experienced by Aboriginal children who are taken into care. One Aboriginal Elder said that the worst thing about Aboriginal children being sent to live with non-Aboriginal people was that they were no longer connected with their parents and culture.[358]

As outlined above, cultural support plans are an important means for maintaining an Aboriginal child's connection to culture while in out of home care. A cultural support plan is an integral part of their overall care plan and 'gives the child the opportunity to build a nurturing network around them and, in this way, develop their identity and sense of belonging'.[359]

According to the New South Wales Deputy Children's Guardian for Aboriginal Children and Young People:

> If a child is removed from their family and placed into out of home care, there should be a good cultural plan that keeps them connected to who they are, who their mob is, and that honours, respects and strengthens their identity as Aboriginal children and young people.[360]

We could not find out the proportion of Aboriginal children in Tasmanian out of home care with a cultural support plan. Nor could we locate any Child Safety Service policies or practice advice on preparing cultural support plans for Aboriginal children in out of home care. Unlike in other jurisdictions such as Victoria, Tasmanian legislation does not require a cultural support plan to be prepared for Aboriginal children under the guardianship of the Secretary.[361]

In 2019, the Tasmanian Commissioner for Children and Young People found that Aboriginal cultural planning was not being consistently conducted for Aboriginal children in out of home care.[362]

The Commissioner for Children and Young People reported that:

- Where cultural support plans had been prepared, they were often developed 'without ascertaining adequate knowledge of the child's cultural identity and community connections or their views'.[363]
- Some non-government out of home care providers appeared unsure about their responsibilities for developing cultural support plans for Aboriginal children, and most did not have the internal resources to undertake cultural planning.[364]

Standard 6 of the *Tasmanian Out of Home Care Standards*, released in June 2022, requires that out of home care providers support Aboriginal children to maintain connection to their family, community and culture in keeping with the Placement Principle, while Standard 7 requires providers to meet the cultural needs of Aboriginal children by implementing 'culturally safe' strategies.[365]

Meaningful cultural support planning is not a straightforward exercise. It should be led by those with cultural knowledge and expertise. It should be guided by and involve the child, family members, kin, Elders or others with cultural authority for the child, and Aboriginal organisations.[366] Those organisations should be supported and resourced to participate in developing and implementing cultural support plans.

Carers, Child Safety Officers and other people who are important in the child's life should also participate in developing cultural support plans.[367] Once a cultural support plan is developed for an Aboriginal child, it should be reviewed regularly to ensure the child's cultural connections are being maintained and their cultural needs are being met.[368]

Expectations for non-government out of home care providers should be clarified for developing and implementing cultural support plans for Aboriginal children. Although it is not appropriate for such providers to lead cultural planning processes, they should be expected to support and help develop and implement plans to ensure Aboriginal children in their placements are connected to community and culture. Clearly, this is particularly important when children have been placed with non-Aboriginal carers, noting that this should be a last resort under the Placement Principle.

5.4 Strengthening implementation of the Placement Principle

The Tasmanian Government has committed to implementing the Placement Principle, but we saw little evidence of implementation activity occurring before or during our Inquiry. The inadequacy of these efforts means Aboriginal children in Tasmanian out of home care have been at increased risk of sexual abuse.

We recommend that the Government fully implements all elements of the Placement Principle. This will require many measures to be undertaken to address the various elements of the Placement Principle. Implementing all these measures should help keep Aboriginal children and young people safe from sexual abuse in out of home care. These measures need to be implemented to ensure the system works in the interests of Aboriginal children.

More generally, the Government should adopt and report on measures to reduce institutional racism and support decolonising practices in the Department to reduce the over-representation of Aboriginal children in out of home care. Through ongoing evaluation, the Department should monitor the sense of cultural safety experienced by Aboriginal staff, Aboriginal carers and Aboriginal children in care—as with all evaluation, the results should be reported publicly.

This recommendation complements many of the other recommendations in this chapter and report, by establishing:

- an Office of Aboriginal Policy and Practice in the Department, with an Executive Director for Aboriginal Children and Young People who is responsible for overseeing the implementation of our recommendations for Aboriginal children in out of home care (refer to Recommendation 9.7)
- a Quality and Risk Committee to receive reports from the Executive Director for Aboriginal Children and Young People (refer to Recommendation 9.5).

Recommendation 9.14

The Tasmanian Government should appoint a Commissioner for Aboriginal Children and Young People with statutory powers and functions to monitor the experiences of Aboriginal children in out of home care and youth detention.

Recommendation 9.15

The Tasmanian Government should fully implement all elements of the Aboriginal and Torres Strait Islander Child Placement Principle by:

a. increasing investment in Aboriginal-led targeted early intervention and prevention services for Aboriginal families, including family support and reunification services, to a rate equivalent to the representation of Aboriginal children in the Tasmanian child safety system

b. adopting and reporting on measures to reduce institutional racism and supporting decolonising practices in the Department for Education, Children and Young People to reduce the over-representation of Aboriginal children in out of home care

c. ensuring that the Aboriginal status of all Aboriginal children in contact with Child Safety Services is accurately identified and recorded at the earliest opportunity, and appropriately shared with non-government out of home care providers and carers

d. introducing legislation to amend the *Children, Young Persons and Their Families Act 1997* to

    i. require decision makers to consult with a relevant recognised Aboriginal organisation in relation to any decision likely to have a significant impact on an Aboriginal child—in particular, decisions about whether to remove a child from their family and where a child should live

    ii. require the involvement of a relevant recognised Aboriginal organisation nominated by an Aboriginal child, or their advocate, in family group conferences, case planning and cultural support planning in respect of the child

    iii. create a statutory framework and plan co-designed with Aboriginal communities for transferring child safety decision-making authority for Aboriginal children to recognised Aboriginal organisations

e. partnering with Aboriginal communities to

   i. promote and support establishing recognised Aboriginal organisations with local knowledge of Aboriginal children, families and communities, to facilitate the participation of Aboriginal children and families in child safety and out of home care decision-making processes

   ii. develop a model or models for the transfer of child safety decision-making authority to recognised Aboriginal organisations

   iii. invest in recognised Aboriginal organisations' capacity to ensure they are fully resourced, and their workforces fully equipped and supported, to participate in child safety and out of home care decision-making processes for Aboriginal children, including involvement in cultural support planning, and to manage any transfer of decision-making authority for Aboriginal children

f. designing and establishing, in partnership with Aboriginal communities, fully resourced, Aboriginal-led, therapeutic residential programs for Aboriginal children who have been removed from their families and for whom an appropriate placement with an Aboriginal carer cannot be found

g. implementing systems to ensure every Aboriginal child in out of home care has a meaningful cultural support plan prepared by or with the involvement of a recognised Aboriginal organisation or an Aboriginal person with relevant cultural knowledge, and regularly reviewing cultural support plans to ensure cultural connections for Aboriginal children are being maintained

h. ensuring non-government out of home care providers comply with the 'placement' and 'connection' elements of the Placement Principle

i. ensuring the Aboriginal status of carers is identified and accurately recorded

j. providing mandatory professional development to Child Safety Services staff to ensure all interactions with and responses to Aboriginal children, families and organisations are culturally safe.

6 Supporting quality care

In Section 3, we recommend that, as part of the process of outsourcing out of home care services, the Department should remain responsible for strategic leadership and ensuring the quality of care that children in out of home care receive. In this section, we consider ways to support the quality of care Child Safety Service staff provide.

A significant proportion of departmental Child Safety Officers are involved in providing case management for the just over 1,000 children in care, under delegation from the Secretary. In this section, we recommend changes to the structures and practices of the Child Safety Service that will enhance the capacity of departmental staff to have 'eyes on' children in care which, in turn, will enable them to identify and respond to risks of child sexual abuse at the earliest possible opportunity. It will also increase opportunities for children in care to develop trusted relationships with adults, which is a protective factor in preventing child sexual abuse.[369] The purpose of our recommendations in this section are to ensure:

- all children in care have an allocated case manager who can be proactive and responsive to children's safety needs
- practice expertise is embedded at all levels of the Child Safety Service, ensuring accessible clinical supervision and reflective practice for Child Safety Officers
- trauma-informed therapeutic models of care are adopted for out of home care, which includes guidance on how departmental staff engage with children and families
- all Child Safety Service staff, carers and volunteers practise and understand standards of ethical conduct.

6.1 Case management

In Tasmania, Child Safety Officers are responsible for case management tasks for children in care, such as:

- establishing and facilitating a care team around the child
- coordinating the development and delivery of the child's care plan
- advocating for the child to access services to meet their needs
- identifying and supporting efforts to ensure the child is loved and safe
- maintaining a connection with the child to understand their views
- monitoring and responding to children's safety.[370]

The National Royal Commission found that when child protection staff have large caseloads, the risk of sexual abuse to children in care increases.[371] We heard that Child Safety Officers in Tasmania carry high caseloads, which diminishes their capacity to care for individual children; in particular, their ability to visit children regularly, attend to the child's case management needs and develop a relationship with each child.[372]

In her second monitoring report, the Commissioner for Children and Young People said that during the 2020–21 financial year, only 56.2 per cent of visits to children in care by their Child Safety Officer were conducted within the required timeframes.[373] The Community and Public Sector Union reported the comments of one Child Safety Officer: 'without workers to know and support these children there is no one to hear their voices and action what they need'.[374] As Faye (a pseudonym) told us (refer to Chapter 8), if a Child Safety Officer had visited more often, she may have disclosed the alleged abuse earlier.[375]

While Claire Lovell, the Executive Director of Children and Family Services, stated that the average caseload for a Child Safety Officer should be 15 children, we heard that some officers had carried caseloads of 50 children.[376] The Community and Public Sector Union reported an anonymous Child Safety Officer as saying a fair caseload was between six and eight for newer staff, no more than 10 for more experienced staff and a caseload of '15 [plus] is not realistic when they want us to do everything'.[377]

Some children do not have case workers at all. One child in care interviewed for our commissioned research said:

> I didn't even know my case worker back then … I don't have one now. I'm on an order but I don't have one. Child protection have not assigned me a case worker, I haven't got one, but I've got someone who's higher up trying to fill those shoes but you're not doing the same job because you're not seeing me.[378]

Ms Lovell told us that, as of 19 July 2022, 107 children in care did not have a Child Safety Officer directly allocated to them, which equated to approximately 10 per cent of children in care.[379] She said that these 107 children have been allocated to a team, members of which were collectively responsible for them. She acknowledged that these children will not receive the same level of support as children with an allocated Child Safety Officer.[380]

On 18 October 2022, during our Commission of Inquiry, the Leader of the Opposition made claims in the Tasmanian Parliament that the Department had removed active case management from all children in care on 18-year guardianship orders (children who will be in care until they turn 18). The Government did not respond directly to this claim.[381] On 27 October 2022, a teenager under an 18-year order, who had been in care for seven years, told us her Child Safety Officer had informed her on 29 September 2022 that:

> … about 300 children and young people were going to be removed from their [Child Safety Officers] and were going to be moved to two teams. Meaning me and all the other children on 18 Year Orders would have no worker of our own.[382]

This young person expressed concern about the 'mental trauma' this decision could cause, describing the support a Child Safety Officer can provide: 'While I am loved and safe, what about other children and young people that need someone looking out for them'.[383]

On 19 December 2022, the Commissioner for Children and Young People announced that she was conducting an 'own motion' investigation into the Department's new 'case management model', requesting submissions by 24 February 2023.[384]

In our view, it is essential that the Department ensures all children in care have a case manager. Also, current caseloads are unsustainable and potentially unsafe. We suggest the Government follows the example of other jurisdictions, such as Western Australia, by setting a maximum caseload for Child Safety Officers. This would allow them more time to invest in each child in care and improve child safeguarding.[385] We recommend key case management figures and activities are reported regularly, as they are in Queensland.[386]

Developing a workforce strategy (refer Recommendation 9.10) should help ensure there are enough Child Safety Officer positions for officers to safely meet their case management responsibilities for children in care.

Recommendation 9.16

1. The Department for Education, Children and Young People should:
    a. ensure all children in care, including those on guardianship orders until age 18, have a case manager
    b. set a maximum case load for Child Safety Officers.
2. The Department should report quarterly to the Quality and Risk Committee on the:
    a. number of children without an individual case manager
    b. average case load for Child Safety Officers
    c. average frequency of case manager visits children received, and the longest and shortest time periods between visits
    d. the number of children with a care team and Aboriginal representatives on the care team (where appropriate)
    e. average frequency of care team meetings
    f. percentage of children with a current care plan.
3. The Department should ensure these figures are published quarterly on its website.

6.2 Clinical supervision

The National Royal Commission found that a lack of clinical supervision for child protection workers increases the risk of child sexual abuse in institutional contexts.[387] Many child protection and out of home care systems use clinical practice supervision to support their frontline staff to make better clinical decisions, stay longer in the role and manage their vicarious trauma.

Dr Miller, from MacKillop Family Services, described the benefits of embedding clinical supervisors in the Victorian department's child protection teams.[388] Locating practice leadership close to the frontline of care modelled good practice for less experienced Child Safety Officers, who could get advice and support in real time.[389]

Secretary Pervan told us that the Department had made some moves towards improving clinical supervision by separating clinical practice from operational management and employing Practice Managers whose 'entire role' is to provide clinical supervision.[390] We understand that although they do not have designated caseloads, Practice Managers are required to pick up unallocated cases due to high rates of Child Safety Officer absence, which must detract from their ability to fulfil their substantive roles.[391]

We were also told of additional roles of Clinical Practice Consultants and Educators that support clinical practice.[392] However, we are unclear how many roles exist and where these positions sit within the structure of the Department. These positions could play a vital role in supporting good clinical decision making, particularly if they are in the Child Safety Service centres around the State for easy access by staff.

Regular clinical supervision can be deprioritised when workload pressures are high. It is important, therefore, that the Department ensures adequate funding and staffing is provided to allow time and capacity for appropriate supervision.[393]

In a small jurisdiction such as Tasmania, it may be difficult to attract practitioners with the experience and aptitude to effectively perform supervisory roles. We are concerned that some Practice Managers may have been fast-tracked to supervisory positions without the necessary experience.[394] Clinical supervisors must have enough experience in child protection to offer evidence-based advice on complex cases. Until enough experience is gained, the Department should ensure it funds virtual clinical supervision from other locations, including interstate, or consider using group supervision as a resource-effective approach.

Deborah Brewer, who managed the Department's Quality Improvement and Workforce Development team from 2017 to 2019, told us that when she worked in the Department, 'practice advisors' for the various regions were in one office in Hobart and were not present on the frontline.[395] In the three years since that observation was made, we hope that supervisors have been moved to regional offices. In any event, we recommend that clinical practice supervisors be co-located with Child Safety Officer teams.

Dr Miller and Ms Taylor also described the importance of having a Chief or Lead Practitioner in their respective departments. In South Australia and Victoria, the Chief Practitioner leads the clinical practice of child protection and out of home care through developing materials and resources, translating research into practice, overseeing clinical supervision for practitioners and consulting on difficult and complex cases.[396]

The Department does not have such a role formally in place currently, but it is our view that the Child Advocate is performing many functions of a Chief Practitioner alongside her advocacy duties.[397] However, as only one person, the Child Advocate does not have capacity to fully enact the role of Chief Practitioner as it is needed in the Department.

In our view, the role internal to the Department should have clarity—that of Chief Practitioner. Below, we recommend a new Child Advocate functioning as an external advocate for children (refer to Recommendation 9.33).

The Chief Practitioner should focus on developing the clinical capacity of practitioners, keeping the Department's practice up to date, developing trauma-informed out of home care and managing clinical supervision arrangements for practitioners. The Chief Practitioner should also be responsible for quality assurance measures, including conducting file audits and receiving care concerns (which we discuss in Section 11) and working closely with the Quality and Risk Committee to monitor data to identify systemic strengths and weaknesses within practice across the Child Safety Service and out of home care.

The Office of the Chief Practitioner should have a close working relationship with the Department's Learning and Development team, ensuring workforce development of the Child Safety Service and out of home care is designed and delivered to support the workforce to deliver best practice. To enhance knowledge and practice across the sector, the Office of the Chief Practitioner may also support the Department's strategic partnerships and collaboration, including with research and teaching institutions and non-government service delivery partners.

The Office of the Chief Practitioner will need dedicated support staff and would likely supervise the Practice Managers and Clinical Practice Consultants and Educators.

The Chief Practitioner should also lead the Harmful Sexual Behaviours Support Unit, which we discuss in Section 10.1.

6.3 Trauma-informed, therapeutic models of care

A history of trauma increases a child's vulnerability to being sexually abused in care and/or engaging in harmful sexual behaviours.[398] Addressing trauma will reduce a child's risk of sexual abuse in care.

Dr Miller told us that the out of home care system must be trauma-informed at its core: '[It] has to be designed on an assumption that children have experienced trauma' when they enter care.[399] Such a system should provide direct specialist therapy services for children to address their abuse and trauma symptoms (such as with a specialised counsellor) and day-to-day care that is informed by an understanding that children in care are often traumatised.[400] We discuss specialist trauma therapy in Section 8.2.

Julian Watchorn, the Clinical Psychologist from the Foster and Kinship Carers Association of Tasmania, considered that children should be screened for trauma symptoms as soon as they come into care to understand their specific trauma triggers and to assess their specific trauma therapy needs.[401] One child in care interviewed for our commissioned research talked about how each child has unique needs:

> Being kind and always making sure they take into consideration [the child's] feelings, and things, so that the young person feels like they can trust them. Well, I think the people that are carers, or are looking after the children, need to be very understanding and have to know that not every child is going to be the same, or even sometimes not similar whatsoever. It's very important that they are open to different [behaviour] … There's going to be challenges that they might have never experienced before, and they need to know how to deal with those instead of having a more violent or worse reaction.[402]

Dr Watchorn told us that without assistance, adults can find it difficult to recognise symptoms of trauma in children, but when they understand a child's trauma history and symptoms, they can respond therapeutically.[403] Another child in care interviewed for our commissioned research said that carers struggled to understand their trauma responses:

> Those next carers, there was a couple, they couldn't deal with me and [my sister's] emotional trauma. It sort of triggered them, so they had to move on, and we moved to somewhere that was two hours away from [where we went to school and had friends] and so I was at that point where I was like, 'I'm not standing for change anymore. I'm not standing for people just kind of pushing me around'.[404]

Experienced carer Mary Dickins told us that the carer screening and education sessions 'Shared Stories Shared Lives' is a 'good start' for educating carers about out of home care and why children are removed, but doesn't go far enough to prepare carers for the presentations of trauma and the task of therapeutically parenting a traumatised child.[405] She said skill development and support in 'therapeutic parenting and trauma-informed parenting are integral to being a better parent to [children in care]'.[406] We discuss the need for carer education in Section 4.6.

Some non-government out of home care providers who operate in Tasmania, such as Life Without Barriers, use a specific trauma-informed therapeutic model of care in their services. This does not appear to be the case for all providers.[407] The Commissioner

for Children and Young People reported that only one non-government out of home care provider was funded to provide 'Therapeutic Residential Care' and the remainder provided 'other residential care'. We detail the types of care provided by various agencies in Chapter 7.[408]

Other jurisdictions have implemented agency-wide, trauma-informed approaches to ensure all children in care receive a trauma-informed therapeutic response, regardless of which care setting they live in. For instance, the Victorian Aboriginal Child Care Agency has embedded a trauma-informed therapeutic approach called Cultural Therapeutic Ways across the agency.[409] Although culturally specific to working with Aboriginal families, a core principle of this approach is an understanding of trauma that translates to all care settings.[410]

Similarly, MacKillop Family Services implements a trauma-informed framework called the Sanctuary Model across the organisation.[411] Every staff member at MacKillop Family Services has been trained in the model, which has measurably improved communication and morale among staff, reduced incidents of violence from children to staff by 41 per cent and reduced staff turnover for several years.[412] Staff have also been trained in an evidence-based 'Therapeutic Crisis Intervention' model.[413]

The South Australian Department for Child Protection has adopted the Sanctuary Model in its residential care settings.[414] Dr Miller thought that such a model could also be implemented in Tasmania, but she cautioned that to do this well, would require leadership and more resourcing from the Department.[415]

While the Department has taken some steps to delivering more trauma-informed, therapeutic care, the results are not yet consistent or comprehensive. Tasmanian children in care are not guaranteed to receive a trauma-informed service.

To reduce the risk of sexual abuse in care, the Department should assess children coming into care for trauma, and fund enough therapeutic support for those who need it. This assessment should be done through the holistic assessment we recommend in Section 8 (Recommendation 9.23). Also, the Department should adopt a whole of organisation, evidence-based approach to trauma-informed care for all children living in the out of home care system, regardless of setting.

The Department should lead the sector by identifying the key components of a trauma-informed, therapeutic model of care for out of home care. The Department should require non-government out of home care providers to deliver services that align with these key components of a trauma-informed therapeutic model of care and report on how it is provided. This work should be led by the Chief Practitioner.

Recommendation 9.17

1. The Department for Education, Children and Young People should appoint a Chief Practitioner to lead clinical practice and quality assurance across Child Safety Services, the Strong Families, Safe Kids Advice and Referral Line, and out of home care.
2. The Chief Practitioner should lead an Office of the Chief Practitioner, manage a team of clinical practice experts across Child Safety Services and report to the Secretary.
3. The Chief Practitioner should be responsible for:
    a. developing the clinical capacity of practitioners through professional development and supervision
    b. informing clinical policies, procedures and practice directions to ensure they reflect best practice in child protection and trauma-informed care
    c. receiving, triaging, recording, monitoring and coordinating responses to complaints about Child Safety Services and out of home care (Recommendation 9.31) and concerns about the safety and wellbeing of children in care (Recommendation 9.32)
    d. supporting best practice responses to children in out of home care experiencing or at risk of child sexual exploitation
    e. conducting file reviews and audits to inform an understanding of current clinical practice and identify areas for reform.
4. The Chief Practitioner should:
    a. work closely with the Quality and Risk Committee to monitor data to identify systemic strengths and weaknesses within practice across Child Safety Services and out of home care
    b. have a close working relationship with the Department's Learning and Development team, ensuring that workforce development of Child Safety Services and out of home care is designed and delivered to support best practice service provision
    c. support the Department's strategic partnerships and collaboration where appropriate, including with research and teaching institutions and non-government service delivery partners to enhance knowledge and practice across the sector (Recommendation 9.13).

5. The Department should ensure clinical practice experts are located in all regional offices of Child Safety Services across the state.
6. The Chief Practitioner should lead the Harmful Sexual Behaviours Support Unit (Recommendation 9.28).

Recommendation 9.18

1. The Department for Education, Children and Young People should require out of home care to be trauma-informed and therapeutic and identify the key components of trauma-informed, therapeutic models of care.
2. The Department should require non-government out of home care providers to deliver services that align with these key components of trauma-informed, therapeutic models of care, noting some providers have already adopted such models of care.
3. The Department should ensure children are assessed for trauma symptoms when entering care through the holistic assessment (Recommendation 9.23) and, where needed, receive appropriate therapy and intervention for their trauma.

6.4 Professional conduct policy

Research for the National Royal Commission found an increased risk of institutional child sexual abuse when expectations of conduct between children and staff are not made clear or are not consistently enforced.[416] The National Royal Commission recommended that a code of conduct have the following characteristics:

- applies to all staff and volunteers, including senior leaders and board members
- clearly describes acceptable and unacceptable behaviour of employees and volunteers towards children (for example, by illustrating behaviours with relevant examples)
- is communicated effectively to all staff
- requires signed acknowledgment by all staff and volunteers
- is published and is accessible to everyone in the institution (including children and families) and communicated throughout the institution using a range of modes and mechanisms

- if breached, requires a prompt response and includes clearly documented response mechanisms, on a continuum from remedial education and counselling through to suspension, termination and official reports.[417]

A number of people familiar with the out of home care sector told us that they believe child protection staff, carers and support workers need a robust and transparent code of conduct that clearly outlines standards and expected behaviour when interacting with and caring for children in care.[418]

Before 2023, the only policy relevant to conduct we could identify was the Department's *Code of Conduct for Approved Carers,* which covered topics such as the expected set up of physical facilities, confidentiality and providing timely medical attention for children in care. We could not find any policy that addressed appropriate conduct for protecting children from sexual abuse, such as grooming behaviour.[419] In February 2023, Services for Children and Families added an interim *Child Safe Code of Conduct* ('Interim Code') onto the Practice Manual intranet site that applies to 'all adults in Child Safety [Services]', including staff and volunteers.[420] It is described as:

> … an interim Child Safe Code of Conduct until a decision is made regarding the development of a broader Code for the Department as part of the National Child Safe Standards and Child and Youth Safe Organisations Framework for Tasmania.[421]

The Interim Code has many of the characteristics recommended by the National Royal Commission; for example, it applies to all staff and volunteers, clearly describes positive and unacceptable behaviours, including grooming, and requires signed acknowledgment. We recommend the Department builds on the Interim Code to develop and implement a professional conduct policy that has a specific code of conduct for all employees and volunteers in out of home care, and that includes all the core components described by the National Royal Commission above.

The professional conduct policy may differentiate between general principles and those specific to particular roles, such as carers or professional staff. The policy should contain important common information for all roles, including what constitutes a boundary violation, grooming behaviour and conflicts of interest.

We recognise, however, that the professional boundary expectations of a case manager will be different from that of a foster or kinship carer who is acting as the child's parent and may have cared for a child from infancy. There is a need in developing conduct policies to differentiate the expectations for different roles, and particularly for carers to be aware of a child's safety *and wellbeing* needs, including the need for nurturing and affection.

The professional conduct policy should address the challenges of maintaining professional boundaries in small communities, such as those in Tasmania, because of the presence of dual roles and inherent conflicts of interest. For example, a Child Safety Officer may need to investigate a family that attends the same school as their children, and the officer may use information they are privy to through social contacts as part of their assessment, in preference to proper procedures. In a larger jurisdiction, there are enough staff for another Child Safety Officer to step in so that roles and relationships remain more defined. 'Suspension 3' in Chapter 8, is an example of how professional boundary breaches can occur in child protection.

In the professional conduct policy, the Department should adopt a low tolerance approach to breaches. In relation to staff, the policy should spell out a process for reporting and responding to breaches. The professional conduct policy should direct that violating the code is grounds for disciplinary processes under Employment Direction No. 5—Breach of Code of Conduct (refer to Chapter 20) and will be managed by the Child-Related Incident Management Directorate (refer to Recommendation 6.6). In relation to carers, the policy should direct a breach to be reported to the Department for triaging by the Chief Practitioner in line with the new policy to guide responses to concerns about the safety and wellbeing of children in care (refer to Recommendation 9.32).

The National Royal Commission also recommended that education for institutional staff on problematic behaviours and boundary violations would prevent and identify grooming because it 'not only provides a basis for staff to recognise problematic behaviour but also potential offenders will know their behaviour is subject to scrutiny'.[422] We recommend mandatory, ongoing education on the professional conduct policy for all adults involved in out of home care.

Recommendation 9.19

1. The Department for Education, Children and Young People, in developing a professional conduct policy (Recommendation 20.2), should ensure:
    a. there is a separate professional conduct policy for staff who have contact with children and young people in Child Safety Services and out of home care
    b. the professional conduct policy for Child Safety Services and out of home care, in addition to the matters set out in Recommendation 20.2, specifies expectations outlined in other relevant policies and procedures, including the policy on concerns about child safety and wellbeing and the duty of care owed by staff members
    c. the professional conduct policy for Child Safety Services and out of home care articulates expected standards of behaviour for volunteers, contractors and sub-contractors, and carers

d. the Department uses appropriate mechanisms to ensure compliance by volunteers, contractors and sub-contractors, and carers with the professional conduct policy for Child Safety Services and out of home care.

2. The Department should develop guidance material and information sessions for children in care about the expected behaviour of carers, staff, volunteers and adults in their lives.

6.5 Record keeping and risk assessments

The National Royal Commission found that accurate record keeping within institutions is an important systemic and structural component of protecting children from sexual abuse.[423]

6.5.1 The current system

The Department uses two database systems to record child safety information—the Child Protection Information System and the Children's Advice and Referral Digital Interface. Since 2008, the Child Safety Service has used the Child Protection Information System to record its activities in relation to children assessed as being at risk and in need of protection, as well as for those children in out of home care.[424] Advice and Referral Line staff also use the Children's Advice and Referral Digital Interface to record 'conversations' they have with callers, which may or may not progress to a referral to the Child Safety Service for more attention.[425] If the matter is referred to the Child Safety Service, the record of the conversation is transferred to the Child Protection Information System.[426]

Ms Lovell told us that as well as recording information about each child in care in the Child Protection Information System, the Department uses this system to record information about foster and kinship carers (or 'care households'), including notes made by Child Safety Officers on activities in care households.[427] The Department can also record the details of alleged child sexual abusers on the system, referred to in the database as 'Persons Believed Responsible'.

6.5.2 Persons Believed Responsible

The Department shares information about Persons Believed Responsible with the Registrar of the Registration to Work with Vulnerable People Scheme every day.[428] To improve data collection, the Department decided in 2021 to direct staff to record the alleged Person Believed Responsible on the system as soon as an allegation of harm was received, rather than waiting until the allegation was investigated or substantiated.[429]

A Person Believed Responsible can only be recorded on the Child Protection Information System and not on the Children's Advice and Referral Digital Interface.[430] Therefore, if the Advice and Referral Line does not refer a matter to the Child Safety Service for action, the alleged abuser is not recorded as a Person Believed Responsible and the Registrar of the Registration to Work with Vulnerable People Scheme will not be automatically advised of the allegation. We were also told that if the information was recorded against a Person Believed Responsible on the Child Protection Information System, it was slow and laborious to search for later.[431] Both these issues limit the Department's ability to track patterns of behaviour and multiple allegations against a particular person.

6.5.3 Limitations to access

Not all departmental staff can fully access one or both data systems. For instance, while the Child Advocate can read files on the Child Protection Information System, she cannot add to a client's file if she undertakes activities in relation to that child. Instead, she relies on handwritten notes in paper files and an email folder on her computer. She stated that plans to scan these handwritten notes into 'the system' had been repeatedly delayed.[432]

When asked about the ability of Child Safety Service managers to access information on the Department's databases about allegations of child sexual abuse, Ms Lovell responded that managers could access both data systems, but that they would need to run two searches—one in the Children's Advice and Referral Digital Interface and one in the Child Protection Information System.[433] This double-handling may increase the risk that relevant information is missed.

We heard from a current Child Safety Service staff member that while Advice and Referral Line staff (employed by the Department) have access to both databases, Child Safety Officers do not have access to the Children's Advice and Referral Digital Interface. We also heard about challenges with Advice and Referral Line staff employed by non-government organisations accessing the Child Protection Information System. This leads to a risk of information that is recorded in only one of the two systems being missed when it could be relevant to a risk assessment for a child in care.[434]

6.5.4 Recording risk assessments

As discussed in Chapter 8, we reviewed 22 case files of children in the Department's care who were at risk of sexual abuse or were displaying harmful sexual behaviours. We observed that frequently, the 'risk assessment' section of the notification record was not updated with new information to support the risk assessment—often the information appeared to have been cut and pasted from previous notification records. In one instance, the risk assessment content referred to the child being seven years of age and living with her parents, when she was in fact 17 and living in residential care. The risk assessment had not been updated from the time she was taken into care.

Accurate recording of information on assessing and managing the risk of sexual abuse for a child in care is vital. Outdated, inaccurate or insufficient information will not support the standard of risk assessment that children in out of home care deserve. The Department must address this practice urgently. The regular audits we recommend as part of the quality assurance and continuous improvement process (discussed in Section 4.2.4) should help improve record keeping.

7 Ensuring quality carers

The National Royal Commission recommended setting up a Carer Register for out of home care.[435] Carers and their households are the backbone of the out of home care system in any jurisdiction. There are many carers who provide excellent care to children under the guardianship of the Department. We also know that some carers, or those close to them, take advantage of the vulnerability of children in their care by sexually abusing them.

Carers can provide the stability and connection of a family environment for children who cannot live with their family of origin. Over time, a skilled, well-supported carer can help a child trust again, rendering them less vulnerable to being exploited and more likely to disclose if they are being sexually abused.[436] In Section 4.6, we recommend increased support and professional development for carers. In this section, we recommend all types of carers be registered with the Department, with minimum requirements for registration, and the capacity for deregistration.

7.1 Children's experiences of carers

Several children in care interviewed for our commissioned research reported positive, warm experiences in family-based (foster and kinship) care—for example, 'I felt safe all of the times, because me and my brother had wonderful carers'.[437]

Other children spoke of abuse at the hands of their carers or while under their care:

> Since I was like, what was I, 8 or 9 years old? I've been sexually, mentally and physically abused while in care, by multiple people including, like, youth and other adults.[438]

7.2 Carer screening

To become a foster carer in Tasmania, a person must complete a three-stage process whereby they: (1) participate in some basic education and screening sessions with other potential carers, called 'Shared Stories Shared Lives', (2) are subject to screening checks and (3) undertake assessment interviews.[439]

For foster carers, these checks happen before a child is placed in their care. However, we heard that kinship care arrangements were (necessarily) often organised at short notice with limited time for an assessment before initial placement—therefore, much of the assessment was instead completed after the child was placed in their kin's care.[440]

In foster and kinship care arrangements, all members of a carer's household over the age of 16 must hold Registration to Work with Vulnerable People.[441] Ms Lovell advised that carers are supposed to notify the Department if there are changes to their household makeup, to ensure any new household members over 16 years of age are also screened.[442]

7.3 Problems with carer records, assessment and review

Kim Backhouse from the Foster and Kinship Carers Association of Tasmania, expressed concern that there is 'no robust selection criteria that all new carers must meet' and that different non-government providers apply their own criteria.[443]

At the time of writing, any information that the Department holds about carers is recorded on the Child Protection Information System and the Children's Advice and Referral Digital Interface.[444] We discuss difficulties with these data systems in Sections 4.2.1 and 6.5.

In August 2022, we were advised that the Department had paused carer recruitment ('temporarily') to give itself time to ensure all existing carers had their Registration to Work with Vulnerable People.[445] We were concerned that the Department had such little oversight of carers' Registration to Work with Vulnerable People status.

We understand that it is departmental policy to review foster carers annually.[446] We also heard from the Department that the temporary pause in carer recruitment had enabled regional out of home care teams to 'continue improving the rate of up-to-date household reviews', from which we infer that such reviews were not previously up to date.[447]

Former departmental employee Sonya Enkelmann expressed concern that such reviews did not always occur.[448] Dr Backhouse was also concerned about the oversight of carers in remote areas of Tasmania because she was not confident that the Department, nor non-government out of home providers, were visiting those carers regularly.[449]

Andrea Sturges, who works in the non-government sector, said staff at Kennerley Children's Services visit their carers at least once a month for informal monitoring, as well as conducting annual reviews for quality of care and carers support plans.[450] Life Without Barriers formally reviews its carers each year.[451]

Beyond the basic screening checks described above, the Department should develop robust selection criteria that all carers must meet to be accepted and registered as carers. Moreover, the Department should ensure all out of home care providers visit carers regularly and review them at least annually.

7.4 Calls for a Carer Register

Many in the out of home care sector, including the Foster and Kinship Carers Association of Tasmania, support establishing a Carer Register.[452] The Association's 2018 survey of carers found that most also supported registration for carers, as well as mandatory training requirements for registration.[453]

Dr Backhouse suggested that a mandatory annual training schedule linked to ongoing registration would improve the consistency of care provided to children in out of home care.[454] She stated that while there are many carers who would like to receive more education and skill development, there is also a cohort of carers who do not.[455]

Dr Backhouse also highlighted a need for a formal deregistration process in cases where a child sexual abuse allegation against a carer was substantiated.[456] She recalled some type of internal process within the Department whereby a decision was made to no longer place children with that carer.[457] However, without a formal process, the carer has no right of appeal and they may be able to work in a care capacity elsewhere (including through a non-government out of home care provider), potentially posing a risk to children.[458] Dr Backhouse said that, in lieu of a formal registration/deregistration system, non-government providers also occasionally communicate between themselves to 'black ban' carers, which she pointed out was not a fair nor robust method.[459]

7.5 Kinship carers

Kinship carers look after children from their own extended family or community when the child's family of origin cannot. In Tasmania, 41.7 per cent of children under the guardianship of the Secretary live with a member of their family or community in a formal kinship care arrangement.[460]

We heard that kinship care is the Department's first choice if a child cannot live safely with their parents.[461]

While the National Royal Commission identified many benefits for children in care living with kin, they also identified some added risks of sexual abuse associated with this form of care, including:

- child protection authorities applying less rigorous screening and assessment processes to kinship carers in comparison with foster carers
- family loyalties and complex family dynamics interfering with keeping a child safe
- lower levels of monitoring, knowledge and skill development, and support for kinship carers, even though the needs of a child in a kinship care placement are likely to be equivalent to that of a child in foster care
- kinship carers facing added challenges caring for a child because they are often older (many are grandparents), financially disadvantaged and have poorer health.[462]

To address these specific risks, the National Royal Commission recommended that kinship carers receive the same education, skill development and support as foster carers, which we also recommend (refer to Recommendation 9.11). Registering kinship carers will provide a way to monitor their training and development history. The National Royal Commission also recommended a tailored approach for assessing the suitability of kinship carers.

As described briefly above, the assessment process for kinship carers does not differ substantially from the process used for foster carers. The Department should adopt a kinship care assessment approach that is informed by evidence and should consider models successfully used in other jurisdictions, which take into account that the kinship carer is being assessed to care for a child with whom they often already have a relationship.[463]

We recommend that kinship carers become registered carers as soon as possible after they take a child into their home. We recognise that many kinship carers will not be able to complete the mandatory education sessions for carer registration immediately. Therefore, we recommend initial conditional registration of kinship carers to allow them time to be supported to complete this training.

We expect the Department to provide the supports necessary for kinship carers to effectively care for the children placed with them. Kinship carers should not be disadvantaged due to issues of literacy, culture or geographical distance, and we expect the Department to sensitively assist carers to receive the support and knowledge they need to protect children in their care. In some exceptional cases, a kinship carer may have a valid reason to not participate in minimum training; therefore, kinship carers should be able to request an exemption.

7.6 Respite carers

Respite carers are essentially foster carers who will care for a child for short periods to allow the child's kinship or foster carers a break from the caring role. Foster carer Robyn Shoobridge told us that insufficient respite care meant she could not continue in her primary caring role for a child with high needs, leading to a placement breakdown and that child being cared for in a residential setting at the age of six.[464]

While respite care is clearly a vital part of the out of home care system, we heard of children being sexually abused in respite care.[465] Therefore, we recommend that registration requirements also be applied to respite carers.

7.7 Third-party guardianship

Courts make third-party guardianship orders under the Children, Young Persons and Their Families Act. This occurs on application from the Secretary of the Department, who proposes a person to become the child's independent guardian.[466] If an order is made to that effect, that person then assumes the same guardianship rights and responsibilities for the child 'as a natural parent of the child would have'.[467]

The Commissioner for Children and Young People reported that, as of 30 June 2018, 223 (or 17.5 per cent) of the children in out of home care in Tasmania were living in a third-party guardianship arrangement—a much higher rate than the Australian average of 1.4 per cent.[468] Secretary Pervan suggested that these figures had remained stable at 30 April 2022.[469]

Dr Backhouse told us that foster and kinship carers often ask to become third-party guardians for children already in their care to improve stability for those children.[470] This is referred to as a 'transfer of guardianship'. We heard it can take a long time for a transfer of guardianship to be progressed, if it happens at all.[471] The Department has not published criteria relevant to transfers of guardianship, making it difficult for carers to know if they meet the requirements.[472] This lack of transparency also makes external oversight and accountability of third-party guardians almost impossible.

The Department's position on its responsibilities for children in the care of third-party guardians is unclear. On one hand, the Department includes these children in its data dashboard of the numbers of children in care, and the Child Advocate included them in her mailout to all children in care in early 2020.[473] On the other hand, the national definition of 'out of home care' specifically excludes those children cared for by third-party guardians. We were also told that if the Advice and Referral Line was contacted about such children, they would respond in the same way as for a child who is not under the guardianship of the Secretary, so that 'children on third-party guardianship orders are not confused with children "in the care of the Secretary"'.[474]

Even if the day-to-day care of a child is provided by a third-party guardian, the Department has taken the significant step of removing that child from their family of origin and placing them permanently with another family. The Department should therefore assume some responsibility for ensuring these children are receiving safe, quality care.

We recommend that the same process for assessing, registering and monitoring all other carers applies to third-party guardians. Furthermore, if concerns are raised about the care of a child under third-party guardianship, this should be assessed through the same process as a concern about the wellbeing and safety of a child in care (refer to Section 11), not the standard Advice and Referral Line process. Supports should then be provided where appropriate, to prevent the placement from breakdown. Decisive action should be taken to protect all children, including those under third-party guardianship, from abuse in care.

7.8 Our observations

The Department has committed to setting up a Carer Register but has not done so to date.[475] We recommend that such a register sets minimum standards for screening, assessing and overseeing carers, and that all carers—foster, kinship, respite, paid residential and third-party guardians—are assessed for and meet the ongoing requirements of registration. For kinship carers, there should be conditional registration and the assessment process should be tailored to their individual context.

Once a Carer Register is established, children should only be placed with a registered carer. Carers should be required to satisfy annual reviews to maintain their status as a registered carer, and there should be criteria and processes in place for carer deregistration (which would include a breach of the professional conduct policy—refer to Section 6.4).

The Carer Register should be designed and managed in a way that makes it easy to update and allows for accurate and comprehensive information sharing across the Department's relevant data systems and the Registration to Work with Vulnerable People database. The processes and systems the Department puts in place for adding relief teachers to or removing them from the Fixed Term and Relief Employment Register, discussed in Chapter 6, could be applied to maintaining a Carer Register and deregistering carers.[476]

Recommendation 9.20

1. The Department for Education, Children and Young People should establish and maintain a Carer Register of all types of carers in the out of home care setting to ensure all third-party guardians, and foster, respite, kinship, and salaried residential carers can provide quality care to children and act protectively.
2. The Department should:
    a. set minimum requirements for registration as a carer
    b. record allegations of concern about a carer or members of their household
    c. set out a process for de-registering carers
    d. enable easy information sharing between the Carer Register, the Registration to Work with Vulnerable People Scheme and the Reportable Conduct Scheme.
3. The minimum requirements for carer registration should include:
    a. current Registration to Work with Vulnerable People and satisfactory National Police Checks
    b. best practice and tailored approaches to foster, kinship and residential carer screening and assessment
    c. mandatory knowledge and skill requirements for carers, including
        i. understanding child sexual abuse, including grooming, harmful sexual behaviours and child sexual exploitation
        ii. understanding the effects of trauma, trauma-informed care and therapeutic responses to trauma
        iii. understanding the professional conduct policy and ethical behaviour
    d. requiring other relevant adults who routinely spend time in the carer household to hold Registration to Work with Vulnerable People and to have been subject to carer assessment
    e. satisfactory annual carer reviews conducted by non-government providers and reported to the Carer Register.
4. The Department should provide for kinship carers to be provisionally registered for 12 months after assuming care of a child. During this time kinship carers should be required to complete their mandatory training requirements or apply for an exemption in exceptional circumstances.

5. Non-government out of home care providers should support kinship carers to access and complete the mandatory training required for full registration as a carer. The mandatory training should contain measures to overcome literacy difficulties, cultural difference or geographical remoteness.
6. The Department should only place children with a carer who is registered or provisionally registered on the Carer Register.
7. The Department should establish a mechanism for reviewing decisions about the registration or deregistration of carers.
8. The Tasmanian Government should adequately resource the Department to establish and maintain the Carer Register.

Recommendation 9.21

To improve placement stability and the oversight of the care of children by third-party guardians, the Department for Education, Children and Young People should:

a. make publicly available the criteria and process for a carer to become a third-party guardian
b. sufficiently resource the team responsible for third-party guardianship applications to ensure appropriate assessments and timely processing
c. require third-party guardians to be registered on the Carer Register to maintain their guardianship
d. ensure third-party guardians receive the same level of support in their caring role as received by foster or kinship carers
e. ensure children in third-party guardianship arrangements continue to have their safety and wellbeing supported and monitored (for example, through independent community visitors (Recommendation 9.34)).

8 Meeting children's needs

If a child's needs are well met in out of home care, their trauma and their vulnerability to sexual abuse are reduced. Not meeting a child's needs can increase a child's sense of isolation and disconnection that can increase their vulnerability to child sexual abuse.

In this section, we make recommendations that will assist the Department to better meet the needs of children in out of home care. Specifically, we recommend that the Department ensures:

- all children's individual needs are met, and children's views inform their assessments, placements and care planning
- all children entering care receive a thorough, multidisciplinary assessment
- all children are in suitable and stable out of home care placements to reduce placement breakdown and the associated increased risk of child sexual abuse
- Child Safety Officers have regular and ongoing contact with all children in out of home care
- each child has a comprehensive care plan to which they have contributed and that is tailored to their individual needs
- all children in care receive specialised, tailored supports for their individual needs.

8.1 Meeting individual needs

Standard 5 of the national out of home care standards requires that 'children and young people have their physical, developmental, psychosocial and mental health needs assessed and attended to in a timely way'.[477] All children's specific needs should be addressed, including attachment difficulties, disengagement from education and gender-specific needs.

Meeting the individual needs of children is particularly important for children who identify with diverse groups or have diverse needs, such as Aboriginal children, children from other culturally diverse backgrounds, children with disability, children with mental illness and children who identify as LGBTQIA+.

Children's participation in their care is vital to ensuring their needs are met. The Child Advocate explained that she gets involved in individual advocacy to help adults to:

> … understand what children who don't have a voice are trying to say, or alternatively, I am challenging adults about why they are not listening to children who are clearly expressing themselves.[478]

In Section 4.2.5, we emphasise the importance of empowering children in the out of home care system in relation to their individual care and at the system level. In that section, we recommend that the Department develops an empowerment and participation strategy for children and young people in out of home care. In relation to their individual empowerment, the strategy should adopt a principle that children's views inform their assessments, placements and care planning.

Recommendation 9.22

1. The Department for Education, Children and Young People's out of home care processes, including assessments, placements and care planning, should be tailored to address the specific needs of individual children.
2. These processes should address the specific needs of all children, including Aboriginal children, children from other culturally diverse backgrounds, children with disability, children with mental illness and children who identify as LGBTQIA+.
3. The Department's empowerment and participation strategy for children and young people in out of home care (Recommendation 9.6) should include processes that enable children's views to inform all elements of their individual care, including their assessments, placements and care planning.

8.2 Assessment and support

In its recommendation 12.21, the National Royal Commission emphasised that:

> Each state and territory government should ensure:
>
> a. the adequate assessment of all children with disability entering out-of-home care
>
> b. the availability and provision of therapeutic support
>
> c. support for disability-related needs
>
> d. the development and implementation of care plans that identify specific risk-management and safety strategies for individual children, including the identification of trusted and safe adults in the child's life.[479]

In this section, we focus on assessments for children in care with disability or mental health concerns.

8.2.1 Meeting a child's health needs

In her 2019 Monitoring Report, the Commissioner for Children and Young People found that the Department's ability to produce data about the health status of children in care was inadequate and that this undermined its capacity to meet their health needs:

> In the [Department]'s responses to both of the Commissioner's questionnaires, the [Department] acknowledged that "a lack of data on the health attributes of children in care" hinders the [Department]'s achievement of health outcomes for children and young people in care.[480]

We heard evidence that the Department is not always meeting the needs of children.[481] Some suggested that basic assessments were not conducted when a child first came into care.[482] We heard that some children in out of home care had undiagnosed learning disabilities or hearing or vision problems that had not been noted.[483]

While there is a range of standardised tools available to screen or assess the health and wellbeing of children coming into care, clinical psychologist, Dr Julian Watchorn, gave evidence that the Department has not used these tools as a matter of course.[484] He expressed a view that the main barriers to timely assessments of children when they are taken into care are resource constraints and the lack of availability of allied health specialists to conduct the assessments.[485]

Secretary Pervan told us that children coming into care were assessed at one of the three out of home care paediatric clinics around the State, which are funded by the Department of Health.[486] Secretary Bullard told us that the assessments provided are 'holistic'.[487] He further advised that the clinics referred children to the Child and Adolescent Mental Health Service and private practitioners for trauma and therapeutic interventions.[488] We note, however, as we discuss below, the Child and Adolescent Mental Health Service has not routinely accepted referrals for children with trauma or who are in out of home care, and the Child Advocate and others in the out of home care system reported that private practitioners are not easily accessible.[489]

Foster carer Ms Shoobridge, told us that the clinic she attended did not respond in a proactive way to her foster child but adopted a 'wait and see' approach. Ms Shoobridge could not wait because of the stress of managing the child's intense needs, so she self-funded a private multidisciplinary assessment for the child. The assessment identified significant disability-related needs and the child was then determined to be eligible for supports funded via the National Disability Insurance Scheme.[490]

We welcome the Department's paediatric review. For the Department to meet Standard 5 of the national out of home care standards, we would like to see all children receive a holistic assessment, including access to comprehensive multidisciplinary assessment where required, whether it is provided through the Department of Health clinics or through a multidisciplinary team based in the Department for Education, Children and Young People.

8.2.2 Disability

As discussed in Chapter 7, children with known disability are overrepresented in out of home care in Tasmania and nationally. Children with disability are almost three times as likely to experience sexual abuse in institutional settings than children who do not have a disability.[491] These rates are even higher for female children with intellectual and behaviour-related disabilities.[492]

The disability status of nearly one-third of children in care was recorded by the Department as 'not stated', leading the Commissioner for Children and Young People to express concern about the 'lack of detailed data about the care experience of children and young people with disability'.[493] The poor recording of disability status can make it difficult for staff to consider disability when making decisions about a child's risk of sexual abuse.

The National Royal Commission found several factors that further increase the risk of sexual abuse for children with disability in care. One risk factor was that out of home care services and supports were often not tailored to the individual needs of a child with disability.[494]

Child Safety Officers are responsible for accessing the National Disability Insurance Scheme on behalf of children in care. Carers therefore depend on Child Safety Officers to access this funding and for ensuring supports are in place for the children in their care. We heard that challenges arise when Child Safety Officers do not work collaboratively with carers to secure timely and appropriate supports under the scheme.[495] Ms Shoobridge's experience, described above, illustrates that some carers are having to self-fund applications to the Scheme.[496]

The National Disability Insurance Scheme is a complex system, and navigating it can be difficult for anyone, let alone where responsibilities are divided between an institutional guardian and a carer.[497] Applying to the Scheme can also be time consuming, in a context where Child Safety Officers are already working at capacity.

Given the specialised knowledge needed to navigate the National Disability Insurance Scheme and the demand on the scheme due to the large number of children in care with disability, the Department should have internal expertise to assist Child Safety Officers with applications. Dr Watchorn told us that he believed the Department had previously considered recruiting a specialised role to support children in out of home care to access the Scheme.[498]

8.2.3 Trauma and mental health

The National Royal Commission found that children who have a history of trauma and mental health difficulties are more vulnerable to sexual abuse.[499]

Professor Helen Milroy, a child and adolescent psychiatrist, told us that trauma and mental health difficulties are inevitably intertwined.[500] She explained, however, that the signs and symptoms of trauma are often missed or misunderstood, so children do not always get timely help:

> The disconnection between event and impact of trauma can mean that health practitioners and other important people in children's lives fail to recognise the little signs that a child might manifest and so therapeutic intervention does not occur soon enough. Often no one intervenes until adolescence when the young person is self-harming or suicidal, using drugs, or in the juvenile justice system.[501]

One child in care interviewed for our commissioned research said they thought their trauma was overlooked when they had mental health problems:

> … they believed I was psychotic and bipolar, and they don't give a fuck about trauma they just label [you with] something and throw you in there and think they can … I ended up going to hospital because I had suicidal thoughts because of my trauma and my pain and my stress from everything that was hitting me in August last year.[502]

Unfortunately, we heard that it can be difficult to find private and not-for-profit mental health services for children in care due to long waitlists.[503] Tasmania has a limited number of private child and adolescent psychiatrists and very few permanent ones in the public system. We heard that while there are private psychologists in most locations around the State, they are in high demand and difficult to access.[504] Many children in care cannot access the Government funded Child and Adolescent Mental Health Service when their presentation is deemed to be primarily trauma-related, even if their difficulties seem severe.[505]

Over the past five years, the Department has funded the Australian Childhood Foundation to provide trauma therapy support to children in care. However, only 30 children (along with their carers) are funded each year for this service.[506] This means that just under 3 per cent of children in care can access trauma-specific therapy at any one time.

Dr Watchorn told us that children are not routinely assessed for trauma when they come into care.[507] Ms Enkelmann expressed concerns that not treating trauma early is a false economy because, if untreated, trauma will often reappear in adolescence, when reversing the damage is much more challenging.[508] Many of the children interviewed for our commissioned research said they were left to manage their trauma alone.[509]

Professor Brett McDermott, Statewide Speciality Director, Child and Adolescent Mental Health Service, has been leading development of a specialist service for children in out of home care who have mental health difficulties. His model is based on a Queensland program and aims to deliver trauma-informed assessment and interventions through a multidisciplinary team that has low caseloads and can work with a child over a longer period. Professor McDermott told us that a feature of the service is that clinicians will also support those caring for the child through skill development and psychoeducation.[510]

We welcome this initiative, which may reduce the risk of sexual abuse for some children in care by addressing their mental health difficulties and trauma. Professor McDermott acknowledged that it may be difficult to recruit suitably qualified mental health clinicians for the service and that there may be limitations to the number of children the service can assist.[511]

8.2.4 Our observations

The Department needs to ensure children and young people in care have their emotional, physical, developmental, psychosocial and mental health needs (including trauma) assessed and attended to in a timely way. To help ensure this, we recommend that all children in care have access to multidisciplinary care, whether provided through the paediatric out of home care clinics or the Department.

The Department should recruit a specialised role to support children in out of home care to access the National Disability Insurance Scheme. Such a role could be the 'go to' within the Department for Child Safety Service staff who have questions or concerns about a child's access to the scheme. The role could also ensure eligibility under the scheme was assessed for all children with disability in out of home care, and if deemed eligible, the role could support Child Safety Officers to maintain the currency of the child's National Disability Insurance Scheme plan. This role should work closely with the multidisciplinary health team.

In conjunction with a new system-wide, trauma-informed therapeutic model of care (refer to Recommendation 9.18), the Department should increase funding for specialist trauma therapy services for children in care.

Given the signs and symptoms of trauma are not always obvious, we recommend routine assessment for trauma and mental health difficulties for all children coming into care. In this way, those who need professional assistance can be identified early, before their mental health worsens.

We recommend that the Department and out of home care providers report on the number of children in care who are receiving multidisciplinary health assessment, are eligible for the National Disability Insurance Scheme and are receiving specialised trauma support and counselling to the Quality and Risk Committee (refer to Recommendation 9.5).

Recommendation 9.23

1. The Tasmanian Government should ensure all children in care have access to:
    a. a timely holistic assessment when entering care across all domains of physical health, trauma and mental health, disability and educational need
    b. health and wellbeing assessments conducted annually, or more often where there is an identified need.
2. Multidisciplinary health teams should provide expert consultation to the care team around a child about the child's needs, and input into the child's care plan.
3. The Department for Education, Children and Young People should create a specialised role to support children in out of home care to access the National Disability Insurance Scheme.

Recommendation 9.24

1. The Tasmanian Government should increase funding for specialist trauma therapy services for children in care to ensure their needs are met.
2. The Tasmanian Government should ensure the Child and Adolescent Mental Health Service's new specialist mental health service for children in out of home care is resourced to meet demand.

8.3 Placement of children

The decision about where a child in out of home care will live is a challenge for child protection staff in any jurisdiction.

Children in out of home care benefit from a stable placement. The National Royal Commission observed that it takes time for a child to build enough trust with a carer to disclose sexual abuse, and that each time a child changes placement they suffer from loss of relationships.[512] Multiple placements may also increase a child's exposure to child sexual abusers, simply because they are exposed to more people in their home environment.

Children in care told us how placement changes affect them. One young person interviewed for our commissioned research said:

> Imagine if you're sitting in a wobbly chair. It feels like that, but emotionally. Like anything could just drop at any moment … I have never had an actual home. There has never been anywhere I've felt [is] like … [a] home, because over the last seven, eight years I've been in foster care, I've had seven, eight placements, so I've moved every year. And because I had never … there was never a place that was mine, which resulted in me feeling not safe.[513]

Another young person said:

> My sister, she's good at not getting emotionally attached because it's obviously a trauma response. The fact that we've moved so much, she doesn't get attached to people, unless she's known you for a very long amount of time, she will not trust you whatsoever … I, on the other hand, get very attached to people, very quickly. I suppose it's the opposite response as her.[514]

The National Royal Commission made the following recommendations to improve the safety and stability of placements for children in care and to reduce their risk of sexual abuse:

a. improved processes for 'matching' children with carers and other children in a placement, including in residential care

b. the provision of necessary information to carers about a child, prior to and during their placement, to enable carers to properly support the child

c. support and training for carers to deal with the different developmental needs of children as well as managing difficult situations and challenging behaviour.[515]

We consider the first two of these strategies in turn below. We discuss support and training for carers in Section 4.6.

8.3.1 Placement matching

Out of home care providers told us that departmental staff have often invested significant time and effort into finding the right place for a child to live.[516] We also heard that, despite these good intentions, placement options are constrained by insufficient numbers of carers and the need to find a placement often at short notice.[517]

Children in care told us they wanted better placement matching between the children themselves and with carers. One young person interviewed for our commissioned research said:

> Group homes don't always turn out well because there's multiple different kids that have all come from different backgrounds, all have their issues. That usually doesn't match a lot of the time. So, I feel like in group home situations, maybe put kids that have had similar backgrounds, rather than just be like, 'Hey, three random kids, plop'.[518]

At times, children are moved into residential care, simply because there is nowhere else for them to live.[519] Residential care carries a higher risk of child sexual abuse than family-based settings.[520] We also heard that, at times, the Department has placed too many high-needs children with a carer who could not reasonably be expected to meet all their needs.[521]

Placement matching involves understanding the child's individual needs, the needs of other children in the placement, and what each carer can provide.

A Carer Register (Recommendation 9.20) would allow the Department to identify carers with special skills or experience; however, unless more carers are recruited and retained (Recommendation 9.8) and alternative care options explored (refer to Section 8.3.3), options for placements will be limited to those available rather than those most suitable.

Other jurisdictions have structured processes to match children with the best carers. The New South Wales Department of Communities and Justice uses a Child Assessment Tool, which is designed to:

> … identify the most appropriate level of care for a child, based on assessment of their behaviour, and health and development needs. The tool improves transparency and consistency of placement decisions and focuses on the needs of the child.[522]

The New South Wales Department then uses 'Placement Matching Panels' to decide which carers will be most suitable for any given child.[523] The Queensland Department of Child Safety, Seniors and Disability Services uses a 'Foster care matching tool' to work systematically through a child's needs and the ability of the proposed carer to meet those needs.[524]

8.3.2 Information for carers

Dr Watchorn warned of an increased risk of harmful sexual behaviours occurring when carers are not given enough information about a child who comes into their care. Presumably, this is because carers are not aware of the need to take steps—such as increased supervision or declining to accept a child into their care—to mitigate the risk.[525]

The Department told us that carers receive 'detail on [the child's] previous carer history and trauma experience' before placement.[526] However, others working in the sector disagreed that this always occurs, telling us that carers often do not get enough information about the children they are caring for, making it very difficult to meet a child's needs.[527]

We were also told that the Department has cited privacy or confidentiality to justify not sharing information with carers about children in their care.[528] Dr Watchorn said that 'if sharing the information would reduce risk for the child, priority has to be with the interests of the child, not the confidentiality of information'.[529]

The Child Advocate stated that carers should have enough information about a child in their care 'to provide adequate care and attuned responses for that child to recover from the effects of trauma'.[530]

When carers have specific information about the child in their care, they are better able to anticipate triggers, respond appropriately to a child's trauma-related behaviour and manage risks.[531]

8.3.3 Funding according to needs

The Department funds out of home care through payments to carers and resourcing non-government agencies to support carers and provide residential care, if required. We are concerned that the current level of funding is not enough to adequately meet the needs of children in care and hence, can disrupt the stability of their placements.

Family-based care

Although foster and kinship carers are essentially volunteers, they receive a 'board payment' from the Department to cover costs of caring for a child. The payment amount depends on the age and assessed needs of the child (standard, intense or complex). At time of writing, Tasmania's 'board payment' was the lowest in Australia.[532]

Andrea Sturges, of the non-government out of home care provider Kennerley Children's Services, told us that the payment does not cover the actual costs of caring for a child, and it can be very difficult to get an increased rate of payment once it is set.[533] She also said that Department funding is not enough to cover providers' operational costs to support carers, so providers must make up the shortfall from their own funds.[534]

Residential care

Residential care is an expensive form of out of home care and least like a family environment when compared with foster or kinship care.[535]

In 2019, the Department 'revised' its funding for Special Care Packages for children in residential care; this resulted in some providers receiving less funding for children in their care on the basis that some children were deemed to not require 'non-material basics' services.[536] 'Non-material basics' services include those costs that exceed the costs of the minimum service that any child in out of home care receives. The Department told us that the revision of the payment system in 2019 was intended to improve the Department's financial controls for Special Care Packages.[537] The Department also said that, while the revised model has 'resulted in a reduction to the amount received by some care providers for some children where those children did not require "non-material basics"', it has 'improved financial oversight and achieved consistent costing for like items'.[538]

However, one provider told us that since then, all children, including children with disability, have received the same level of funding regardless of their needs.[539] We heard that funding continues to cover food, activities, rent and salaried staff but not extra supervision or allied health supports that might be needed for an individual child. We also heard that the Department had suggested to one provider that they cover children's supervision and health costs themselves.[540] This provider could not make up the shortfall and observed that as extra supports decreased, serious incidents and workplace injuries increased. Consequently, the provider exited the 'material basics' funding program.[541] This example highlights the importance of funding care for a child according to their needs.

We consider it unreasonable for the Department to require a non-government provider to supplement departmental funding with their own resources to care properly and safely for children under the Secretary's guardianship. It amounts to an abdication of the Secretary's duties, obligations and liabilities under the Children, Young Persons and Their Families Act.[542] We consider these circumstances likely arose due to prolonged underfunding of out of home care by the Tasmanian Government.

Alternatives to residential care

Ms Enkelmann suggested that we consider trauma-informed models of intensive therapeutic foster care being used in other Australian jurisdictions, such as the TrACK program in Victoria.[543]

Ms Enkelmann told us that the TrACK model is an alternative model of care for children not suited to traditional foster care. Under the model, carers are highly trained, paid at a much higher rate than other carers to allow them to care for the child full-time, and receive intensive support from an out of home care worker and therapeutic specialist.[544] Ms Enkelmann advised that this model was most effective when implemented proactively for a child and 'not as an option of last resort'.[545]

In her June 2022 report to the Secretary, the Child Advocate argued strongly for salaried family-based care.[546]

8.3.4 Improving the placement of children

There are several steps the Department could take to improve placements for children in out of home care. For example, we see value in the Department using a placement matching tool such as those described earlier. Even if the Department cannot find a perfect placement for a child, a tool would highlight the gaps in a carer's skill set, enabling the Department to provide that carer with tailored supports. It could also consider the child's existing relationships, such as where siblings are placed. A placement tool can also assist with decisions about placing children together in a facility. In particular, this could help avoid co-placements where children are at risk

of harmful sexual behaviours.[547] In conjunction with this tool, carers must be supported by receiving information about the children in their care that can help protect them from sexual abuse.

The number, quality and stability of placements can also be improved by providing adequate funding to meet the needs of children in care. As we have seen, meeting children's needs and improving placement stability are protective factors in child sexual abuse. We agree with the Child Advocate that while salaried family-based care is more expensive than regular foster care, it would certainly be much less expensive than residential care, as well as providing the child with a safer and more therapeutic care environment and greater likelihood of developing a trusting relationship with an adult.[548] For this reason, we recommend introducing a salaried or professional care model.

Recommendation 9.25

The Department for Education, Children and Young People should improve placement stability and reduce the risk of sexual abuse of children in care by:

a. considering the views of the child or children about their out of home care placement

b. using placement matching guidelines to aid placement decisions and support planning

c. placing siblings together or maintaining sibling connection where safe to do so

d. ensuring carers are aware of any history of abuse in relation to the child and the child's specific needs relevant to this

e. introducing an intensive salaried or professional foster care model to allow children with challenging behaviours to remain in family-based care

f. funding all placements (including kinship, foster, respite and residential care) to fully meet all the child's assessed needs to the extent these are not covered by other schemes (such as the National Disability Insurance Scheme and public health or education services).

8.4 Care plans

The National Royal Commission stated that all children in care should have an individualised care plan.[549] In particular, all children with disability should have an individualised care plan that helps strengthen the child's safety. This should be based on adequate assessment of needs, incorporate 'specific risk management and safety strategies' and identify 'trusted adults in the child's life' (among other elements).[550]

Standard 4 of the national out of home care standards also requires that 'each child and young person has an individualised plan that details their health, education and other needs'.[551]

According to the Children, Youth and Families Practice Manual, the Department launched the current care teams and care planning process in December 2020.[552] The Department's care plan template covers the six domains of the *Tasmanian Child and Youth Wellbeing Framework*: 'being loved and safe', 'material basics', 'being healthy', 'learning', 'participating' and 'culture and identity'. Each domain represents an aspect of the child's life that the care team must consider. For each domain, the care team identifies the following for the child: current goals, 'what's going well?', 'what needs to improve?' and 'what are we going to do?'.[553]

We understand that several policy and procedural documents guide Child Safety Officers in developing care plans. The *Care Teams and Care Planning Procedure* requires Child Safety Officers to establish a care team within six weeks of the 'first legal order' for a child. The care team must then meet every six weeks for the first year. The care team must develop the child's care plan within the first two care team meetings and review the plan at least annually, as well as whenever there is a significant change in a child's circumstances.[554]

Care teams should also complete an agreement that states the role of each team member in the child's life, the objectives of the team and how the team will work together. The care team agreement should be reviewed each year along with the care plan, or more frequently if circumstances change.[555]

The child's care team appears critical for developing a thorough care plan. Ms Lovell said the ideal care team has the right people in it, develops and follows a care plan that is effective and child-informed, and shares power between team members.[556]

In June 2022, Ms Lovell told us that some children in out of home care had a minimal care team and some children did not have a care team at all. She said that the Child Safety Service was 'working toward' the goal of every child having a comprehensive functioning care team but could not report on progress due to 'data quality issues'.[557]

We have received vastly different figures from the Department, a non-government provider and the Commissioner for Children and Young People about how many children in care have care plans.[558]

We conclude that, while many children in out of home care may have an approved care plan recorded, a good proportion of those care plans will not be current, and many have not been created and implemented by a functioning care team. We infer it is unlikely that children without an allocated case worker will have an up-to-date care plan or active care team—such as children on 18-year guardianship orders.

It is not clear to us whether the care plans are structured in a way to undertake 'specific risk management and safety strategies', as was recommended by the National Royal Commission. If a child's assessment indicates that they are at risk of child sexual abuse, child exploitation or harmful sexual behaviours, the care plan should include specific strategies to manage these risks.

Care plans should also be informed by the multidisciplinary health assessments we recommend above (refer to Recommendation 9.23).

Addressing risk in relation to child sexual exploitation and harmful sexual behaviours is considered in Section 10.

Recommendation 9.26

The Department for Education, Children and Young People should ensure:

a. each child is involved in developing their care plan

b. each child's care plan is informed by the holistic assessment (Recommendation 9.23) and the interests and aspirations of the child

c. care plans include strategies to address identified risks of child sexual abuse, including the risk of harmful sexual behaviours and child sexual exploitation

d. the care team reviews any risk assessments and management plans for child sexual abuse at least every six months, or more frequently if incidents occur or circumstances change such as when a new child joins the household.

9 Children on out of home care orders involved with youth justice

In this section, we identify the specific needs of 'crossover children'—children who are in out of home care and who are also involved with youth justice.[559]

We discuss the specific risks of sexual abuse for children in Ashley Youth Detention Centre at length in Chapter 10. Those risks are unacceptably high.

Children in care can be particularly vulnerable to child sexual abuse in youth detention for a number of reasons, including their over-representation, their experiences of previous trauma and because 'many children in youth detention are disconnected from families, community and culture and may not have even limited access to an adult they trust'.[560]

In this section, we recommend measures to prevent the sexual abuse of crossover children by:

- actively advocating for children in care to not enter youth detention, except when absolutely necessary
- providing active case management when a child in care does enter youth detention.

9.1 Reducing over-representation

The National Royal Commission found that children in out of home care are 16 times more likely to be under 'youth justice supervision' than the general population.[561] The correlation between out of home care and youth detention is not surprising considering that children in both settings are likely to have experienced abuse and trauma.[562] Brett's experience, described in Chapter 8, showed us how being placed in care can lead to a child entering youth detention.

The relationship between children living in out of home care and involvement in the youth justice system is well established but not straightforward.[563] Being in care does not automatically mean a child will go on to youth detention.[564] Between 2007 and 2022, only 3.3 per cent of Tasmanian children in care had ever been sent to Ashley Youth Detention Centre, with yearly rates ranging from 1.2 per cent up to 7.1 per cent.[565]

Conversely, many children in youth detention have been in out of home care. Between 2007 and 2022, the average percentage of young people in Ashley Youth Detention Centre who had ever been in out of home care was 27.9 per cent, with yearly percentages ranging from 18.2 per cent up to 42.6 per cent.[566] These rates are similar to those in other jurisdictions.[567] Also, while the total number of detainees in Ashley Youth Detention Centre steadily declined between 2007 and 2021, the percentage of those who had ever been in out of home care increased, suggesting that children in out of home care have become increasingly over-represented in youth detention in Tasmania over time.[568]

Aboriginal children in Tasmania, particularly younger Aboriginal children, are over-represented in care and further over-represented in youth justice.[569]

Children in care can end up in youth detention more frequently for several reasons:

- residential care homes are more likely than a family of origin to call police for assistance in response to property damage or theft[570]
- youth detention is sometimes seen as an alternative placement for difficult-to-place children in care[571]

- children may be remanded or kept in detention longer than their sentence due to difficulties finding them a placement.[572]

Child protection veteran Jack Davenport told us that he thought some within the Child Safety Service saw youth detention as a means of effectively delegating their guardianship responsibilities:

> There was no doubt in my mind that [Ashley Youth Detention Centre] was often seen by [Child Safety Service] staff as a de-facto placement option. It was felt that incarceration often solved problems once a child was in [Ashley Youth Detention Centre]. This was principally on the basis that children couldn't leave [Ashley Youth Detention Centre] and there were other people responsible for them (rather than [the Child Safety Service]). Because of this, workers were happy for children to go to [Ashley Youth Detention Centre]. This attitude was partly driven by workload, but primarily by the sense that the responsibility of carrying risk for the child was relinquished.[573]

Our recommendations in other sections of this chapter address some of the reasons children in care are over-represented in youth detention. For example, introducing a trauma-informed therapeutic model in out of home care (refer to Recommendation 9.18) should reduce the need for residential care staff to involve police because they will have other ways of approaching challenging behaviours. In Section 5, we make recommendations for reducing the over-representation of Aboriginal children in out of home care.

We also consider that the Department, as guardian, should advocate for a child in care to not enter youth detention, unless it is unavoidable. We discuss the mechanisms for preventing children entering youth detention more generally in Chapter 12 but recommend here that a representative of the Department with knowledge of a child in care advocates, at all times, for that child to not enter youth detention, including in the Magistrates Court.

9.2 Active case management

According to the 2017 *Visiting Children and Young People on Orders* procedure, when a child is detained at Ashley Youth Detention Centre, Child Safety Officers must follow a minimum visiting schedule.[574] We received no information to satisfy us that the Department monitors compliance with this requirement.

Andrea Sturges from Kennerley Children's Services told us that when she worked for the Department, she noticed children in care who were admitted to youth detention were recorded inappropriately and incorrectly by their Child Safety Officers as having left care.[575] Consequently, active case work was suspended while a child was in detention.[576]

We found it difficult to assess the level of case management a crossover child receives while in youth detention but, given the closed institutional setting of youth detention and the associated risks of child sexual abuse, we are compelled to be prescriptive about the Department's responsibilities to children in care who enter youth detention. These children need more support, not less, from their guardian. We recommend that the Department ensures Child Safety Officers undertake and report on specific case management tasks while a child is in youth detention, including visiting them frequently, ensuring their needs are being met and planning for their release.

Ongoing case management will show the child that their guardian is actively involved in their care, even when they are in custody. Regular visits by Child Safety Officers will provide opportunities for a child to disclose if they have been victimised.

Recommendation 9.27

In its role as statutory guardian of a child in care, the Department for Education, Children and Young People should:

a. ensure a representative of the Department with knowledge of the child appears for a child in out of home care in the Magistrates Court (Youth Justice Division) and in the new specialist children's division of the Magistrates Court (Recommendation 12.15), in order to

    i. support the child in court

    ii. inform the court of all relevant considerations to the court, including the child's child protection history

    iii. make submissions to the court on behalf of the child

    with arrangements in place for this to occur in out-of-hours bail hearings as well as those that occur during normal business hours

b. take actions that may address any causes contributing to child offending, including changes to care plans

c. ensure, when a child in care is admitted to youth detention or another residential youth justice facility, that the child's Child Safety Officer

    i. arranges an immediate review of the child's care plan with their care team, which includes developing a transition plan for when the child leaves detention

    ii. visits the child as soon as practicable and regularly thereafter, with a minimum of one visit during their admission in line with the child's revised care plan

iii. notifies the Commission for Children and Young People of the child's admission to youth detention

d. report to the Quality and Risk Committee on the number of children in care in detention and on the activities listed above.

10 Addressing other risks of sexual harm

In previous sections on supporting quality care and carers (Sections 6 and 7), we consider measures that focus primarily on reducing the risk to children in care from adults within the out of home care system, as well as the risks posed by children not having their needs met. In this section, we focus on the risk of children in care experiencing harmful sexual behaviours from other children or sexual exploitation from adults outside the care system, and how the Department can address these sources of abuse.

10.1 Harmful sexual behaviour

Harmful sexual behaviours are a known risk for children in care.[577] Research commissioned by the National Royal Commission suggested that children in out of home care were at greater risk of sexual abuse by peers than by adult staff members.[578] The research suggests that children living in residential care were more likely to have engaged in or experienced harmful sexual behaviour than children in other care settings.[579]

Research indicates that children who engage in harmful sexual behaviours in out of home care settings are more likely to be older, male, biological children of carers; children who have received inadequate or no sex or relationship education; and young males who have themselves experienced sexual abuse.[580] Other research shows children who have experienced family violence or been exposed to sexual activity such as pornography, are at heightened risk of displaying harmful sexual behaviours.[581]

Research conducted for the National Royal Commission also found that certain organisational features common to out of home care settings, particularly residential care, appeared to increase the risk of children engaging in harmful sexual behaviours. These features include:

- where there are attitudes that 'boys will be boys' and that normalise force as part of male sexuality[582]
- where there is the attitude that girls are responsible for defending themselves against such abuse[583]

- where there is a 'culture of silence' on discussing sex and child sexual abuse with children in out of home care services, which may inadvertently normalise sexual aggression or abuse as part of normal sexual exploration or experimentation[584]
- where abuse is used as a way of asserting power and establishing 'pecking orders'[585]
- when out of home care staff are poorly or inadequately trained to differentiate between what is age appropriate and what is abusive sexual behaviour between peers[586]
- where those who have experienced sexual abuse and those who have engaged in harmful sexual behaviours are placed in the same living arrangement[587]
- rostered care settings with a higher ratio of young men to young women[588]
- sometimes the sexual abuse histories of the children in a placement can create a 'hypersexualised culture', which may lead young people to cross the boundaries of acceptable sexual behaviours.[589]

The case example of Orson and Ivan described in Chapter 8 highlights the risk of harmful sexual behaviours for children in care, and how prevention and responses need to be improved.

10.1.1 Prevalence and examples

In our file analysis of 22 cases of children in Tasmanian out of home care, we identified that harmful sexual behaviours occur frequently (refer to Chapter 8). Half of the 22 cases involved at least one concern about harmful sexual behaviours and most of those concerns were raised in relation to multiple instances of harmful sexual behaviours. The severity of alleged harmful sexual behaviours ranged from developmentally, socially or culturally inappropriate to coercive and/or violent sexual behaviours (refer to Chapter 21 for more on the spectrum of harmful sexual behaviours). All the children involved were known to have a history of sexualised or harmful sexual behaviours before being moved to the placement where the alleged incident(s) took place.

We also heard directly from providers and victim-survivors about harmful sexual behaviours in care.[590] For example, Brett Robinson told us that he had experienced abuse from an older child at his respite care.[591] He said that when he disclosed the alleged abuse, his foster carers did not believe him. He later told his father, who took him to police to make a statement. Brett said he found it too difficult to finish his statement to police. He told us that he did not know if there was an investigation in response to his allegations because he was never asked further about it.

Caroline Brown, an experienced out of home care provider quoted earlier in this chapter, told us about an investigation into allegations that a child had been raped by their foster brother. Ms Brown told us that, at a meeting with the Department about the investigation, the Senior Practice Consultant did not believe the younger child's account, instead determining that the child had self-injured their genitals.[592] Ms Brown stated that the Senior Practice Consultant placed responsibility for any abuse on the younger child, stating that the child needed help because of their 'perpetrative behaviours towards older boys' and that the older boy needed to 'learn how to say no' when a younger child jumped on him.[593] It appeared to Ms Brown that the Senior Practice Consultant thought that the older boy could not have abused the younger child because of his intellectual disability.[594]

10.1.2 National Royal Commission recommendations

The National Royal Commission made two specific recommendations to decrease the risk of harmful sexual behaviours in out of home care. Recommendation 12.12 focused on identifying, assessing and providing appropriate interventions and support for those children who had engaged in harmful sexual behaviours, as well as 'rigorously' assessing and managing the risk that such behaviours would continue.[595] Recommendation 12.13 required the Department to ensure carers and staff understood harmful sexual behaviours and provided them with guidelines and advice about how to prevent and respond to these behaviours.[596]

10.1.3 The Department's response

Prevention Assessment Support and Treatment program

The Tasmanian Government's response to the National Royal Commission's multiple recommendations about harmful sexual behaviours, including those related to out of home care, primarily involves its funding of the Sexual Assault Support Service to provide a statewide primary and secondary prevention and therapeutic intervention program for children and adolescents engaging in harmful sexual behaviours.[597]

The Sexual Assault Support Service's Prevention Assessment Support and Treatment program is discussed in Chapter 21. For the purposes of this section, the main components of the program are:

- limited professional development in harmful sexual behaviours that departmental staff have the option to access[598]
- assessment, treatment and intervention for children with harmful sexual behaviours, to which Child Safety Officers regularly appear to refer children for assistance[599]
- advice for staff who can call the Sexual Assault Support Service for guidance when they are faced with alleged harmful sexual behaviours.[600]

The Prevention Assessment Support and Treatment program appears to be based on principles of best practice.[601] However, the program is limited in what it can provide because the funding is not enough to meet the need.[602]

We consider that funding a community service to provide limited access to education, expert consultation and therapy for children who have engaged in harmful sexual behaviours is an insufficient response to children in the care of the State. The Government must go further and develop a comprehensive policy for preventing, identifying and responding to harmful sexual behaviours in the out of home care sector.

Harmful sexual behaviours policy

The Department does not have a policy to guide staff and out of home carers in identifying, preventing and responding to children who display harmful sexual behaviours, victims of harmful sexual behaviour and other affected parties. We heard that the only resource available to staff to help identify harmful sexual behaviour is the 2006 *Traffic Lights* tool.[603] This tool has some limitations, primarily that it does not assist the user to decide how to respond.[604]

We were told that the Department's care concerns process (refer to Section 11) would not necessarily apply in instances of harmful sexual behaviours because the alleged abuser is not a carer but another child.[605] If there was some indication that the carer did not act to prevent the harmful sexual behaviours, then a Child Safety Officer could raise a quality of care concern—the less serious of the two care concern options. As discussed in Section 11.4, a quality of care concern focuses on the behaviour of the carers and not the impact on the child. We could not identify any other policy that outlines how to respond to and manage harmful sexual behaviours, and the Department does not provide mandatory training to Child Safety Service staff or out of home care carers and staff about harmful sexual behaviours.[606]

10.1.4 A new whole of government harmful sexual behaviours framework

Other jurisdictions have invested heavily in a whole of government coordinated approach to preventing and responding to harmful sexual behaviours. For instance, in response to National Royal Commission recommendations, New South Wales has publicly released *Children First 2022–2031*. Children First is a whole of government shared framework for preventing and responding to problematic and harmful sexual behaviours by children and young people, which 'sets the vision and priorities for how [New South Wales] can and will work together to support children and young people who have displayed, or been affected by, problematic and harmful behaviours by applying a sector wide, multiagency public health approach'.[607]

The Western Australian Government contracted the Australian Centre for Child Protection to develop the *Framework for Understanding and Guiding Responses to Harmful Sexual Behaviours in Children and Young People*, released in June 2022.[608] The Western Australian framework 'is a conceptual map of research evidence, relevant theoretical underpinnings, general practice principles and practice wisdom' to assist 'practitioners, policy makers and carers to provide responses that are safe, effective and trauma informed'.[609] The framework outlines what is known about harmful sexual behaviours, how to interpret sexual behaviours at various developmental stages, and key principles of practice. It also has a section dedicated to responding to harmful sexual behaviours in residential care.[610] The framework is publicly available.

We note that the New South Wales and Western Australian frameworks are not limited to out of home care; instead they aim to provide a common, whole of government framework for understanding and responding to harmful sexual behaviours, and are supplemented by more nuanced guidance for specific contexts, including out of home care.

We recommend the Tasmanian Government develops a statewide framework and plan for preventing, identifying and responding to harmful sexual behaviours that provides a common understanding of harmful sexual behaviours, high level guidance on how to respond and a clear articulation of the roles and responsibilities of different government provided and funded agencies within the response in Chapter 21 (Recommendation 21.8).

10.1.5 A Harmful Sexual Behaviours Support Unit

The Department for Education, Children and Youth is responsible for out of home care, youth justice and schools. We have concluded that these are the three institutions in which there is the greatest risk of children displaying or experiencing harmful sexual behaviours. Additionally, the Department is responsible for the Advice and Referral Line and the Child Safety Service, which are responsible for receiving reports from the public and mandatory reporters regarding child sexual abuse. The Department for Education, Children and Young People must be equipped to provide high quality, best practice responses to harmful sexual behaviours displayed or experienced by children in its care in schools, out of home care or youth detention.

As outlined in Chapter 6, Secretary Bullard described departmental initiatives to prevent and respond to harmful sexual behaviours in Tasmanian schools including employing four additional full time-equivalent senior support staff—two psychologists and two social workers—'to provide further support for children and young people affected by harmful sexual behaviours or child sexual abuse' and additional Student Support Response Coordinators.[611] We were encouraged by these and other developments in school settings to enhance responses to harmful sexual behaviours. We did not see parallel initiatives to enhance responses in out of home care or youth justice but conclude there is a profound and urgent need for this to occur.

We have concluded that a Harmful Sexual Behaviours Support Unit should be established within the Department for Education, Children and Young People located within the Office of the Chief Practitioner (refer to Recommendation 9.17). The Harmful Sexual Behaviours Support Unit should support all child-facing services in the Department to manage harmful sexual behaviour through the provision of advice, guidance and support and context specific policies. The Unit should have specialist advisors who can:

- support staff to identify whether an incident constitutes harmful sexual behaviour
- assist in the development of appropriate and proportionate local responses to inappropriate and problematic sexual behaviour
- support and guide a critical incident response to persistent, abusive and/or violent harmful sexual behaviours
- help develop tailored risk mitigation plans that are the least restrictive possible and balance the needs of all children
- assist in advising on when and how to communicate with other affected parties (where appropriate)
- assist in arranging access to counselling, and support children displaying harmful sexual behaviours, victims and other affected parties, where required
- advise on appropriate notifications, reporting and information sharing, and follow the child while the risk remains
- ensure accurate and appropriate records are created and appropriately stored.

The Harmful Sexual Behaviours Support Unit would likely benefit from having access to the detailed response guidance in the Child-Related Incident Management Directorate, which could be used to inform the detailed policies, protocols and guidance for responding to harmful sexual behaviours in out of home care, youth justice and schools that we recommend.

The Harmful Sexual Behaviours Support Unit would also work closely with the Quality and Risk Committee (refer to Recommendation 9.5) to ensure systemic risks, practice issues and opportunities for improvement are identified.

The Department's new senior support staff mentioned above could form part of the Harmful Sexual Behaviours Support Unit. The Tasmanian Government will need to allocate additional funding to resource the Unit to also support out of home care and youth justice responses to harmful sexual behaviours.

Detailed specific policies, protocols and guidance for out of home care

Responding to harmful sexual behaviours in out of home care, where the Department may be the guardian of the child displaying the behaviours and children harmed by the behaviours, requires careful consideration and specialist guidance. This guidance would include the initial response to the incident, but also consider issues such as placement suitability; carer support; the safety and therapeutic needs of the child displaying the behaviours; the safety and therapeutic needs of other children impacted by the behaviours; appropriate information sharing; the role of police; and communication with birth parents. Detailed, specific out of home care policy, protocols and practice guidance are required to support best practices responses to harmful sexual behaviours displayed or experienced in out of home care, including:

- correctly identifying and distinguishing developmentally appropriate, inappropriate and harmful sexual behaviours
- supporting Child Safety Officers, non-government out of home care providers and carers to implement proportionate local responses to inappropriate and problematic sexual behaviour in placements
- balancing the safety, treatment, support and connection needs of the child displaying harmful sexual behaviours with the safety needs of other children in the child's life, including siblings, and encompassing safety planning guidance for the out of home care context
- considerations for placement matching and decision making, and conditions under which placements would be temporarily or permanently changed as a consequence of harmful sexual behaviours
- the safety, treatment and support needs of other children in care harmed by or who reside with the child displaying harmful sexual behaviours
- strategies to ensure that appropriate support and referrals/reports occur in response to a child displaying harmful sexual behaviour
- what information should be recorded and the circumstances in which it should be shared with external authorities, affected parties, other services and supports engaged with the child
- guidance about communicating with families and affected parties
- review processes for safety and participation plans, recognising that risk is not static.

We consider this guidance should be proceduralised where possible and used by Child Safety Officers in conjunction with advice, support and guidance from the Harmful Sexual Behaviours Support Unit.

Guidance should direct staff record all incidents of harmful sexual behaviours as a concern about the safety and wellbeing of a child in care and respond in accordance with this policy. Guidance should also advise staff on when and how to seek assistance from the new Harmful Sexual Behaviours Support Unit.

Minimum and advanced education and training in preventing, identifying and responding to harmful sexual behaviours

As identified in Section 4.6 of this chapter, Child Safety Officers, including those providing case management to children in out of home care, receive little professional development on sexual abuse or harmful sexual behaviours as part of their mandatory induction. We recommend mandatory minimum and advanced continuing professional development and education for Child Safety Officers providing out of home care case management (refer to Recommendation 9.11). Advanced professional development should include tailored professional development offerings for Child Safety Officers and carers in understanding and responding to harmful sexual behaviours. Staff working in the Harmful Sexual Behaviours Support Unit must be suitably experienced or undertake additional professional development to advance their knowledge in responding to harmful sexual behaviours. This may be internally developed and implemented or be accessed through specialist external providers. Advanced professional development in harmful sexual behaviours should also be made available to relevant staff in schools and youth justice, such as psychologists or social workers working within these settings.

Power to Kids

As discussed elsewhere in this volume, children in out of home care have heightened vulnerability to displaying harmful sexual behaviours, and to experiencing child sexual exploitation—particularly those living in residential care. They may have experienced child sexual abuse or displayed harmful sexual behaviours (or both) prior to coming into care.

While children in out of home care are more vulnerable to sexual harms, they are also more likely to experience school absences and educational disengagement, which means they miss out on school-based sexual health, respectful behaviours and sexual abuse prevention curriculum. They may not have experienced conversations with parents or carers about sexuality, particularly those in residential care with rostered staff. Residential care staff are often inexperienced with limited qualifications and training. Research for the National Royal Commission showed that residential care staff struggled to have appropriate sexual health conversations with children in their care and to respond to harmful sexual behaviours and risk of sexual exploitation.[612]

Recognising the unique vulnerabilities and needs of children in residential care, Dr Robyn Miller told us that MacKillop Family Services had developed and implemented a prevention and intervention model for harmful sexual behaviours (and child sexual exploitation) called ‘Power to Kids’, across all MacKillop Family Services’ residential care homes in Victoria and New South Wales.[613]

Power to Kids is a whole of residential unit, multi-faceted program aimed at ensuring that identified risks are managed, escalated and responded to appropriately by residential carers, the Child Safety Officer, senior managers and the clinical team.[614] It has been proven to reduce the risk to children in residential care of sexual abuse in the form of harmful sexual behaviours, child sexual exploitation and dating violence.[615]

Dr Miller described the three prevention strategies of the Power to Kids model: respectful relationships and sexuality education for the whole house, including staff; the missing from home strategy (primarily relevant for child sexual exploitation); and the sexual safety response.[616] A key element of the Power to Kids approach is to upskill all residential carers within a household to equip them to have 'brave' but appropriate conversations about sexuality and risks of sexual harm.[617] Education for children is not formal or structured, but occurs in the moment; for example, as children and a residential carer are travelling in a car or in response to sexualised material a child may have accessed or been exposed to in an online gaming environment. Power to Kids is a supplementary strategy tailored specifically to the high-risk residential care context and was designed to be implemented in residential care contexts with a trauma-informed therapeutic model of care (MacKillop uses the Sanctuary model).

We recommend the Tasmanian Government facilitates the adoption of Power to Kids or another program or approach with comparable common elements in government funded residential care homes. Any response should contain key elements evident in models such as Power to Kids, namely:

- Education—the approach must educate all roles across the sector in identifying, preventing and responding to harmful sexual behaviours. The education must also involve children in care, so that they understand boundaries in relationships and what is unacceptable. Education in this context is not formal class-based education. Education is individual and responsive to the context in the moment where carers are equipped to have 'brave conversations' with children in care about sexual abuse and harmful sexual behaviours.[618]
- Prevention strategies—specific strategies and guidance about actions that carers and staff can take to reduce the risk of harmful sexual behaviours for children in care. These strategies should be informed by the available evidence.
- Intervention guidance—clear practice guidance for all those involved in the care of each child when harmful sexual behaviours occur. This may involve practice principles, procedures and tools to guide an appropriate response.
- Therapeutic intervention—ensuring sufficient evidence-informed therapeutic resources are available to intervene with children who engage in, or experience, harmful sexual behaviours.

- Whole of workforce knowledge and skill building.

In Chapter 12, we also suggest that Power to Kids or a comparable program or approach may be of benefit in Residential Youth Detention facilities, which share many of the same risks as residential out of home care.

Access to treatment and support for children affected by harmful sexual behaviours while in out of home care

In Chapter 21, Recommendation 21.8, we recommend a sufficiently resourced therapeutic service system for children displaying harmful sexual behaviours. Without an appropriate response, harmful sexual behaviours can escalate and become entrenched and they can seriously compromise the safety, wellbeing and life outcomes of the child displaying the behaviours. Where a child in out of home care displays persistent, abusive or violent sexual behaviours and no timely publicly funded service is available to meet their needs, the State should engage a private service. Similarly, where a child who is sexually harmed in out of home care requires treatment and no timely publicly funded response is available, a private service should be engaged by the State.

Recommendation 9.28

1. The Department for Education, Children and Young People should establish a Harmful Sexual Behaviours Support Unit to support best practice responses to harmful sexual behaviours across the Department, including in schools, Child Safety Services, out of home care and youth detention. The unit should:
    a. provide advice, guidance, and support across the Department
    b. develop context-specific policies for all settings informed by the Tasmanian Government's statewide framework and plan to address harmful sexual behaviours (Recommendation 21.8)
    c. work closely with the Quality and Risk Committee (Recommendation 9.5) to ensure systemic risks, practice issues and opportunities for improvement are identified.
2. The Tasmanian Government should allocate additional funding to support responses to harmful sexual behaviours in out of home care and youth justice.
3. The Harmful Sexual Behaviours Support Unit should develop detailed out of home care-specific policies, protocols and practice guidance to support best practice responses to harmful sexual behaviours in out of home care.

4. The Department should ensure the advanced professional development for departmental staff in understanding and responding to harmful sexual behaviours (Recommendation 9.11) includes tailored professional development for both Child Safety Officers and carers, and is available to staff in relevant roles in schools and youth justice.
5. The Department should ensure staff working in the Harmful Sexual Behaviours Support Unit are suitably experienced or undertake additional professional development to advance their knowledge in responding to harmful sexual behaviours.
6. The Department should ensure Power to Kids or another program or approach with comparable components is implemented in government funded residential care homes as a supplementary strategy to address the heightened risk of harmful sexual behaviours (including child sexual exploitation and dating violence) in out of home care.

10.2 Child sexual exploitation

The National Royal Commission defined sexual exploitation of children in care as children being 'manipulated or coerced to participate in sexual activity by an adult outside the placement in exchange for, or for the promise of, an incentive'.[619]

In its 2015 report on sexual abuse in residential care, the Victorian Commission for Children and Young People stated that 'external predators posed the greatest risk to children in residential care'.[620] In 2016, Victorian data suggested that 63 per cent of sexual abusers of children in care were other adults (external to the placement) who were sexually exploiting children they had targeted in residential out of home care.[621]

In this section, we examine the Department's response to the sexual exploitation of children in its care and the role of Tasmania Police in preventing and responding to these crimes. We consider the multiagency initiatives in Victoria that have reduced the incidence of, and improved responses to, sexual exploitation of children in care.[622] Our recommendations build on these effective interstate responses and require the Department and Tasmania Police to work with other agencies to adopt more coordinated, strategic and proactive responses to the sexual exploitation of children in care.

10.2.1 Increased risk for children in out of home care

While child sexual exploitation occurs across the general population, there are adults who actively target children in out of home care, particularly in residential care.[623] Children in care can be particularly vulnerable to manipulation and grooming by these predators due to their trauma history, previous experiences of sexual abuse and disrupted attachments.[624] Moreover, according to a researcher in this area, Dr Gemma McKibbin, children are increasingly grooming and recruiting their peers for the purposes of child sexual exploitation, particularly via online means and social media.[625]

Dr McKibbin told us about six models of child sexual exploitation that occur in the out of home care setting, as described in the Victorian Government's 2017 publication, *Child Sexual Exploitation: A Child Protection Guide for Assessing, Preventing and Responding*:

- inappropriate relationships model—a significantly older person uses inappropriate power ('physical, emotional and/or financial') over a child to sexually exploit them; the child believes the adult loves and protects them
- boyfriend/girlfriend model (also called the 'loving relationship' model)—the adult befriends the child and grooms them into a 'relationship' but then manipulates or forces the child to have sex with others
- trusted friend or other peer model—a child is encouraged into sexual exploitation by a peer
- organised/networked model—a child is coerced into sexual activity with multiple men; children may be used to recruit others to 'sex parties'; sometimes associated with organised crime
- online model—this model may be used with other models to initiate or maintain contact and exploitation; can be used to target younger children; once children share images, they can be used against them to coerce them into further activity
- betrayal model—the child is befriended by a trusted adult who then organises the child to be sexually exploited by others for their own personal gain.[626]

We heard about or identified many of these models being used to sexually exploit Tasmanian children in care. For example, as described in Linda's case example (Chapter 8), Linda (a pseudonym) was groomed online by an adult male. He convinced her to send him sexually explicit pictures of herself and, once he had them, he used them to coerce her into trying to recruit other, younger children in care. In another example, we heard that a child had a series of 'boyfriends' aged in their 20s or older who were all known to each other and who supplied her with alcohol and drugs. A non-government provider told us about a girl in care who they believed was being trafficked by her 40-year-old 'boyfriend' to his associates during parties at his house.[627]

Several children in our commissioned research indicated that they were aware that children in care were vulnerable to child sexual exploitation. They thought that sometimes children in care were seeking a loving relationship with an adult or could not identify an abusive relationship.[628] One young person said:

> I think it's more with kids in care that they're willing to do … If someone reached out, had no idea who the kid was, and was like, 'Hey, do you want to meet up?' I feel like a kid in care … I don't know if this is true, but I feel like a kid that's in care would be more likely to agree to that because … They want to make connections and they possibly aren't … They probably don't have that many friends. I hate to say it, but I know a lot of people in care that are very isolated. And if someone that is kind to them via social media and looks like a nice person, why wouldn't you go physically?… I feel like if you're in care, you're going to want to talk to more people and be able to let them know about what's going on in your life. And sometimes people that reach out to you, aren't the best people to talk to.[629]

Some children in care interviewed for our commissioned research could identify grooming behaviours—for example:

> I think it's where you slowly build up to doing things to a younger person, and it's more sexual things. And it can sometimes lead to it feeling OK. And if not, a lot of the time, it can end up that they're too scared to do something about it and they think, 'Oh, well, if it's happening this much, it must be normal'.[630]

However, the researchers found that most children they interviewed did not know what grooming was and could not describe it or how they might respond to it.[631] Children said they thought this was important information to know and would like adults to talk to them about it.[632]

Children in care who are being sexually exploited often do not view the exploitation as abuse because they have believed the lies of the abuser, and because they do not always have a good sense of what makes a 'healthy' or 'appropriate' relationship.[633] Instead, they may consider the abuser to be their 'boyfriend' or that they are a willing participant in the abuse. Children who are being sexually exploited often present as 'hostile, aggressive, involved in low-level criminality … under the influence of drugs or drunk and disorderly', making it difficult to engage with them.[634] These children are often unwilling to cooperate with police or child protection officers to facilitate their own protection.[635] Consequently, those in the out of home care system may believe they are powerless to stop the abuse and take little, or no, action.[636] We heard evidence of this attitude in Tasmania, which we discuss below.

10.2.2 National Royal Commission recommendations

The National Royal Commission made specific recommendations to protect children in care from child sexual exploitation:

- Recommendation 12.14—governments implement strategies that identify and disrupt activities involved in child sexual exploitation and that encourage children to cooperate in investigation of the offences.
- Recommendation 12.15—governments align their definitions of child sexual exploitation and report on child sexual exploitation as a form of child sexual abuse.[637]

10.2.3 Identifying child sexual exploitation

The National Royal Commission noted that it is difficult to estimate the prevalence of child sexual exploitation in out of home care in Australia because it is largely 'hidden', possibly due to a lack of awareness of what sexual exploitation is or a lack of reporting by those working with children in out of home care.[638]

The National Royal Commission observed that child protection staff, out of home care workers and police can struggle to recognise child sexual exploitation, instead misidentifying it as adolescent sexual experimentation, normal behaviour for a young person in residential care, a free 'choice' being made by the young person, or engagement in prostitution. Another common misunderstanding is that nothing can be done to protect a child if they are unwilling to make a sworn statement to police.[639] In Victoria, reporting rates increased after steps were taken to raise awareness of child sexual exploitation among child protection and out of home care workers.[640] This suggests that, without an understanding of child sexual exploitation, workers may fail to recognise that a child is being sexually exploited and know how to respond.

In our review of 22 children's case files from Tasmania, we found evidence of child sexual exploitation in four cases, all of whom were females in their teens. All were exploited by more than one adult outside the placement (refer to Chapter 8). Three of these girls had a known intellectual disability, which may have increased their vulnerability to exploitation.[641]

Despite the National Royal Commission raising awareness of these issues more than five years ago, we observed that poor attitudes and misunderstandings remain in some parts of Tasmania's out of home care system. Child Safety Service staff and police often do not recognise child sexual exploitation for what it is, instead describing such behaviour as prostitution or as the child 'self-selecting' a placement or relationship.[642] We heard that some workers feel powerless to intervene when a child is being sexually exploited or worse, do not see intervention as a priority.[643]

10.2.4 Tasmania's response

The two government agencies primarily responsible for preventing and responding to child sexual exploitation are the Department and Tasmania Police.

Department responses

We heard from providers that the children who were missing from placement—'self-selecting' or 'self-placing' as the Department sometimes termed it—were often those being sexually exploited.[644]

During his time with the Department, Jack Davenport formed this view of the Department's ability to respond to child sexual exploitation:

> [Child Safety Services] demonstrated a limited ability to manage complex networks of offenders, notably sexual offenders targeting children. There was no mechanism to manage social media being used to target children, including those in care. The police had little involvement if no criminal activity explicitly took place. There was no capacity for undertaking complex assessments for [child sexual abuse] where there were multiple abusers.[645]

Non-government providers told us they had each developed their own ways of responding to child sexual exploitation, despite the Department not requiring them to do so.[646] Some non-government providers said they addressed the risk of child sexual exploitation by working with carers and children on enhancing protective behaviours.[647] They informed us that current funding levels meant they did not have enough carers available to respond effectively to exploitation when it occurred.[648]

Non-government providers also told us that when they reported instances of child sexual exploitation to the Department, responses were variable. Sometimes reports were not registered as quality of care concerns and no action was taken; on other occasions, Child Safety Officers would visit the child and conduct a safety assessment.[649]

The Department's possible guidance for staff about child sexual exploitation appears to be limited to two documents:

- the *Missing Persons Response Children in Care Practice Advice* and an associated flowchart, which describes the response to missing persons generally[650]
- the *Keeping Children Safe Handbook*, used by the Department and Tasmania Police, which includes a section on responding to children who are absent from placement by filing a missing person's report (discussed below).[651]

However, neither of these documents discuss the risk of child sexual exploitation, nor do they allude to it. Other than these documents, we could not find any other explicit references in the online Practice Manual to preventing or responding to the sexual exploitation of children in care.

Secretary Pervan said the Department does not have a 'general rule or practice' to guide practitioners' responses.[652]

Claire Lovell, Executive Director, Children and Family Services, acknowledged that the Department should be engaging in preventative measures for child sexual exploitation, such as making sure a child in care has secure relationship networks so they can access safe people to disclose to, who can then take action.[653] Ms Lovell also said that Tasmania Police should take more responsibility to prevent and respond to child sexual exploitation.[654]

Tasmania Police responses

Police responses to concerns about child sexual exploitation were described as variable.[655] Providers expressed grief and frustration over situations where they knew a child was being exploited, but because the child would not lodge a complaint, police and the Department took no action.[656]

In one of the 22 cases we reviewed, we read notes from an interagency meeting about a girl who was being sexually exploited—Tasmania Police did not consider it a priority to retrieve the girl because of a perception that she was consensually living with the abuser.[657]

However, in another case we reviewed, where a teenager in care was being exploited by adult males in exchange for alcohol and drugs, police and the Department actively worked together to disrupt the sexual exploitation. Although the girl was unwilling to make a statement, police applied pressure to the abusers through repeated visits and ensuring that minor offences (such as driving violations) were responded to. Where possible, they returned the girl to her care home each time they visited. The Child Safety Officer sought and obtained a restraining order on behalf of the child against one of the men, her 'boyfriend' in his late 20s, and out of home care staff continued to make regular contact with the girl, encouraging her to return home.[658]

To explain how Tasmania Police approach child sexual exploitation, Jonathan Higgins APM, then Assistant Commissioner of Operations, Tasmania Police, told us about police involvement in national online child sexual exploitation initiatives—the Australian Centre to Counter Child Exploitation and the Joint Anti Child Exploitation Team—which enable police to track and interrupt the online component of child sexual exploitation.[659] However, he was less clear on how Tasmania Police could be involved in preventing child sexual exploitation that moves from online to face-to-face interactions with children in care.[660]

Assistant Commissioner Higgins agreed that Tasmanian Police, and the State as a whole, could do better in preventing the sexual exploitation of children in care.[661]

10.2.5 Missing persons and 'self-placement'

Research for the National Royal Commission identified that a child 'missing from placement' is a key 'red flag' indicator of sexual exploitation for service providers and child protection authorities.[662] In its 2021 *Out of Sight* report on children who are absent or missing from residential care, the Victorian Commission for Children and Young People found that an 'alarmingly high number' of such children were 'sexually exploited, abused and assaulted, often by adult men', with devastating and long-term consequences.[663]

Several non-government providers told us that Child Safety Officers regularly referred to children who had gone missing from a placement as having 'self-placed', and that if a child was older than 13 or 14, the Department has not always prioritised assertive outreach to ensure their safety.[664] We heard that sometimes the Department considered children as young as 12 to be able to 'self-protect'—that is, to be able to recognise grooming behaviour and remove themselves from an unsafe situation.[665] As one provider rightly pointed out:

> … the idea or notion that young people (some as young as 12), would have the ability to make fully informed, safe decisions for themselves without a safe and protective guardian or adult around to help them was and is something I find incredibly difficult to comprehend. I do not know how that label can be applied to vulnerable children, especially children who have suffered trauma, when it is not a label we would apply to our own children.[666]

Dr Miller told us that the practice of allowing children in care who were around the age of 15 or older to choose where they live is not followed in Victoria.[667] She said she was aware that this was allowed in Tasmania and New South Wales but described it as a 'dangerous practice' because of the risk of exploitation and poor outcomes for the child.[668]

As indicated above, section 9 of the *Keeping Children Safe Handbook* outlines the conditions under which Tasmania Police would respond if a child went missing from a placement.[669] The handbook includes the following:

- a missing person's report should only be made to Tasmania Police when the child's 'whereabouts are unknown, **and** where there are concerns for the safety **and** welfare of that person'—the handbook acknowledges that 'a child's age or vulnerability may put a child into this category' [bold emphasis is ours][670]
- the police require the Department to apply for and obtain a warrant under the Children, Young Persons and Their Families Act 'if it is assessed that intervention will be required to take the child into safe custody', otherwise a missing persons report 'does not provide police with any power to apprehend, detain or return the child to their placement'[671]
- the missing person's report remains 'live' on the police system until the missing person is found.[672]

Section 9 does not mention that a child missing from placement is at risk of child sexual exploitation but treats the child as any other missing person who 'may' fit criteria for a missing person's report. The guideline does not appear to cover the circumstance in which a child is missing from placement and their location is known but they are considered at risk of sexual exploitation.

There is no discussion in the handbook about the option for police to charge adults involved in child sexual exploitation with specific offences under sections 95 and 96 of the Children, Young Persons and Their Families Act (refer to discussion below). In fact, child sexual exploitation is not addressed in the handbook at all.

10.2.6 Intervention and disruption

The term 'disruptive policing' refers to lawful police action that may interfere with, delay or complicate criminal activity. As indicated above, when describing disruptive policing methods employed by Tasmania Police, Assistant Commissioner Higgins primarily referenced police responses to online child sexual exploitation identified by the Australian Centre to Counter Child Exploitation and the Joint Anti Child Exploitation Team.[673]

Assistant Commissioner Higgins also identified actions available to Tasmania Police that could disrupt child sexual abuse including:

- mandatory reporting obligations for children suspected of being abused in their family
- automatic information sharing between police databases and Registration to Work With Vulnerable People
- the management of serious sex offenders
- red flags on the police intelligence system for child sex offences
- automatic numberplate recognition
- closed-circuit television coverage across metropolitan areas.[674]

Counsel Assisting our Inquiry asked Assistant Commissioner Higgins to explain how police might respond to a common scenario of child sexual exploitation involving a child in care—that of a 15-year-old girl reported missing by her residential care provider and believed to be staying with a 40-year-old male who gave her alcohol and drugs in exchange for sex.[675] Assistant Commissioner Higgins talked about the difficulty of extricating a child from this situation if she does not want to leave and suggested that a warrant under the Children, Young Persons and Their Families Act for her retrieval could be counterproductive. He thought that police might be able to use their 'powers of persuasion' to negotiate with the child to return to her placement, they could interrogate the male involved and there were 'certainly avenues that would be followed to bring [the young person] back'.[676]

In some circumstances, police could charge those exploiting children in care with specific offences under the Children, Young Persons and Their Families Act—section 95 ('Harbour or conceal a child') and section 96 ('Remove a child without authority'). Assistant Commissioner Higgins told us that since 1 January 2000, Tasmania Police had only charged four people for offences under these sections of the Act.[677] He agreed that these provisions are available to police but he did not offer a reason for their infrequent use.

10.2.7 Preventing and responding to child sexual exploitation in other jurisdictions

Some young people interviewed for our commissioned research indicated that prevention strategies directed at addressing the risk of child sexual exploitation would be helpful. One young person said:

> So, I know that sometimes people … their parents might have been sexually abusive, so they … Even if your parents are horrible, you still associate that with love, so I think then children go on to sort of associate that abuse with being in a relationship with somebody. So, I think that that might be one of the ways that we can help children and young people help themselves to stop being taken advantage of is helping them relearn that love and a relationship doesn't have abuse in it, and any … If a relationship has abuse, it's not a loving relationship. It's a manipulative one. I think that helping them learn that and relearn that is probably an important way or a good way, because people sometimes tend to go back to that, subconsciously, or sometimes even consciously.[678]

Child sexual exploitation policy approaches from other jurisdictions may help inform change in Tasmania.

The Victorian Government's *Child Sexual Exploitation: A Child Protection Guide for Assessing, Preventing and Responding* ('Victorian guide') outlines how and why multiple agencies work together to prevent, detect, disrupt, intervene and assist children 'known to child protection' to recover from child sexual exploitation.[679]

The Victorian guide summarises the research and practice knowledge available about child sexual exploitation, such as indicators of risk and protective factors, as well as push and pull factors, that lead children into child sexual exploitation.[680] It then lays out the 'five elements of effective practice in response to child sexual exploitation': prevention, detection, disruption, intervention, and recovery and connection.[681] Finally, the Victorian guide details the legislation for sexual crimes against children involved in child sexual exploitation.[682]

As mentioned above, Dr Miller told us the 'Power to Kids' program is used in MacKillop Family Services' residential care homes in New South Wales and Victoria to prevent, disrupt and respond to harmful sexual behaviours, child sexual exploitation and dating violence.[683] All three prevention strategies relate to child sexual exploitation, namely:

- ‘whole-of-house respectful relationships and sexuality education’—educating carers and staff to recognise and respond to child sexual exploitation, and educating children about safety, respectful relationships and sexual health—which enables staff to have ‘brave conversations’ with children in care about sexual safety[684]
- ‘missing from home strategy’—establishing protective relationships between children and their carers to counteract grooming, safety planning with children and assertively maintaining contact with children when they are missing from home[685]
- ‘sexual safety response’— ‘proactively supporting exit strategies for child sexual exploitation’ and working with child protection and local police.[686]

Dr Miller told us that in addition to these preventative strategies, MacKillop Family Services has developed partnerships with Victoria Police that have helped identify perpetrators of child sexual exploitation and kept children safe.[687] In relation to the Victorian approach, Dr Miller stated:

> This focus on safety and disruptive policing and a multi-agency, ‘joined up’ response is a key aspect of keeping young people safe. The system needs to focus on the perpetrators much more in order for boundaries and safety to be gained.[688]

Dr Miller said that policing of child sexual exploitation in some jurisdictions was moving away from ‘success equalling a criminal conviction’ to considering success to be the child’s safety and disruption of the sexual exploitation (which may or may not end up in a charge or conviction of a sex crime).[689] Such a cognitive shift might allow Tasmania Police to act more protectively for children in care who are being sexually exploited.

The final component of the Power to Kids model is strong partnerships with mental health, allied health services and education or schools to meet the needs of children in care.[690]

An evaluation of Power to Kids showed it to be effective in reducing the risk of child sexual exploitation. The evaluation found that children subject to this model were missing from home less often, and carers were better able to identify those who needed help and to then help them out of sexually exploitative situations.[691]

10.2.8 Our observations

We consider that the Department and Tasmania Police could greatly improve their responses to sexual exploitation of children in care by developing a framework for preventing and responding to child sexual exploitation based on the example and experience of other jurisdictions. We recommend that the Department and Tasmania Police work with relevant stakeholders to develop such a framework.

Recommendation 9.29

1. The Department for Education, Children and Young People and Tasmania Police should work with non-government providers and other relevant stakeholders to develop a framework for preventing and responding to sexual exploitation of children in care that is informed by best practice and evidence from other jurisdictions. The framework should:
    a. acknowledge the responsibility of the Department to lead the protection of children in care from child sexual exploitation
    b. outline the prevention strategies to be used and each agency's role in delivering those strategies
    c. outline the detection, disruption and intervention strategies to be used and each agency's role in delivering those strategies
    d. outline how children in care who have been exploited will be supported to heal and recover
    e. describe how agencies will work together
    f. implement a reporting framework about the incidence of sexual exploitation of children in care, which is reported to the Quality and Risk Committee.
2. The Chief Practitioner should lead the development of the framework.
3. The *Keeping Children Safe Handbook* and Tasmania Police operating guidelines should be updated to reflect the role of police in responding to child sexual exploitation in the new framework.

Recommendation 9.30

Tasmania Police should more fully utilise the offences in sections 95 and 96 of the *Children, Young People and Their Families Act 1997* (the offences of harbouring or concealing a child and of inducing a child to be absent without lawful authority) to deter behaviour by adults that puts children in out of home care at risk of sexual abuse.

11 Responding to complaints and concerns about child sexual abuse

In this section, we consider the Department's response to complaints and concerns about child sexual abuse.

In Chapter 8, we outline the different ways in which an allegation of child sexual abuse of a child in care can be categorised as an allegation, notification, incident or care concern. In particular, the term 'care concern' is generally used in the out of home care context to refer to any concern about the wellbeing of a child in care.[692]

The Department can become aware of a concern about the welfare of a child in care from several sources, including the child themselves; a carer; a non-government provider; observations by a Child Safety Officer; someone in the child's life, such as a teacher or family member; or someone from another entity such as the Commissioner for Children and Young People. A person may alert the Department to a concern in a variety of ways, including by contacting the Department's Advice and Referral Line, having a conversation with a Child Safety Officer or informing the Child Advocate.

With respect to sexual abuse of a child in care, complaints and concerns may relate to the conduct of adults in the out of home care system (departmental or provider staff, volunteers or carers), the conduct of other adults (such as family members or others during access visits), harmful sexual behaviours or child sexual exploitation. Each form of child sexual abuse requires a different response. In this section, we focus on responding to complaints and concerns in relation to adults in the out of home care system, although note how other types of concerns need to be triaged to the correct response.

We discuss below what we heard about complaints and concerns. We then discuss the Department's policies and processes for responding to complaints and concerns, making recommendations directed at improving the Department's processes. We recommend:

- developing a publicly-available complaints policy
- a function within the Department for triaging concerns and complaints about the Child Safety Service sitting within the Office of the Chief Practitioner, and sufficiently resourced to enable same-day triaging of care concerns and complaints against staff for children in out of home care
- that the Office of the Chief Practitioner guides and supports experienced practitioners who are independent of the case (this may be a Practice Manager) in assessing and responding to less serious concerns
- that the Office of the Chief Practitioner be responsible for assessing, investigating and leading responses to serious concerns about the safety and wellbeing of children in care, with two exceptions: complaints against state servants should

be referred to the Child-Related Incident Management Directorate; and concerns involving harmful sexual behaviours should be referred to the Harmful Sexual Behaviours Support Unit

- improvements to the process for responding to concerns about allegations of child sexual abuse, including ensuring all concerns about child sexual abuse by adults in the system are directed to the Child-Related Incident Management Directorate we recommend (refer to Chapter 6, Recommendation 6.6).

11.1 What we heard about complaints and concerns

Several witnesses told us of their frustration with the Department's complaints process. A former departmental employee told us that a complaints investigation could take up to 18 months and that the Department's communication about the process and progress of an investigation is poor.[693]

Dr Kim Backhouse of the Foster and Kinship Carers Association of Tasmania observed that the Department does not manage complaints centrally—instead, 'complaints within the Department seemed to go all over the place'.[694]

Several of the children interviewed for our commissioned research did not trust that adults would listen or keep them safe if they did raise concerns.[695]

As discussed in Chapter 8, our review of the 22 children's files revealed that, overall, there is evidence that departmental and out of home care staff undertook some form of investigation or assessment of each concern raised in relation to the children, although it was not always clear what process was followed.

As also discussed in Chapter 8, we are aware of only four or five instances of Child Safety Service staff being suspended or terminated over more than 20 years. Because of poor record keeping, it was difficult to determine whether there has been more disciplinary action than that reported to us, or whether the Department has been slow to act against staff for concerning behaviour.[696]

11.2 The Department's policies and processes

The National Royal Commission recommended that institutions have a clear complaints-handling policy and procedure to respond to complaints about the sexual abuse of a child, including how to make a complaint, responding to and investigating a complaint, providing support and assistance, and systemic improvements following a complaint. It recommended these policies be 'clear, accessible and child focussed'.[697]

The Department's 2015 *Service Review and Continuous Improvement Policy* outlines how complaints, care concerns, critical incidents and appeals of decisions are to be managed.[698] The policy requires the Department to:

- Manage feedback from clients and the public in a consistent and transparent manner through robust compliments and complaints processes.
- Improve services through rigorous internal evaluation and compliance with external investigations and reviews where appropriate.
- Prioritise and investigate appeals, concerns, critical incidents and reviewable events.[699]

Three key processes under the policy are:

- the 2013 *Protocol for Managing Complaints* and 2013 *Complaint Handling and Reviews Practice Advice*, which provide general principles and strategies to guide departmental staff in responding to complaints[700] (the protocol further describes what decisions could be reviewed and how the review of a decision should proceed up the line of delegation)[701]
- the care concerns policy and processes, which describe how departmental staff should respond to concerns about the care of children[702]
- the 'Serious Events Review' process, which describes how staff should respond to a serious event involving a child in out of home care where the actions or inactions of the Department may have contributed to the event.[703]

We discuss each of these below, noting that the latter two have recently been discontinued. None of these policies are, or were at the time of our review, publicly available on the Department's website.

The Child Advocate also has a role in the Department's complaints processes, providing support and assistance for children wishing to resolve complaints (we discuss the role of the Child Advocate in Section 12).

11.3 Responding to complaints

11.3.1 Complaints handling

We understand that the *Protocol for Managing Complaints* and the *Complaint Handling and Reviews Practice Advice* are still current policies.[704] However, they do not refer to some central roles in the Department's complaints process, including the Child Advocate.[705]

The new Department for Education, Children and Young People's webpage titled 'Complaints – Child Safety and Youth Justice Services' explains that complaints can be made by a person who has a 'valid interest in an issue' relating to a decision, a service provided or the behaviour of Child Safety and Youth Justice Services staff.[706] If the issue relates to the rights of a child in care, the webpage directs the person to contact the

Child Advocate. The page also makes suggestions about what information should be included in the complaint.[707]

If not satisfied with the outcome of a complaint, the 'Complaints' webpage directs complainants to contact the Ombudsman Tasmania.[708] We discuss the adequacy of external review mechanisms separately in Section 12.

Apart from a simple explanation of 'what you can expect when making a complaint', the 'Complaints' webpage does not fully outline the Department's complaints process. It would not be possible for someone to know if the Department had followed a reasonable process in response to their complaint or how they might receive 'timely feedback' about the outcome of the complaint.[709]

The Child Advocate's webpage has slightly more information, suggesting methods for contacting the Child Advocate, with links to a list of the rights of children in care, an explanation of how the Child Advocate can assist in upholding the rights of a child in care, and how to let someone know if 'something's not OK'.[710]

The Child Advocate told us she had also produced a 'child-friendly' flip card version of the Child Safety Service complaints process, which was mailed out to all children in care, including those under third-party guardianships, in 2020.[711]

11.3.2 Improving complaints handling

The Child Advocate said the Children, Youth and Families Executive acknowledged that the complaints process is an 'area of need'.[712]

Ms Lovell, from Children and Family Services, acknowledged that a coordinated response was necessary to accurately assess the risk of sexual abuse to a child:

> … it's more likely that multiple services will have some pieces of relevant information … It's not until you piece together all of that information that you can identify a pattern and history and really appreciate how serious the matter might be and how great the risk to a child might be.[713]

In his letter dated 9 February 2023, Secretary Bullard described hoping to engage in a 'whole-of-government approach to complaints management' that is based on the Department of Health's complaints management system project.[714] In the meantime, Secretary Bullard told us that the Department has started its own 'complaints management review project' to develop a child safe complaints policy and process 'that takes into account any relevant recommendations of the Commission [of Inquiry]'.[715]

We welcome Secretary Bullard's prioritisation of complaints management and recommend that the Department develops a publicly-available complaints policy.

This policy should involve a 'no wrong door' approach so all concerns and complaints make their way to a central location for recording, triaging, monitoring and coordinating of a response—this function should sit within the Office of the Chief Practitioner (refer to Recommendation 9.17). It should report regularly to the Quality and Risk Committee.

The policy should apply to the whole of the Child Safety Service, including out of home care, and address all types of complaints and concerns. It should cross-refer to the specific policy for concerns about the safety and wellbeing of children in care, which we discuss in the following section (refer to Recommendation 9.32).

A good complaints process also allows for internal review of decisions. Internal review is an especially important mechanism for people who are concerned that a departmental decision may increase a child's risk of child sexual abuse (refer to Section 12 for a discussion of external reviews of out of home care decisions in circumstances where the internal review process has not succeeded in resolving someone's concern).

Recommendation 9.31

1. The Department for Education, Children and Young People should develop and maintain a complaints policy and procedures for Child Safety Services and out of home care. The policy and procedures should:
    a. explain how to make a complaint and who to complain to using a 'no wrong door' approach
    b. direct who should be informed when a person receives a complaint
    c. direct who is responsible for responding and within what timeframes
    d. ensure a child-friendly complaints procedure is made available to all children in care
    e. apply to all types of complaints or incidents
    f. cross-refer to the new concerns about the safety and wellbeing of children in care policy (Recommendation 9.32)
    g. explain how to seek an internal review of a decision made by the Department
    h. outline how to provide feedback and support for a complainant.
2. The Department should implement a centralised complaints and incident recording system.
3. The Chief Practitioner should receive all complaints about Child Safety Services and out of home care and be adequately resourced to receive, triage, record, monitor and coordinate responses.

4. The Chief Practitioner should report regularly on complaints handling to the Quality and Risk Committee and the Commission for Children and Young People.
5. The complaints policy and procedure should be published on the Department's website.

11.4 Responding to concerns about the safety and wellbeing of children in care

The Department owes children in care a higher duty of care than children who are not under its guardianship. The 2006 Jacob–Fanning report stated that the Department's 'parenting bar should be set high and our parenting should be exemplary if children are removed from their families'.[716] One way to ensure this duty is met is to take concerns about the safety and wellbeing of children in care more seriously.

Between February 2013 and December 2022, the Department followed a care concerns policy and related procedures to guide its response to concerns about the safety and wellbeing of children in care.[717] We discuss this former policy approach in some detail because there are some strengths and weaknesses in this policy that should inform the Department's approach in the future.

11.4.1 Care concerns policy

The *Responding to Care Concerns Impacting a Child in Out of Home Care* policy ('care concerns policy'), which has since been superseded, stated that 'all concerns relating to the care of a child in out of home care should be treated as serious'.[718] It outlined the processes for responding to two different types of care concerns—quality of care concerns and serious care concerns—to ensure 'allegations of a more severe or chronic nature [are] responded to by our most skilled and qualified staff, given the possible impact and implications of such abuse'.[719]

The policy directed staff to follow a 'quality of care concern' process if the complaint related to a less serious care issue, such as concerns about inadequate supervision, not supporting a child to engage with school, 'lack of positive regard for the child' or not providing an adequate diet.[720] For more serious concerns—defined as acute or chronic physical abuse, sexual abuse, chronic neglect and/or emotional abuse, or cumulative concerns that were ongoing despite intervention with the carers—the policy directed the Department to follow a higher-level investigative process.[721]

Essentially, the difference in response between the two pathways was the level of the responder's seniority and the degree of independence from the child's case management. Quality of care concerns could be handled within the Child Safety Service team or office responsible for the child's case management, while concerns about

more severe abuse were to be escalated for investigation by more experienced and objective Senior Quality Practice Advisors from the Quality Improvement and Workforce Development team.[722]

The care concerns policy required that serious care concerns investigations were reviewed by a 'Care Concern Monitoring Group', which was supposed to meet every six months and include departmental staff as well as non-government care providers and the Commissioner for Children and Young People.[723]

Overall, we consider that the care concerns policy placed an appropriately specific focus on responding to the safety and wellbeing concerns of children in care, allowed for specialist investigatory processes for serious concerns, and had a governance process for monitoring responses to care concerns. We have reservations about some gaps in the policy, as well as the operation of the policy in practice. We discuss these reservations in the following section.

11.4.2 Problems with the care concerns policy

In relation to child sexual abuse, one of the problems we identified with the care concerns policy was that it did not define child sexual abuse. Importantly, it did not address harmful sexual behaviours, child sexual exploitation or grooming behaviours. In addition, privacy violations—which can indicate voyeuristic abuse—were classified as a lower-level 'quality of care concern'.[724]

Also, the policy focused on care concerns associated with the behaviour of a carer or the care environment—for example, if the alleged abuser was outside the care home, the policy did not apply. For those concerns about child sexual abuse that fell outside the scope of a care concern, the Department provided no real guidance to staff beyond adopting the 'Child Safety assessment'.[725]

The care concerns policy was also very procedurally focused rather than child centred. The underpinning framing appeared to be disciplinary in nature, with no clear process for involving the child or supporting non-offending caregivers to protect and support the child in care.

11.4.3 Problems with implementing the care concerns process

We are also concerned about the operationalisation of the care concerns policy. Dr Deborah Brewer was the Manager of the Quality Improvement and Workforce Development team in the Department from 2017 to 2019. On joining the Department, Dr Brewer said she identified a lack of experience and capacity within the Quality Improvement and Workforce Development team, noting that 'none of the team of quality improvement investigators … had an investigation qualification or experience in abuse in care investigations'.[726] She said that she raised concerns about this with leadership and, on one occasion, before going on leave, she refused to sign off on three investigations

'because I did not feel that they had covered all the areas needed'.[727] When she returned from leave, the three investigation reports had been approved without her concerns being addressed.[728]

Dr Brewer said that she also attempted to introduce investigations training for team members while she was in the role, but she said her suggestion was not accepted.[729] She remains an advocate for investigators receiving specialist training:

> Interviewing children in an investigation situation is a specialised skill. You can do so much harm if it is done incorrectly, and information collected incorrectly can jeopardise the whole investigation.[730]

Dr Brewer suggested that the whole care concerns system needed an overhaul, from 'referral of care concerns up the chain' and policies, to training of investigators and referrals to other agencies, such as police.[731] She identified the need for an 'organisational lead' to be responsible for responding to care concerns and ensuring investigations were initiated where necessary, as well as for managing mandatory reporting:

> There should be a proper end to end process clearly identified where outcomes are tracked and learnings from the incident translated into quality improvements as required.[732]

Dr Brewer expressed a view that a unit for 'serious concerns in care' be 'completely separate' from the Department, and that learnings from care concerns investigations be collated and systematically tracked to assist with quality improvement.[733]

We understand that the Quality Improvement and Workforce Development team—including the roles of Senior Quality Practice Advisors—was abolished during the Strong Families, Safe Kids redesign, which began in 2019.[734] Secretary Pervan told us that these roles were substantively replaced with new roles performing similar functions, including Practice Leader; Practice Manager; Principal Practice Manager; Service Development Manager; and Service Development Practice Advisor.[735] We are unclear about how these roles assisted with the management of care concerns. Ms Lovell advised in June 2022 that she had been overseeing serious care concerns with assistance from her director and other practitioners.[736]

The Department also told us that the Care Concern Monitoring Group, which was intended to monitor the Department's response to serious care concerns, 'was never fully implemented' and that there is 'no evidence that this group ever met'.[737]

11.5 Serious Events Review Team

The Department established a Serious Events Review Team in response to the 2015 death of an infant known to the Tasmanian child protection system. This team operated between December 2017 and June 2020.[738] Prior to the Serious Events Review Team, the Department did not have a formal mechanism for reviewing such events.[739]

The *Serious Events Review Procedure* defined the mandate of the Serious Events Review Team in a way that included children in care:

> The Serious Event Review Team undertakes a review when a child or young person or adult who is known to Children, Youth and Families has experienced a serious event, and it appears that the Children, Youth and Families service system (including contracted services) may have contributed to the event through action or inaction.[740]

While the Serious Events Review Team investigated allegations of harmful sexual behaviour in the context of youth detention, it had not been used to investigate concerns about the sexual abuse of children in care.[741] We discuss some of these investigations in Chapter 11 but note here the variability in quality of those investigations, with some being excellent.

The Serious Events Review Team comprised senior practitioners supported by a comprehensive set of policies.[742] It provided another specialised investigative pathway that could have been used for serious events that involved children in care—one that had external oversight in the form of the multiagency Serious Events Review Committee.[743]

The Serious Events Review Team was disbanded in June 2020, although we were told it can be reconvened.[744] We are unclear what efforts are being taken to maintain the investigatory skills of the staff who have been 'returned to their substantive positions'.[745] We also understand that reconvened Serious Events Review Team investigations are not subject to the oversight of the Serious Events Review Committee (refer to Chapter 11).

11.6 Recent reforms

Secretary Pervan told us that the Practice Performance and Governance Committee (refer to Section 4.2) had identified an 'increase in care concerns' as an 'emerging risk' and the need to establish a process to respond to adverse incidents.[746]

The Department replaced the care concerns policy described above with the *Wellbeing in Care Procedure* and associated practice advice, which was uploaded to the Child Safety Service's Practice Manual intranet on 15 December 2022.[747]

The *Wellbeing in Care Procedure* delineates between less serious concerns ('wellbeing worries') and more serious concerns ('wellbeing concerns'). The two levels of concerns are differentiated in the Procedure as follows:

- a wellbeing worry relates to worries about the child's wellbeing in placement (and could relate to any domain of wellbeing)
- a safety [wellbeing] concern relates to worries specific to the child's safety (specifically Loved & Safe domain), that indicates potential risk as per section 4 of [the Children, Young Persons and Their Families] Act and/or a breach in the Child Safe Code of Conduct.[748]

Wellbeing worries can be dealt with by the care team, whereas wellbeing concerns are escalated to a 'Wellbeing in Care consultation', which comprises, at minimum, the Child Safety Officer, the Practice Leader, out of home care representatives and the Practice Manager.[749] The procedure outlines who decides the level of concern, how worries and concerns are recorded in the Child Protection Information System, how all parties (including the child) will be kept informed of progress, conditions for referral to Tasmania Police and how meetings of the Wellbeing in Care consultation are to be conducted and recorded.[750]

A statewide Allied Health Professional Level 4 Practice Manager has also been appointed to provide guidance and oversight for managing all wellbeing in care concerns and is accountable to the Director via the Practice and Performance Governance Committee.[751]

The new procedure explicitly classifies a concern that relates to a carer's breach of the Department's newly released interim *Child Safe Code of Conduct* (refer to Section 6.4) as a more serious 'wellbeing concern'. Noting that the code of conduct covers unacceptable behaviours such as grooming and boundary breaches, the procedure includes a range of concerning behaviours related to sexual abuse in the more serious category, which were not captured in the former care concerns policy. This is an important improvement.

The *Wellbeing in Care Practice Advice* adopts an explicitly supportive and strengths-based approach to a child in care and those involved in the child's life.[752] This approach is particularly helpful for responding to non-complicit carers and where the abuser is outside the household or is a child. However, the practice advice and procedure must be more explicit about how these forms of child sexual abuse are to be addressed.

11.7 Ongoing problems

The *Wellbeing in Care Procedure* (and associated practice advice) is a clear improvement on the outdated care concerns policy in that it has updated the positions involved in responding to reflect staffing arrangements and it provides much-needed guidance to staff. It also describes how departmental staff are to communicate with the child, carers and other parties during the process of resolving the concern.

While we welcome the focus on a broader range of conduct and on a more child-focused approach, we consider there are some gaps that should be addressed.

We are concerned that the new procedure does not have a replacement for the investigative capacity, independence and oversight contained in the care concerns policy or the Serious Events Review Team's remit.

Secretary Pervan told us that the *Wellbeing in Care Procedure* reflects the Signs of Safety approach:

> Work has been done to re-imagine how the Department can respond to concerns about children in Out of Home Care placements (Care Concerns) in a way that reflects the Signs of Safety approach and the holistic wellbeing of children in care. The Department aims for this approach to be similar to the mechanism used to work with any other family about issues that are impacting the safety and wellbeing of children.[753]

We do not have a view on the suitability of the Signs of Safety approach to the practice of child protection, but we are concerned that the same approach applied to concerns about children in their family of origin will be applied to concerns about the sexual abuse of children in care. As indicated above, the Department owes children in care a higher duty of care than children who have not been removed from their family of origin.

Signs of Safety was designed for a different context than out of home care—a context where the responsibility and risk for a child's welfare are shared between the child's natural guardians and those around them, including the powerful statutory entity that is the Department.[754] In the context of out of home care, the Department is guardian and statutory entity—consequently, the risk of sexual abuse for a child in out of home care is entirely the Department's to bear.

11.8 Our observations

We consider it fundamental that there is a specific process for responding to concerns about the safety and wellbeing of children in care, which is distinct from the assessment tools applied to children living with their family of origin.

We propose a new process for the Department to respond to concerns about the safety and wellbeing of children in care that addresses the shortcomings of the previous and current processes, while maintaining their strengths.

Earlier, we recommend a directorate-wide complaints process, which cross-references the new safety and wellbeing of children in care policy. We also recommend that the Office of the Chief Practitioner triages, records, monitors and coordinates all complaints. For less serious concerns, or for concerns that fall outside our terms of reference, the Chief Practitioner should monitor and oversee a more localised response.

The new safety and wellbeing of children in care policy should ensure it has clear processes for responding to all types of sexual abuse. Primarily, the Office of the Chief Practitioner's care concerns and complaints unit should be responsible for assessing, investigating and leading responses to serious care concerns, with two exceptions: complaints against state servants should be referred to the Child-Related Incident Management Directorate; and care concerns involving harmful sexual behaviours should be referred to the Harmful Sexual Behaviours Support Unit.

In Section 3.2, we recommend that the Department sets expectations in its contracts with out of home care providers (Recommendation 9.3). This should include requirements for reporting all serious concerns about the safety and wellbeing of children in care to the Chief Practitioner, which would include all types of child sexual abuse and related conduct.

The Child-Related Incident Management Directorate should include mechanisms for experts in child safety who understand out of home care settings to help interpret investigation outcomes where technical knowledge is needed to understand if behaviour was reasonable in the course of employment. While the Child-Related Incident Management Directorate will be responsible for investigation, it will need to work closely with the Chief Practitioner and Child Safety Officers to ensure a child in care who has been sexually harmed by a state servant receives appropriate treatment and support.

Concerns about the safety and wellbeing of children in care should form part of the Department's reporting framework and be reported to the Quality and Risk Committee by the Chief Practitioner.

Recommendation 9.32

1. The Department for Education, Children and Young People should develop a new policy to guide responses to concerns about the safety and wellbeing of children in care. The policy should:
    a. identify all forms of sexual abuse—including grooming, child sexual exploitation, harmful sexual behaviours, abuse by adults within and outside the out of home care system—as serious and requiring a higher-level response
    b. describe response pathways for concerns about the sexual abuse of children in care depending on the context. Specifically
        i. concerns or complaints about the sexual abuse of a child in care, or related conduct, by departmental staff should be referred to the Child-Related Incident Management Directorate (Recommendation 6.6)

ii. responses to concerns about the sexual abuse of children in care, or related conduct, by adults who are not departmental staff should be led or overseen by the Chief Practitioner

iii. responses to concerns about sexual exploitation of children in care should be led or overseen by the Chief Practitioner (Recommendation 9.17)

iv. responses to concerns about harmful sexual behaviours involving children in care should be led or overseen by the Harmful Sexual Behaviours Support Unit (Recommendation 9.28).

2. The Chief Practitioner should receive all concerns about the safety and wellbeing of children in care and be adequately resourced to receive, triage, record, monitor and coordinate responses. Where the Chief Practitioner has referred a matter to another entity, the Office of the Chief Practitioner should support the localised response to the child's safety and ongoing welfare.
3. The Office of the Chief Practitioner should include staff with skills in investigation and child interviewing to conduct investigations.
4. The outcomes of all concerns about the sexual abuse of children in care should be reported to the Quality and Risk Committee.

12 Independent advocacy and oversight

Children in out of home care need independent advocacy and oversight. As Penny Wright, South Australian Guardian for Children and Young People, said:

> To ensure that children can be protected there must be roles that enable fearless and tenacious advocacy and independent public scrutiny that demands accountability. The only agenda for such roles must be the interests of children and young people and no conflict with any other interest.[755]

Given the vulnerability of children in out of home care, there is a need to strengthen individual advocacy and systemic oversight mechanisms to ensure:

- independent advocates take a proactive stance, actively engaging children in care in discussions about their safety, so the onus is not on the child disclosing or raising a concern
- children in care have a trusted adult, who is independent of the Department, with whom they can raise any concerns relating to their experiences in out of home care, including concerns about child sexual abuse

- children are supported and assisted to raise their concerns about out of home care with the Department or another relevant body, and to make a complaint about the Department's responses to their concerns, where necessary
- complaints about out of home care are investigated by a body with relevant knowledge and expertise
- departmental actions or decisions about out of home care, including responses to allegations of child sexual abuse, are subject to independent review
- allegations of child sexual abuse in out of home care that are outside the Reportable Conduct Scheme (such as harmful sexual behaviours or child sexual exploitation) are reported to another appropriate oversight body
- an appropriate independent oversight body has clear functions and powers to monitor and undertake systemic inquiries into the operation of the out of home care system and out of home care services.

In Chapter 18, we recommend establishing a new Commission for Children and Young People, with broader and clearer functions than those currently bestowed on the Commissioner for Children and Young People, as well as specific functions in relation to vulnerable children (refer to Recommendation 18.6). In out of home care, we recommend the new Commission for Children and Young People is responsible for individual advocacy for children in out of home care, systemic monitoring of out of home care and oversight of investigations into reportable allegations involving children in out of home care. The new Commission would include a new Commissioner for Children and Young People (refer to Chapter 18), a new Commissioner for Aboriginal Children and Young People (refer to Section 5 in this chapter) and a new Child Advocate (Deputy Commissioner) (refer to Section 12.1 in this chapter).

The roles of other oversight or similar bodies for the out of home care system would be as follows:

- the Ombudsman would receive and investigate complaints about the Department's actions from children in care, parents, carers or the new Child Advocate on behalf of a child
- the Tasmanian Civil and Administrative Tribunal would have jurisdiction to review departmental decisions about children in out of home care
- the Integrity Commission would have the power to investigate allegations of misconduct by public officials in the out of home care system (refer to Chapter 18)
- the Auditor-General could continue to undertake performance audits of the Department to examine its effectiveness in complying with internal policies and procedures in out of home care (refer to Chapter 2).

12.1 Independent advocacy for children in out of home care

The importance of supportive adult–child relationships to children's wellbeing and development is well established.[756] Research we commissioned found that children in out of home care and other institutions:

> … wanted and needed allies and confidants that were accessible and, preferably, proactive in engaging children and young people to ask if they had any worries or concerns or wanted to make a complaint. These adults needed to be non-judgmental, have a good appreciation of risks and how to deal with them and to demonstrate a commitment to acting on what children wanted and needed.[757]

Ideally, every child in out of home care would have such a relationship with their carer(s) and Child Safety Officer. In Section 6.1, we recommend that the Department sets a maximum caseload for Child Safety Officers (Recommendation 9.16) and, in Sections 4.6 and 7, we make recommendations to develop and support quality carers (Recommendations 9.11, 9.20 and 9.21). This should increase opportunities for children in care to develop supportive relationships with a trusted adult. However, there is also a need to consider other ways to ensure all children in care have a trusted adult with whom they can raise concerns.

12.1.1 The Child Advocate

Tasmania's first Child Advocate was appointed in June 2018 following publication of a report on advocacy for children in Tasmania prepared by Dr Maria Harries in 2013.[758] The purpose of the proposed role within the Department was to provide a means for ensuring concerns and complaints by children in care were appropriately directed and dealt with.[759]

In 2017, the former Commissioner for Children and Young People, Mark Morrissey, published a report on children in out of home care in Tasmania. This report identified the importance of individual advocacy for children in out of home care and suggested that 'at the very least, consideration could be given' to establishing a Children's Advocate within the Department.[760] The former Commissioner referred to the existence of a similar role in Western Australia and observed that a 'clear disadvantage' of such a role was its lack of independence from the Department.[761]

The role of the Tasmanian Child Advocate is in the Department and reports directly to the Secretary. The Child Advocate provides 'advocacy services for and on behalf of all children and young people in the care of the Secretary' and ensures children in care 'have a voice in decisions that affect them and in services provided to them'.[762] The Child Advocate has many responsibilities, covering advocacy for children and departmental capacity building.[763] These responsibilities include:

- giving children information on policies and procedures that underpin decisions and service delivery in a format appropriate to their understanding
- promoting the Department's *Charter of Rights for Tasmanian Children and Young People in Out of Home Care*
- determining when advocacy for children in care should be escalated within the Department
- providing support and assistance for children wishing to resolve complaints
- ensuring the opinions of children are provided to departmental staff
- informing development of policy, procedures, practice standards and quality improvement tools
- developing the knowledge base of the Department for consulting with children in care
- reporting quarterly to the Secretary and the Minister.[764]

The Child Advocate told us that the location of her role inside the Department, but separate from Children, Youth and Families, creates 'a degree of independence', which allows her to act 'like an internal watchdog'.[765] She said the benefits of being located within the Department include:

- being available to Child Safety Service staff seeking advice on how to uphold a child's rights
- having collegial relationships within the Department, enabling the role to influence decision making
- having access to the Child Protection Information System to review the files of individual children.[766]

However, the Child Advocate acknowledged that her role in the Department as 'disruptor and supporter, as well as guide and critic' has the potential to create confusion.[767]

We heard that the Child Advocate performs crucial work and acts as an important safeguard for children in out of home care.[768] One person described her as an 'impressive and dedicated advocate', while another said she was 'doing an excellent job'.[769] One young person living in out of home care who was consulted for our commissioned research explained their confidence in the Child Advocate to act quickly and decisively on their behalf.[770] However, this young person reflected that it could be difficult for other young people to make contact with the Child Advocate if they did not know her or were very young.[771]

We are concerned that with only two people in this advocacy role, and no support staff, many children will not have an established relationship with the Child Advocate.

Several people raised concerns about the independence of the Child Advocate's role and its ability to be the 'safe person' for every child in out of home care.[772]

We acknowledge and commend the tireless and important work the current Child Advocate has undertaken for individual children in out of home care. However, we note in relation to the role and structure of the Child Advocate more broadly, that:

- the number of children in out of home care makes it impossible for the Child Advocate—even with the assistance of another role—to visit every child regularly and proactively
- for a child who has a concern or complaint about their placement or carer, and who cannot rely on the assistance of an adult, the onus is on that child to contact the Child Advocate—many children will not feel confident enough to do so (despite the child-friendly resources that the Child Advocate has created to publicise her role)
- children may not always feel comfortable raising their concerns or complaints about the Department with the Child Advocate, given the location of this role inside the Department
- there is an inherent conflict in having the Child Advocate internal to the department that makes decisions about children.

In our view, despite the benefits identified by the Child Advocate (outlined above) of being located within the Department, the function of undertaking advocacy for individual children in out of home care should be genuinely independent of the Department. An independent community visitor scheme, administered by the new Commission for Children and Young People and led by the new Child Advocate, could achieve this and is discussed below. The guidance role the Child Advocate offers staff should be maintained and expanded in the new role of Chief Practitioner we recommend (refer to Section 6 and Recommendation 9.17).

12.1.2 Independent community visitor schemes

Across Australia, community visitor schemes exist in many different settings, including disability, mental health, prison, youth detention and out of home care. In such schemes, independent members of the community—known as 'visitors'—have powers to visit, inspect and report on the experiences of residents of these institutions.[773] They are an important way to safeguard the rights of those whose care has been entrusted to institutions.

Tasmania has a Mental Health Official Visitors Program and a Prison Official Visitors Program, both of which are administered by the Office of the Ombudsman.[774] There are no community visitor schemes in Tasmania for children in youth detention or out of home care.

In Queensland, the Public Guardian administers a community visitor program for children, whose purpose is to protect the rights and interests of children staying at 'visitable locations'.[775] These are detention centres, residential care facilities and homes where children who have been placed under the custody or guardianship of the chief executive are living, among other locations.[776]

Community visitors are appointed by the Queensland Public Guardian under the *Public Guardian Act 2014* (Qld) ('Queensland Public Guardian Act').[777] They are not employees of the public service.[778] The Queensland Public Guardian must decide the remuneration and allowances payable to community visitors.[779] A person is only eligible for appointment as a community visitor for children if the Queensland Public Guardian considers the person has the 'knowledge, experience or skills needed' to perform the functions of the role.[780] In these respects, the Queensland scheme differs from some other community visitor schemes, where visitors may be volunteers and are not necessarily required to have particular knowledge, skills or experience.

A Queensland community visitor has a range of statutory functions with respect to each child they visit in care. These include:

- developing a trusting and supportive relationship with the child, so far as is possible
- advocating on behalf of the child by listening to, giving voice to and helping to resolve the child's concerns and grievances
- seeking information about, and facilitating access by the child to, support services appropriate to the child's needs
- enquiring about and reporting on the adequacy of information given to the child about their rights
- enquiring about and reporting on the physical and emotional wellbeing of the child
- inspecting the home or care facility and reporting on its appropriateness for the accommodation of the child, and ensuring carers are meeting the child's needs.[781]

The Queensland Public Guardian Act requires children in residential care to be visited 'regularly'.[782] Acting Public Guardian, Catherine Moynihan, told us that the default frequency of visits for children in residential care is quarterly, but this can be increased to monthly.[783] The Queensland Public Guardian has the power to decide the frequency

of visits to a child not living in residential care, considering a range of factors including the child's age and any physical disability or impairment.[784] Ms Moynihan told us that there are about 100 community visitors for children in Queensland.[785]

Queensland community visitors can assist children in care with issues or concerns about their placement, contact with their birth family, allowances and their Child Safety Officer.[786] After each visit, the community visitor completes a report that is provided to the Public Guardian. The report covers the child's concerns and grievances, support services, rights (including family contact and cultural rights), physical and emotional wellbeing, and placement conditions and suitability.[787] Community visitors are mandatory reporters under the Queensland Child Protection Act.

The Queensland community visitor attempts to resolve any issues arising from the visit with relevant service providers and the Department of Children, Seniors and Disability Services. However, if an issue is not resolved, the visitor may formalise the issue into a complaint and/or seek the assistance of a 'child advocate' (discussed below).[788] Information-sharing provisions in the Queensland Public Guardian Act enable the Public Guardian to obtain information from various entities. Such information may be used for various purposes, including linking a child with another entity to meet the child's needs, supporting a child to resolve an issue with an entity, and helping the child to lodge a complaint with an entity.[789]

In South Australia, the *Children and Young People (Safety) Act 2017* (SA) establishes the role of an independent Child and Young Person's Visitor.[790] The main functions of this role are to visit and advocate for children in out of home care.[791] The South Australian Guardian for Children and Young People, Penny Wright, told us that she was appointed to the role of Child and Young Person's Visitor in 2018 but resigned from the position in August 2021 because the appointment was not provided with any extra funding or resources.[792] The role has been vacant since this time. The South Australian Guardian for Children and Young People has a team that advocates on behalf of individual children in out of home care. This is discussed below.

12.1.3 Other models of individual advocacy for children

In many cases, a Queensland community visitor will be able to help resolve concerns for a child in out of home care. However, where the concerns are more complex or difficult to rectify, a 'child advocate' may also become involved.[793] Queensland child advocates are legally trained officers appointed by the Queensland Public Guardian who can:

- provide information and advice to the child about legal issues they might be concerned about
- help the child resolve disputes and make complaints if they are unhappy with a decision made about their time in the child protection system

- support the child and, if requested, speak for the child in meetings with the child protection agency (or any other agency) to make sure their needs are being met and their views and wishes are being heard
- support the child in child protection court proceedings or proceedings in the Queensland Civil and Administrative Tribunal for reviews of decisions about their placement, contact arrangements or other matters.[794]

There are 11 child advocates in the Queensland Office of the Public Guardian.[795]

In South Australia, the Guardian for Children and Young People has an individual advocacy function for children who are under the guardianship or in the custody of the chief executive of the South Australian Department of Child Protection and, in particular, for any such children who have suffered or are alleged to have suffered sexual abuse.[796] There are four advocates in the South Australian Guardian's advocacy team who assist children in resolving their concerns and upholding their rights.[797]

12.2 A community visitor scheme for out of home care

In 2009, the former Commissioner for Children in Tasmania set up a small pilot visitor scheme for children in out of home care; this scheme ran for 12 months between 2010 and 2011 in southern Tasmania.[798] Visitors in the pilot scheme were volunteers.[799] An evaluation of the scheme recommended that it be established as an ongoing program within the then Office of the Commissioner for Children.[800] Similarly, in 2011, a Select Committee on Child Protection recommended that the pilot be extended to all children in state care.[801] However, the pilot was 'discontinued once it became apparent it was not within the functions or powers of the Commissioner for Children'.[802] In 2013, Dr Maria Harries' report on advocacy for children in Tasmania concluded that a visitors scheme for children in care was 'not a priority at this point' for the committee that oversaw the report.[803]

In her 2019 *Monitoring Report No. 1* on the Tasmanian out of home care system, the current Commissioner for Children and Young People, Leanne McLean, recommended establishing a visitor program, initially focusing on children in out of home care living in non-family-based care settings.[804] Commissioner McLean reiterated support for a children's visitor program in her statement to us but recommended against the model adopted for the pilot, given its 'limited scope'.[805] Rather, the Commissioner pointed to the more comprehensive model operating in Queensland (described above), comprising community visitors and child advocates, as a preferred model.[806]

We agree that individual advocacy for children in out of home care in Tasmania would be significantly strengthened by establishing an independent community visitor scheme for children in out of home care (based on the Queensland model) that would subsume the advocacy functions of the Child Advocate. Community visitors could proactively ask children about their safety as well as enabling children in care who have a concern

about their placement or any other issue—including a concern relating to child sexual abuse—to raise it confidentially with a supportive person who is independent of the Department, who can then raise that concern with the relevant entity and try to resolve it on the child's behalf. An independent visitor who has 'eyes on a child', and proactively asks for the child's views and concerns, empowers children to communicate when those concerns arise. Such an arrangement is likely to reduce the risk of those children experiencing sexual abuse and for abuse to be identified and responded to early.[807]

An independent community visitor scheme for children in care should be established in legislation and adequately funded to enable visitors to develop supportive relationships with children in care and to undertake advocacy on their behalf as necessary. As in Queensland, visitors should be paid rather than appointed as volunteers, and have appropriate child-related knowledge, skills and expertise. They should have access to the Child Protection Information System to assist them in their advocacy work. They should also be mandatory reporters. Wherever possible, Aboriginal children in care should have access to an Aboriginal community visitor.

We recommend that the program includes scope for appointing a small number of legally trained child advocacy officers (based on the Queensland model) to assist with more complex concerns and to support children in applying for an external review of a departmental decision (discussed below).

We also recommend that independent community visitors visit children and young people in detention facilities and in the Tasmanian Government's proposed assisted bail and supported residential facilities, which we refer to as residential youth justice facilities. We discuss this in Chapter 12.

12.2.1 Responsibility for administering the program

As noted above, the Office of the Ombudsman administers the Mental Health Official Visitors Program and the Prison Official Visitors Program.[808] The Ombudsman is the Principal Official Visitor under the *Mental Health Act 2013* and the coordinator of the Prison Official Visitors Program.[809] In 2021–22, visitors made 51 visits to adult correctional facilities.[810] At the end of June 2022, there were six visitors in the Prison Official Visitors Program.[811] It is not clear how many dedicated visitor roles the Ombudsman has established under that Act.

Given these responsibilities, there is an argument that an independent community visitor scheme for children in out of home care should be administered by the Office of the Ombudsman, alongside its existing visitor programs. It is arguably logical for a single body to be responsible for both visiting children in care and handling their complaints about the Department where issues they raise with a visitor cannot be resolved (complaints handling is discussed more below). However, we are concerned that the Ombudsman already has many roles and functions and lacks specialisation

and expertise in matters relating to children, including children's rights, effective communication with children and the specific risks and issues facing children in out of home care—in particular, the risk of child sexual abuse (discussed in Chapter 18).

We consider there are significant benefits in giving responsibility for administering a community visitor scheme for children in care to a body that has expertise in child-related matters and the out of home care system. There are also advantages associated with co-locating individual advocacy functions and systemic monitoring functions for the out of home care system (discussed below) in a single independent body—issues children raise with visitors would provide valuable insight into the operation of the system.

As noted above, the Commissioner for Children and Young People's functions do not include individual advocacy for children in out of home care. In contrast, the Commissioner's statutory functions *do* include individual advocacy for children in youth detention (refer to Chapter 12).[812]

Although there is no visitors program for children in youth detention, the Commissioner for Children and Young People told us that she personally visited Ashley Youth Detention Centre approximately every three weeks.[813] Also, an Advocate for Young People in Detention, based in the Office of the Commissioner for Children and Young People, was appointed in February 2022.[814] We note that the Victorian Commission for Children and Young People administers an independent visitor program that involves monthly visits by volunteer visitors to children in Victoria's two youth justice centres.[815]

As noted above, in Chapter 18 we recommend establishing a new Tasmanian Commission for Children and Young People, with broader functions than those currently performed by the Commissioner for Children and Young People (refer to Recommendation 18.6). We recommend that the functions of this new entity include advocating for individual children in out of home care and youth detention, as well as systemic monitoring of out of home care and the youth justice system (Recommendation 9.38). The Commission's individual advocacy functions should be performed by a new Child Advocate, who would also be a Deputy Commissioner (Recommendation 18.6).

On this basis, we consider that the independent community visitor scheme for children should be administered by the new Commission for Children and Young People. The legislation establishing the new Commission would need to ensure the Child Advocate has the necessary powers to appoint visitors, determine their remuneration and direct them to undertake visits to children in care and children in residential youth justice facilities. Community visitors should be appropriately experienced and qualified, and remuneration should be comparable to similar paid roles in other jurisdictions.

Recommendation 9.33

1. The Tasmanian Government should establish an independent Child Advocate, to be included in the Commission for Children and Young People (Recommendation 18.6).
2. The Child Advocate should have responsibility for:
    a. the independent community visitor scheme (Recommendation 9.34)
    b. individual advocacy for children, including making complaints to the Ombudsman on behalf of a child in care (Recommendation 9.35)
    c. the permanent out of home care advisory group (Recommendation 9.6).

Recommendation 9.34

1. The Tasmanian Government should introduce legislation to establish an independent community visitor scheme for children in out of home care, youth detention and other residential youth justice facilities.
2. The scheme should be administered by the Commission for Children and Young People (Recommendation 18.6) and led by the Child Advocate (Recommendation 9.33).
3. The scheme should be funded to enable every child in care, youth detention or another residential youth justice facility to receive regular and frequent visits, and children in family-based care to be visited regularly or when they request a visit. Resourcing should also enable community visitors to undertake advocacy on behalf of the children they visit.
4. Community visitors should be appointed by the Child Advocate based on their skills, knowledge and expertise, and remuneration should be comparable to similar paid roles in other jurisdictions.
5. Aboriginal children should have access to Aboriginal community visitors under the scheme.
6. Community visitors should be responsible, among other matters, for:
    a. developing trusting and supportive relationships with children in out of home care, youth detention or other residential youth justice facilities
    b. advocating on behalf of children by listening to, giving voice to and helping to resolve their concerns and grievances

c. facilitating children's access to support services

d. inquiring about and reporting on children's physical and emotional wellbeing

e. inquiring about whether children's needs are being met.

7. The program should include funding for a small number of legally trained child advocacy officers, also appointed by the Child Advocate (Recommendation 9.33), to assist children with more complex concerns and to support them in seeking independent review of departmental decision making.

12.3 Improving independent complaints handling

There should be effective mechanisms for an independent body to investigate how the Department has responded to complaints about child sexual abuse.

Currently, the Ombudsman is responsible for receiving and managing complaints about the Department. The Ombudsman is an independent statutory officer appointed under the *Ombudsman Act 1978*, whose primary role is to investigate the administrative actions of public authorities to ensure they are lawful, reasonable and fair.[816] The Ombudsman does not have the power to alter the decision of an agency but may make recommendations about what should be done to rectify or mitigate the action under investigation.[817]

The current Ombudsman, Richard Connock, told us that his office receives 'very few, if any' complaints about child sexual abuse or related matters.[818] The Ombudsman's most recent annual report indicates that only 12 of 81 complaints received in 2021–22 about the Department of Communities related to Children and Youth Services (most often involving complaints about child protection matters).[819] The Ombudsman does not appear to have specialist skills in dealing with complaints involving children, nor does that office have the opportunity to promote its role to, or invite complaints from, children in out of home care.[820] Children interviewed for our commissioned research did not identify the Ombudsman as someone with whom they would raise a complaint or concern.[821]

In contrast, the New South Wales Ombudsman has a youth liaison officer who is responsible for 'developing strategies and providing advice to assist young people [to] access [its] services'.[822] The youth liaison officer also provides support, advice and assistance to young people about making a complaint.[823]

Commissioner McLean told us that she regularly receives calls from people with complaints about the Department in relation to out of home care; she refers these callers to the Department, the police or the Ombudsman.[824] She said that people are often confused about her role and sometimes become frustrated and angry that her office cannot investigate and resolve complaints.[825] It is unusual for children's commissioners to have a complaints-handling and investigation function. In most Australian jurisdictions,

another body, such as an Ombudsman, is responsible for investigating complaints about out of home care.[826] The Northern Territory Children's Commissioner is unusual in having the power to receive and investigate complaints concerning services provided to vulnerable children.[827]

Giving the Commissioner for Children and Young People a complaints investigation function would involve a significant shift from the current skills, expertise and focus of that office. It would require a substantial investment to develop the capacity of that office to undertake such a function.

In our view, the new Commission for Children and Young People (refer to Chapter 18) should not be given a complaints-handling function. Rather, that body should focus on individual advocacy for children in out of home care through the independent community visitor scheme recommended above (Recommendation 9.34), systemic monitoring and oversight of the out of home care system (discussed below) and regulating the Child and Youth Safe Standards and the Reportable Conduct Scheme (discussed in Chapter 18). Supporting children through individual advocacy to express their concerns and make a complaint if necessary, and remaining involved with a child until their concern or complaint is resolved, will significantly improve children's participation in complaints processes and go a considerable way to ensuring their concerns are heard and acted on.[828]

In addition:

- Our recommendations in Section 11.3 for creating a proactive, child-informed and, thus, child-friendly internal complaints process in the new Department should improve the experiences of children (and adults) who make a complaint about out of home care.
- Our recommendation to give the Tasmanian Civil and Administrative Tribunal the power to review departmental decisions will provide another pathway for challenging out of home care decision making (refer to Recommendation 9.36).

To improve the Ombudsman's processes, the Office of the Ombudsman should work with the new Commission for Children and Young People to set up an accessible, child-friendly complaints process and develop specialisation among investigators for managing complaints from or involving children in out of home care, youth detention or other residential youth justice facilities. The Ombudsman should regularly share information with the Commission for Children and Young People on the outcomes of complaints from children.

To assist children to raise concerns who may not otherwise be able to do so, we also recommend that the new Child Advocate be given the power, with the child's agreement, to make a complaint to the Ombudsman on behalf of a child in out of home care, youth detention or another residential youth justice facility.

While we recommend several different oversight functions—visitor schemes and

advocacy and complaints handling—across different agencies, these agencies should adopt a 'no wrong door' approach. People should be able to raise concerns with any of these agencies and be assured that their matter will be referred to the appropriate agency. In Chapter 18, we recommend the relevant agencies enter into a memorandum of understanding to facilitate this no wrong door approach and develop child-friendly guides to assist people wishing to raise concerns.

Recommendation 9.35

Legislation establishing an independent Child Advocate in the Commission for Children and Young People should provide the Child Advocate with power to make a complaint to the Ombudsman on behalf of a child who is in out of home care, youth detention or another residential youth justice facility, seeking the child's permission to do so first.

12.4 Independent review of out of home care decisions

Several witnesses, including the Commissioner for Children and Young People, argued for establishing independent, external merits reviews of a departmental decision about out of home care.[829]

The Queensland Child Protection Act enables children or other 'aggrieved person(s)' to apply to the Queensland Civil and Administrative Tribunal to have certain decisions of the child protection agency reviewed.[830] Reviewable decisions include:

- deciding in whose care to place a child under a child protection order granting the chief executive custody or guardianship[831]
- removing a child from their carer[832]
- refusing to allow, or restricting or imposing conditions on, contact between a child and the child's parents or a member of the child's family[833]
- decisions about other care arrangements.[834]

Some of these decisions could increase or decrease a child's risk of sexual abuse in out of home care.

Also, the Queensland Public Guardian may apply to the Queensland Civil and Administrative Tribunal on behalf of a child or on the Public Guardian's own initiative to review certain decisions made by the child protection agency.[835] This includes a decision by the chief executive to take, or to not take, a step under the Queensland Child Protection Act to ensure a child in care is cared for in a way that meets the 'statement of standards' under that Act.[836] These standards cover children's physical, emotional,

cultural, educational, medical, social, recreational and material needs, as well as any needs arising from a child's disability.[837] For these purposes, the chief executive's failure to act is treated as a decision to not take a step.[838]

The Queensland Public Guardian may only apply for a review of a decision if they have been unable to resolve the matter with the chief executive, and if satisfied that it is in the child's best interests to do so.[839]

In exercising jurisdiction, the Queensland Civil and Administrative Tribunal must consider principles under the Queensland Child Protection Act, including the principle that 'the safety, wellbeing and best interests of a child … are paramount' and specific principles for Aboriginal children.[840] The Tribunal must have three members with 'extensive professional knowledge and experience of children' and experience in one or more fields of 'administrative review, child care, child protection, child welfare, community services, education, health, indigenous affairs, law, psychology or social work'.[841]

The Queensland Child Protection Act also has several provisions for children to participate in proceedings.[842] These include ensuring children have necessary information and support to participate, access to appropriate representation and the right to express their views.[843]

Child advocates from the Queensland Office of the Public Guardian can support a child in applying for a review of an out of home care decision and during tribunal proceedings.[844]

The Tasmanian Civil and Administrative Tribunal was established by the *Tasmanian Civil and Administrative Tribunal Act 2020* and began operations in November 2021.[845] It has no jurisdiction to review child protection or out of home care decisions.

In her evidence to our Commission of Inquiry, Commissioner McLean indicated that the Tasmanian Government had advised her it would consider including reviews of decisions affecting children in out of home care in the jurisdiction of the Tasmanian Civil and Administrative Tribunal as part of the third stage of its establishment in late 2021, but that the implementation timeframe for this had been delayed.[846]

In our view, the Tasmanian Civil and Administrative Tribunal should be given jurisdiction to review departmental decisions affecting a child's experiences in out of home care based on the model established for the Queensland Civil and Administrative Tribunal by the Queensland Child Protection Act and the Queensland Public Guardian Act. This should occur without delay.

Reviewable decisions should include decisions the Department makes about a child's care arrangements following an allegation of child sexual abuse in relation to that child. It would greatly assist the Tribunal's understanding of these matters if Tribunal members received training about child sexual abuse.

As an extension of the individual advocacy functions of the new Commission for Children and Young People (Recommendation 9.38), the new Child Advocate should be given the power to apply to the Tasmanian Civil and Administrative Tribunal for review of an out of home care decision on behalf of a child, or on the Child Advocate's own initiative.

As discussed above, a child advocacy officer appointed by the Child Advocate (refer to Recommendation 9.34) could provide legal support for a child wishing to apply to the Tribunal for review of a decision, as occurs in Queensland.[847]

Recommendation 9.36

1. The Tasmanian Government should introduce legislation to:
    a. expand the jurisdiction of the Tasmanian Civil and Administrative Tribunal to include review of decisions of the Department for Education, Children and Young People in exercising its custody or guardianship powers—including decisions about where a child should live and arrangements for the child's care
    b. ensure children whose cases are subject to review have the right to express their views and participate in Tribunal proceedings
    c. give the Child Advocate the power to apply for a Tribunal review of a decision about the care arrangements for a child on behalf of the child, or on the Child Advocate's own initiative
    d. grant parties, such as parents or carers, the right to apply for a Tribunal review depending on the nature of the decision.
2. To support their understanding of the experiences of children in out of home care, Tribunal members should be specifically trained in the nature and effects of trauma and child sexual abuse.

12.5 Monitoring investigations into child sexual abuse in out of home care

In Chapter 18, we examine the Tasmanian Government's Reportable Conduct Scheme, introduced by the Child and Youth Safe Organisations Act. The Act provides for an 'Independent Regulator' to be appointed and a 'Deputy Independent Regulator' to regulate the Reportable Conduct Scheme.[848] We recommend that the new Commission for Children and Young People be responsible for administering the Reportable Conduct Scheme (Recommendation 18.6).

Under the Child and Youth Safe Organisations Act, the Reportable Conduct Scheme will apply to entities that provide services or facilities for the care of children under the Children, Young Persons and Their Families Act.[849] The Scheme will require the 'head' of an entity to notify the Independent Regulator of a reportable allegation or a reportable conviction against a 'worker' of the entity (including a volunteer), investigate or arrange for an independent investigation of the allegation, and inform the Independent Regulator of the outcomes of the investigation.[850]

Given that it is intended to be limited to allegations against 'workers', the Reportable Conduct Scheme will not capture allegations of child sexual abuse and child sexual exploitation against adults outside the child protection or out of home care systems. It will also not cover allegations of harmful sexual behaviours involving children in out of home care because a 'worker' is defined as a person aged 18 years or older. The National Royal Commission did not recommend that such allegations be included in reportable conduct schemes, and they are not included in the Victorian scheme.[851]

In Section 11.8, we recommend that all allegations of child sexual abuse in out of home care be reported to the Quality and Risk Committee. This will provide a degree of oversight for the Department's responses to child sexual abuse against children in out of home care.

However, it is also important that the body responsible for overseeing the out of home care system has a complete picture of what is happening in that system. Therefore, we recommend that the Department be required to notify the new Commission for Children and Young People of all allegations of child sexual abuse or risk of sexual harm in out of home care, including those that are not covered by the Reportable Conduct Scheme, such as harmful sexual behaviours and child sexual exploitation. This will ensure this body is fully informed about the scale of child sexual abuse in the out of home care system and the Department's responses to allegations. The Department should also provide the Commission for Children and Young People with reports on the progress and outcomes of investigations into such allegations.

The Commission for Children and Young People should have the power to audit information about the Department's responses to allegations of sexual abuse by staff or carers, child sexual exploitation or harmful sexual behaviours.

Recommendation 9.37

1. The Secretary of the Department for Education, Children and Young People should notify the Commission for Children and Young People of sexual abuse allegations involving children in out of home care that fall outside the Reportable Conduct Scheme, including incidents of child abuse by non-carers, and of the outcomes of investigations into those allegations.
2. The Commission for Children and Young People should have the power to require the Department to provide it with information about its responses to such allegations.

12.6 Strengthening systemic monitoring and oversight of out of home care

In this section, we discuss the role of the Commissioner for Children and Young People in monitoring of the out of home care system more broadly. As noted above, in Chapter 18, we recommend establishing a new Commission for Children and Young People, with responsibility for administering the Child and Youth Safe Standards and the Reportable Conduct Scheme.

In this section, we recommend that the new Commission for Children and Young People also be given clear and specific systemic monitoring and oversight functions for children in the out of home care system.

12.6.1 Commissioner for Children and Young People

The Commissioner for Children and Young People is an independent statutory officer appointed by the Governor on the advice of the Minister for Education, Children and Youth, for a term not exceeding five years under the *Commissioner for Children and Young People Act 2016* ('Commissioner for Children and Young People Act').[852] We discuss the role of the Commissioner for Children and Young People, and their broad powers, in Chapter 18. Here we focus on out of home care.

12.6.2 The Commissioner's role in monitoring out of home care

The functions of the Commissioner for Children and Young People do not refer to children in out of home care. With the exception of the function to advocate for children in youth detention, the functions apply to 'children and young people generally'.[853] There is a single, indirect reference to children in out of home care in the Commissioner for Children and Young People Act—this is in the context of the principle that the interests and needs of 'vulnerable' children 'should be given special regard and serious consideration' in the administration of the Act.[854] 'Vulnerable' children include children

who are the subject of care and protection orders or who are receiving services under the Children, Young Persons and Their Families Act.[855] The Commissioner for Children and Young People's statutory powers are also broad. They are empowered to do all things necessary or convenient in connection with performing their statutory functions.[856]

The funding allocated to the Commissioner for Children and Young People was $1,386,000 in 2021–22.[857] In April 2022, Commissioner McLean told us that she had nine staff, with several new positions recently established.[858] She also indicated that resourcing for her office 'has remained a constant challenge' and resourcing constraints have limited her ability to fulfil her functions.[859]

In January 2017, former Commissioner for Children and Young People, Mark Morrissey, published a report that recommended the Tasmanian Government:

> Establish independent external oversight and monitoring of the [out of home care] system, including by providing the Commissioner for Children and Young People with six-monthly reports on compliance with Standards and other agreed indicators of the wellbeing of children and young people in the [out of home care] system in Tasmania.[860]

In the State Budget that followed this report (2017–18), the Tasmanian Government committed dedicated resources to enable the Commissioner to conduct independent systemic monitoring of out of home care over four years, beginning in July 2017.[861] Commissioner McLean described 'systemic monitoring' for these purposes as follows:

> … I look at how Tasmania's children and young people in out-of-home care are going overall, and I look into the processes or features of the out-of-home care system that affect their wellbeing.[862]

This encompasses:

- 'regular data monitoring', whereby a discrete dataset is regularly provided to the Commissioner on specified matters relevant to out of home care, including the number of care concerns and associated substantiations, but not including the nature of the care concerns or information on other incidents in out of home care[863]
- 'thematic monitoring', whereby monitoring activities focus on an annual theme drawn from one of six domains of wellbeing such as 'being loved and safe' and 'being healthy'[864]
- 'responsive investigations', whereby the Commissioner uses the 'own motion' investigation powers under the Act to undertake targeted, in-depth investigations of a particular issue in out of home care[865]
- monitoring the Tasmanian Government's implementation of the Commissioner's recommendations on out of home care.[866]

Commissioner McLean told us that the current resourcing of her office limits her ability to undertake own motion investigations or inquiries.[867] We note, however, that in December 2022, Commissioner McLean announced she would undertake an own motion investigation into the allocation of Child Safety Officers for children in Tasmanian out of home care, under the new out of home care case management model.[868]

In both of the Commissioner for Children and Young People's monitoring reports for out of home care, she has reported on the demographics of children in care, various placement types, case management activities (such as care planning) and expenditure.[869] Also, in the first monitoring report, Commissioner McLean reported on the first thematic monitoring of the out of home care system, which focused on 'being healthy'.[870] This report made five broad recommendations supported by more detailed recommendations, one of which was to expand 'the capacity of the existing independent oversight of out-of-home care currently undertaken by the Commissioner for Children and Young People' to engage in systemic monitoring based on agreed standards for out of home care.[871]

The theme of the second thematic monitoring report was 'being loved and safe'.[872] Commissioner McLean indicated that child sexual abuse was 'not the main reason' for selecting this second theme, as it is one of a range of issues that can affect the safety of a child in care.[873] The Commissioner for Children and Young People published a monitoring plan for this theme in February 2021.[874] The plan proposed a series of engagement activities with children, foster carers, kinship carers and staff of relevant organisations.[875] The plan also indicated that reporting activities may include 'focus reports', described as containing 'findings from a deep-dive into a particular topic'.[876]

In our view, while there is a certain logic in using the six domains of wellbeing to set the parameters for monitoring the out of home care system, the wellbeing themes are so broad as to seriously limit the Commissioner for Children and Young People's ability to meaningfully examine the drivers of children's adverse experiences in out of home care and the system's responses to those experiences. Commissioner McLean agreed that it would be better to focus monitoring on standards for out of home care rather than on wellbeing themes.[877]

12.6.3 Approaches in other jurisdictions

Children's commissioners in other jurisdictions have considerably more targeted functions and powers in relation to the out of home care system and children in care than the Tasmanian Commissioner for Children and Young People.

For example, in Victoria, several functions of the Commission for Children and Young People are directed at the safety and wellbeing of 'vulnerable children and young persons', which includes children who are or have been child protection clients.[878] These functions include monitoring and reporting to ministers on the implementation

and effectiveness of strategies relating to the safety or wellbeing of vulnerable children and young people, and promoting the interests of vulnerable children and young people in the Victorian community.[879]

The Victorian Commission for Children and Young People also has several specific functions for monitoring out of home care services.[880] These include advising the responsible minister and secretary on the performance of out of home care services and, at the request of the minister, reporting on a specific out of home care service.[881]

The Victorian Commission for Children and Young People also has specific powers in relation to children in out of home care. It may inquire into the safety and wellbeing of a vulnerable child or group of vulnerable children, where the inquiry relates to the services provided or omitted to be provided to that child or group of children.[882]

Also, the Victorian Commission for Children and Young People has a broad systemic inquiry power that enables it to inquire into (among other matters) child protection services or other services to vulnerable children, if it identifies a persistent or recurring systemic issue in providing those services, and considers that a review will improve those services.[883] The Victorian Commission for Children and Young People has produced several significant reports on the out of home care system using this systemic inquiry power, including a 2015 report on the sexual abuse of children in residential care and a 2019 report on the lived experience of children in out of home care in Victoria.[884]

The Victorian Commission for Children and Young People also monitors all serious incidents in out of home care, undertakes onsite inspections of residential care services and monitors government action on past inquiries.[885]

Several of the Northern Territory Children's Commissioner's functions also focus on 'vulnerable children'. [886] These include:

- undertaking inquiries into the care and protection of vulnerable children
- monitoring 'the ways in which the Chief Executive Officer deals with suspected or potential harm to, or exploitation of, children in the Chief Executive Officer's care'
- promoting an understanding of the rights, interests and wellbeing of vulnerable children.[887]

As noted above, the Northern Territory Children's Commissioner also has a complaints-handling function for out of home care.[888]

There are risks associated with establishing a monitoring role that is not structured or resourced to perform effectively. As outlined above, the South Australian Guardian for Children and Young People resigned from the role of Child and Young Person's Visitor in 2021 due to a lack of funding to support that role.[889] In describing her decision to inform the public that she was unable to perform the role Ms Wright said:

> … I was concerned that the public thought there was this role, there was certainly a legislated role, there was a person in the role and they might have taken comfort to think that there was a person going out and visiting these children and young people in residential care … these are some of the most vulnerable children and young people in South Australia, and so it was important to me that the public knew that essentially I wasn't doing the job, it was a bit of a fraud really in my view.[890]

A monitoring role that is not performed effectively risks creating the illusion that the out of home care system is operating without major problems. This means that serious flaws in the out of home care system are likely to go unaddressed, and that children will continue to be unacceptably exposed to the risks of sexual abuse.

The preceding discussion highlights the need for greater clarity and specificity in the functions of the Commissioner for Children and Young People for monitoring the out of home care system. As noted, in Chapter 18 we recommend establishing a new Commission for Children and Young People with responsibility for overseeing the Child and Youth Safe Standards and the Reportable Conduct Scheme. We recommend that the new Commission for Children and Young People be given expanded functions and powers in relation to advocacy for individual children and monitoring of the out of home care system, which must be fully resourced. The interaction of those functions and the independence of the new Commission for Children and Young People are discussed in Chapter 18.

In Section 5, we also outline the basis for, and recommend establishing, a Tasmanian Commissioner for Aboriginal Children and Young People who has the statutory powers and functions to monitor the experiences of Aboriginal children in out of home care (refer to Recommendation 9.14). We envisage this role functioning alongside and in partnership with the Commissioner for Children and Young People.

We discuss the role of the Commission for Children and Young People in overseeing the youth detention system in Chapter 12.

Recommendation 9.38

1. The Commission for Children and Young People should have the following functions in relation to out of home care:
    a. monitoring the operation of the out of home care system and the provision of out of home care services to children, by regularly monitoring data and conducting own motion systemic inquiries into aspects of the system
    b. conducting own motion inquiries into the services received by an individual child or group of children in out of home care

c. making recommendations to the Government for out of home care system improvements

d. advocating for individual children in out of home care, including supporting children to make complaints to the Ombudsman and to apply for independent reviews of departmental decision making

e. administering the independent community visitor scheme

f. upholding and promoting the rights of children in out of home care.

2. The Commission should be fully resourced on an ongoing basis to perform these functions.

13 Conclusion

Out of home care should be a place for children and young people to heal from abuse, not a place where children and young people are at risk of further abuse. Children and young people should leave care settings stronger, healthier and more emotionally equipped to deal with life's challenges. The out of home care system must be working to prevent and interrupt intergenerational contact with child protection services, not perpetuate cycles of abuse and harm.

We acknowledge that out of home care is a challenging environment. Holding the trauma of children in care and helping them turn their lives around for the better requires enormous effort, even in a well-resourced out of home care system staffed by the most dedicated workers. We accept that fully implementing significant reform is a long process. This is even more reason why the Government and the Department must prioritise rebuilding the out of home care system now. We urge the Government and the new Secretary to not allow out of home care to again get lost in the process of transitioning to a new, bigger department and the implementation of a broader reform agenda.

Considerable funding is required to ensure our reform recommendations for the out of home care system are implemented in ways that significantly improve the safety of children and young people in out of home care. The Government must commit this funding so the Secretary can effectively acquit his responsibility as the statutory guardian of children in out of home care, and to allow the Department and sector to work with purpose and intent to protect the best interests of children.

Notes

1 Statement of Sonya Enkelmann, 26 April 2022, 21 [87].

2 Refer to, for example, Statement of Michael Pervan, 6 June 2022, 5 [18–19], 12–14 [44].

3 Michael Pervan, *Procedural Fairness Response,* 30 March 2023, 4 [2.23]–5 [2.28].

4 Michael Pervan, *Procedural Fairness Response,* 30 March 2023, 5 [3.6]–6 [3.11].

5 Michael Pervan, *Procedural Fairness Response,* 30 March 2023, 5 [3.1]–6 [3.12].

6 The Child Advocate did not provide a date for when human resources support began but described it as 'in recent times': Statement of Sonya Pringle-Jones, 16 June 2022, 26 [69].

7 Statement of Sonya Pringle-Jones, 16 June 2022, 27 [70].

8 Statement of Sonya Pringle-Jones, 16 June 2022, 27 [70].

9 Tasmania's 'real expenditure on care services per placement night' steadily increased up to 2019 and then decreased each year until 2021 (the most recent figures available): Productivity Commission, *Report on Government Services 2022* (Report, 25 January 2022) Part F, Section 16, Table 16.35.

10 Department of Health and Human Services, *Out of Home Care Strategic Framework* (December 2007) 15.

11 Department of Health and Human Services, *Out of Home Care Strategic Framework* (December 2007) 14; Statement of Caroline Brown, 9 June 2022, 3 [21].

12 Department of Health and Human Services, *Out of Home Care Strategic Framework* (December 2007) 30, 55.

13 Department of Health and Human Services, *Out of Home Care Strategic Framework* (December 2007) 45–55.

14 Statement of Julian Watchorn, 8 June 2022, 9 [53]; Statement of Caroline Brown, 9 June 2022, 7 [36]; Consultation with non-government out of home care providers, 25 October 2021.

15 Statement of Caroline Brown, 9 June 2022, 7 [37–40].

16 Statement of Julian Watchorn, 8 June 2022, 18 [95–96]. Refer also to Consultation with non-government out of home care providers, 25 October 2021.

17 Statement of Sonya Enkelmann, 26 April 2022, 13–14 [54]; Statement of Andrea Sturges, 16 June 2022, 21–22 [88].

18 Statement of Michael Pervan, 4 August 2022, 3 [17].

19 Statement of Caroline Brown, 9 June 2022, 8 [41]; Transcript of Nicola Crates, Paul Cairns and Andrea Witt, 16 June 2022, 1458 [17–33].

20 Statement of Caroline Brown, 9 June 2022, 8 [41]; Transcript of Nicola Crates, Paul Cairns and Andrea Witt, 16 June 2022, 1458 [17–33].

21 Statement of Andrea Sturges, 16 June 2022, 8 [18]; Transcript of Nicola Crates, Paul Cairns and Andrea Witt, 16 June 2022, 1458 [17–33].

22 Statement of Michael Pervan, 6 June 2022, 68 [327–329].

23 Michael Pervan, *Procedural Fairness Response*, 26 July 2023, 4.

24 In New South Wales, out of home care service provision began transitioning to non-government providers from 2012; guidelines and transition policies were developed for the transfer process to enable a 'smooth and consistent transition', which the Tasmanian Government may find useful. NSW Government, 'Transfer Process', *OOHC Transition Policies, Procedures and Tools* (Web Page, 24 September 2019) <https://www.facs.nsw.gov.au/providers/children-families/oohc/transition/tools/chapters/transfer-process>; NSW Government, 'Transition Program Office Policy Paper 1: Transition Cohort Priorities', *OOHC Transition Policies, Procedures and Tools* (Web Page, April 2012) <https://www.facs.nsw.gov.au/download?file=320037>.

25 For example, Australian Centre for Child Protection, *Review of Data and Outcomes for the Permanency Support Program (PSP): Data Roadmap* (Report, February 2022).

26 Commissioner for Children and Young People, *Monitoring Report No. 1: The Tasmanian Out-of-Home Care System and 'Being Healthy', Out-of-Home Care Monitoring Program 2018–19* (Report, October 2019) 66.

27 Statement of Timothy Bullard, 28 October 2022, 1 [1].

28 Statement of Michael Pervan, 6 June 2022, 38–39 [163].

29 Statement of Michael Pervan, 6 June 2022, Annexure 54 (Department of Communities, Template: 'Funding Agreement', undated).

30 Statement of Michael Pervan, 6 June 2022, Annexure 54 (Department of Communities, Template: 'Funding Agreement', undated) 15.

31 Statement of Michael Pervan, 6 June 2022, Annexure 54 (Department of Communities, Template: 'Funding Agreement', undated) 37–38.

32 Statement of Michael Pervan, 6 June 2022, Annexure 54 (Department of Communities, Template: 'Funding Agreement', undated) 16.

33 Department of Families, Housing, Community Services and Indigenous Affairs, *An Outline of National Standards for Out-of-Home Care: A Priority Project under the National Framework for Protecting Australia's Children 2009–2020* (Report, Australian Government, July 2011) 2, 4; *Royal Commission into Institutional Responses to Child Sexual Abuse* (Final Report, 2017) vol 6, 141–214; *Child and Youth Safe Organisations Act 2023*, sch 1.

34 Department of Families, Housing, Community Services and Indigenous Affairs, *An Outline of National Standards for Out-of-Home Care: A Priority Project under the National Framework for Protecting Australia's Children 2009 – 2020* (Report, Australian Government, July 2011).

35 Department of Families, Housing, Community Services and Indigenous Affairs, *An Outline of National Standards for Out-of-Home Care: A Priority Project under the National Framework for Protecting Australia's Children 2009 – 2020* (Report, Australian Government, July 2011) 2, 4.

36 Department for Education, Children and Young People, *Tasmanian Out of Home Care Standards* (June 2022) 10.

37 Transcript of Michael Pervan, 17 June 2022, 1595 [25–31].

38 Department for Education, Children and Young People, *Tasmanian Out of Home Care Standards* (June 2022); Tasmanian Government, *Tasmanian Child and Youth Wellbeing Framework* (undated) 5.

39 Department for Education, Children and Young People, *Tasmanian Out of Home Care Standards* (June 2022) 10.

40 Statement of Andrea Sturges, 16 June 2022, 23 [97]; Statement of Michael Pervan, 6 June 2022, 38 [157]; Statement of Michael Pervan, 6 June 2022, Annexure 57 (Department of Health and Human Services, 'The Quality and Safety Framework for Tasmania's DHHS Funded Community Sector', 17 January 2014) 6.

41 Statement of Sonya Enkelmann, 26 April 2022, 19 [79].

42 Transcript of Claire Lovell, 14 June 2022, 1185 [28–41].

43 Transcript of Claire Lovell, 14 June 2022, 1185 [35–44].

44 Statement of Sonya Pringle-Jones, 16 June 2022, 24–25 [61].

45 Transcript of Claire Lovell, 14 June 2022, 1185 [35]–1186 [31].

46 Transcript of Timothy Bullard, 12 September 2022, 3926 [47]–3927 [5]; Statement of Timothy Bullard, 28 October 2022, 1 [1]–2 [4(e)].

47 *Children, Young Persons and Their Families Act 1997* s 5.

48 Australian Human Rights Commission, *National Principles for Child Safe Organisations* (2018) 9.

49 Keith Kaufman et al, *Risk Profiles for Institutional Child Sexual Abuse: A Literature Review* (Report for the Royal Commission into Institutional Responses to Child Sexual Abuse, October 2016) 27.

50 Statement of Professor Donald Palmer, 12 April 2022, 15 [54].

51 Statement of Professor Donald Palmer, 12 April 2022, 15 [55].

52 Statement of Caroline Brown, 9 June 2022, 8 [44–45]; Statement of Deborah Brewer, 8 June 2022, 10 [46]; Statement of 'Ophelia', 10 June 2022, 9 [38]–10 [39]. The name 'Ophelia' is a pseudonym; Order of the Commission, restricted publication order, 30 August 2023.

53 Statement of Caroline Brown, 9 June 2022, 8 [44–45].

54 Statement of Andrea Sturges, 16 June 2022, 13 [44].

55 Statement of Andrea Sturges, 16 June 2022, 13 [45].

56 Statement of Andrea Sturges, 16 June 2022, 14 [47].

57 Statement of Andrea Sturges, 16 June 2022, 17 [63–64]; Transcript of Andrea Sturges, 16 June 2022, 1511 [37]–1512 [45].

58 Transcript of Claire Lovell, 14 June 2022, 1208 [46]–1209 [16].

59 Transcript of Leanne McLean, 17 June 2022, 1564 [38–42].

60 Transcript of Michael Pervan, 17 June 2022, 1612 [3]–1613 [6].

61 Transcript of Michael Pervan, 17 June 2022, 1610 [13]–1615 [2].

62 Transcript of Michael Pervan, 17 June 2022, 1611 [38]–1612 [1].

63 Department for Education, Children and Young People, *Structure from 1 October 2022* (7 October 2022).

64 Department for Education, Children and Young People, *Structure from 1 October 2022* (7 October 2022).

65 Department for Education, Children and Young People, *Structure from 30 April 2023* (30 April 2023).

66 Transcript of Catherine Taylor, 12 September 2022, 3900 [15]–3902 [40].

67 Transcript of Catherine Taylor, 12 September 2022, 3900 [23–32].

68 Transcript of Catherine Taylor, 12 September 2022, 3900 [29–32].

69 Transcript of Catherine Taylor, 12 September 2022, 3901 [11–32], 3902 [39–40].

70 Statement of Catherine Taylor, 8 September 2022, 4 [22], [24].

71 Transcript of Catherine Taylor, 12 September 2022, 3908 [7]–3909 [17].

72 Stephen Smallbone and Tim McCormack, *Independent Inquiry into the Tasmanian Department of Education's Responses to Child Sexual Abuse* (Report, 7 June 2021).

73 Statement of Kathy Baker, 18 August 2022, 32 [181].

74 Refer generally to Secretary Pervan's description of the implementation of the Strong Families, Safe Kids redesign in Statement of Michael Pervan, 6 June 2022, 16 [59]–19 [73]; Statement of Michael Pervan, 7 June 2022, 2 [12]–3 [20]; Statement of Sonya Pringle-Jones, 16 June 2022, 24 [58(q)], [61].

75 Tasmania, *Ministerial Statement*, House of Assembly, 24 May 2022, 28 (Jeremy Rockliff, Premier).

76 *Royal Commission into Institutional Responses to Child Sexual Abuse* (Final Report, December 2017) vol 6, 147.

77 Statement of Samantha Crompvoets, 10 September 2022, 15 [60]–16 [61].

78 Statement of Kim Backhouse, 8 June 2022, 22 [119].

79 Commissioner for Children and Young People, *Monitoring Report No. 1: The Tasmanian Out-of-Home Care System and 'Being Healthy', Out of Home Care Monitoring Program 2018–19* (Report, October 2019) 66.

80 Commissioner for Children and Young People, *Monitoring Report No. 2: Key Data on Tasmania's Out-of-Home Care System, 2020–2021, Out of Home Care Monitoring Program 2023* (Report, 14 March 2023) 4.

81 Department of Communities, 'Table of Non-Government Providers Who Are Funded by the Tasmanian Government to Provide Out of Home Care Services', 20 August 2021, provided by the Tasmanian Government in response to a Commission notice to produce. Refer also to Statement of Michael Pervan, 6 June 2022, Annexure 83 ('Data: Out of home care providers', 22 April 2022); Commissioner for Children and Young People, *Monitoring Report No. 1: The Tasmanian Out-of-Home Care System and 'Being Healthy', Out of Home Care Monitoring Program 2018–19* (Report, October 2019) 22.

82 Department of Health and Human Services, 'Responding to Care Concerns Impacting a Child in Out of Home Care', February 2013, 7–8, produced by the Tasmanian Government in response to a Commission notice to produce.

83 Statement of former Manager, Serious Events Review Team, 11 November 2022, 4 [17], 15 [72], 16 [84].

84 Children and Youth Services, 'Information Sheet – Serious Event Reviews', 29 August 2019, 1, produced by the Department for Education, Children and Young People in response to a Commission notice to produce; Children and Youth Services, 'Serious Events Review Procedure', 29 August 2019, 1, produced by the Tasmanian Government in response to a Commission notice to produce

85 Transcript of Michael Pervan, 17 June 2022, 1624 [43]–1625 [40], 1627 [34]–1628 [26]; Transcript of Leanne McLean, 17 June 2022, 1562 [25–39]; Statement of Michael Pervan, 4 August 2022, 4 [26–28]; Statement of Michael Pervan, 6 June 2022, 52 [232]; Transcript of Claire Lovell, 4 July 2022, 2296 [17–20].

86 Department for Education, Children and Young People, *Procedural Fairness Response,* 16 February 2023, 5.

87 Statement of Michael Pervan, 7 June 2022, 5 [38]–6 [39].

88 Statement of Michael Pervan, 7 June 2022, Annexure 1 (Department of Communities, 'Children and Family Services Practice Performance and Governance Committee: Terms of Reference', 30 July 2021) 1–2.

89 Statement of Michael Pervan, 7 June 2022, Annexure 1 (Department of Communities, 'Children and Family Services Practice Performance and Governance Committee: Terms of Reference', 30 July 2021); Statement of Michael Pervan, 7 June 2022, 5 [38]–6 [39].

90 Statement of Michael Pervan, 7 June 2022, 6 [39].

91 Statement of Michael Pervan, 7 June 2022, Annexure 75 (Department of Communities, 'Child Safety State-Wide Service Development Committee: Terms of Reference', undated) 1.

92 Statement of Michael Pervan, 7 June 2022, Annexure 75 (Department of Communities, 'Child Safety State-Wide Service Development Committee: Terms of Reference', undated) 1.

93 Statement of Michael Pervan, 7 June 2022, 9 [60].

94 Transcript of Catherine Taylor, 12 September 2022, 3910 [22–44]. Refer also to Statement of Muriel Bamblett, 10 June 2022, 19 [100]–20 [105], 22 [118–119], 32 [176]; Transcript of Muriel Bamblett, 15 June 2022, 1331 [12–31], 1343 [20–27], 1344 [37–46].

95 Transcript of Catherine Taylor, 12 September 2022, 3911 [1–19].

96 Statement of Catherine Taylor, 8 September 2022, 9 [54].

97 Statement of Robyn Miller, 9 June 2022, 15 [72–74].

98 Statement of Robyn Miller, 9 June 2022, 15 [74].

99 Transcript of Catherine Taylor, 12 September 2022, 3905 [13–16], 3915 [17–45]; Statement of Robyn Miller, 9 June 2022, 17 [80]–18 [83(g)], [85].

100 Secretary Pervan referred to the Department's 2014 *Quality and Safety Framework for Tasmania's DHHS Funded Community Sector*, but he provided no further context: Statement of Michael Pervan, 6 June 2022, 37 [155]. Although not mentioned by Secretary Pervan, the Department of Premier and Cabinet's website stated that 'consultation on the new approach will commence in 2023/2024: Department of Premier and Cabinet, 'Quality and Safety Services', *Community and Disability Services* (Web Page) <https://www.dpac.tas.gov.au/divisions/cpp/community-and-disability-services/quality-and-safety-services>.

101 Statement of Michael Pervan, 6 June 2022, 33 [138].

102 Statement of Michael Pervan, 6 June 2022, 9 [28], 33 [138].

103 Children and Youth Services, *Service Review and Continuous Improvement policy* (Intranet Page, 1 July 2015); Children and Youth Services, *Transparency and Accountability policy* (Intranet Page, 1 July 2015).

104 Dr Deborah Brewer told us that during her time with the Department from 2017 to 2019, she had developed a quality and accountability framework for the Department, but it was not adopted: Statement of Deborah Brewer, 8 June 2022, 19 [93]–20 [99].

105 Statement of Michael Pervan, 7 June 2022, Annexure 5 (Department of Communities, 'A Children and Youth Services Framework for Organisational Leadership and Sustainability', 1 November 2019) 9.

106 Refer generally to Statement of Michael Pervan, 6 June 2022, Annexure 80 (Children and Youth Services, 'The Signs of Safety Framework', undated).

107 Statement of Professor Donald Palmer, 12 April 2022, 18 [63–65].

108 Statement of Timothy Moore, 28 April 2022, 16 [81].

109 *Child and Youth Safe Organisations Act 2023* sch 1, Standard 2.

110 Department of Families, Housing, Community Services and Indigenous Affairs, *An Outline of National Standards for Out-of-Home Care: A Priority Project under the National Framework for Protecting Australia's Children 2009–2020* (Report, July 2011) 7.

111 *Children, Young Persons and Their Families Act 1997* s 10D (3)(c).

112 *Children, Young Persons and Their Families Act 1997* s 10E (2)(b).

113 *Children, Young Persons and Their Families Act 1997* s 10F.

114 Statement of Sonya Pringle-Jones, 16 June 2022, 4 [17(a)].

115 Statement of Sonya Pringle-Jones, 16 June 2022, 17–18 [54(a)].

116 Statement of Sonya Pringle-Jones, 16 June 2022, 18 [54(b)(iii)(A)], 19–20 [54(c)(ii)].

117 The Victorian Commission for Children and Young People's *Guide for Organisations Working with Children and Young People* includes a tailoring guide for participation of children and young people of different ages and provides guidance on creating safe and inclusive spaces for children and young people and promoting their voice: Commission for Children and Young People, *Empowerment and participation: A Guide for Organisations Working with Children and Young People* (Guide, 2021) 62.

118 Other survey platforms may also be considered, such as 'Mind of My Own': Mind of My Own, 'One app', *Our Products* (Web Page, 2023) <https://mindofmyown.org.uk/one-app/>.

119 Department of Premier and Cabinet, *Aboriginal Partnerships* (Web Page) <https://www.dpac.tas.gov.au/divisions/cpp/aboriginal-partnerships>.

120 *National Agreement on the Closing the Gap* (July 2020) 35.

121 Department for Child Protection, *Aboriginal and Torres Strait Islander Requirements* (Web Page, 18 April 2019) <https://www.childprotection.sa.gov.au/service-providers/service-provision-requirements/aboriginal-and-torres-strait-islander-requirements>.

122 Department for Child Protection, *Reconciliation Action Plan May 2022–May 2025* (South Australian Government, undated) 28.

123 Department for Child Protection, *Reconciliation Action Plan May 2022–May 2025* (South Australian Government, undated) 11.

124 Statement of Elizabeth Jack, 29 April 2022, 6 [28].

125 Department of Health and Human Services, *Out of Home Care Strategic Framework* (December 2007).

126 Tasmanian Government, *Out of Home Care Reform in Tasmania* (Report, 2014) 11–13.

127 Department of Health and Human Services, *Strategic Plan for Out of Home Care in Tasmania 2017–2019* (2017).

128 Department of Communities, *Strong Families Safe Kids: Next Steps Action Plan 2021–2023* (undated) 20.

129 Refer generally to Secretary Pervan's description of the implementation of the Strong Families, Safe Kids redesign in Statement of Michael Pervan, 6 June 2022, 16 [59]–19 [73]; Statement of Michael Pervan, 7 June 2022, 2 [12]–3 [20]; Statement of Sonya Pringle-Jones, 16 June 2022, 24 [58(q)], [61].

130 Statement of Michael Pervan, 6 June 2022, 68 [329].

131 Keith Kaufman et al, *Risk Profiles for Institutional Child Sexual Abuse: A Literature Review* (Report for the Royal Commission into Institutional Responses to Child Sexual Abuse, October 2016) 9–10, 38.

132 Australian Human Rights Commission, *National Principles for Child Safe Organisations* (2018) 18; *Child and Youth Safe Organisations Act 2023* sch 1.

133 In February 2023, we reviewed the Department's Practice Manual intranet and identified some policy documents had been replaced in December 2022. We acknowledge these new documents where relevant in the following discussion.

134 This refers to websites for the Department of Communities and Department for Education, Children and Young People. The *Consumer Related Reportable Incident Policy for Tasmania's DHHS Funded Community Sector* and the *Consumer Related Reportable Incident Procedure for Tasmania's DHHS Funded Community Sector* were the only publicly-available policy documents we could locate; Statement of Mary Dickins, 2 June 2022, 4 [21].

135 Tim Moore and Morag McArthur, *Take notice, believe us and act! Exploring the safety of children and young people in government run organisations* (Research Report prepared for the Commission of Inquiry into the Tasmanian Government's Responses to Child Sexual Abuse in Institutional Settings, February 2023) 45, 62.

136 Queensland Government, *Child Safety Practice Manual* (Web Page, 29 July 2021) <https://cspm.csyw.qld.gov.au/>; Government of South Australia, *Department for Child Protection Policy Documents* (Web Page, February 2023) <https://www.childprotection.sa.gov.au/__data/assets/pdf_file/0004/116878/dcp-policy-list.pdf>; Victoria State Government, 'Child Protection Manual', *Health and Human Services* (Web Page) <https://www.cpmanual.vic.gov.au/>; ACT Government, 'CYPS Policies and Procedures', *Policies* (Web Page, 21 December 2022) <https://www.communityservices.act.gov.au/ocyfs/policies>.

137 Statement of Sonya Pringle-Jones, 16 June 2022, 29 [77].

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157 Transcript of Claire Lovell, 14 June 2022, 1205 [29–42].

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164 Statement of Sonya Enkelmann, 26 April 2022, 11 [39].

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Commission of Inquiry into the Tasmanian Government's Responses to Child Sexual Abuse in Institutional Settings

Who was looking after me? Prioritising the safety of Tasmanian children

Volume 5: Children in youth detention
Book 1

August 2023

Commission of Inquiry into the Tasmanian Government's Responses to Child Sexual Abuse in Institutional Settings Report

Volume 5
Children in youth detention (Book 1)

The Honourable Marcia Neave AO
President and Commissioner

Professor Leah Bromfield
Commissioner

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Commissioner

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Introduction to Volume 5

In accordance with the Order establishing our Commission of Inquiry, Volume 5 examines the Tasmanian Government's responses to allegations of child sexual abuse at Ashley Youth Detention Centre since 2000. Any references to the Centre's predecessor—Ashley Home for Boys—are solely to cast light on the present system of youth detention.

Ashley Youth Detention Centre is Tasmania's primary dedicated youth detention facility. However, it is not the only facility where children and young people are held in detention in Tasmania. Some adult custodial facilities have been declared to be youth detention centres, including Hobart Reception Prison, Launceston Reception Prison and Risdon Prison.[1] Children and young people can also be transferred from Ashley Youth Detention Centre to an adult prison facility.

While we have not inquired into the treatment of children and young people in adult custodial facilities, many of the issues raised in this volume will also have implications for children and young people in those settings. We encourage the Government to consider our recommendations broadly and approach implementation consistently in relation to children and young people in all custodial settings in Tasmania.

Under the *Youth Justice Act 1997*, the Secretary of the government department with responsibility for Ashley Youth Detention Centre is designated as the 'guardian' of children in detention and is responsible for the security and management of detention and for the safe custody and wellbeing of detainees.[2]

There are high rates of sexual abuse for children in detention, making children in detention among the most vulnerable in our community to this abuse.[3] We know children in detention have often experienced trauma, maltreatment and significant development disorders, all of which are risk factors for abuse.[4] There is also an over-representation of Aboriginal children in detention. Aboriginal children experience heightened vulnerability because of the impacts of intergenerational trauma stemming from the damaging legacy of colonisation.[5] The already substantial barriers to disclosing sexual abuse are heightened for children in detention, who some in the community perceive as 'criminals'.[6]

The 'closed' nature of detention environments compounds these vulnerabilities, creates opportunities for abuses of power and heightens the risk of child sexual abuse. Risk factors for child sexual abuse in detention include:

- the deprivation of children's liberty and a lack of privacy
- isolation and disconnection from friends, family and community
- lack of access to trusted adults

- the power imbalance between adult staff and detained children
- the use of rigid rules, discipline and punishment
- the lack of voice afforded to children
- cultures of disrespect for, and humiliating and degrading treatment of, children
- strong group allegiance among management.[7]

Ashley Youth Detention Centre is located in an area that is geographically remote from Hobart, Launceston, Burnie and Devonport, resulting in the isolation of many children and young people from their homes, families, communities and services. This location meant that the widespread and systematic abuse experienced by some children and young people at the Centre occurred away from the public eye. This volume contains harrowing details not only of allegations of child sexual abuse, but of a culture of unauthorised use of force, restraints and isolation and of belittling and humiliating behaviours allegedly used to dehumanise children and young people in detention.

For more than two decades, concerning incidents and risks to children at Ashley Youth Detention Centre have populated the media.[8] The Tasmanian Government has been alerted to the risk of sexual abuse for children in state care on many occasions, including through the findings of previous reviews of the Tasmanian statutory child protection and out of home care systems, the National Royal Commission report, and many internal and external briefings, reviews and reports into Ashley Youth Detention Centre. Our Commission of Inquiry uncovered a pattern of the Government either ignoring reviews and recommendations, or implementing them without achieving meaningful or sustained reform.

We know there are current and former staff at Ashley Youth Detention Centre who care about and are committed to supporting the wellbeing of children. We also know that some staff felt, at times, fearful and unsafe in their work and insufficiently equipped or trained to deal with the distressing and complex behaviours exhibited by some traumatised children and young people. Despite these challenges, we found former detainees who spoke positively about the members of staff who were not complicit in harmful and abusive behaviours.

We acknowledge these hardworking and dedicated staff at Ashley Youth Detention Centre who performed to the best of their ability in a highly complex, fraught and difficult environment to meet the needs of children detained at the Centre and to act in their best interests. We appreciate and acknowledge the impact and toll our Inquiry has had on Ashley Youth Detention Centre staff. However, it was critical to the wellbeing of children in detention that we engaged in a comprehensive examination of the conditions at the Centre.

Our examination of Ashley Youth Detention Centre drew from multiple sources of information. We visited the Centre and reviewed thousands of documents. We heard from numerous victim-survivors, who described similar experiences of abuse over different periods—similar to each other and similar to the records we reviewed of critical incidents and complaints. We thank these victim-survivors, without whom we would not have understood patterns of abuse. We recognise others from whom we did not hear personally.

We also heard from former and current staff, and others with experience of the Centre. Some shared their previous efforts to change what was occurring at the Centre, and their deflation and frustration as problems persisted. We are indebted to all those who took the time to share information with us, sometimes at a personal cost. Without some of these witnesses, particularly whistleblower Alysha (a pseudonym), we would not have known where to focus our Inquiry.[9]

This volume contains three chapters. In Chapter 10—Background and context: Children in youth detention—we describe the background to and context for, our examination of Ashley Youth Detention Centre. We discuss the risks of child sexual abuse in youth detention and the National Royal Commission's recommendations to address these risks. We then give an overview of Ashley Youth Detention Centre, including the demographics of children in detention and the Centre's management, staffing, operations, key processes and oversight mechanisms. We also summarise previous reports and inquiries into Ashley Youth Detention Centre.

In Chapter 11—Case studies: Children in youth detention—we present seven case studies that examine:

- the nature and extent of allegations of child sexual abuse at Ashley Youth Detention Centre
- allegations of harmful sexual behaviours and the responses to those behaviours
- unauthorised use of isolation as a common practice
- the excessive use of force
- two examples of how complaints from staff and detainees were managed
- the Tasmanian Government's response to allegations of child sexual abuse by staff at the Centre.

These case studies illustrate the scale of systematic abuse and an entrenched culture that threatened the safety of children and young people in detention.

In Chapter 12—The way forward: Children in youth detention—we make recommendations to improve the safety and wellbeing of children in detention. Our recommendations are directed at addressing the legacy of abuse at Ashley Youth

Detention Centre, achieving lasting cultural change in youth detention, reducing the number of children in detention, addressing the over-representation of Aboriginal children and creating a child-focused detention system where practices such as isolation and the use of force are minimised. We also recommend changes to improve responses to harmful sexual behaviours in youth detention and to strengthen complaints and oversight mechanisms to reduce the risks of child sexual abuse.

A note on language

Children and young people in detention are referred to in different ways, including 'detainees' and 'residents'. In our report, we refer to 'children and young people in detention' or 'detainees' because we consider this terminology more accurately reflects their situation. Similarly, we tend to refer to 'cells' or 'rooms' rather than 'bedrooms' at Ashley Youth Detention Centre.

In this volume, we use the term 'Department' to mean the department responsible for youth detention at the relevant time. From 2000 to 2018, this was the Department for Health and Human Services.[10] From 2018, it became the Department for Communities (also referred to as Communities Tasmania).[11] In October 2022, the department responsible for youth detention changed to the newly formed Department for Education, Children and Young People.[12] Where there is potential ambiguity, we use the full name of the relevant department.

10 Background and context: Children in youth detention

1 Introduction

In this chapter, we discuss the risks of child sexual abuse in youth detention and the recommendations made by the National Royal Commission in response to these risks. We outline the international and domestic rights of, and obligations to, children and young people in detention.

We then focus on Tasmania's primary dedicated youth detention facility, Ashley Youth Detention Centre, discussing the demographics of children and young people at the Centre; its management, staffing and operations; its key processes in managing children and young people's behaviour and responding to incidents; and the oversight mechanisms for youth detention.

Finally, we discuss previous reports and inquiries into Ashley Youth Detention Centre and identify common themes that emerged from these reports, including concerns about the treatment of children and young people in detention. We end with some conclusions about a system in crisis.

2 Risks of child sexual abuse in youth detention

It is common for children and young people who have contact with the justice system, including those who are held in detention, to have experienced prior trauma.[13] International research shows that many incarcerated children and young people have grown up in the most disadvantaged families, neighbourhoods and communities.[14] Also, many have been exposed to violence, abuse or neglect in their immediate social environment, resulting in the involvement of child protection authorities.[15]

Elena Campbell, Associate Director, Research, Advocacy and Policy at the Centre for Innovative Justice in Melbourne, told us that 'adverse childhood experiences', including childhood sexual abuse and neglect, are key drivers of children and young people's contact with the justice system.[16] Ms Campbell noted that more than two-thirds of children in youth justice environments in Victoria had experienced violence, abuse or neglect. Research in Queensland and Western Australia has found that three-quarters of young people in contact with the justice system have experienced some form of non-sexual abuse.[17]

It is also common for children in out of home care to have contact with the youth justice system. The 'crossover' from out of home care to youth detention can be driven by multiple factors, including exposure to peers with difficult behaviours, inadequate carer training, poor placement decisions and poor interagency relationships—all of which create volatile living environments and increase the likelihood of police intervention.[18] Under such conditions, events such as 'underage drinking, smoking marijuana or smashing the wall out of frustration' that could be minor in nature will often result in children being transferred from the out of home care system into the criminal justice system.[19]

Research shows that prior maltreatment affects the psychological, emotional and social wellbeing of children and young people in detention and places them at greater risk of ongoing abuse, including sexual victimisation and assault, while in detention.[20] The National Royal Commission noted that the combination of several factors may increase the risk of child sexual abuse in youth detention.[21] Also, the longer a child or young person stays in detention, the greater the likelihood they will experience sexual victimisation.[22]

Recent international studies have estimated that about 7 per cent of girls and 6 per cent of boys in detention are exposed to sexual victimisation by peers or staff.[23] Studies have also concluded that children and young people who identify as LGBTQIA+ are at greater risk of victimisation than their peers.[24]

Youth justice centres are characteristically highly controlled institutions that are largely closed off from the outside world; they are also hierarchical institutions, with significant power disparity between staff and the young people who are detained. In 'total' or 'closed' institutions, such as youth detention centres, there is a greater risk that children or young people are dehumanised and that staff adopt attitudes and practices of punishment and control.[25] These factors, in turn, increase the risk of, and opportunities for, the sexual abuse of children and young people.[26] Also, as researcher Eileen Ahlin explains:

> Unlike adult jails and prisons, where guards and inmates are above the age of 18, youth are poised to experience exploitation or coercion that could be cloaked behind the guise of guardianship.[27]

The National Royal Commission outlined numerous factors that increase the risk of child sexual abuse in contemporary detention environments and, more specifically, youth detention facilities. These factors may be environmental, operational or cultural, and include:[28]

- the deprivation of liberty and lack of privacy
- blind spots in building design that impede the visibility of children
- inadequate supervision of staff and inadequate oversight of day-to-day operations
- isolation, lack of access to a trusted adult and disconnection of young people from family, friends, community and culture
- power imbalances between staff and children, including staff control of the day-to-day lives of children
- the use of strict rules, discipline and punishment
- cultures of disrespect for, and humiliating and degrading treatment of, children
- cultures where children's voices are not encouraged, and their welfare is not prioritised
- group allegiance among staff and among managers.[29]

We discuss other risk factors for mistreatment of children and young people in detention in Chapter 12.

As part of our Inquiry, we commissioned researchers to engage with Tasmanian children and young people to explore how they perceived safety in institutional contexts, including youth detention.[30] Broadly, children and young people identified 'safe' institutions as stable and predictable environments marked by the availability of protective adults and peers. Children and young people also associated safety with having some agency over their lives.[31]

On the other hand, the feeling of being 'unsafe' in an institution was commonly linked to experiences or observations of bullying, intimidation and violence.[32] Many young people in our commissioned research reported that a major problem with youth detention is the tendency for this environment to be, in the researchers' words, 'chaotic, damaged or in disrepair', lacking privacy and occupied by the kinds of people who would be more, not less, willing to respond to conflict with disproportionate violence.[33]

Some young people with experiences of detention also told our researchers that separating younger children in detention from older ones would be an effective way to keep young people safe, but this did not occur in detention facilities as a matter of course.[34] As one young person put it:

> Why put the 13 year old up with all the fucking people that are like 17 and 18 years old? But now they've got one little 13 year old in there. He's trying to get up with all of us and then he says something wrong, and he ends up getting himself bashed.[35]

Another young person recalled his attempts to avoid victimisation at the hands of other young people in detention by asking staff for help. He said:

> I told them multiple times over the years [about being physically assaulted], not just when I was younger … [that] I've been bashed by lots of people … They're like, 'You've been a cunt to us, so why should we protect you?' … That's what really pissed me off with the whole centre. They're supposed to be there, worrying about our safety, but they're sitting there, and they let us get bashed and stuff. And they sit there and watch you get bashed; they laugh about it. They say "Oh, I reckon you won that fight" or "he won that fight." What the fuck's that shit? That's wrong![36]

In other instances, some young people spoke about being assaulted by staff members, often in the context of being restrained or after a critical incident:

> I had a few restraints, because I was young, back then I was having fun. Got restrained a heap of times. Got taken to my room. I got bashed multiple times by the staff and just thrown around. Obviously, they had to restrain me, but they're trained to restrain people in a certain [way] like … Not sit there and lay knees into you and that, and hit you in the back of the head. And there have been times where they've just stripped me of all my clothes and left me in my room and that.[37]

One young person gave the following account of his treatment by staff in detention:

> And even if I had, they're supposed to put me in a [cell with a camera] and not strip me of me clothes. But they done that anyway. And that was really awkward, having three blokes, they're looking at you, why? You're young, naked, standing there. And then making jokes, saying, "Oh, you've got a little one, there." And I'm like sitting there, bawling my eyes out, because I've just been fucked up and I've just gotten my clothes stripped off, full invasion of your privacy.[38]

The research we commissioned also identified that some young people who have been detained have experienced or perceived barriers to raising concerns when they were mistreated. These barriers included a fear of retaliation, a reluctance to break the

time-honoured prisoner code (sometimes referred to as 'argot rules') against 'snitching', a lack of knowledge about or access to complaints processes, staff discouragement of making formal complaints and doubts about the confidentiality of any complaint made. Some young people interviewed also felt powerless to challenge staff members' versions of an event. As our commissioned research reported:

> One young person in youth detention described being searched by workers who used significant force that intentionally caused him pain. After saying he would complain about what had happened, the worker replied "Go on do it. No-one is going to believe you".[39]

These excerpts offer a small but significant insight into how youth detention environments can place children and young people at risk of abuse.

3 National Royal Commission

Volume 15 of the National Royal Commission's Final Report focused on institutional responses to child sexual abuse in detention, particularly youth and immigration detention. The National Royal Commission highlighted that the Australian Government, as a party to the United Nations Convention on the Rights of the Child, was responsible for taking 'all appropriate measures to protect children from all violence, injury, or abuse, neglect or negligent treatment and maltreatment or exploitation, including sexual abuse'.[40]

The National Royal Commission found that ongoing scrutiny was required for:

- the physical environments of youth detention facilities
- strip searches in detention
- ensuring young people have contact with trusted adults while in detention
- the institutional culture and staffing of youth detention facilities
- the needs of vulnerable groups of children in detention
- complaints handling and reporting processes for child sexual abuse in detention
- preventive monitoring of youth detention facilities
- independent oversight of detention facilities.[41]

The National Royal Commission made 10 recommendations in its volume on youth detention for implementing the Child Safe Standards; providing expertise in preventing and responding to child sexual abuse as part of Australia's commitment to ratify the Optional Protocol to the Convention against Torture (discussed in Section 4); reviewing building and design features and relevant legislation, policy and procedures to create

a safer physical environment; strategies to respond to children's different needs, including the cultural safety of Aboriginal children in youth detention; supporting and training for staff; improving complaints handling systems; and independent oversight of youth detention.[42] The National Royal Commission also made several observations about improving the safety of children and young people in youth detention. These included:

- ensuring a safer physical environment for children in youth detention by introducing closed-circuit television systems, body-worn cameras and electronic systems that monitor staff movements, noting also the need to protect the privacy of children[43]
- ensuring clear articulation of the circumstances in which a child can be strip searched, the process for conducting searches, and training for staff and children on what is appropriate and inappropriate when conducting strip searches[44]
- providing therapeutic treatment to sexual abuse victim-survivors in youth detention[45]
- providing adequate support and training to staff, including aiming to change attitudes and behaviours[46]
- avoiding issues regarding poor workforce retention, a casual workforce, staff feeling unsafe and unsupported in a high-pressure environment, a failure to maintain professional boundaries, and poorly defined and articulated roles and responsibilities.[47]

The National Royal Commission also noted that improving institutional responses to child sexual abuse requires changes to reporting and information-sharing processes to ensure:

- making a complaint is accessible and free from backlash for children and young people through confidential and unrestricted external channels[48]
- allegations of staff misconduct are reported to child protection authorities and police by heads of institutions[49]
- records relating to child sexual abuse are held for at least 45 years[50]
- internal monitoring and evaluation, as well as external and independent oversight, is in place to ensure compliance with policies and procedures.[51]

Importantly, the National Royal Commission indicated that children are safer in community settings rather than in closed detention settings.[52]

The Tasmanian Government's most recent Annual Progress Report and Action Plan in response to the National Royal Commission reports that the implementation of many of these recommendations is underway.[53] We explore the need for further reform in Chapter 12.

4 Legislative and other obligations when detaining children and young people

Children and young people in detention have rights that are set out in international and domestic law. Operators of youth detention centres also have duties and obligations, set out in those same laws. These rights and obligations are supported, explained or expanded on in various international and domestic standards and policies produced by governments, child advocate groups and statutory watchdogs.

In this section, we briefly outline the key international and national standards, and then focus on Tasmanian legislation and standards relevant to youth detention. As well as legislation and standards, there are departmental policies and procedures relevant to youth detention. These policies and procedures aim to give effect to obligations under the *Youth Justice Act 1997* ('Youth Justice Act') and to reflect some of the broader expectations established under international and domestic frameworks. We discuss these policies and procedures throughout Chapter 12.

The United Nations Convention on the Rights of the Child is the key international instrument setting out the rights of children and young people, including their rights in detention.[54] This Convention provides an international standard against which the operation of youth detention centres in Australia can be considered and assessed. Upholding these rights protects a child or young person in detention from abuse, including child sexual abuse.

Articles 37 and 40 of the United Nations Convention on the Rights of the Child relate explicitly to youth justice. Article 37 states that detaining a child should be a measure of last resort and that, when a child is detained, the detention should be for the shortest appropriate time.[55] Article 40 states that every child who is accused of having infringed penal law should be treated 'in a manner consistent with the promotion of the child's sense of dignity and worth'.[56]

In 2019, the Committee on the Rights of the Child, which is responsible for monitoring the Convention, released General Comment No. 24 on children's rights in the youth justice system. This comment provides more guidance on how the Convention should be implemented.[57]

Other relevant United Nations documents include the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment ('Convention against Torture'), the Optional Protocol to the Convention against Torture ('OPCAT'), the reports of the Special Rapporteur on the right of all to the enjoyment of the highest attainable standard of physical and mental health ('Report of the Special Rapporteur on the right to health'), the reports of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment ('Report of the Special Rapporteur on torture')

and the United Nations Standard Minimum Rules for the Treatment of Prisoners ('Nelson Mandela Rules').[58] Paragraph 53 of the 2018 Report of the Special Rapporteur on the right to health states that 'the scale and magnitude of children's suffering in detention and confinement call for a global commitment to the abolition of child prisons … alongside scaled up investment in community-based services'.[59]

OPCAT requires signatory states to establish a system of oversight and regular preventive visits to places of detention by domestic independent bodies known as National Preventive Mechanisms, and to accept visits from the United Nations Subcommittee on the Prevention of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment and the National Preventive Mechanisms.[60] Tasmania was the first Australian jurisdiction to pass a comprehensive statutory framework on OPCAT.[61] In late 2021, the Tasmanian Parliament passed the *OPCAT Implementation Act 2021* ('OPCAT Implementation Act'). We discuss the role of the oversight body under the OPCAT Implementation Act—the Tasmanian National Preventive Mechanism—in Chapter 12.

Three more United Nations instruments provide important normative principles on how the rights of children should be implemented in the youth justice system. They are the United Nations Standard Minimum Rules for the Administration of Juvenile Justice (the 'Beijing Rules'), adopted in 1985; the United Nations Guidelines for the Prevention of Juvenile Delinquency (the 'Riyadh Guidelines'), adopted in 1990; and the United Nations Rules for the Protection of Juveniles Deprived of their Liberty (the 'Havana Rules'), adopted in 1991.[62]

These international laws and standards have been implemented to varying degrees at the national level in Australia. The Australasian Juvenile Justice Administrators (now known as the Australasian Youth Justice Administrators) developed the Juvenile Justice Standards (2009), and the Australian Children's Commissioners and Guardians issued principles relevant to the conditions of youth detention and the treatment of detained young people in 2017.[63] Although these standards and principles are not binding, they provide a reference against which youth detention centre operations in Tasmania can be measured.

In Tasmania, the primary legislative instrument governing youth detention is the Youth Justice Act. The key objectives of the Act include to provide for the safe, therapeutic and secure management of young people held in detention centres; to promote their rehabilitation, including through providing appropriate programs; and to support their reintegration with the community.[64] Section 129 of the Youth Justice Act outlines the rights of a child in detention, including the rights to have their developmental, medical, religious and cultural needs met; to receive visitors; and to be able to make complaints. The Act permits the clothed and unclothed searches of detained young

people in some circumstances (sections 25A to 25L), prohibits certain actions in relation to detained young people (section 132) and authorises the use of isolation in some circumstances (section 133).

In 2018, the Tasmanian Custodial Inspector published the *Inspection Standards for Youth Custodial Centres in Tasmania*, which state that they are based on the principles set out in the *Inspection Standards for Juvenile Custodial Services in New South Wales*.[65] The Custodial Inspector monitors youth detention facilities against these standards. More detail on the Custodial Inspector's role is in Chapter 12.

4.1 Strip searches

In this volume, we sometimes use the term 'strip search' because this is the phrase victim-survivors used when referring to a search involving any removal of clothing, whether partial or full. However, we note that in the Youth Justice Act and custodial standards and procedures, this practice is commonly referred to as an 'unclothed search', with a distinction drawn between partially clothed and fully unclothed searches. In this section, we refer to 'strip searches', 'fully unclothed searches' and 'partially clothed searches', depending on the context.

The 2015 Report of the Special Rapporteur on torture states that strip searches should not be performed on children without 'reasonable suspicion', but does not define this term.[66] The Nelson Mandela Rules, which cover the treatment of children and adults in prison, state that searches should be conducted in a manner that is 'respectful of the inherent human dignity and privacy of the individual being searched, as well as the principles of proportionality, legality and necessity'.[67] Rule 51 of the Nelson Mandela Rules states that searches should not be used to 'harass, intimidate or unnecessarily intrude' on a prisoner's privacy.[68] The rule also states that records should be kept of any searches, with the record including the reasons for the search, the identities of those conducting the search and any results of the search.[69]

Rule 52 of the Nelson Mandela Rules states that intrusive searches, such as strip and body cavity searches, should be undertaken only if absolutely necessary and conducted in private by trained staff of the same sex as the detainee.[70] It also states that body cavity searches should be conducted by a qualified health-care professional or by a staff member who is not primarily responsible for the detainee's care and who is appropriately trained by a medical professional.[71]

In Tasmania, the Youth Justice Act regulates searches of children and young people in custody, including at Ashley Youth Detention Centre.[72] On 1 December 2022, amendments to the provisions of the Youth Justice Act regarding searches of detained young people came into effect, with amendments including the introduction of sections 25A to 25L.[73]

Previously, section 131(2) of the Youth Justice Act stated that a detention centre manager could submit a detainee to a search for weapons, metal articles, alcohol, articles capable of being used as weapons, drugs or other prohibited items. They could do this as soon as possible after admission or on returning from a temporary leave of absence from the detention facility, and at any other time when there were reasonable grounds to believe that the detainee may have had contraband in their possession, or, in the manager's opinion, it was necessary to conduct the search in the interests of security.

As a result of the 2022 amendments, the references to searches being conducted on admission or after temporary leave have been removed. Searches can now only be conducted where the search officer believes on reasonable grounds that the search is necessary for the 'relevant search purpose' and the type and manner of search are proportionate to the circumstances.[74] Relevant search purposes are set out in section 25F of the Youth Justice Act and include ensuring the safety of the young person or other people, obtaining evidence relating to the commission of an offence or preventing the loss or destruction of evidence, and ascertaining whether the young person has possession of a concealed weapon or drugs.[75]

A search officer conducting a search under the Youth Justice Act must ensure it is conducted, as far as practicable, in a manner that retains the young person's dignity and self-respect; minimises any trauma, distress or harm that may be caused to the young person; is the least intrusive search and conducted in the least intrusive manner necessary; is completed as quickly as is reasonably possible; accords reasonable privacy; does not remove more clothing than necessary; and, if clothing is seized, the young person is provided with adequate clothing to wear.[76]

In determining the least-intrusive type of search that is necessary and reasonable to achieve the 'relevant search purpose', the search officer or relevant authorising officer must consider factors such as the health and safety of the young person, their age, intellectual maturity, sex, sexual or gender identity, religion, disabilities, history and any other relevant matters.[77]

As indicated, the Youth Justice Act does not use the term 'strip search' but instead refers to an 'unclothed search'. The following definition of 'unclothed search' was introduced with the 2022 amendments: 'A search of the youth that requires the youth's torso or genitals to be exposed to view or the youth's torso or genitals, clothed only in underwear, to be exposed to view'.[78] In contrast, a 'clothed search' is defined under the Youth Justice Act as 'a search (other than a body cavity search) of the youth that is not an unclothed search'.[79]

Unclothed searches cannot be conducted in a detention centre under the Youth Justice Act unless they are authorised by the detention centre manager or the Secretary of the Department for Education, Children and Young People, and unless the search

is conducted in line with any conditions specified in that authorisation.[80] An unclothed search cannot be authorised unless the person authorising the search believes, on reasonable grounds, that:

- the search is necessary
- the type and manner of the search are the least intrusive, proportionate to the circumstances, and necessary and reasonable to achieve the relevant search purpose.[81]

The Youth Justice Act now also requires a search that involves removing clothing or touching to be conducted by a search officer of the same gender as the young person.[82]

A 'body cavity search' is defined as a 'search of the rectum or vagina of the youth, but does not include a search of the youth by a scanning device that does not touch the youth'.[83] The amendments clarify that body cavity searches are not authorised under the Youth Justice Act in any circumstances.[84]

Force may be used if it is the only means by which the search can reasonably be conducted.[85] In such circumstances, the force must be the least amount of force that is reasonable and necessary to enable the search to be conducted.[86]

Under the Act, records of searches must be kept in a search register and made available for inspection by oversight bodies such as the Ombudsman and the Custodial Inspector.[87]

Following the 2022 amendments, the Youth Justice Act now better reflects domestic standards for strip searches.

The Inspection Standards for Youth Custodial Centres in Tasmania, issued in 2018 before the amendments to the Act, state that searches of a young person must be conducted safely, 'only when reasonable and necessary' and that they must be proportionate to the situation.[88] The Inspection Standards also state that unclothed searches should be a last resort, with pat searches, searches using metal detectors and increased surveillance used before an unclothed search. The Inspection Standards provide that staff should be appropriately trained to conduct searches and that the staff member conducting the search should be the same sex as the young person unless the young person identifies as transgender, in which case the young person should nominate the gender of the person they want to conduct the search.[89]

Under the Inspection Standards, unclothed searches are not to be routinely conducted on entry and exit to a detention facility where a young person has been in a secure vehicle while off the premises. The Standards confirm that cavity searches should never be conducted.[90]

Strip searches at Ashley Youth Detention Centre are also guided by internal policies and procedures set by the Secretary of the Department. The Centre's policies, in line with the Youth Justice Act, do not refer to the term 'strip search' but instead refer to an 'unclothed search'.[91] These policies and procedures give effect to obligations in the Youth Justice Act and reflect some of the broader expectations in international law and domestic guidance. We discuss these policies and procedures in detail and make recommendations to strengthen them in Chapter 12.

4.2 Isolation

General Comment No. 24, issued by the United Nations Committee on the Rights of the Child, states that disciplinary measures such as 'placement in a dark cell, solitary confinement or any other punishment that may compromise the physical or mental health or wellbeing of the child' is a violation of Article 37 of the Convention on the Rights of the Child, and is strictly prohibited.[92] While not defined in the Convention, 'solitary confinement' is understood in international law to mean 'confinement of prisoners for 22 hours or more a day without meaningful human contact'.[93]

Specifically on isolation, General Comment No. 24 sets the following standards for solitary confinement and separation practices in youth detention, in the context of Article 37 of the Convention on the Rights of the Child:

> Solitary confinement should not be used for a child. Any separation of the child from others should be for the shortest possible time and used only as a measure of last resort for the protection of the child or others. Where it is deemed necessary to hold a child separately, this should be done in the presence or under the close supervision of a suitably trained staff member, and the reasons and duration should be recorded.[94]

Similarly, the Havana Rules state:

> Any disciplinary measures and procedures should maintain the interest of safety and an ordered community life and should be consistent with the upholding of the inherent dignity of the juvenile and the fundamental objective of institutional care, namely, instilling a sense of justice, self-respect and respect for the basic rights of every person.
>
> All disciplinary measures constituting cruel, inhuman or degrading treatment shall be strictly prohibited including … placement in a dark cell, closed or solitary confinement or any other punishment that may compromise the physical or mental health of the juvenile concerned.[95]

The link between solitary confinement or segregation practices and poor physical or mental health is recognised in several international instruments. Article 19 of the Convention on the Rights of the Child requires that signatories take steps to protect children from, among other things, 'mental violence' while in the care of a legal

guardian.[96] General Comment No. 13, issued by the United Nations Committee on the Rights of the Child, provides that, in this context, 'mental violence' can include '[p]lacement in solitary confinement, isolation or humiliating or degrading conditions of detention'.[97]

The 2015 Report of the Special Rapporteur on torture has stated that solitary confinement of any duration 'constitutes cruel, inhuman or degrading treatment or punishment or even torture'.[98] The report recommended that solitary confinement of children in detention (of any duration and for any purpose) be prohibited.[99] The negative mental impact of solitary confinement was reiterated in the 2018 Report of the Special Rapporteur on the right to health.[100]

In Tasmania, section 133(1) of the Youth Justice Act defines isolation as 'locking a detainee in a room separate from others and from the normal routine of the detention centre'. Section 133(2) of the Act states that a detention centre manager may only authorise isolation if a detainee's behaviour poses an immediate threat to their own safety, that of another person or property and all other reasonable steps to prevent the harm or damage have been unsuccessful, or if it is in the interest of the security of the centre.[101]

Under the Act, reasonable force may be used, if necessary, to place a young person in isolation.[102] When in isolation, the young person must be 'closely supervised and observed' at intervals of no longer than 15 minutes.[103] The detention centre manager must also ensure the particulars of every use of isolation are recorded in an isolation register.[104] The period of isolation must not contravene any instructions issued by the Secretary of the Department.[105]

The Inspection Standards for Youth Custodial Centres in Tasmania provide that if it is necessary for a young person in detention to be placed into 'separation, segregation or isolation' for their own safety, the safety of others or for the good order of the detention centre, such actions should be:

- for the 'minimum time necessary'
- only used when all other means of control have been exhausted
- recorded accurately in a separation and segregation register, including details of the young person's routine while in isolation.[106]

In line with international obligations, the Inspection Standards suggest that staff closely supervise young people during isolation episodes.[107] The Inspection Standards also state that isolation should take place under conditions providing 'not less amenity than normal accommodation', except where a young person presents a serious risk of suicide or self-harm.[108]

The use of isolation at Ashley Youth Detention Centre is also guided by internal policies and procedures set by the Secretary of the Department. These policies and procedures are intended to give effect to the Youth Justice Act obligations and to reflect some of the broader expectations in international law and domestic guidance. We discuss these policies and procedures in detail in Chapter 12.

4.3 Use of force

International law prohibits the use of restraint or force against young people in detention, except in exceptional circumstances. Both the 2019 General Comment No. 24 and the 2015 Report of the Special Rapporteur on torture state that restraint or force can only be used against a child in detention if that child poses an imminent threat of injury to themselves or others and only when all other means of control have been exhausted.[109] General Comment No. 24 also states that prison staff should be adequately trained in the use of force, and that force should never be used as a means of punishment:

> Restraint should not be used to secure compliance and should never involve deliberate infliction of pain. It is never to be used as a means of punishment. The use of restraint or force, including physical, mechanical and medical or pharmacological restraints, should be under close, direct and continuous control of a medical and/or psychological professional. Staff of the facility should receive training on the applicable standards.[110]

General Comment No. 24 also provides that states should record, monitor and evaluate all incidents of restraint or force used on children in detention and that those who violate these rules should be punished.[111]

These principles are reflected in a range of other international instruments including the Havana Rules and the Nelson Mandela Rules.[112] These instruments describe best practice in relation to the use of force on detained young people as follows:

- The use of force is only permitted when it is strictly necessary—that is, where the child poses an imminent threat of self-harm or injury to others—and where other methods of control have been exhausted.[113]
- When the use of force is deemed strictly necessary, it must be used:
  - for the shortest possible time or a limited time[114]
  - without causing humiliation and degradation[115]
  - by properly trained staff[116]
  - only in self-defence, in response to attempted escape or in response to active or passive physical resistance.[117]

In Tasmania, section 132 of the Youth Justice Act prohibits the use of physical force against young people in detention unless the force is reasonable. The use of force must also be necessary to prevent the detainee harming themselves or anyone else, or damaging property, necessary for the security of the centre or otherwise authorised.

The Inspection Standards for Youth Custodial Centres in Tasmania provide that force must only be used 'when it is necessary to prevent an imminent and serious threat of self-harm or injury to others, and only when all other means of control have been exhausted'.[118] The Inspection Standards also state the following:

- The use of force must only occur for 'the shortest time required'.[119]
- Force should never be used as punishment or to obtain a young person's compliance.[120]
- Force should never be used in a way that causes humiliation or degradation.[121]
- All instances of the use of force should be recorded, investigated and reported.[122]
- Cameras should be used to record planned interventions involving the use of force.[123]
- A young person who has been subjected to a use of force should be provided health care following the incident.[124]

The Inspection Standards require that any use of force involve only approved techniques and restraints and that the young person should be given an opportunity to speak with staff not involved in the incident following the use of force.[125]

The use of force at Ashley Youth Detention Centre is also guided by internal policies and procedures set by the Secretary of the Department. These policies and procedures are intended to give effect to the Youth Justice Act obligations and to reflect some of the broader expectations in international law and domestic guidance. We discuss these policies and procedures in Chapter 12.

4.4 Punishment, intimidation, humiliation, physical or emotional abuse, discrimination

As a party to the Convention against Torture, Australia is obligated to take effective legislative, administrative, judicial or other measures to prevent acts of torture. The Convention against Torture defines torture as any act by which severe physical or mental pain or suffering is intentionally inflicted to punish, intimidate or coerce, or for any reason based on discrimination of any kind.[126] It occurs when inflicted by, or instigated with the consent or acquiescence of, a public official.[127]

Under the Havana Rules, all disciplinary measures constituting cruel, inhuman or degrading treatment are strictly prohibited, including corporal (physical) punishment or any other punishment that may compromise the physical or mental health of the juvenile concerned.[128]

In Tasmania, section 132 of the Youth Justice Act also prohibits corporal punishment that inflicts or is intended to inflict physical pain or discomfort as punishment; the use of any form of psychological pressure intended to 'intimidate or humiliate' the detainee; the use of any form of physical or emotional abuse; and the adoption of any kind of discriminatory treatment.

The Inspection Standards for Youth Custodial Centres in Tasmania state that no young person should experience disadvantage, discrimination or abuse while in custody.[129] Standard 8.6 covers behaviour management systems and states that rules must be applied fairly and consistently without discrimination. Standard 8.10 states that young people, staff and visitors understand that bullying and intimidating behaviour are not acceptable.[130]

5 Understanding the youth detention context in Tasmania

5.1 An overview of Ashley Youth Detention Centre

Ashley Youth Detention Centre is Tasmania's primary dedicated youth detention facility.[131] After a refurbishment in 2022, Ashley Youth Detention Centre can accommodate up to 40 young people across five accommodation units at any given time.[132] The Centre is managed by the Department for Education, Children and Young People (formerly the Department of Communities) under the Youth Justice Act.[133] We outline the management, staffing and operations of Ashley Youth Detention Centre in Section 5.3.

The Centre is in regional Tasmania near the town of Deloraine, which has a population of about 6,000 people.[134] Deloraine is about 50 kilometres from Launceston and Devonport, and more than 200 kilometres from Hobart. During our Inquiry, we became aware that the geographical remoteness and isolation of the Centre may contribute to unfavourable outcomes for the young people detained there; for example, some young people cannot access the services required to support their complex needs. In many instances, family members, cultural support people, specialists (including medical practitioners, psychologists and alcohol and other drug support services) must travel from Hobart, Launceston or Melbourne to deliver services to young people at the Centre.[135]

An assessment of the Centre commissioned by the Tasmanian Government in 2016 concluded that the location of Ashley Youth Detention Centre 'makes it difficult to deliver a throughcare approach, which builds on pro-social relationships with a young person's family, community and service providers'.[136]

Ashley Youth Detention Centre operates on the site of the previous institution known as Ashley Home for Boys.[137] Ashley Home for Boys transitioned to a secure youth detention centre for males and females aged between 10 and 18 years on 28 June 2000.[138] Allegations of physical, sexual and emotional abuse made by former residents of Ashley Home for Boys have been the subject of a Tasmanian Ombudsman review, resulting in compensation and a State Government apology in 2005 to former wards of the state abused in care.[139] Some staff from Ashley Home for Boys continued to work at Ashley Youth Detention Centre once it opened and remained working there for many years.[140] Also, several current staff have been working in Ashley Youth Detention Centre since the early 2000s.[141] We discuss concerns about the culture and operations of Ashley Youth Detention Centre over the past two decades in Section 6 and throughout Volume 5.

5.2 Children and young people at Ashley Youth Detention Centre

5.2.1 Demographic profile

According to data published by the Australian Institute of Health and Welfare, on an average day in 2021–22 there were eight children and young people aged 10 to 17 years in detention in Tasmania and, of these, six were on remand.[142] The average length of time young people spent in detention during the year in Tasmania in 2021–22 was 72.5 days.[143] As with other jurisdictions, Tasmanian legislation requires that detention of children and young people should be a last resort and for the shortest time necessary.[144]

Hannah Phillips, a lawyer with experience working with youth in the Tasmanian justice and child safety systems, told us that children and young people are often detained on remand because they have nowhere else to live while their charges are being processed by the court.[145] Ms Phillips said that common factors associated with remanding rather than bailing children and young people include the lack of a fixed residence, the absence of family support (including kinship support) and appropriate supervision, the instability or breakdown of out of home care placements, and the presence of undiagnosed mental health issues or disability that has led to the offending behaviour.[146] Ms Phillips told us that many young people who have contact with the justice system 'live on the street or couch surf' due to limited stocks of immediately available housing or emergency accommodation for young people.[147] She noted 'a magistrate or Justice of the Peace is rarely going to bail a young person without a stable address'.[148]

Vincenzo Caltabiano, former Director of Tasmania Legal Aid, told us this situation 'leads to a greater number of the most vulnerable children being remanded in custody and exposes them to the adverse impacts of detention'.[149]

Mark Morrissey, former Commissioner for Children and Young People, observed that children and young people detained at Ashley Youth Detention Centre:

> … often have serious psychological or emotional damage and issues, brain injury due to childhood trauma or conditions such as fetal alcohol spectrum disorder (FASD), family violence, chronic neglect, failed attachment and developmental delay.[150]

On an average day in youth detention in 2021–22, Aboriginal children and young people aged 10 to 17 years accounted for 44 per cent of the detention population in Tasmania for that age group, despite only comprising about 10 per cent of the total Tasmanian population aged 10 to 17 years.[151] The impacts of colonisation, including poverty and disadvantage, have continued to drive the over-representation of Aboriginal children in detention.

Although the Tasmanian Youth Custodial Information System does not capture information about young people with disabilities in detention, broader data suggests that adults and young people with mental and cognitive disabilities are over-represented in detention settings.[152] We heard that 'significant mental health problems' and previously unknown or unaddressed disability-related need are often not identified until children are in detention.[153] Ms Phillips questioned the adequacy of Tasmania's mental health system, particularly the absence of a dedicated facility for young people experiencing mental health issues and complex behaviours.[154] Ms Phillips observed that 'Ashley Youth Detention Centre is used to manage behaviour and address immediate risk rather than address[ing] the underlying issues' that contribute to a young person's offending.[155]

There are significant behaviour and learning challenges in the cohort of young people at Ashley Youth Detention Centre.[156] The Ashley School Principal, Samuel Baker, told us that the literacy and numeracy skills of students at the school are, in general, 'many years behind their peers in the community', predominantly due to socioeconomic disadvantage and having missed significant amounts of schooling.[157]

Data provided by the former Department of Communities indicates that 43 per cent of all young people in detention in Tasmania in 2020–21 had also been in out of home care.[158] Recent research indicates that, for young people with cognitive disability and complex support needs, the association between involvement in child protection and the justice system is particularly strong.[159]

5.2.2 Ashley Youth Detention Centre, reoffending and Risdon Prison

We heard that a high number of children cycle in and out of Ashley Youth Detention Centre in a relatively short period. Mr Caltabiano told us that more than 50 per cent of children aged between 10 and 16 years return to the Centre within 12 months of their release.[160] He observed that, 'like detention and imprisonment for adults, detention for children tends to contribute to a cycle of recidivism and then institutionalisation'.[161]

Ms Phillips described a tendency for some young people in Tasmania to view Ashley Youth Detention Centre as a viable alternative to life outside. She told us that detention could provide a sense of belonging for the most disadvantaged young people in Tasmania, where 'they do not have to worry about drug debts, a household where there is family violence, or how they are going to get food every day'.[162] Ms Phillips referenced one young person who asked for his bail to be revoked because 'he wanted to go to school where he did not feel different' and because 'he did not feel he could avoid getting into trouble where he lived'.[163] Ms Phillips noted that, in the absence of structure, family support, routine and the services and infrastructure known to enhance social inclusion and personal opportunity, it is virtually impossible for some young people to imagine living in conventional and prosocial ways.[164]

We also heard about the correlation between children who are detained at Ashley Youth Detention Centre and their incarceration as adults at Risdon Prison.[165] Ms Phillips told us that she continues to represent many adult clients for whom she acted when they were children.[166] The frequency of this phenomenon has led Ms Phillips to refer to Ashley Youth Detention Centre as 'the kindergarten for Risdon Prison'.[167] She told us that incarceration at Risdon Prison is 'an expected course' for some young people.[168]

Mr Morrissey similarly referred to the Centre as a 'conduit' for an adult criminal career. He highlighted the tendency for highly vulnerable young people to establish criminal networks in the Centre, which they maintained on release.[169] Professor Robert White, Emeritus Distinguished Professor of Criminology, University of Tasmania, described the incarceration of children and young people in detention centres and prisons as contrary to the rehabilitative and restorative ideals that are commonly associated with youth justice:

> If you put somebody into, say, a youth prison, there is a whole bunch of things that accompany that, detachment from home, from school, a whole bunch of things, but also the stigma that's attached to spending time inside, all [of] that then generates a track record which makes it more difficult for young people to succeed into the future and a similar process with the adult prisons, as well.[170]

5.3 Management, staffing and operations of Ashley Youth Detention Centre

In July 2018, the department responsible for Ashley Youth Detention Centre changed from the Department of Health and Human Services to the Department of Communities.[171] At this time, responsibility for administering the Centre sat with the Children and Youth Services division of the Department of Communities.[172] In October 2022, the Department of Communities was folded into the Department for Education, Children and Young People, which has overall responsibility for the health, safety and welfare of children and young people in detention at Ashley Youth Detention Centre.[173] As noted in the introduction to this volume, we use the term 'Department' in this volume to mean the department responsible at the relevant time for youth justice, with the specific department noted where required for clarity.

5.3.1 Management

The Secretary of the Department is responsible for the security and management of Ashley Youth Detention Centre and the safe custody and wellbeing of children and young people in detention.[174] From 2000, when the Centre was established, until October 2022, the Secretary delegated the power to issue instructions concerning the management of the Centre and the safe custody and wellbeing of children and young people in detention to the Deputy Secretary, Children, Youth and Families and the Director, Youth and Family Violence Services, although the Secretary still held ultimate responsibility.[175] Before October 2022, the Deputy Secretary reported directly to the Secretary of the Department and the Director reported to the Deputy Secretary, Children, Youth and Families.[176]

Before October 2022, the Director, Youth and Family Violence Services, also known by other titles including Director, Services to Young People and Director, Strategic Youth Services, was the senior executive in the organisational structure of Ashley Youth Detention Centre, but was not based at the Centre.[177] We have elected to refer to this role as Director, Strategic Youth Services. Previously, this position oversaw other areas in the family violence and youth justice portfolio, but, in early 2022, oversight of Ashley Youth Detention Centre became a dedicated role.[178] In August 2022, the newly created position of Executive Director, Services for Youth Justice became responsible for Ashley Youth Detention Centre. This position reports to the Associate Secretary of the Department for Education, Children and Young People.[179]

Before the October 2022 restructure, the Manager, Custodial Youth Justice ('Centre Manager') reported to the Director, Youth and Family Violence Services.[180] The Centre Manager was responsible for managing the day-to-day operations of the Centre, developing and leading a management team, and providing direction for programs at the

Centre.[181] As of May 2022, there were four direct reports under the Centre Manager—an Assistant Manager for Operations; a Manager, Professional Services and Policy; a Fire, Safety and Security Coordinator; and a Practice Manager.[182]

The general hierarchy has been in place at Ashley Youth Detention Centre since at least 2007, with some changes over time to specific reporting lines and roles. This hierarchy has the Secretary of the Department ultimately responsible for Ashley Youth Detention Centre, the Director level and above located in the Department, a Centre Manager at the Centre, and two streams (Operations and Professional Services) in the Centre.[183]

5.3.2 Staffing and operational structure

In this section, we outline the operational structure of Ashley Youth Detention Centre in broad terms, noting that the structure has changed over time. As noted, since at least 2007, the Centre's organisational structure has been primarily divided between Operations and Professional Services staff, with each cohort reporting to the Centre Manager.[184]

Ashley Youth Detention Centre's Operations Team works in the residential units and provides the day-to-day supervision, support and care of young people.[185]

The Operations Team includes:

- the Operations Manager, who manages the day-to-day operations of Ashley Youth Detention Centre and leads the Operations Team
- Operations Coordinators, who oversee the delivery of services to young people and coordinate and supervise youth workers
- youth workers, who assist in the daily operation of residential units and supervise and support young people attending programs and activities or taking part in daily routines.[186]

We understand that Operations staff work in fixed teams with an Operations Coordinator and multiple youth workers per team, and that teams are established with staff skills, gender and experience in mind.[187]

Stuart Watson, Manager, Custodial Youth Justice ('Centre Manager'), told us that the Operations Team, specifically the youth workers:

> … represent a parent-like person who assists the young people to meet their daily goals, including making their beds, cleaning, laundry, pro-social conversation and recreational activities such as playing cards or kicking the football.[188]

Operations staff also supervise offsite excursions and may engage in behaviour management actions such as restraining a young person where required.[189]

The Professional Services and Policy team was a multidisciplinary team that supported the development, review and implementation of relevant policies, procedures and programs.[190] The team also provided case management and therapeutic supports to young people.[191] It led the development of case or care plans and exit plans, undertook case conferencing and managed referrals to other services in the community.[192] It also advised, developed and delivered training to the Operations Team, including on behaviour management strategies.[193] Today, the team is known as 'Ashley Team Support' and it conducts similar functions. For the purposes of our report, we refer to it as the 'Professional Services Team'.

The Professional Services Team includes:

- the Manager, Professional Services and Policy, who leads the development, review and implementation of practice standards, policies, procedures, programs and case management strategies, and manages and supervises some, but not all, Professional Services staff
- the Policy and Program Support Officer, who oversees programs and services to young people and provides policy advice on restorative justice and therapeutic responses
- the Practice Manager, who leads, supervises and mentors Operations staff and the Training Coordinator, and leads the development and evaluation of learning and development programs at the Centre
- the Training Coordinator, who develops, implements and evaluates staff training and professional development
- the Program Coordinator, who coordinates and facilitates program delivery, in conjunction with Ashley School
- the Case Management Coordinator, who maintains the case management system at Ashley Youth Detention Centre and provides direction, support and supervision to staff involved in case management
- the Case Management Officer, who assists with the provision of case management services.[194]

We have not received an updated organisational structure for the internal Ashley Youth Detention Centre management since the October 2022 restructure, although we have noted the creation of new positions in our discussion of the Keeping Kids Safe Plan in Chapter 12.

The conduct of staff at Ashley Youth Detention Centre is governed by standard operating procedures, which cover topics as diverse as the supervision and movement of young people, admissions, isolation, use of handcuffs, health care and searches of children and young people.[195]

Other Tasmanian government departments provide healthcare and education services to the children and young people detained at Ashley Youth Detention Centre.

5.3.3 Healthcare services

Correctional Primary Health Services and Ashley Youth Detention Centre work together to assess the physical and mental health status of young people in custody; deliver appropriate health services for young people; offer timely responses and treatment; and provide appropriate referrals and access for specialised assessment and treatment.[196] They also share responsibilities for the care of young people with physical and cognitive disabilities.[197]

Michael Pervan, former Secretary of the Department of Communities, told us that the Department of Health, which was 'independent' of the former Department of Communities' organisational structure, was responsible for staffing, supporting and running the general health service provided to young people at Ashley Youth Detention Centre.[198]

Correctional Primary Health Services has overseen Ashley Youth Detention Centre's Health Team since 2011.[199] Correctional Primary Health Services sits in the Department of Health, under the umbrella of Statewide Mental Health Services.[200] In conjunction with its role at the Centre, Correctional Primary Health Services provides services to Risdon Prison, Hobart Reception Prison and Launceston Reception Prison.[201] Correctional Primary Health Services is under the management of the Group Director of Forensic Mental Health and Correctional Primary Health Services ('Group Director').[202]

Health practitioners at the Centre are employees of (or are otherwise engaged by) the Department of Health.[203] Members of the Centre's Health Team do not report to Ashley Youth Detention Centre management or the Department for Education, Children and Young People, but to officials in the Department of Health.[204] Health Team members are also subject to relevant Department of Health legislation, policies and procedures.[205]

This organisational separation is reflected in a memorandum of understanding between the former Department of Communities and Correctional Primary Health Services, dated May 2021, which is in place until February 2026.[206] The Group Director told us that a memorandum of understanding in some form has been in place since 2011, when health services at Ashley Youth Detention Centre were transferred to Correctional Primary Health Services.[207]

We understand that the memorandum of understanding is reviewed annually. It states that the role of Correctional Primary Health Services at Ashley Youth Detention Centre is to provide:

- primary health and mental health care and treatment
- specialist referrals
- specialist mental health care and treatment
- initial treatment for Centre staff who are injured at work.[208]

The specific services to be provided by Correctional Primary Health Services are outlined in a schedule to the memorandum of understanding.[209]

While the Department of Health plays a central role in delivering healthcare services at Ashley Youth Detention Centre, Secretary Pervan confirmed that the former Department of Communities retained the 'overall responsibility' for the health, safety and welfare of young people at the Centre.[210] This is reflected in the memorandum of understanding.[211]

Importantly, the memorandum of understanding sets out that Ashley Youth Detention Centre is responsible for:

- providing timely referrals to clinicians for health assessments according to existing policies
- facilitating transports and escorts to enable residents to attend appointments with health service providers in the Centre and externally
- providing Correctional Primary Health Services with information that will facilitate the ongoing health management and care of residents.[212]

The Health Team at Ashley Youth Detention Centre is made up of nursing staff, medical officers (doctors) and mental health professionals. Nursing staff appear to provide the bulk of healthcare services at the Centre. The Nurse Unit Manager is responsible for health services operations and is employed for 0.5 full-time-equivalent hours (working a further 0.5 full-time-equivalent hours at Launceston Reception Prison).[213] The Nurse Unit Manager is on site at Ashley Youth Detention Centre most days and provides on-call assistance and shift cover as required.[214] Any on-call assistance provided by the Nurse Unit Manager is unpaid.[215]

The Nurse Unit Manager oversees registered nurses who provide services on site.[216] There is one registered nurse at the Centre for 12 hours a day, seven days a week, between the hours of 7.00 am and 7.00 pm (in addition to the Nurse Unit Manager).[217] Outside those hours, a nurse is available on call.[218]

Nursing staff at Ashley Youth Detention Centre report to the Department of Health. The Nurse Unit Manager and registered nurses report to the Assistant Director of Nursing at the Department of Health, who reports to the Director of Nursing for Forensic Health Services ('Director of Nursing'), who in turn reports to the Group Director.[219]

The Nurse Unit Manager and registered nurse on shift are stationed in an area known as the 'health corridor' or 'health centre' at Ashley Youth Detention Centre.[220] In that area, there are two offices, a consultation room, a treatment room and a secure pharmaceutical storage area, with a medicine administration hatch.[221] Most treatments and consultations take place in the health centre, but treatment can be provided elsewhere at the Centre if required—for example, in the gym or in the young person's unit.[222]

A medical officer is employed at 0.2 full-time-equivalent hours at Ashley Youth Detention Centre and is supported by on-call medical officers for after-hours attendances.[223] The medical officer provides consultative assistance to nursing staff, including by prescribing medication. As with other health staff at Ashley Youth Detention Centre, medical officers are employees of the Department of Health and report to the Clinical Director, Correctional Primary Health Services.[224] The Nurse Unit Manager told us that medical officers are only on site at Ashley Youth Detention Centre for two hours a week.[225]

Regarding mental health support, a 'forensic' or 'clinical' psychologist is usually employed by the Department of Health for 1.0 full-time-equivalent hours.[226] The psychologist reports to the Manager, Community Forensic Mental Health Services.[227] We understand the role of the psychologist to be:

- addressing young people's criminogenic needs and providing therapy
- undertaking self-harm and suicide risk assessments
- educating young people on 'pro-social attitudes and behaviour modification'.[228]

The psychologist position has been vacant since November 2021.[229] The Group Director told us that psychology telehealth sessions were available to detainees between November 2021 and June 2022.[230] He also said that 'alternative services have been access[ed] from private providers and there is a clinic 3 hours per week via telehealth'.[231] The Group Director also told us that, given the ongoing challenges in recruiting a psychologist, Correctional Primary Health Services decided in March 2022 to change the psychology input into a sessional timetable rather than a psychologist being permanently based at the Centre.[232]

A child psychiatrist also provides onsite care to young people at Ashley Youth Detention Centre.[233] The psychiatrist visits the Centre one day a month to assess, diagnose and treat young people.[234] This psychiatrist is not an employee of the Department

of Health and is instead funded via a Commonwealth Government outreach program.[235] The Department of Health provides clinical oversight of the psychiatrist.[236] Otherwise, psychiatry services for children and young people in detention are accessed via telehealth.[237]

All Ashley Youth Detention Centre Health Team members must be registered with the Registration to Work with Vulnerable People Scheme, and those employed by the State must comply with the State Service Code of Conduct.[238] We understand that there is no specific training for health staff who work in youth detention, aside from the normal tertiary education required for medical roles.[239] Some nursing staff may undertake further education relevant to youth detention as part of their continuous professional development, such as for trauma-informed care and drug and alcohol dependency.[240] However, this does not appear to be specific to the youth detention context. Health services for children in detention are discussed in Chapter 12.

5.3.4 Education services

The right of children and young people to access education continues in detention. A core principle of delivering youth justice services under the Youth Justice Act is that 'no unnecessary interruption of a youth's education' occurs so far as the circumstances of the individual case allow.[241]

Ashley School, which is a Tasmanian Government school on the Ashley Youth Detention Centre site, delivers schooling to children and young people in detention. Young people do not start attending Ashley School until they have completed a school induction delivered by an Ashley School teacher or the principal, which occurs after they are remanded or detained for seven days.[242] Students are generally expected to attend school from 9.00 am to 2.30 pm every weekday.[243] Attendance at Ashley School is consistent with the attendance policy at other Tasmanian Government schools: there is an expectation that young people attend school if they can.[244] A student might not attend a school program at Ashley Youth Detention Centre for a variety of reasons including due to a safety risk assessment, the need to attend an offsite appointment or because a student has indicated that they 'don't want to attend'.[245]

Ashley School offers a curriculum in literacy and numeracy, as well as specialist and vocational classes including art, woodwork, cooking, STEM (science, technology, engineering and mathematics), physical education, health, 'fit gym' and Aboriginal studies.[246] The 'core' curriculum in literacy and numeracy forms about 30 per cent of each student's schooling and is tailored to meet each student's individual learning needs.[247] Ashley School also promotes and educates young people in prosocial behaviours and values.[248]

Mr Baker told us that most, if not all, Ashley School students display challenging school behaviours and that Ashley School staff are often required to be hypervigilant, flexible, adaptable and resilient.[249]

We heard that Ashley School staff apply a therapeutic educational model that incorporates positive behaviour support to promote and acknowledge the behaviour they want to see in young people.[250] Ashley School also provides a highly scheduled timetable and explicit expectations and learning intentions, so students know what is required and how to achieve it, and to minimise surprises or overstimulation.[251]

Mr Baker told us that Ashley School staff use a variety of strategies to support students to increase their functional literacy and numeracy including individual learning plans, individualised learning tasks, collaborative planning, high-intensity teaching strategies and high teacher-to-student ratios.[252] He said that, for most classes, at least one teacher and one teacher assistant are assigned to no more than four students.[253]

Until October 2022, the Department of Education managed Ashley School independently from the former Department of Communities.[254] The Department of Education was responsible for staff appointments for, support to, and the day-to-day running of, Ashley School.[255] Mr Baker told us that the Department of Communities and the Department of Health shared essential information and feedback about the young people at Ashley Youth Detention Centre with the Department of Education to support Ashley School in making decisions in the interests of detained young people.[256]

Since October 2022, the newly formed Department for Education, Children and Young People has been responsible for administering Ashley School. As of August 2022, Ashley School was staffed with 6.0 full-time-equivalent teachers, 1.28 full-time-equivalent teacher assistants, 0.52 full-time-equivalent education facility attendants and a full-time School Business Manager.[257] Ashley School staff have to follow the processes, policies and strategic planning of the Department for Education, Children and Young People.[258] Education services for children in detention are discussed in Chapter 12.

5.3.5 Decision making and recommendation forums

Secretary Pervan told us that Ashley Youth Detention Centre 'operates as a multidisciplinary centre' and that the Operations and Professional Services Teams 'work collaboratively through multidisciplinary teams, weekly review meetings, and program meetings'.[259] The structure of team meetings changed in mid-2022. In this section, we set out the relevant features of teams and meetings before this change.

The Centre Support Team was a longstanding feature of Ashley Youth Detention Centre's operation until mid-2022. The Centre Support Team determined a young person's 'colour level' in line with the Behaviour Development System (replaced with the Behaviour Development Program in April 2022).[260] The Behaviour Development System and the Behaviour Development Program are discussed in Section 5.4 and Chapter 11,

Case study 3, but essentially the System/Program is a behaviour management tool used to incentivise engagement and positive behaviour from young people. It allocates privileges or restrictions to a child or young person based on their ranking in a colour system. A child or young person's colour corresponds to their behaviour and is reviewed at least weekly.

The Centre Support Team also determined a child or young person's eligibility for leave, decided which unit a child or young person should be placed in, reviewed and managed responses to incidents in the Centre, and managed formal requests from children and young people, including for offsite activities and unit changes.[261]

The Centre Support Team's membership changed over time and, although staff from the Professional Services Team were included as general members, it primarily included staff from the Operations Team and was chaired by the Operations Manager.[262]

The Centre Support Team met weekly and held interim meetings as required (either by the Centre Manager or Chair, or if requested by a general member and with the chairperson's or Centre Manager's approval).[263] The outcomes of these meetings, including a child or young person's colour rating and unit placement, were communicated to detainees after the weekly meeting. Alysha (a pseudonym), a former Clinical Practice Consultant at Ashley Youth Detention Centre, described this process in the following terms:

> The [Centre Support Team] would meet from 9am to 12pm every Monday, and the Centre would then be locked down from approximately 12pm to 2pm and every child sent to their cell in what was effectively entirely accepted isolation. The [Centre Support Team] members, as a group, would go to each room and speak to each child about the outcome of the [Centre Support Team] meeting for them; whether they had moved up or down in the colour behaviour management system, and why. The children would be forced to sit on their beds while the adults stood to deliver the results. It would often not be good news and children would become distressed.
>
> There would be four to five adults in the room, speaking to the child about how naughty and bad they had been. It was a visibly crushing and humiliating experience for a child. I could see how dehumanising and traumatising it was to have people they were generally afraid of, standing over them and telling them they were essentially bad. There was always a particularly negative lean on the feedback provided to each child and after difficult news was delivered the child would be locked into their cell alone whilst we went to see the other children. [264]

Alysha also told us she considered the way in which the Centre Support Team delivered its decision to children to be 'inappropriate, re-traumatising and ineffective'.[265]

We have been advised that this practice has since changed and is now referred to as the Weekly Review Meeting.[266] Following this Weekly Review Meeting, in the early afternoon the Operations Coordinator visits the units.[267] The Operations Coordinator

and unit staff let the children and young people know their 'colour' and give them their incentives award/voucher if applicable through an incentives-based process.[268] We were advised that the units have 'quiet time' from 12.30 pm until 1.15 pm, which immediately follows lunch.[269] In the following couple of days (Tuesday/Wednesday depending on the number of detainees), the Ashley Team Support staff (Case Management) and an Australian Childhood Foundation staff member visit the young people to discuss their therapeutic plan, the reason for the Weekly Review Meeting decision, and their future needs. This is done in a meeting room, not on the unit, to give the young people the space and privacy to discuss any issues or concerns they might have.[270]

The Multi-Disciplinary Team has also existed for a long time at Ashley Youth Detention Centre. Copies of Multi-Disciplinary Team terms of reference documents made available to us indicate that the purpose, membership and decision-making protocols of the team have not changed substantially since at least 2018.[271] We are aware of Multi-Disciplinary Team meetings as early as 2012.[272]

The Multi-Disciplinary Team provides 'assessment, review, monitoring and a referral forum to address the needs of all young people' at Ashley Youth Detention Centre.[273] Its purpose is to 'optimise health outcomes, address other risk factors and plan for the young person's return to the community'.[274]

Among the tasks and responsibilities of the Multi-Disciplinary Team are:

- discussing care and case management plans for all young people at Ashley Youth Detention Centre
- developing plans to address risk factors and to provide ongoing reviews of those plans
- providing 'professional liaison and support' for Operations staff 'in the supervision and management of young people as requested and/or required'.[275]

Case plans, safety plans and exit plans are updated following Multi-Disciplinary Team discussions.[276]

We understand the membership of the Multi-Disciplinary Team has changed over time but has generally reflected a broad range of Professional Services staff and a small representation from the Operations Team.[277] The chairperson is the Manager, Professional Services (or delegate, Care Management Coordinator).[278] Other staff or stakeholders (such as a youth worker or program provider) may be invited to a Multi-Disciplinary Team meeting as required.[279] Mr Watson, Centre Manager, told us that regular invitees include nurses, paediatricians, psychologists, psychiatrists and representatives of the National Disability Insurance Scheme.[280]

According to its terms of reference, the Multi-Disciplinary Team develops, implements and documents responses to individual care/case management plans and provides feedback through the case management process to the child or young person in detention.[281]

In mid-2022, a Risk Assessment Process Team was established. Pamela Honan, Director, Strategic Youth Services in the Department, told us that this team was established in response to concerns that Ashley Youth Detention Centre staff felt unsafe at work because of the behaviour of children and young people in detention, the behaviour of staff and/or unsafe staffing levels.[282] The Risk Assessment Process Team's terms of reference are effective from 8 June 2022.[283] Membership of the team includes the Ashley Team Support or Operations Manager as the Chair, the Assistant Manager of the Centre, Case Management Coordinator, Practice Manager, Operations Coordinator and representatives from Education (School Principal), the Department of Health (Clinical Psychologist/CPHS nurse) and a guest at the discretion of the Chair.[284] The terms of reference note that the team reports to the Senior Management Team, which reports to the Director, Youth and Family Violence Services.[285]

The Risk Assessment Process Team's terms of reference provide that the team's purpose is to 'establish a reliable, evidence-based framework for decision-making, analysis, planning, and implementation of risk management strategies to support staff with the ongoing care of young people' at Ashley Youth Detention Centre.[286]

The Risk Assessment Process Team is primarily involved in reviewing incidents. Its tasks and responsibilities are described in the terms of reference as, among other things:

- analysing incidents, including considering underlying causes and assessing all available evidence (including closed-circuit television)
- developing behavioural management plans for young people involved in a 'significant incident'
- making recommendations to the Centre Manager
- providing advice on operational practices and procedures
- providing practical support and advice for managing risks.[287]

The terms of reference state that meetings are held 'as per the category timeframes for responding to a significant incident and following a new admission'.[288] Two categories of incidents should initiate a response from the Risk Assessment Process Team:

- Category one incidents are incidents that are 'significantly serious and critical in nature'.[289] These are defined to include 'all incidents involving immediate and/or ongoing acute risk'.[290] Examples include attempted suicide or significant self-harm, actual or alleged sexual assault, uses of force or physical assaults requiring medical treatment, 'pattern[s] of behaviour … that on a cumulative basis are a serious concern to safety' and riotous behaviour.[291]
- Category two incidents are incidents that are 'significantly serious but involve a less critical and/or immediate level of risk to the safety and wellbeing of young people, staff, and the Centre'.[292] Examples include other physical assaults, attempted assaults, 'sexualised behaviours' (such as sexual threats, sexually demeaning language or indecent exposure) and having contraband.[293]

Category one incidents require a response from the Risk Assessment Process Team within two hours if possible, and no more than 24 hours.[294] Category two incidents require a response from the team on the same or next business day.[295]

All other incidents are considered in the Weekly Review Meeting.[296] The terms of reference for the Weekly Review Meeting state that it contributes to 'celebrating the successes of young people and assists in the development of behaviour support strategies'.[297] They state that, as part of the program to engage with young people and incentivise positive behaviour, the Weekly Review Meeting will review information and reports on young people to determine their colour level.[298] Membership of the Weekly Review Meetings is the Operations Manager (Chair), the on-duty Operations Coordinator, Case Management Coordinator, a youth worker representative from respective residential units, Clinical Practice Consultant and support officer (alternate Chair), clinical psychologist and School Principal, and an administrative officer as executive support.[299]

Since introducing the Risk Assessment Process Team, the Weekly Review Meeting is no longer responsible for risk assessment or managing serious incidents.[300] When required, the Risk Assessment Process Team also determines a young person's unit allocation, although we understand this remains the usual responsibility of the Weekly Review Meeting.[301] Unit placement decisions are discussed in Section 5.5.

We are also aware that there is a Program Assessment Team meeting to assess the suitability of placing detainees in programs offered by the Centre, including off site.[302] Membership of the Program Assessment Team is the Program Coordinator, the Case Management Coordinator, the Operations Manager, the Operations Coordinator and the Ashley School Principal.[303]

5.4 Behaviour Development System

A program for behaviour development was implemented at Ashley Youth Detention Centre in 2001.[304] Historically, it was known as the Behaviour Development System.[305] In April 2022, it was replaced with the Behaviour Development Program.

As mentioned, the Behaviour Development System was established as a behaviour management tool under which children and young people in detention were allocated a colour rating based on their behaviour, which would, in turn, determine the privileges or restrictions for which they were eligible. The new Behaviour Development Program similarly operates as a behaviour management tool.

The case studies in Chapter 11 deal with incidents before April 2022. Therefore, we have summarised in this section the Behaviour Development System in place before that time. We consider the Behaviour Development Program and its appropriateness in Chapter 12.

The former Behaviour Development System had two distinct schemes: the 'Incentive Scheme' and the 'Incident Management Scheme'.[306] Together, the stated aims of these schemes were to:

> Support the positive behaviour and manage the negative behaviour of young people in custody.
>
> Encourage young people in custody to understand the consequences, both positive and negative, of their choices.
>
> Integrate the key principles of restorative justice into the direct management of young people in custody (i.e. responsibility, reparation, diversion, rehabilitation and deterrence).
>
> Provide a simple, clear and fair system that can respond consistently, accurately and in a timely manner to the behaviour of young people in custody.[307]

The following discussion focuses on the Incentive Scheme.

5.4.1 Colour system

Detainees were allocated one of four (or five) colour levels under the Behaviour Development System, corresponding to the perceived level of risk demonstrated by a child or young person at the time. Those colours were (from highest to lowest risk):

- Red—The red level was applied to young people who posed 'an immediate threat' to Centre security and safety, including to staff and young people.[308] Examples of such immediate threats included escape, attempted escape, assaultive behaviour, possession of a weapon or a 'persistent history' of contraband possession and/or use.[309] Young people who incited others to 'behave in a way that is subversive and/or disruptive' may also have been placed on the red level.[310]

- Orange—The orange level 'represent[ed] a transition from red … to a more settled and acceptable behaviour'.[311] It was applied to young people who demonstrated 'medium level risks behaviours', including 'an accumulation of low-level incidents and/or an uncooperative or disinterested attitude'.[312]
- Yellow—The yellow level applied to young people who were 'starting to show a higher level of pro-social responsibility and acceptance, participation in programs was on the increase and young people were attempting to meet their goals'.[313] It was applied to all new admissions.[314]
- Green—The green level was applied to young people 'promoting a high level of pro-social behaviour, tak[ing] responsibility for their actions and participating fully in Case Management Case Plan Review'.[315]

A fifth colour, blue, was a feature of the Behaviour Development System at various times (at least in practice).[316] It was applied to the highest risk detainees and severely restricted their freedoms. The blue colour level, also known as 'the Blue Program', was most recently used at Ashley Youth Detention Centre for a period in 2019, although we note that Secretary Pervan gave evidence suggesting that versions of the Behaviour Management System that included the Blue Program were not 'formalised or approved'.[317] The Blue Program is discussed in Chapter 11, Case study 3.

Young people could also earn daily 'points' based on their behaviours, which would contribute to their colour level.[318] We understand the criteria for these points were set out in a Daily Incentive Assessment sheet.[319]

Factors such as a young person's attendance at programs or school, the level of responsibility they displayed in addressing their behaviour and the number of incidents they had been involved in would also contribute to their colour level.[320]

The Centre Support Team determined a young person's colour level weekly or at interim meetings as required.[321] Decisions at interim meetings were required to be ratified at the next standing meeting of the Centre Support Team.[322]

5.4.2 Benefits and restrictions

Each colour level was allocated particular 'benefits' or 'restrictions'.[323]

Some of these benefits and restrictions appeared to correspond to the level of risk a young person was perceived to pose and the need to control their activities in the interests of safety or security, noting that the perceived risks may not have been imminent. For example, a young person on the green level was eligible for all activities and programs at the Centre, while a young person on the red level was only eligible for activities and programs in their unit.[324]

Other restrictions appeared more punitive (with no apparent risk management or harm prevention aim). For example, a young person on the red level had a bedtime of 7.30 pm, compared with a bedtime of 10.00 pm for a young person on the green level, though we note that the bedtime on green level appears to have been amended to 9.00 pm in September 2022 according to revised Unit Rules.[325] Other benefits and restrictions related to canteen allowances, eligibility for leave, access to visitors and the number of phone calls, among other things.[326]

In addition to their colour designation, children and young people could also earn points to use on incentives.[327] Incentives included more television time, extra phone calls, later bedtimes and access to a DVD player or gaming device.[328]

5.5 Placement decisions

Young people at Ashley Youth Detention Centre live in one of four units, in which they are assigned their own bedroom. When a unit is in use, one or more young people may be housed in the unit at any one time. Decisions are made regularly about which unit a young person stays in.

We understand that before 31 May 2022, the Centre Support Team determined unit placements (during standing weekly meetings or as part of interim meetings).[329] Most evidence we received stated that placements were reviewed at least weekly.[330] One staff member said that placement decisions were reviewed every day and that decisions were talked about 'regularly' by staff.[331] Another staff member said that placement decisions were regularly reviewed by the Centre Support Team 'anything from [every] one or two days to [once] a week'.[332]

We received evidence that placement decisions took into account some or all of the following factors: age, gender, safety/security, legal status, length of sentence, individual needs, behavioural issues, relationship dynamics between young people and staff, and the views of staff.[333]

Patrick Ryan, former Manager, Custodial Youth Justice ('Centre Manager'), told us that the relevant procedure 'allowed for operational dynamic decisions to be made by the Operations Coordinator'.[334] Piers (a pseudonym), who held various positions at the Centre including operational, policy and managerial roles, told us that decisions made for a 'safety and security reason' were the responsibility of the Operations Manager and Operations Coordinator.[335] We understood Mr Ryan's and Piers' comments to mean that Operations staff could initiate a unit move in emergency circumstances, such as during a riot. At least one policy dating back to 2017 acknowledged that the Operations Coordinator could 'advise the Operations Manager/On Call Manager if a young person/s is required to be moved for operational reasons from a unit'.[336] That policy did not define what constituted a suitable 'operational reason'.

We received evidence that unit placement decisions made after hours due to new admissions or behavioural issues were made by the On Call Manager and the Operations Coordinator.[337]

Policy documents dating back to 2017 indicated that young people could make a formal request for a unit transfer, which the Centre Support Team would consider.[338]

Some Ashley Youth Detention Centre staff noted that unit placement decisions often required a fine balance between operational realities and the individual needs of young people. Those operational realities often included staffing issues. For example, a former Manager, Professional Services and Policy, reflected:

> Over my time, thousands of placement decisions were made but until pressure came on in 2015 to reduce staffing levels and hence close down Units for a period, the prime motivation for Unit placement was what was in the best interests of the young person on the available known factors and information.
>
> It goes without saying that deciding what was in the best interests of the child was often choosing the best out of a poor range of options.[339]

We discuss placement decisions since May 2022 in Chapter 12.

5.6 Incident reporting

During our Inquiry, we heard of several incidents at Ashley Youth Detention Centre, including riots and harmful sexual behaviours between young people. When an event occurs that staff cannot contain or readily resolve—for example, a potentially violent situation—and this requires immediate assistance in dealing with one or more young people, staff can initiate a 'code black'.[340] This means that the Operations Coordinator or designated youth worker and any other available staff member trained in non-violent crisis intervention who can safely leave their post must go to the location, evaluate the scene and coordinate a response.[341]

Staff must also record and report an incident that has arisen from the behaviour of a young person or young people. Incident reporting at Ashley Youth Detention Centre is governed by the *AYDC Incident Reporting Procedure* and the *AYDC Incident Reporting* form.[342] Staff need to record details of the incident, including the date, time and location of the incident, the names of those involved or otherwise present (including staff), a description of the incident and a description of any evidence gathered.[343]

Staff also need to identify any 'personal factors' that may be affecting the young person.[344] These include, for example, age/maturity, cognitive development, emotional regulation, fear, lack of family contact, physical development, sexuality/gender, substance withdrawal and whether the young person has an impending court date.[345]

'Moderating factors' must also be identified—for example, the extent to which a young person was incited or provoked by another, whether the young person accepted responsibility for their actions and whether the young person cooperated with staff.[346]

For each young person involved, the staff member must also note whether the young person was searched or if practices such as force, mechanical restraints or isolation were used against the young person, and identify the nature of the young person's involvement in the incident (such as being a witness or participant).[347]

The staff member must support each young person involved to prepare a witness or victim statement and then collect their completed statement.[348]

Staff must categorise the incident into one of three categories:

- Recorded incident—an incident of a 'very minor nature, where there is insufficient evidence to support a Minor Incident or a Detention Offence'.[349]
- Minor incident—a breach of Centre rules that 'does not warrant court action or substantiation of evidence at the level required by a court'.[350] Examples include disobeying published rules and reasonable instructions; lying; abusive, indecent, threatening language; behaviour 'of a low-level nature'; petty stealing; '[d]eliberate harassment or provocation' of staff, visitors or young people of a low level; play fighting; and minor damage to government property.[351]
- Detention offence—detention offences are prescribed by the Youth Justice Act.[352] These include, for example, absence from a detention centre without lawful authority; assault of another person; possession of a weapon; wilful damage or destruction of property; using threatening language or a threatening manner; behaving in a disorderly or riotous manner; and possession or use of unauthorised substances.[353]

The staff member may gather evidence to support the incident report. The report is reviewed by the Operations Coordinator, who must oversee the quality of the report, collect any more evidence, and agree with how the incident is categorised or make an alternative recommendation.[354]

The report is then subjected to a 'Management Assessment'.[355] Neither the *AYDC Incident Reporting Procedure* nor the *AYDC Incident Reporting* form has been updated to reflect the disbandment of the Centre Support Team and the establishment of the Risk Assessment Process Team and Weekly Review Meeting—both the form and procedure continue to refer to the Centre Support Team and its role in reviewing incidents.[356]

The Management Assessment considers the level of seriousness of the incident, identifies whether a conference is needed, identifies whether one or more authorities or people should be notified (for example, the police, Child Safety Services or a young person's parents), and whether any other actions are required (such as a program referral or an independent investigation).[357]

The policy provides that the Director, Strategic Youth Services, confirms whether to proceed with an independent investigation.[358] In the new Department for Education, Children and Young People, the Director, Custodial Operations, chairs a weekly Incident Review Committee meeting at which all incidents are reviewed. [359] The Director, Custodial Operations, refers matters on for further investigation.[360]

As described, the Risk Assessment Process Team considers incidents that fall into particular categories of seriousness. Incident reports are also read by the Chair of the Weekly Review Meeting.[361]

5.7 Dealing with a detention offence

Section 140 of the Youth Justice Act outlines the way in which detention offences should be handled. Section 140(2)(b) of the Act requires that, before a complaint may be filed in respect of a detention offence that an offender admits committing, the Secretary must be notified of the offence. The Secretary must, where practicable:

- confer with the offender, a guardian (unless one cannot be found after reasonable enquiry) and any other person whose participation the Secretary considers is likely to be beneficial in determining how to deal with the offence
- consider how the offence should be dealt with.[362]

After doing so, the Secretary may:

- suspend further action, 'on the undertaking of the offender to be of good behaviour for a period not exceeding 2 months'
- caution the offender
- delay the offender's release by no more than three days, and/or
- file a complaint against the offender.[363]

The Youth Justice Act requires that a conference be held where practicable.[364] *Standard Operating Procedure No. 24: Conferencing* describes conferencing as 'an opportunity for both the offender and victim to enter a restorative discourse and for the offender to take responsibility for their behaviour and to make appropriate reparation'.[365] Standard Operating Procedure No. 24 provides that sanctions may result from a conference, such as a 'good behaviour bond'.[366]

We understand that, for a conference to be held, the offender must admit to the offence and agree to participate in the conference.[367] If possible, the conference should involve the victim-survivor, a support person, a guardian and appropriate staff representatives.[368]

As of March 2022, Secretary Pervan delegated his functions with respect to dealing with a detention offence to the Deputy Secretary, Children, Youth and Families, the Director, Youth and Family Violence Services, the Centre Manager, the Assistant Manager and (to a more limited extent) the Operations Manager and the Coordinator, Training and Admissions.[369]

5.8 Oversight of youth detention in Tasmania

As highlighted by the National Royal Commission, external oversight bodies play a critical role in responding to allegations of child sexual abuse. The National Royal Commission recognised that external oversight bodies facilitate transparency and accountability and can have a positive impact on organisational culture, changes in policy and practice, and the capacity of an institution to implement best practice.[370] The National Royal Commission also observed that, in jurisdictions that do not have independent oversight arrangements, there was significantly less publicly available information about the youth detention system.[371]

The National Royal Commission recommended that risks of child sexual abuse associated with youth detention centres be mitigated by preventive monitoring and independent oversight by custodial services, community visitor schemes, Ombudsman's offices and children's commissioners and guardians.[372] The primary independent oversight mechanisms for youth detention in Tasmania are the Ombudsman, the Commissioner for Children and Young People, the Custodial Inspector and the National Preventive Mechanism under OPCAT. We describe these mechanisms and discuss ways to strengthen the oversight of youth detention in Chapter 12.

6 Previous reviews into Ashley Youth Detention Centre

The evidence and material available to our Commission of Inquiry included no less than 17 internal and external briefings, reports and reviews about Ashley Youth Detention Centre since 2003. While few of these briefings, reports and reviews directly considered child sexual abuse at the Centre, they all identified problems affecting the safety of young people in the detention environment. This section summarises the most relevant briefings, reports and reviews into Ashley Youth Detention Centre.

The summaries of these separate documents may seem repetitive. That is because they are. It was apparent to us when reviewing them that successive Tasmanian governments have repeatedly and consistently been made aware of persistent systemic issues in the treatment of children and young people detained at Ashley Youth Detention Centre and failed to achieve sufficient meaningful change to address those issues. Information we received through our Inquiry further suggests that many of the problems highlighted in these briefings, reports and reviews have persisted at Ashley Youth Detention Centre and continue to increase the risk of child sexual abuse. The language in the reports describes behaviour using euphemisms such as 'inappropriate strip searching' or 'punitive' approaches. Considering the international and domestic standards described previously in this chapter, these behaviours can only be described as human rights violations.

6.1 Abuse in State Care Program (July 2003)

In 2003, the Tasmanian Government announced a review of claims of abuse from adults who had been in state care as children, including youth detention.[373] The announcement followed media coverage about a man who alleged he had been sexually abused as a child by his foster parent, who was a convicted paedophile.[374]

The review was undertaken by the Tasmanian Ombudsman in cooperation with the Department of Health and Human Services.[375] The scope of the review was broad—it applied to allegations of abuse in state care in Tasmania, including in youth detention, with no qualifying period.[376] After the review started, the Tasmanian Government announced that ex gratia payments of up to $60,000 would be available to eligible claimants who had suffered abuse in state care and that an independent assessor had been appointed to prepare a report and make decisions about individual cases.[377]

This program, called the Abuse in State Care Program, operated in four rounds from 2003 to 2013.[378] Specific details of the nature of the abuse alleged at the Centre and at Ashley Home for Boys, and the outcomes of individual claims, were not publicly reported.[379]

According to reports published on the various rounds of the Abuse in State Care Program (which varied in the level and type of information they provided about claims):

- During the first round, which ran from 2003 to 2004, 32 people made claims about abuse that occurred at Ashley Home for Boys.[380] The report described, in general terms, that most of these claims related to 'sustained physical and emotional abuse', with allegations of sexual abuse described as 'less common' in boys' homes (including Ashley Home for Boys).[381]

- In the second round, which ran from 2005 to 2006, 117 claimants came forward about abuse that occurred at Ashley Home for Boys.[382] We are unclear what type of abuse these claims relate to but note that, across all claims made in this period, 189 (or 45 per cent) related to sexual abuse.[383]
- There were 995 claims (in total) made in the third round, which ran from 2007 to 2010. We have not been able to identify the number of claims that were made about Ashley Home for Boys or Ashley Youth Detention Centre because a detailed report relating to this third round of claims was not available (we drew the 995 figure from the report of the fourth round of claims).[384]
- The fourth round of the program, which ran from 2011 to 2013, resulted in 172 claims against Ashley Home for Boys and Ashley Youth Detention Centre.[385] We are unsure what proportion of these claims relate to sexual abuse but note that, across all 199 claims of sexual abuse, nearly 50 per cent were made by claimants who were placed in an institution.[386]

When the program wound up in 2013, it was replaced by the Abuse in State Care Support Service.[387] We discuss the Abuse in State Care Program and the Abuse in State Care Support Service, and the nature of the claims made about Ashley Youth Detention Centre, in Chapter 11, Case studies 1 and 7, and in Chapter 12.

6.2 Review for the Secretary, Department of Health and Human Services (September 2005)

In 2005, following reports of assaults on two young people at Ashley Youth Detention Centre by other young people detained there, the Secretary of the Department of Health and Human Services established a review team to examine the robustness of systems and protocols at the Centre, and the effectiveness of those systems in ensuring the safety and wellbeing of detained young people.[388] The review team consisted of the Commissioner for Children and Young People and two senior departmental officers.[389] The review was to specifically examine the Centre's systems for minimising abuse towards children and young people by other 'residents' or staff, for reporting allegations of abuse, and for responding adequately and in a timely manner to allegations of abuse.[390]

The review team identified several problems and made 23 recommendations, including the following:[391]

- There were varying levels of intimidation, from bullying to violence, among residents.[392] The review team recommended that accommodation unit allocations be reviewed based on the mixture of residents at the Centre.[393]

- Physical blind spots impeded effective monitoring of residents and therefore affected the Centre's ability to provide a safe environment. The review team recommended that these blind spots be assessed, and solutions implemented, along with a 12-month trial of closed-circuit television in one of the accommodation units.[394]
- There was a need for documented procedures to manage incidents and complaints.[395] The review team acknowledged that children and young people in detention may not report incidents due to fear of retaliation or ridicule, and due to their lack of confidence that complaints would be effectively managed. The review team also found that residents did not have access to independent people from outside the Centre with whom they could discuss issues and concerns.[396] The review team recommended that the complaints processes at the Centre be revised and that an Ashley Youth Detention Centre Residents' Advocate position be created in the Office of the Commissioner for Children and Young People.[397]

There was no clear response from the Tasmanian Government to these recommendations at the time. We note that, from February 2022, the Commissioner for Children and Young People has had an advocacy role in place for children and young people in detention.[398] The Commissioner's *2020–2021 Annual Plan* states that a function of this role is to regularly visit Ashley Youth Detention Centre.[399] We also note that the Tasmanian Government's most recent Annual Progress Report in response to recommendations of the National Royal Commission states that an Advocate for Young People in Detention, employed by the Commissioner for Children and Young People, 'is present within the Centre as an independent person with whom the young people can speak … including to discuss any concerns or complaints'.[400]

It is unclear to us when closed-circuit television was introduced at Ashley Youth Detention Centre. Media reports indicate that closed-circuit television footage was used as evidence in relation to a staff member who allegedly assaulted two detainees at the Centre in July 2016.[401] The Custodial Inspector's *Annual Report 2019–20* states that, following an inspection, more cameras had been added to known blind spots, and that more cameras would be installed as part of the Centre's redevelopment.[402]

6.3 Ashley, Youth Justice and Detention Report, Legislative Council Select Committee (2007)

In 2007, a Legislative Council Select Committee was established amid concerns that previous reviews had failed to resolve longstanding problems at Ashley Youth Detention Centre, and that rehabilitation rates for children and young people in detention had not improved.[403] In its report, the Committee stated that:

> The system is under stress. Security is lax, contraband enters the site illegally and management struggles to maintain a well-trained, professional, and committed staff. From time to time there are violent aggressive episodes involving both residents and staff. There is a need to maintain a secure unit.[404]

The Committee made 32 recommendations to improve the youth justice system. Recommendations specifically relating to Ashley Youth Detention Centre included that the Government acknowledge the cost-effectiveness of diverting young people away from detention, that attendance at the Centre's school be mandatory, that the low morale among employees be addressed, that only female workers supervise female detainees and that the Centre be renamed Ashley Secure Care Centre.[405]

The Tasmanian Government's response in 2008 indicated that:

- Six of the recommendations were not supported. These recommendations were about amending the Youth Justice Act to allow access to diversionary programs before any guilty plea, creating supported accommodation for children on remand, creating dedicated youth justice magistrates, re-establishing a secure unit at the Centre separate from the rest of the facility and renaming the Centre.
- Twenty-six recommendations were in progress, under review, supported or had been actioned. They included those relating to improved bail and remand options for children, increased funding and support for the community service order system and youth justice programs, improved early intervention and prevention programs for children at risk of entering the youth justice system, improved diversionary opportunities (including for Aboriginal children), improved access to educational opportunities, improved staff recruitment and training, consistent implementation of standard operating systems and improved support for staff who experience adverse incidents.[406]

6.4 Reviews following the death of Craig Sullivan in detention at Ashley Youth Detention Centre

On 25 October 2010, Craig Sullivan died in his room while on remand at Ashley Youth Detention Centre.[407] He was 18 years old.[408] In the weeks before his death and before his admission to Ashley Youth Detention Centre, Craig was involved in a car accident.[409] On 8 October 2010, while at the Centre, Craig was the victim of an assault by another detainee. During this assault, he was punched in the head and subjected to at least one, and possibly two, forceful headbutts.[410] In the days before his death, Craig had vomited multiple times and had complained of headaches to other young people detained at the Centre and to a number of staff.[411] At the inquest into Craig's death, there was evidence before the Coroner that staff at the Centre had provided Craig with a mop and bucket, with the 'somewhat callous' expectation that he would clean up his own vomit. It appears

that Craig did this the evening before he died.[412] After being monitored intermittently by Centre staff through the weekend, Craig was found unresponsive after he failed to come out of his room for breakfast on Monday morning.[413]

Following Craig's death, the Department commissioned two reviews—a clinical assessment and a serious incident investigation.[414] These reviews were completed and reported before the coronial inquest into Craig's death. After the coronial inquest, the Coroner considered that all the recommendations of the Clinical Assessment Report and the Serious Incident Investigation Report were appropriate, and therefore adopted them as recommendations for the coronial inquest.[415] The Coroner also made additional recommendations.

We summarise the findings and recommendations of the two reports and the Coroner in the sections that follow.

6.4.1 Clinical Assessment Report (November 2010)

Following Craig's death, the Minister for Children requested that the Chief Health Officer undertake a clinical assessment of Ashley Youth Detention Centre's policies and protocols for health issues.[416] The Chief Health Officer's report, *Clinical Assessment of Ashley Youth Detention Centre's Current Policy and Protocols for Health Issues* ('Clinical Assessment Report'), dated 30 November 2010, listed recommendations including that clinical support and governance arrangements be established with the Department of Health and Human Services' Correctional Primary Health Services; young people in detention have access to the same standard of health care as the wider community; clinical advice and assessment be available 24 hours a day; standard operating procedures relevant to clinical matters be updated; and clinical staffing levels be increased.[417]

6.4.2 Serious Incident Investigation Report (March 2011)

The Department of Health and Human Services also established a Serious Incident Investigation Committee to examine the specific circumstances of Craig's death.[418]

The committee's report, *Serious Incident Investigation Report Ashley Youth Detention Centre—Death of a Youth on Remand* ('Serious Incident Investigation Report'), was issued on 30 March 2011.[419] It appears that the report was left in 'final draft' form.

Although the committee was primarily tasked with investigating Craig Sullivan's death, the report included examples of other instances where the health and wellbeing of Ashley Youth Detention Centre detainees were placed at significant risk.[420]

The committee's findings, as documented in its report, included that:

- There was a failure to recognise the need for and/or seek further clinical advice after Craig was assaulted.[421]
- Despite Craig's long history of engagement with Youth Justice and the Department of Health and Human Services, his specific needs were not addressed in a comprehensive or coordinated way.[422]
- There was a lack of risk-based decision making by Centre staff.[423]
- The youth workers at the Centre were unprofessional, with no formal approach to caring for young people in detention.[424]
- The Centre failed to provide humanitarian conditions to young people.[425]
- The practices and behaviours at the Centre were in breach of the United Nations Rules for the Protection of Juveniles Deprived of their Liberty, which require that 'every child who is ill or complains of illness … should be promptly examined by a medical officer'.[426]
- The Centre lacked accessible 24/7 healthcare services or on-call clinical advice.[427]
- The training provided to Centre staff was inadequate for responding to critical incidents.[428]
- Not all staff had completed the induction program and there was no ongoing culture of education and training. While there had been some changes to recruitment processes, 'there is a strong likelihood the pervading cultural norms and practices may be undermining this' change.[429]
- Operating protocols, including for emergency response, were not routinely complied with, and 'a system of "custom and practice" rather than rules based behaviour may exist'.[430]
- There was a lack of preparedness for a death in custody and foresight that such an event might happen.[431]
- The physical design of the Centre building created several problems, including that sick children and young people were locked in their cells because there was no space for a sick room or hospital bed. The ability to observe sick children and young people while they were in their cells was very limited.[432]
- 'There is a lack of continuity of care or information between teams, units, individuals and shifts that has resulted in key information not being passed on to relevant staff in a timely manner'.[433] This included failures in communicating information about Craig's car accident and the assault.[434] There was also no ability for key information or healthcare requirements to be reliably communicated

or followed up, and no system for ensuring reliable ongoing communication between health and custodial services.[435] Part of this was attributed to communication being paper based.[436]

- There was a general lack of respect for, or value attached to, communication with families, including parents, of detainees.[437]
- The provisions for clinical governance and oversight of Centre health and wellbeing services were inadequate.[438]

The report also documented several specific findings concerning the Ashley Youth Detention Centre Health Service, including:

- The health service was inadequate in the areas of after-hours clinical advice and response; facilities for observing young people who were unwell or sick; clinical assessment and treatment of young people affected by drugs and alcohol on admission; prompt access to necessary medications; contemporary youth health needs assessment, care planning and treatment services; and linkages to external services. The health service 'readily devolves its responsibility for medical care to untrained people with manifestly inadequate skills and abilities to deliver medical care'.[439]
- The recommendations from the 2002 health service review at the Centre had not been implemented, and no other review of the adequacy of health services had been completed since then.[440]
- Health facilities and equipment were inadequate and did not meet Australian General Practitioner Accreditation and Licensing requirements.[441]
- The Centre's location in Deloraine reduced young people's access to health care.[442]
- 'Systems in place for medication management are not adequate. Routine medication is primarily delivered by youth workers and not nursing staff. The ability to obtain urgent prescriptions and medications is limited due to the lack of a medical practitioner after hours, which puts at risk any immediate or urgent after-hours medication response'.[443]
- 'Management of chronic health conditions such as Insulin Dependent diabetes or asthma is compromised after the nurse has left the facility as there is no on-call procedure'.[444]

The key recommendations of the Serious Incident Investigation Report included that:[445]

- the philosophy and model of care for youth detention be reviewed[446]
- immediate action be taken to address concerns about the culture at the Centre[447]

- the youth worker role at the Centre be reviewed, including to ensure the role encompasses youth health and wellbeing interventions as well as custodial responsibilities, and includes developing basic clinical assessment and observation skills to support onsite management of ill or injured young people[448]
- standard operating procedures, and lack of compliance with those standard operating procedures, be reviewed[449]
- the Centre's health service be improved, including through implementing the Clinical Assessment Report recommendations[450]
- communication systems at the Centre be reviewed and improved, including by implementing an effective system of shift handover to ensure timely communication of all relevant information[451]
- respectful engagement and communication with young people's parents and significant others be mandated in the policy framework, and operations, of the Centre.[452]

Professor White, a member of the Serious Incident Investigation Committee between late 2010 and 2011, gave evidence to us about the response of authorities following Craig's death.[453] He characterised the findings of the investigation as 'damning' of operations at Ashley Youth Detention Centre 'on all levels'.[454]

6.4.3 The Department's response to the Clinical Assessment Report and the Serious Incident Investigation Report

A Department of Health and Human Services report, *Ashley Youth Detention Centre Overview Report* ('Overview Report'), dated August 2013, provides commentary on the progress that had been made on implementing the recommendations set out in the Clinical Assessment Report and the Serious Incident Investigation Report.[455]

It notes that, in April 2011, the former Department of Health and Human Services established two governance bodies to progress the reforms to Ashley Youth Detention Centre recommended after Craig's death:[456]

- A Reform Steering Committee, chaired by the Deputy Secretary for Children, was charged with overseeing the implementation of the Clinical Assessment and Serious Incident Investigation Report recommendations.[457]
- The Review and Monitoring Team was tasked with verifying implementation of the reforms.[458] The Reform Steering Committee provided progress reports to the Review and Monitoring Team.[459] The Review and Monitoring Team used site visits and a detailed desktop audit to verify progress.[460]

The Overview Report noted that there had been progress towards implementing the recommendations, but there were still areas requiring action, including to staff training and health assessments, and monitoring to improve the Centre's emergency management response.[461]

Professor White was appointed to the Review and Monitoring Team. He explained that, as part of implementing the investigation's recommendations in 2011 and 2012, the management team at Ashley Youth Detention Centre redesigned and redrafted standard operating procedures, in particular for how vulnerable young people in detention would be identified and supported.[462] Professor White told us that the work and purpose of the Review and Monitoring Team in improving Ashley Youth Detention Centre was ultimately undermined by the lack of senior departmental support for substantive change and by the monitoring team's dissolution.[463] He gave evidence that about 18 months after the Review and Monitoring Team was created, its work stopped 'abruptly' following the shift of the executive lead in the Department of Health and Human Services, who had oversight of the project, to another area.[464] Professor White told us that while it was not communicated to him at the time, he believed there may have been an intention by senior members of the Department of Health and Human Services to end the work of the Review and Monitoring Team.[465]

When asked whether the Review and Monitoring Team's role had been completed at the time the team was effectively dissolved, Professor White replied:

> No. And, in fact, one of the clear things that—and we were quite keen to keep the monitoring going—one of the clear things was that it had to be a continuous process well into the future, because that was the way to have culture change … you can have a whole bank of new standard operating procedures, but if you don't do your monitoring and auditing, then they can just be ignored like the previous ones were.[466]

6.4.4 Coroner's report (November 2013)

The Coroner found that Craig's death was caused by an abscess rupturing in his brain.[467] The Coroner could not conclusively rule out either the car accident or assault in detention as contributing to the abscess, describing their potential contribution as 'possible, but less likely' causes than the extension of a sinus infection.[468]

The Coroner did find that the assault on Craig at Ashley Youth Detention Centre was 'clearly capable of causing a head injury'.[469] The Coroner also found that, based on Craig's symptoms, he should have been referred for a medical assessment by a doctor the evening before he died.[470] The Coroner further found that Craig's death would likely have been avoided if he had received medical attention before the rupture of the brain abscess.[471] As stated in the Coroner's report, '[d]espite evidence that Craig was unwell, particularly during the weekend prior to his death, he was not referred for medical assessment and treatment'.[472]

When adopting the recommendations of the Clinical Assessment Report and the Serious Incident Investigation Report, the Coroner noted that some of the recommendations had been substantially implemented, while others had 'not yet been implemented at all'.[473]

As well as adopting the recommendations from the two reports, the Coroner made a number of other recommendations in November 2013. These included:

- All staff should undertake training to ensure rigorous compliance with the requirement to obtain medical review of children and young people who complain of being or who appear to be unwell. This recommendation was made as a result of the Coroner's finding that the Operations Coordinator at Ashley Youth Detention Centre at the time of Craig's death did not understand the relevant standard operating procedure.[474]
- All matters relevant to a detainee's health should be recorded in a way that ensures they are communicated and available to the staff responsible for the care and supervision of children and young people and for medical personnel reviewing detainees.[475]

Barry Nicholson, Group Director, Forensic Mental Health and Correctional Primary Health Services, told us that, immediately following Craig Sullivan's death, the Chief Health Officer carried out a clinical assessment of policy and protocols for providing health services and the ensuing report contained recommendations, all of which were implemented by November 2013.[476] These included transferring the functions of the Ashley Youth Detention Centre Health Service to the former Department of Health and Human Services' Correctional Primary Health Services, increasing nursing capacity and establishing a healthcare information system to store and share all client information in one place.[477]

6.5 Independent Review of Ashley Youth Detention Centre, Tasmania, Heather Harker, Metis Management Consulting (June 2015)

In 2014, the Deputy Secretary, Children and Youth Services commissioned an independent review of Ashley Youth Detention Centre. The purpose of the review was to inquire into a range of resource and operational matters, including increases in workers compensation claims, how to manage absences from work due to sickness (and therefore potentially excessive use of casual staff) and the extent to which these matters affected the Centre's philosophy and operational model.[478] The reviewer, Heather Harker, met with staff, detainees, family members of detainees and other stakeholders, and considered a range of materials including reports and memorandums.[479]

In her report, Ms Harker commented on the long tenure of staff and found that this had established a certain culture at the Centre. Ms Harker also expressed concern about 'a lack of governance and management presence, direction and scrutiny in a number of critical areas that have a specific impact on the Centre's budget and daily operations'.[480]

The report described a culture that leaned more towards punishment than restoration and rehabilitation, and a preference for using force to manage children and young people in detention rather than techniques taught in training, which focused on de-escalation.[481] The report also referred to a culture of 'passive resistance' to change.[482]

Also, Ms Harker found:

- There were poor living conditions for children and young people, along with 'wholly unacceptable' visiting facilities.
- There was little meaningful interaction between young people and the youth workers who supervised them.
- There was a lack of visibility and communication from leadership and senior management.
- There were concerns about some staff members' behaviour towards other staff, visitors and detainees.[483]

Ms Harker called for a 'more assertive' stance to addressing these problems and more active complaints management.[484] She made 13 recommendations covering budgetary compliance, staff rostering, management of workers compensation, and leadership and training—this included the need for 'strong visible leadership' to achieve 'accountability for professional practice and daily operations'.[485]

When the report was released in 2015, a year after its delivery to the Tasmanian Government, the Human Services Minister stated that a cultural change process, as well as additional training on risk management and intervention, had been implemented at the Centre, and that the Government had commissioned a youth detention options paper (discussed in Section 6.6).[486]

6.6 Custodial Youth Justice Options Paper: Report for the Department of Health and Human Services, Noetic Solutions Pty Ltd (October 2016)

In 2016, the Tasmanian Department of Health and Human Services engaged Noetic Solutions Pty Ltd ('Noetic') to develop an options paper setting out potential custodial youth justice models.[487]

Noetic undertook extensive research and consulted with the Department of Health and Human Services and external stakeholders, including young people in detention at the time, to understand the current and future needs of the custodial youth justice system in Tasmania.[488] One of the issues revealed by consultations was that staff at Ashley Youth Detention Centre were sceptical of a therapeutic approach to managing young people in detention:

> Some AYDC staff see a therapeutic approach as an ineffective deterrent for young people, which are considered by them to be less successful than a risk-based approach. These staff see this approach as removing useful strategies for managing young people's challenging behaviour. For example, staff saw the strategy of using isolation of young people when angry or upset as an effective means of mitigating a potentially unsafe situation.[489]

After reviewing the existing custodial model at Ashley Youth Detention Centre, Noetic provided four options for a new custodial youth justice model and stated that any model should be underpinned by trauma-informed practice and a therapeutic approach.[490] The options were to:

- upgrade the existing Centre
- maintain the Centre and construct an additional, smaller purpose-built facility
- establish a single purpose-built secure detention facility
- establish two purpose-built secure detention facilities.[491]

Noetic recommended the fourth option—that the Tasmanian Government build two detention facilities—one in Hobart and the other in Launceston. Noetic proposed that each facility have a 12-bed capacity, noting that rates of youth offending and incarceration had recently declined.[492] The data available to Noetic showed that between 2008–09 and 2014–15 the number of youth offenders in Tasmania had declined by 47 per cent. Noetic projected that by 2020 there would be 90 young people on community-based supervision orders and six young people in detention at any given time.[493]

The options paper highlighted:

- Ashley Youth Detention Centre cost more than $9.4 million a year to operate, despite only accommodating about 10 children or young people on any given day.[494]
- Therapeutic or trauma-informed care was not being practised at the Centre.[495]
- The average cost of accommodating a young person at the Centre was $3,562 per day, which was 2.5 times the national average of $1,391 per day.[496]

- Tasmania's recidivism rates showed that most children or young people reoffended within 12 months of their release from detention, demonstrating that the existing custodial model did not divert young people from the system.[497]
- Key challenges for the Centre were managing the use and scalability of a large facility with fixed costs and providing rehabilitation opportunities to a small number of young people with complex needs.[498]
- The Centre's location made it difficult to provide the full range of services required to support the complex needs of children and young people in detention.[499]

The Tasmanian Government decided not to proceed with Noetic's preferred and recommended option, instead announcing in June 2018 that it would commit $7.3 million to upgrading Ashley Youth Detention Centre.[500] In commenting on this choice of action, the Minister for Human Services was quoted as saying: 'We have sought to balance the needs of youth offenders with the importance of the [Ashley Youth Detention Centre] facility and the 60 jobs in the Deloraine community'.[501]

We note that the Government has now committed to closing Ashley Youth Detention Centre and establishing several new youth justice facilities, although in July 2023 the Government cast doubt on its earlier commitment to close the Centre by the end of 2024.[502] We discuss the closure of Ashley Youth Detention Centre in Chapter 12.

6.7 Reviews of use of force incidents (2016–19)

On 14 and 15 July 2016, a series of incidents occurred at Ashley Youth Detention Centre during which detainees were alleged to have damaged property at the Centre, including kicking doors, breaking windows and wielding pieces of broken glass. While the incidents raised issues with respect to worker safety, there were also concerns in relation to the use of force and isolation by Centre staff in managing the incidents.[503] We are aware of three reports prepared in response to the incidents: a Report to the Minister for Human Services (August 2016), a Critical Incident Investigation Report prepared by the Department of Health and Human Services (undated) and a WorkSafe Tasmania report (February 2017).[504]

Further incidents involving the use of force occurred in November and December 2017, during which detainees were restrained by Ashley Youth Detention Centre staff and one young person was placed in isolation because of a perceived threat that he would assault other young people and staff.[505] In 2018, the Department of Health and Human Services initiated an internal review of these incidents.[506] In 2019, the Tasmanian Ombudsman completed a preliminary inquiries report into one of the 2017 incidents in response to a complaint received from a young person in detention about the use of force by Centre staff.[507]

In the following sections, we outline the main findings from these five reports as they relate to the use of force at Ashley Youth Detention Centre.

6.7.1 Report to the Minister for Human Services from the Department of Health and Human Services (August 2016)

A report prepared by the Department of Health and Human Services for the Minister for Human Services about the 14 and 15 July 2016 incidents examined the possible use of excessive force, with a particular focus on the actions of one youth worker against children and young people in detention during the incidents.[508]

The report noted that, while the youth worker had been trained in non-violent crisis intervention, the restraints used were not consistent with the manual.[509] The report also noted that the use of force appeared to be 'excessive to that which might be considered reasonable', given that the young person was seen calmly sitting before the use of force.[510]

The report contained the following actions to be undertaken:

- immediate action in relation to the youth worker, including Employment Directions No. 4 and No. 5 processes, appointing an appropriate independent investigator and a request for the worker to be absent from the workplace on full pay[511]
- a change-management process, including allocating $300,000 to appoint a senior change manager and to develop a training package[512]
- developing a WorkSafe Corrective Action Plan[513]
- continuing to roll out a Children and Youth Services review of priority practices and procedures[514]
- developing a process to ensure timely review of all critical incidents[515]
- delivering risk assessment training in August 2016[516]
- developing a proposal to strengthen the use of multidisciplinary teams to support a 'therapeutic informed approach'.[517]

The Secretary of the Department referred the conduct of the staff member in question to Tasmania Police, suspended the staff member on full pay under Employment Direction No. 4 and started a formal process pursuant to Employment Direction No. 5, to run in parallel with the Tasmania Police investigation.[518] Ultimately, the disciplinary process resulted in counselling, a reprimand and a temporary reassignment of duties.[519]

6.7.2 Critical Incident Investigation Report (undated)

The Department of Health and Human Services prepared a Critical Incident Investigation Report for WorkSafe Tasmania in relation to the incidents on 14 and 15 July 2016.[520]

The report categorised the events as five separate incidents and it reviewed footage, policy and procedure documents, investigation reports and witness statements.[521] It noted difficulties due to delays in receiving statements from staff, inconsistencies between individual statements, lack of closed-circuit television coverage in certain areas in the Centre and lack of audio accompanying the closed-circuit television footage.[522]

The report's findings included:

- Despite statements from staff suggesting that they feared for their safety and the detainees were acting in a 'riotous manner', no staff member activated their duress alarm or called a 'code black' in accordance with the relevant standard operating procedures.[523]
- The actions of staff were 'contrary to policy' and identified an organisational deficiency.[524]
- The actions of staff highlighted deficiencies in staff training and staff capability in relation to emergency response, risk reduction, de-escalation of violent behaviour and sound decision making to support proactive risk awareness and safety.[525]
- The closed-circuit television footage did not appear to reveal the use of de-escalation strategies.[526]
- The restraint used by youth workers did not comply with non-violent crisis intervention training.[527]

6.7.3 WorkSafe Tasmania Investigation Report (February 2017)

WorkSafe Tasmania also conducted an investigation into the 14 and 15 July incidents.[528] The investigation report indicated that several factors led to significant deficiencies in Ashley Youth Detention Centre's safety management system. These factors were 'training, consultation, resourcing, communication and, particularly, risk identification and effective management and control'.[529] The report noted 'the use of isolation, the use of force, and the provision of a less institutionalised appearance within the facility' were factors that contributed to the incidents on 14 and 15 July 2016.[530]

WorkSafe Tasmania indicated that, while it recommended that no prosecution action be taken against any party, the Secretary of the Department of Health and Human Services (Secretary Pervan) was required to provide monthly status reports in relation to the implementation of a remedial corrective action plan and a comprehensive safety management plan.[531] The remedial corrective action plan included, as a high priority, to:

> … review, evaluate and reinforce the agenc[y's] culture. Ensuring compliance with the programme, policies and procedures (change-management process identified and approved) [within 12 months].[532]

6.7.4 Department of Health and Human Services Review of Incidents at Ashley Youth Detention Centre (2018)

The Department of Health and Human Services initiated an internal review of the use of force in response to incidents that occurred at Ashley Youth Detention Centre in November and December 2017.[533] An Incident Review Committee was established and the committee's report included recommendations relevant to the use of force and staff practices including:

- Any incident that had a use of force component was to be downloaded from the closed-circuit television footage in its original form and securely stored on a separate drive.[534]
- More training and information sessions were to be provided on isolation procedures and relevant delegations.[535]
- There should be greater clarity in the Supervision and Movement of Young People standard operating procedure about the required numbers of staff when moving compliant and noncompliant children and young people in detention.[536]
- Ashley Youth Detention Centre should be provided with its own training budget; a fixed-term position for a training manager should be created as a matter of urgency; the training manager should undertake a full audit of the training for each staff member; a permanent position for a training facilitator and assessor at the Centre should be created; and the possibility of professional qualifications for all employees at the Centre should be explored.[537]
- Discussions should be held with onsite management, providing clear guidelines and clarifications about their roles and responsibilities for managing employees, including their ongoing professional development.[538]
- The Centre Manager must review every incident involving the use of force.[539]
- Future legislative amendments should consider changing the definition of the word 'isolation'.[540]
- All staff were to be trained and undertake regular review training in verbal judo or similar de-escalation techniques and motivational interviewing techniques by suitably qualified people.[541]
- A Use of Force Review Committee should be established, and a proportion of all incidents should be reviewed by the committee. This committee should have a maximum of four people and include representatives from the following areas:
    - the Centre's Training Manager or representative from Professional Services
    - Human Resources

- Workplace Health and Safety
- Quality Improvement and Workforce Development.[542]

We understand the Human Resources, Workplace Health and Safety, and Quality Improvement and Workforce Development units were based in the Department of Health and Human Services and not Ashley Youth Detention Centre.

The Department decided that no action would be taken against the staff members involved in these incidents 'due to gaps in training and procedures' at the Centre.[543]

6.7.5 The Ombudsman's preliminary inquiries into the assessment of a use of force incident (December 2019)

In December 2019, the Tasmanian Ombudsman, Richard Connock, provided a preliminary inquiries report to Secretary Pervan after receiving a complaint from a detainee about excessive use of force by staff at Ashley Youth Detention Centre in December 2017.[544]

In his report to the Secretary, Mr Connock questioned the quality and thoroughness of the Department's 2018 internal review (referred to earlier), describing it as 'perfunctory'.[545] Among other criticisms of the internal review, Mr Connock stated that the Department had failed to gather basic evidence to inform its assessment of the use of force against the young person who had complained to him, including speaking to that young person about his version of events, detailing any injuries that the young person may have suffered and reviewing what training on the use of force had been provided to youth workers at Ashley Youth Detention Centre.[546] Mr Connock also noted that the internal review had not included an assessment of whether the use of force was excessive against criteria in the Youth Justice Act relevant to what constitutes 'reasonable force'.[547]

Mr Connock also noted in his report to the Secretary that the Department had been aware for some time that there were gaps in the training of staff members at the Centre in relation to the use of force.[548] Mr Connock emphasised that an independent review of Ashley Youth Detention Centre, undertaken in 2015 (refer to Section 6.5), had identified that:

> A number of people who are involved in the training of youth workers expressed concerns at youth workers preferring to use physical means of dealing with young people rather than the de-escalation techniques emphasised in the training.[549]

Mr Connock also emphasised that documentation relevant to a therapeutic change program adopted by Ashley Youth Detention Centre before 2016, known as the 'Ashley+ Approach', had included significant investment in training, but that such training was not working:

> In December 2016, there was a majority of youth workers and staff [at Ashley Youth Detention Centre] with 10+ years experience in the Centre. The majority of these staff were originally trained for a corrections rather than a therapeutic environment. The training and the transition over recent years from a corrections focus to a rehabilitation and therapeutic focus are often at odds and despite significant training some staff continue to operate from a corrections philosophy.[550]

Mr Connock highlighted several similarities between the use of force incident in December 2017 and the earlier use of force incident that occurred in July 2016. According to Mr Connock, these similarities included that:

- de-escalation attempts appear to be limited
- the use of force was questionable
- there were no obvious immediate threats to the staff involved.[551]

Mr Connock questioned why the Department had not sought advice about whether the use of force in December 2017 amounted to an offence, considering that uses of force during the July 2016 incident had been referred to Tasmania Police.[552] Mr Connock said that it became apparent to him, when following up the December 2017 incident, that 'an unwritten reason for not pursuing any formal action in this case was due to concerns about already low staff morale following the prosecution in 2016'.[553] Mr Connock characterised this rationale as 'concerning', considering that 'the paramount consideration for the Department should be the safety and care of the vulnerable children in its care'.[554]

At the end of his report to the Secretary, Mr Connock suggested that the Department implements a formal process to ensure greater oversight of the use of force by Centre staff, namely that the Ombudsman's office be notified of all future use of force incidents at Ashley Youth Detention Centre.[555]

6.8 Memorandum of Advice: Searches of children and young people in custody in custodial facilities in Tasmania, Commissioner for Children and Young People Tasmania (May 2019)

In 2019, the Commissioner for Children and Young People provided a Memorandum of Advice to the Tasmanian Government about personal searches of young people in detention and the promotion of young people's rights regarding these searches.[556] The memorandum was prepared amid media reports of routine strip searches of children in custodial environments, and in light of government data indicating 203 children were subject to an unclothed search at Ashley Youth Detention Centre between 1 June and 30 November 2018, with no contraband found.[557]

The Commissioner for Children and Young People considered legislation, policies and procedures applicable to children and young people in custody, and the National Royal Commission's recommendation that jurisdictions review their legislation, policies and procedures, to ensure best practices were in place for strip searches and other forms of physical contact between children and staff.[558] The Commissioner for Children and Young People noted that the Tasmanian Government had accepted this recommendation in principle.[559]

The Commissioner for Children and Young People concluded that the legislative framework appeared to allow routine strip searches of children in custodial environments.[560] She also observed that strip searching had the potential to distress, humiliate and traumatise children and young people.[561] The Commissioner for Children and Young People concluded that searches in custodial settings were sometimes necessary to ensure safety and stop contraband entering environments; however, given their potential to traumatise, the basis upon which such searches were to be conducted should be clear, consistent and contained in a single document.[562]

The Commissioner for Children and Young People made eight recommendations, including that the routine practice of strip searches cease, and that legislation be amended to require that searches of children only be conducted 'when reasonable, necessary and proportionate to a legitimate aim'.[563] Recommendations were also made to provide greater accountability for searches of children and young people in custody.[564]

The Tasmanian Government's response, dated 24 June 2020, indicated that the Government accepted all the recommendations and had reviewed operational procedures governing the searching of children in custodial settings.[565] We note that the *Youth Justice Amendment (Searches in Custody) Act 2022*, which amended the Youth Justice Act (as previously discussed), reflects the Commissioner for Children and Young People's recommendations. We discuss searches of young people at Ashley Youth Detention Centre in Chapters 11 and 12.

6.9 Inspection of Youth Custodial Services in Tasmania, 2018: Custody Inspection Report, Custodial Inspector Tasmania (August 2019)

In 2019, the Custodial Inspector reported findings following a 2018 inspection of Ashley Youth Detention Centre.[566] The report covered topics such as admission to custody, infrastructure, security, complaints, transport of young people in detention, use of force, use of isolation and emergency management.[567] The report raised concerns about reporting practices and procedures at Ashley Youth Detention Centre (which made it difficult to measure compliance and outcomes), the lack of a broad drug strategy, the use of force against young people in detention and the isolation of young people in detention.[568]

In responding to the report, the Department stated that in the 18 months since the inspection, 'many of the issues identified in the report have already been addressed'.[569] The response indicated that a review of procedures for searches had occurred, and that the Government had committed $7.28 million to upgrade Ashley Youth Detention Centre, after consultation with the Centre's management, the Department, the Commissioner for Children and Young People, the Child Advocate and non-government organisations.[570] No specific reference was made to any consultation with current or former detainees of the Centre about the upgrade.

The Tasmanian Government expressed its general support for recommendations related to improved reporting and recording systems for incidents and risk assessments; improved complaints mechanisms; young people's access to private phone calls; staff training, reporting and review of use of force and de-escalation techniques; and reviews of and improved reporting on the use of isolation.[571] The Government did not support two recommendations related to physical security at the Centre.[572] The Government's response to another six recommendations in the report was redacted.[573]

6.10 Through the Fence and into Their Lives: Ashley Youth Detention Centre Trauma Informed Practice Framework, Discovery Phase, Janise Mitchell, Australian Childhood Foundation (April 2020)

In 2020, Adjunct Associate Professor Janise Mitchell, Deputy Chief Executive Officer, Australian Childhood Foundation, prepared a brief report summarising key learnings from consultations with internal and external stakeholders about developing a trauma-informed operating model for Ashley Youth Detention Centre.[574]

Consultations explored the strengths and challenges of the existing youth detention model, a needs analysis, and opportunities for 'further development' of a trauma-informed operating model.[575] Noting that previous efforts to develop trauma-informed models ultimately did not proceed, the report emphasised that 'a trauma-informed practice framework and operating model will represent a significant paradigm shift for [Ashley Youth Detention Centre] and require a strong and sustained change-management approach'.[576] The report found that some staff lacked confidence in therapeutic approaches and were therefore fearful 'of being critiqued negatively by managers' if they used such approaches.[577]

The following key themes emerged from stakeholder consultations:

- There are many factors underlying young people's offending behaviours, including poor mental health, trauma backgrounds and disabilities.[578]
- Awareness and understanding of the Ashley Youth Detention Centre Model of Care, which was designed in 2019 and sought to articulate a trauma-informed practice model, was very low, with some staff and stakeholders describing it in unfavourable terms.[579]
- Support for change from Centre staff was mixed, with a lack of support influenced by ineffective efforts to facilitate change in the past.[580]
- The culture and practice of Centre staff was characterised by confusion and a lack of safety, including a view that the approach to young people was more punitive than therapeutic.[581]
- The Centre's operational environment was reactive, ad hoc and unsafe for staff and young people.[582]
- The culture at the Centre was 'risk averse, focused on containment, and punitive in nature'.[583]
- Minimum qualifications for operational staff were not adequate, and staff with the 'right attributes' were needed.[584]
- The cultural needs of young people were often overlooked.[585]

The report identified that policies and procedures relevant to searches, the use of mechanical restraint, the use of physical force, personal identity/possessions, the use of isolation and cultural awareness guidelines should be reviewed as a matter of priority.[586]

The report suggested that the next steps towards establishing a bespoke, fit-for-purpose practice framework for youth detention included consultations with young people about what would be helpful for them.[587] The report did not nominate a timeline for this future work.

7 A system in crisis

Although few of the reports noted in this chapter directly considered child sexual abuse at Ashley Youth Detention Centre, they all identified problems affecting the safety of children and young people at the Centre. Broadly, these problems included:

- outdated policies and procedures
- insufficient staff understanding of, and adherence to, legislative and policy requirements relevant to the treatment of children and young people in detention
- a preference among management and staff for punishment rather than rehabilitation, including the use of force, strip searches and isolation techniques
- inappropriate facilities for young people in detention and their visitors
- lack of confidence among staff in management and governance arrangements
- resistance to change among staff and administrators
- limited access to support services for young people
- a lack of monitoring of some spaces
- a lack of access for young people to family, independent representatives or advocates
- poor incident reporting
- inappropriate records management
- inadequate complaints processes
- inadequate human resources support for staff, including oversight of sick leave, a reliance on casual staff and a high number of workers compensation claims.

A common theme in many of the previous reports and inquiries discussed in this chapter is the treatment of children and young people in detention. For example, the independent review of Ashley Youth Detention Centre by Ms Harker in 2015 found there was a culture of punitive responses to children and young people.[588] We note that, in describing a 'punitive' culture, the reports also raise concerns about the use of force, searches and isolation, a preference for securing compliance over de-escalation strategies and an ideological belief that a therapeutic approach is not a deterrent to recidivism. In our view, the term 'punitive' in this context minimises the true extent of the crisis in the treatment of children in Tasmanian youth detention. We consider it is an environment that is harmful to children and perversely increases, rather than decreases, a lack of safety for staff.

A recent Victorian parliamentary report examining youth detention in that state concluded that:

> Punitive approaches to the management of youth justice services … are unlikely to resolve the behavioural issues of detainees; instead, they serve to reinforce the sense of mistrust experienced by many children and young people in custody. Without a trauma-informed approach to the management of youth justice centres, at-risk children and young people will continue to face significant obstacles in their paths to recovery and rehabilitation, and staff in youth detention centres will continue to face significant difficulties in managing children and young people in their care.[589]

As an allied matter, the reports and inquiries show systemic challenges related to staffing at Ashley Youth Detention Centre that appear to contribute to the persistent problems in the culture and treatment of children detained there. These challenges appear to be well recognised, with more evidence provided to our Inquiry confirming they had existed for a long time and persist into the present. The Centre's isolated location appears to have been a significant contributor to the intractable nature of these systemic staffing challenges, which included:

- difficulties fully staffing the Centre due to challenges in attracting staff, high staff turnover and unplanned staff absences
- difficulties in resourcing, attracting, retaining and training an appropriately skilled and qualified workforce
- the long tenure of a core group of staff who resisted cultural change.

In conclusion, before our examination into institutional responses to child sexual abuse at Ashley Youth Detention Centre, it appeared that successive Tasmanian governments had been made aware of persistent systemic issues in the treatment of children detained at the Centre and had failed to achieve sufficient meaningful change to address those issues.

Notes

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1 Commissioner for Children and Young People, *Procedural Fairness Response*, 4 August, 2–3.

2 *Youth Justice Act 1997* ss 3, 83(3), 124(1).

3 Nina Papalia et al, 'Patterns of Maltreatment Co-occurrence in Incarcerated Youth in Australia' (2022) 37 *Journal of Interpersonal Violence* 7–8.

4 Statement of Elena Campbell, 4 July 2022, 2 [15]–3 [19]; Statement of James Ogloff, 22 August 2022, 18 [76]; Statement of Mark Morrissey, 9 August 2022, 4 [26]; *Royal Commission into Institutional Responses to Child Sexual Abuse* (Final Report, December 2017) vol 15, 41; Tim Moore and Morag McArthur, *Take notice, believe us and act! Exploring the safety of children and young people in government run organisations* (Research Report prepared for the Commission of Inquiry into the Tasmanian Government's Responses to Child Sexual Abuse in Institutional Settings, February 2023) 93.

5 *Royal Commission into Institutional Responses to Child Sexual Abuse* (Final Report, December 2017) vol 15, 41.

6 Statement of Mark Morrissey, 9 August 2022, 19 [120].

7 *Royal Commission into Institutional Responses to Child Sexual Abuse* (Final Report, December 2017) vol 15, 49.

8 Refer to, for example, to Nick Clark, 'Ashley Boss Defends Action in Standoff', *The Mercury* (Hobart, 20 December 2002); Danny Rose, 'Ashley Called Training Ground for Risdon. Changes Urged for Youth Jail', *The Mercury* (Hobart, 5 April 2003) 7; Patrick Caruana, 'Detention Centre Where Teen Died May Close', *AAP General News Wire* (Sydney, 27 October 2010); Adam Holmes, 'Dozens Aged 13 and Under Strip-Searched in 2018', *The Examiner* (Launceston, 16 March 2019); Richard Baines, 'Ashley Youth Detention Standoff: Tasmanian Minister Demands Report into Staff Conduct: The Conduct of Staff During a Standoff at the Ashley Youth Detention Centre in Tasmania's North Prompts an Urgent Investigation and Calls for the Facility to be Closed', *ABC News* (Sydney, 16 August 2016).

9 The name 'Alysha' is a pseudonym; Order of the Commission of Inquiry, restricted publication order, 18 August 2022.

10 Statement of Kathrine Morgan-Wicks, 24 May 2022, Annexure 2 (Department of Health, 'Timeline of Organisational Structure and Governance Arrangements', undated).

11 Statement of Kathrine Morgan-Wicks, 24 May 2022, Annexure 2 (Department of Health, 'Timeline of Organisational Structure and Governance Arrangements', undated); Department of Communities, *Annual Report 2018–2019* (Report, October 2019) 6

12 Statement of Michael Pervan, 27 July 2022, 52 [114].

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213 Statement of Barry Nicholson, 18 August 2022, 3 [22]; Statement of Nurse Unit Manager, Ashley Youth Detention Centre, 11 November 2022, 1 [4].

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215 Statement of Nurse Unit Manager, Ashley Youth Detention Centre, 11 November 2022, 6 [19].

216 Statement of Barry Nicholson, 18 August 2022, 3 [22]; Statement of Nurse Unit Manager, Ashley Youth Detention Centre, 11 November 2022, 1 [4], 2 [7].

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221 Statement of Nurse Unit Manager, Ashley Youth Detention Centre, 11 November 2022, 6 [19].

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224 Statement of Barry Nicholson, 18 August 2022, 4 [22(viii)], 4 [23–28].

225 Statement of Nurse Unit Manager, Ashley Youth Detention Centre, 11 November 2022, 4 [14].

226 Statement of Barry Nicholson, 18 August 2022, 4[23], 5 [36].

227 Statement of Barry Nicholson, 18 August 2022, 4 [22(vii)].

228 Statement of Barry Nicholson, 18 August 2022, 2 [9].

229 Statement of Barry Nicholson, 18 August 2022, 5 [36]; Statement of Director of Nursing, Statewide Forensic Mental Health Service, 3 November 2022, 5 [22]. We heard that an August 2022 recruitment process for the position had been successful: Transcript of Barry Nicholson, 19 August 2022, 2923 [11–17].

230 Statement of Barry Nicholson, 18 August 2022, 5 [37].

231 Statement of Barry Nicholson, 18 August 2022, 5 [38].

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242 Statement of Samuel Baker, 8 August 2022, 3 [17].

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246 Statement of Samuel Baker, 8 August 2022, 3 [20]; Statement of Pamela Honan, 18 August 2022, 19 [22.4].

247 Statement of Samuel Baker, 8 August 2022, 3 [20–21].

248 Statement of Samuel Baker, 8 August 2022, 3 [20]; Statement of Pamela Honan, 19 [22.4].

249 Statement of Samuel Baker, 8 August 2022, 5–6 [43], 7 [51–54].

250 Statement of Samuel Baker, 8 August 2022, 4 [32–36].

251 Statement of Samuel Baker, 8 August 2022, 4 [36].

252 Statement of Samuel Baker, 8 August 2022, 5 [42]; Transcript of Samuel Baker, 19 August 2022, 2906 [34-42].

253 Statement of Samuel Baker, 8 August 2022, 5 [42]; Transcript of Samuel Baker, 19 August 2022, 2906 [34-42].

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255 Statement of Michael Pervan, 27 July 2022, 45 [80]. Refer also to Statement of Michael Pervan, 27 July 2022, Annexure 28 ('Ashley Learning Centre, New School Development Education and Learning Programs 2004–2005: Memorandum of Understanding between Ashley School (Department of Education) and Ashley Youth Detention Centre (DHHS) in relation to the Usage of the Learning Centre for Educational and Learning Programs 2004–2005', 19 July 2004').

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257 Statement of Samuel Baker, 8 August 2022, 2 [10].

258 Statement of Samuel Baker, 8 August 2022, 2 [6].

259 Statement of Michael Pervan, 27 July 2022, 19 [32], 39 [44].

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262 Statement of Pamela Honan, 18 August 2022, Annexure 3 ('Centre Support Team – Terms of Reference', Ashley Youth Detention Centre, March 2018); Ashley Youth Detention Centre, 'Centre Support Team – Terms of Reference', 21 November 2019, 2, produced by the Tasmanian Government in response to a Commission notice to produce.

263 Statement of Pamela Honan, 18 August 2022, Annexure 3 ('Centre Support Team – Terms of Reference', Ashley Youth Detention Centre, March 2018) 2; Ashley Youth Detention Centre, 'Centre Support Team – Terms of Reference', 21 November 2019, 2, produced by the Tasmanian Government in response to a Commission notice to produce.

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274 Statement of Michael Pervan, 27 July 2022, Annexure 23 ('Terms of Reference: AYDC Multi-Disciplinary Team', Custodial Youth Justice Services, 21 December 2021) 1.

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279 Statement of Michael Pervan, 27 July 2022, 41 [52]; Statement of Michael Pervan, 27 July 2022, Annexure 23 ('Terms of Reference: AYDC Multi-Disciplinary Team', Custodial Youth Justice Services, 21 December 2021) 2.

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285 Statement of Michael Pervan, 27 July 2022, Annexure 25 ('Terms of Reference: Risk Assessment Process Team', Custodial Youth Justice Services, 8 June 2022) 1.

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287 Statement of Michael Pervan, 27 July 2022, Annexure 25 ('Terms of Reference: Risk Assessment Process Team', Custodial Youth Justice Services, 8 June 2022) 1.

288 Statement of Michael Pervan, 27 July 2022, Annexure 25 ('Terms of Reference: Risk Assessment Process Team', Custodial Youth Justice Services, 8 June 2022) 2.

289 Statement of Pamela Honan, 18 August 2022, Annexure 13 ('Draft Practice Advice: Risk Assessment Process Team', Custodial Youth justice Services, undated) 2.

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292 Statement of Pamela Honan, 18 August 2022, Annexure 13 ('Draft Practice Advice: Risk Assessment Process Team', Custodial Youth justice Services, undated) 2.

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299 Custodial Youth Justice Services, 'Terms of Reference: AYDC Weekly Review Meetings', undated, 1–2, produced by the Tasmanian Government in response to a Commission notice to produce.

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330 Statement of Patrick Ryan, 18 August 2022, 13 [128]; Statement of 'Piers', 15 [45(b)]; Statement of former Manager, Professional Services and Policy, Ashley Youth Detention Centre, 16 [56(b)]; Statement of Operations Manager, Ashley Youth Detention Centre, 1 August 2022, 5 [29].

331 Statement of Operations Manager, Ashley Youth Detention Centre, 1 August 2022, 5 [31].

332 Statement of Operations Manager, Ashley Youth Detention Centre, 1 August 2022, 5 [29].

333 Statement of Ginna Webster, 13 January 2023, Annexure 1 (Letter from Ginna Webster to Richard Connock, 14 November 2018) 2–3; Statement of Patrick Ryan, 18 August 2022, 13 [129]; Statement of Operations Manager, Ashley Youth Detention Centre, 1 August 2022, 5 [32]; Statement of Operations Manager, Ashley Youth Detention Centre, 1 August 2022, 5 [29]; Statement of former Manager, Professional Services and Policy, Ashley Youth Detention Centre, 8 August 2022, 16 [56(a)]; Statement of former Case Management Coordinator, Ashley Youth Detention Centre, 8 August 2022, 4 [59]; Statement of Fiona Atkins, 15 August 2022, 11 [39(c)]; Statement of 'Piers', 15 August 2022, 16 [45(c)].

334 Statement of Patrick Ryan, 18 August 2022, 13 [128].

335 Statement of 'Piers', 15 August 2022, 15 [45(a)].

336 Statement of Ginna Webster, 13 January 2023, Annexure 1 (Letter from Ginna Webster to Richard Connock, 14 November 2018) 3 [2].

337 Statement of Operations Manager, Ashley Youth Detention Centre, 1 August 2022, 5 [29]; Statement of Fiona Atkins, 15 August 2022, 11 [39(a)].

338 Statement of Ginna Webster, 13 January 2023, Annexure 1 (Letter from Ginna Webster to Richard Connock, 14 November 2018) 3.

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361 Custodial Youth Justice Services, 'Terms of Reference: AYDC Weekly Review Meetings', undated, 2, produced by the Tasmanian Government in response to a Commission notice to produce.

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374 Ombudsman Tasmania, *Listen to the Children: Review of Claims of Abuse from Adults in State Care as Children* (Report, November 2004) 1.

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376 Ombudsman Tasmania, *Listen to the Children: Review of Claims of Abuse from Adults in State Care as Children* (Report, November 2004) 1.

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378 Department of Health and Human Services, *Report of Claims of Abuse of Children in State Care: Final Report –Round 4* (Report, November 2014) 3.

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387 Statement of Michael Pervan, 7 June 2022, 19 [118].

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11 Case studies: Children in youth detention

Content warning

Please be aware that the content in this report includes descriptions of child sexual abuse, attempted suicide and self-harm, and may be distressing or raise issues of concern for some readers.

We encourage readers to exercise discretion in their engagement with this content and to seek support and care if required.

1 Introduction to case studies

In this chapter, we present seven case studies that examine different aspects of Ashley Youth Detention Centre.

The focus of our Commission of Inquiry is the State's response to known risks of child sexual abuse in institutions, including Ashley Youth Detention Centre. In this chapter, we also examine other forms of mistreatment of detainees (for example, physical abuse or degrading treatment) that we consider relevant to understanding the context in which child sexual abuse occurs. We also note that children's vulnerability to child sexual abuse is heightened in contexts where other abuses and rights violations are prevalent.[1]

In Case study 1, we describe the nature and extent of abuse at the Centre, including the evidence we received from several current and former detainees, as well as allegations

made through redress schemes and civil claims. This evidence is harrowing, describing abuses that are callous, cruel and degrading. Children and young people's powerlessness in the face of such ingrained abuse and mistreatment is palpable and devastating. The consistency of themes across all these accounts, despite coming from multiple sources, is striking and includes:

- sexual, physical and psychological abuse of detainees by staff
- harmful sexual behaviours between detainees, sometimes with the knowledge of Centre staff
- staff using strip searches as a tool of control, and as an opportunity to sexually abuse children and young people
- staff humiliating, belittling and threatening detainees
- inappropriate use of isolation and use of force, including to punish and control detainees.

While we did not test the truth of individual accounts, we gave particular weight to the consistency across the accounts of victim-survivors whom we heard from directly and those that we read in claims under the Abuse in State Care Program and the National Redress Scheme. In the accounts of different people detained at the Centre over different periods, and the information coming from direct accounts, critical incident reports and state and Commonwealth redress schemes, we saw a striking consistency (and enough variability) to the places and ways abuses occurred, the people who were allegedly responsible and the patterns and kinds of sexually abusive behaviours.

Taken together, alongside previous reviews and the evidence we received about a longstanding corrosive culture that doubts and disbelieves reports by detainees, we find that, for decades, some children and young people detained at Ashley Youth Detention Centre experienced systematic harm and abuse.

In Case study 2, we examine the extent of harmful sexual behaviours at the Centre and responses to such behaviour. We include some accounts of former detainees who describe sexual harm by other detainees at the Centre and how this was often ignored by staff. We also heard allegations that staff sometimes actively used the harmful behaviours, including harmful sexual behaviours, of some detainees to control or frighten other detainees. We make findings in this case study about failures to respond appropriately to the risks of harmful sexual behaviours, which are listed in Section 9 and explained further in the case studies. In particular, we find that Ashley Youth Detention Centre has been aware of harmful sexual behaviours at the Centre and has not taken steps to protect children and young people from these harms.

Case studies 3 and 4 examine isolation and use of force at the Centre and make a range of findings that these practices have been misused, sometimes excessively and unlawfully, to punish and degrade detainees in breach of their human rights. In particular, we find that:

- the use of isolation as a form of behaviour management, punishment or cruelty has been a regular and persistent practice at Ashley Youth Detention Centre since at least the early 2000s and, in July 2023, we received information to suggest that some harmful isolation practices are still occurring
- the excessive use of force has been a longstanding method of abusing children and young people by some staff at Ashley Youth Detention Centre, and the Department and Tasmanian Government have not always responded appropriately.

When the isolation of young people at Ashley Youth Detention Centre is unauthorised, unregulated and unreported, or there is excessive use of force, the risk of and opportunities for the physical and sexual abuse of young people increases. Such belittling and dehumanising practices also reduce the likelihood of children and young people making disclosures of child sexual abuse because their sense of what is right and wrong, trust in adults at the Centre and self-worth have been undermined.

Case studies 5 and 6 describe how complaints about the safety and treatment of detainees have been managed—including complaints by a staff member called Alysha (a pseudonym) and a detainee called Max (a pseudonym).[2] We make findings about the State, the Department and the Centre's response to these complaints, and identify systemic problems in these responses.

Case study 7 describes how the Department has responded to alleged sexual abuse of detainees by staff at Ashley Youth Detention Centre. This traces revelations from the Abuse in State Care Program (which began in 2003) and the perceived legal barriers that the Department told us limited its ability to act against staff, despite sometimes receiving multiple allegations of serious sexual assaults by staff still working at the Centre. Over time, corporate memory of the Abuse in State Care Program (and the information it revealed about current staff) was lost within the Department. Another wave of information alleging abuses by current and former staff came with the introduction of the National Redress Scheme in 2018, which was also met with confusion and inaction due to legal advice and practices that precluded use of that information, until a belated change of practice in the second half of 2020. We make a range of findings about failures to manage risks to detainees arising from this information.

1.1 How to read our case studies and examples

Many of our case studies are closely related and benefit from being read together. While findings may sit within a particular case study, in some instances those findings

also draw on evidence described in others. For example, our finding that, for decades, some children and young people detained at Ashley Youth Detention Centre experienced systematic harm and abuse in Case study 1, also draws on the evidence we examined in Case studies 3, 4 and 7. Case studies 3 and 4 expand on some of the common themes we heard in Case study 1 about alleged abuse and mistreatment connected to isolation practices and the use of force, including previous reports and reviews. Case study 7 discusses a range of documentation outlining allegations of abuse that were in addition to the accounts we heard from people who had been detainees at the Centre or their families.

Case studies 5 and 6 describe responses to complaints (in one instance from a detainee and, in the other, a staff member). Taken together, our seven case studies have informed our recommendations in Chapter 12.

1.2 Key witnesses and sources of information

Throughout the case studies in this chapter, we refer to several people who held senior departmental roles. In addition to our requests for information from the Tasmanian Government, we also requested statements and information from people who had a role in the response or may have had access to relevant information. Some of these people were no longer in the Department, which limited their access to information. Some joined the Department after the events into which we inquired and gave us information based on what was available to them, but in relation to matters with which they had no personal involvement.

Here, as a reference point, we summarise the key role-holders and witnesses who provided information in relation to our case studies:

- Michael Pervan held the role of Secretary in the then Department of Health and Human Services and Department of Communities for the period from around October 2015 until July 2022 (other than between May 2018 and September 2019 during the split of the Department of Communities from the Department of Health and Human Services).[3] The functions previously held by Secretary Pervan have since moved to sit within the Department for Education, Children and Young People, overseen by Secretary Timothy Bullard.[4] Prior to his formal appointment, Secretary Pervan had been Acting Secretary of the Department of Health and Human Services from March 2014 until his permanent appointment in October 2015.[5]
- Ginna Webster has been Secretary of the Department of Justice since September 2019, and was previously the Secretary of the Department of Communities from May 2018 to September 2019.[6] Prior to May 2018, Secretary Webster held the role of Deputy Secretary, Children and Youth Services in the then Department of Health and Human Services.[7]

- Mandy Clarke held the role of Deputy Secretary, Children, Youth and Families, which had portfolio responsibility for Ashley Youth Detention Centre, among other things.[8] Ms Clarke reported to then Secretary Pervan.[9] Ms Clarke was Deputy Secretary from 11 September 2019 to 11 February 2022, with her last working day being 21 January 2022.[10]
- Kathy Baker held the role of Executive Director, Capability and Resources between July 2018 and September 2021. That role was subsequently reclassified Deputy Secretary, Corporate Services, and was held by Ms Baker between September 2021 and 30 June 2022, although she was seconded to the Department of Health between 10 March 2020 and 5 June 2020.[11] She reported directly to then Secretary Webster between July 2018 and September 2019 and subsequently to then Secretary Pervan (except during her secondment).[12] The role had responsibilities for corporate areas including People and Culture, Legislation and Legal Services, and Governance Risk and Performance (as they were then known)[13] [14]
- Jacqueline Allen commenced the role of Acting Assistant Director, Safety, Wellbeing & Industrial Relations, which was part of the People and Culture Division, in July 2020.[15] She reported to the then Director of People and Culture.[16] At the time she gave evidence at our public hearings in August 2022, Ms Allen was the Acting Executive Director, People and Culture (but had left that role by December 2022). We note that, despite her short tenure at the Department, Ms Allen provided us with a large amount of documentary evidence in response to our requests for information. This included in relation to events that occurred before her commencement at the Department and with which she was not involved, and often where we had not been provided with those documents in response to other requests. We were grateful for her efforts in this regard.
- Greg Brown held the role of Director, Strategic Youth Services, within the Department between December 2017 and October 2019.[17]
- Pamela Honan has held the role of Director, Strategic Youth Services (also titled Director, Youth and Family Violence Services) within the Department since 28 October 2019.[18] The title of this role has changed over time but we understand that Ms Honan has had responsibility for Ashley Youth Detention Centre since she commenced employment with the Department.[19] Ms Honan reported to Ms Clarke.[20]
- Patrick Ryan was Manager, Custodial Youth Justice ('Centre Manager') at Ashley Youth Detention Centre from January 2017 until March 2020. Mr Ryan reported to Mr Brown and Ms Honan.[21]
- In March 2020, Stuart Watson was appointed Acting Centre Manager (from his role as Assistant Manager, which he had held since January 2020).[22] Mr Watson was appointed as the ongoing Centre Manager in March 2021.[23] Mr Watson reported to Ms Honan.[24]

Case study 1: The nature and extent of abuse in Ashley Youth Detention Centre

1 Introduction

In this case study, we find that children and young people at Ashley Youth Detention Centre have experienced systematic harm and abuse for decades.

This finding is based on several sources—described in this case study—as well as the evidence outlined across the subsequent case studies.

This case study contains a series of concerning allegations against Ashley Youth Detention Centre staff. We acknowledge that there have been, and are, staff at Ashley Youth Detention Centre who have tried to do their jobs lawfully and appropriately. References to problematic practices by 'staff' in this case study are not intended as a reference to all staff at Ashley Youth Detention Centre, unless explicitly stated in a specific context.

While we focus primarily on allegations of abuse by staff, we also heard of allegations of abuse by other children and young people, which were sometimes said to have occurred with the knowledge or endorsement of staff.[25] We discuss this type of abuse (harmful sexual behaviours) in more detail in Case study 2. Understanding the extent and nature of abuse at Ashley Youth Detention Centre was essential to informing our recommendations. It is also important that any agency responding to allegations of abuse at the Centre does so with knowledge of this history of abuse.

On the evidence that was available to us, it was apparent that sexual abuse at Ashley Youth Detention Centre occurred alongside physical and verbal abuse. The sexual abuse perpetrated by some staff appears to have been motivated by a desire for sexual gratification. For other staff, the sexual abuse appears to have been one of many ways they asserted their dominance over, and otherwise degraded, detainees at the Centre, and may not have been sexually motivated.

In this case study, we outline sources of information about sexual and other abuse at Ashley Youth Detention Centre. Data from these sources tells us that numerous allegations of abuse, including of sexual abuse, at the Centre and its predecessor, Ashley Home for Boys, have been made through formal channels since 2003, when the Abuse in State Care Program was established.

We then summarise several of the many accounts of abuse that we received from victim-survivors of Ashley Youth Detention Centre, or their family members, during our Commission of Inquiry. In total, 11 victim-survivors and family members gave us permission to report their experiences, albeit anonymously.

It was not possible for our Commission of Inquiry to test the veracity of all the allegations outlined in victim-survivors' accounts. However, we were struck by the common accounts of sexual, physical and other abuse by staff at the Centre, or older detainees, or both. Themes included the misuse of strip searches by Centre staff, how and where the abuse was perpetrated, and the absence or failure of effective reporting mechanisms when children and young people sought help to stop the abuse. While we do not make findings in relation to any individual allegation, we note the similarities across accounts.

The accounts of victim-survivors documented in this case study allege sexual and other abuse at Ashley Youth Detention Centre from the early 2000s to as recently as the early 2020s. At least some of the staff who were alleged to have perpetrated this abuse had worked at the Centre for many years at the time complaints were first made against them. They continued to work at the Centre for many more years due to the Department's slow and uncoordinated response to redress claims and allegations of abuse (we discuss this in Case study 7).

Later in this case study and in Case study 7, we discuss the Department's realisation in 2020 that many staff members against whom allegations of abuse had been made were still working at Ashley Youth Detention Centre.

We have included these accounts because we consider it is necessary that the Tasmanian Government understands the experiences of young people in detention, as well as the culture of sexual and other forms of abuse, denigration and human rights violations of children and young people that has persisted at Ashley Youth Detention Centre, to respond effectively to allegations of abuse in youth detention.

2 Data about child sexual abuse at Ashley Youth Detention Centre

The Department has received allegations of child sexual abuse at Ashley Youth Detention Centre, from multiple sources, over a long period. In this section, we outline the avenues through which the Department has received these allegations. We note various inconsistencies about the extent of abuse between the data collected by different bodies and for different purposes. In Chapter 12, we emphasise the importance of collecting and comparing data about the sexual and other forms of abuse of children and young people under the care of the State and recommend an audit of allegations of abuse (refer to Recommendation 12.5).

2.1 Response to our notice to produce

To understand the nature and extent of child sexual abuse at Ashley Youth Detention Centre, we issued a notice to produce information, which asked the Department to:

> Produce any document which summarises—or if no such document exists, prepare a document which describes—the following information for … Ashley Youth Detention Centre in relation to any allegations or incidents of child sexual abuse (including allegations or incidents of misconduct against children which may constitute child sexual abuse) in Institutional Contexts for each year of the Relevant Period [this is defined as 1 January 2000 to the date of the notice]:
>
> a. the number of allegations or incidents
>
> b. the dates of those allegations or incidents
>
> c. the nature of those allegations or incidents
>
> d. any investigation of those allegations or incidents
>
> e. any reporting or referral of those allegations or incidents to a law enforcement or regulatory agency, or Child Safety Services, or
>
> f. any action or outcome as a result of those investigations, allegations or incidents.[26]

The Department told us it collected child sexual abuse allegations made by former detainees from a range of sources including claims made through the Abuse in State Care Program, civil litigation claims and the National Redress Scheme to provide us with a number of documents.[27] We continued to receive information (often in the form of spreadsheets) over the course of our Inquiry.

There were significant discrepancies across the data we received about sexual abuse incidents at Ashley Youth Detention Centre. Barriers to us understanding the scope and scale of abuses included the following:

- *Incompatible documentation*. We received multiple and differing documents and spreadsheets recording varying numbers of incidents, which were difficult to reconcile across different sources and agencies, particularly where dates were vague or within a broad range. Also, different aspects of an incident were described or reported to different audiences and in some instances, alleged abusers and victim-survivors were unnamed.
- *Very limited details relating to some incidents*. We accept that sometimes this was unavoidable due to the limited nature of information the Department received (for example, through a National Redress Scheme claim) but, at times, suggested incomplete departmental record keeping.

- *Differences in how data is segmented and reported*. For example, the various public reports relating to the Abuse in State Care Program segmented data differently, sometimes breaking down the number of claims by institution, allowing us to understand specifically how many related to Ashley Youth Detention Centre or Ashley Home for Boys, and other times generalising to institution type ('government institution'), which made this impossible.

We consider some discrepancies may have arisen in the number and nature of incidents that the Department reported to us because of the following:

- *Confusion around what fell within the 'Relevant Period'*. There was uncertainty about whether our request related to incidents that had occurred within that period or were reported or otherwise made known to the Department within that period (but may have occurred before 2000). In most documents, the Department has appeared to have adopted the former approach in only reporting incidents that fall within the relevant period (noting sometimes abuse may have predated but overlapped with this period—for example, 1998–2002).
- *The Department not adopting a consistent definition of what constitutes child sexual abuse*. For example, the Department sometimes did not include incidents relating to harmful sexual behaviours between detainees or complaints about a staff member applying cream to a detainee's genitals. At other times, the Department did include such incidents.

We consider that the discrepancies were more likely to lead to an underreporting of incidents to us.

We invested significant effort to accurately reflect the information we received, but it has been difficult—indeed impossible—for us to entirely assure ourselves of the completeness and accuracy of some of the figures and information we received. Often, witnesses could not help us clarify discrepancies or broaden our understanding of some of these incidents.

These challenges mean there are internal inconsistencies in some of the information we present. In the interests of the reader, we have at times prioritised clarity ahead of providing detailed explanations or clarifications of inconsistencies and limitations in the documentation we received, particularly where we could find no such explanation.

With these limitations in mind, the next section outlines the key sources of information relating to reports of child sexual abuse at Ashley Youth Detention Centre.

2.2 The Abuse in State Care Program

In July 2003, the Tasmanian Government announced a review of claims of abuse, including sexual abuse, by people who had been in state care as children, including in youth detention and in out of home care. The Government ran the Claims of Abuse in State Care Program ('Abuse in State Care Program') over four rounds between 2003 and 2013, resulting in 2,414 claims and 1,848 ex gratia payments (voluntary payments made as a gesture of goodwill without any legal obligation). These payments totalled to $54.8 million.[28] To be eligible to make a claim, a person had to be aged 18 or older on 11 July 2003 and not have been a claimant in a previous round of the Abuse in State Care Program.[29] The eligibility criteria were set at the beginning of the first round and remained the same (including in relation to the age requirement) through all rounds of the program.[30]

The Department of Communities' predecessor, the Department of Health and Human Services, was involved in each round of the program, with the first two rounds delivered as a joint undertaking with the Office of the Ombudsman and the Department of Health and Human Services. The third round was administered by the Department of Premier and Cabinet in partnership with the Department of Health and Human Services. The Department of Health and Human Services was solely responsible for administering the final round of the program.[31]

Many allegations of abuse at Ashley Youth Detention Centre (and Ashley Home for Boys) were raised in each round of the program. New rounds of the Abuse in State Care Program were initiated in response to new claimants coming forward.[32]

According to reports published on the various rounds of the Abuse in State Care Program (which varied in the level and type of information they provided about claims):

- During the first round, which ran from 2003 to 2004, 32 people made claims relating to abuse that occurred at Ashley Home for Boys.[33] The report described, in general terms, that most of these claims related to 'sustained physical and emotional abuse', with allegations of sexual abuse described as 'less common' in boys' homes (including Ashley Home for Boys).[34]
- In the second round, which ran from 2005 to 2006, 117 people came forward claiming abuse that occurred at Ashley Home for Boys.[35] We are unclear what type of abuse these claims relate to but note that across all eligible claims (423) made in this period, 189 (or 45 per cent) included sexual abuse.[36]
- There were 995 claims (in total) made in the third round, which ran from 2007 to 2010. We have not been able to identify the number of claims that were made relating to Ashley Home for Boys or Ashley Youth Detention Centre because a detailed report on this third round of claims was not available (we drew the overall 995 figure from the report of the fourth round of claims).[37]

- The fourth round of the program, which ran from 2011 to 2013, resulted in 172 claims against Ashley Home for Boys and Ashley Youth Detention Centre.[38] We are unsure what proportion of these claims relate to sexual abuse but note that, of the 199 claims of sexual abuse made during that round, nearly 50 per cent were made by claimants who were placed in an institution (including Ashley Youth Detention Centre).[39]
- The number of claims listed in the reports on rounds 1, 2 and 4 of the Abuse in State Care Program indicate that, in these three rounds alone, 321 claims of abuse were made in relation to Ashley Youth Detention Centre or Ashley Home for Boys.

The Department provided us with a spreadsheet listing allegations or incidents of child sexual abuse since 2000. The spreadsheet showed that 18 claims of child sexual abuse were made against Ashley Youth Detention Centre staff through the Abuse in State Care Program (some of which included multiple allegations).[40] It also indicated that the Department of Health and Human Services began to receive these claims in 2008 and that the period of abuse to which these claims related spanned 1995 to 2013.[41] Not all claims received by the Department of Health and Human Services were eligible for redress, due to not meeting the age requirement or for other reasons.[42]

The discrepancy between the Department's spreadsheet and the data in the Abuse in State Care Program reports is likely to be partially attributed to the scope of our request to the Department, which did not include a request for allegations relating to Ashley Home for Boys, which closed in 2000. The discrepancy may also be partly due to the Abuse in State Care Program reports referring to physical and sexual abuse, as well as abuse alleged to have been perpetrated by other children and young people (which were not captured in the Department's spreadsheet). Discrepancies may also be due to different interpretations of sexual abuse.

2.3 Other government data

The Department provided us with several other documents indicating that many claims of child sexual abuse were made against staff at Ashley Youth Detention Centre and Ashley Home for Boys through the Abuse in State Care Program:

- A spreadsheet provided by the Child Abuse Royal Commission Response Unit in the Department of Justice to the Department of Communities on 19 September 2020 indicated there were 127 claims of child sexual abuse made against named staff members through the Abuse in State Care Program (some of whom were named on multiple occasions).[43]

- The Department of Justice also provided our Commission of Inquiry with a different table of data relating to the Abuse in State Care Program that was 'extracted from a manual review of hard copy files during the Royal Commission into Institutional Responses to Child Sexual Abuse'.[44] This information indicated that:
    - Claims of sexual abuse were made against Ashley Youth Detention Centre or Ashley Home for Boys staff through the Abuse in State Care Program as early as 2003, although it is unclear when the Department received these earlier claims given there were different administrators of the scheme (we consider it would have been during the period of the first phase of the scheme—2003 to 2004).[45]
    - Based on our review of the listed claims in the Abuse in State Care Program, at least 95 of the accepted claims involved named staff, and at least 44 involved unnamed staff, at Ashley Youth Detention Centre or Ashley Home for Boys.[46] Several staff had multiple claims made against them. We note that the number of claims of child sexual abuse against staff members is likely higher because there were claims that did not specifically refer to, or name, staff members and, therefore, have not been included in our analysis because they may have related to harmful sexual behaviours.
    - The period of abuse spanned much longer, dating back to the 1940s.

As we discuss later in this case study, staffing at the Centre had been relatively stable, with many staff moving from Ashley Home for Boys to Ashley Youth Detention Centre in 2000 and continuing to work there through the 2000s.

We note that the Department of Communities' and the Department of Justice's spreadsheets described above provide summaries of the claims made under the Abuse in State Care Program.[47] It is clear from these documents that there is a commonality in the types of sexual abuse claims against staff at Ashley Home for Boys and Ashley Youth Detention Centre. The claims include allegations of rape, abuse during strip searches, abuse through applying scabies cream on detainees' genitals, detainees being watched in the shower, the use of bribes and threats to force detainees to engage in sexual acts, forcing detainees to engage in sexual acts with each other, and sexual abuse occurring in the Centre's 'secure unit' and when detainees were taken off site.[48] As we describe, these types of abuse were also raised through other avenues over different periods and correlate with the accounts provided to us by victim-survivors.

2.4 The Abuse in State Care Support Service

When the Abuse in State Care Program wound up in 2013, it was replaced by the Abuse in State Care Support Service. The Abuse in State Care Support Service was set up to provide financial support to people who experienced abuse, including sexual abuse, in state care when they were children.

As with the Abuse in State Care Program, the Abuse in State Care Support Service is available to people who had previously been detained at Ashley Youth Detention Centre, as well as those who were in other forms of state care.[49] The process for accessing financial support under the service involves the applicant being interviewed by the Department and having a 'discussion with the Applicant about counselling and other supports'.[50] Up to $2,500 is available for successful claimants to pay for goods and services related (but not limited) to education, employment, counselling, personal development, family connection and medical and dental services.[51]

Michael Pervan, former Secretary, Department of Communities, told us in a statement dated 14 June 2022 that 185 people had made applications or requested information since the service began in 2013, of which 89 applications alleged sexual abuse.[52] We understand that this relates to claims in relation to all forms of state care. Secretary Pervan could not provide us with the number of applications that had been approved, but said that of those who received financial support through the service, fewer than 20 applicants received less than $2,000.[53]

Information provided to us by the Department of Communities in response to our notice to produce indicated that, as of 20 July 2021, 26 claims had been made through the Abuse in State Care Support Service involving allegations of sexual abuse at Ashley Youth Detention Centre (or its predecessor, the Ashley Home for Boys).[54] Most of the allegations related to conduct by Ashley Youth Detention Centre staff.[55] The period of abuse spans from 1995 to 2012.[56]

The claims raised through the Abuse in State Care Support Service include similar allegations against staff to those raised through other avenues and in victim-survivors' accounts. The allegations again included abuse during regular and random strip searches; abuse by applying cream, powder and lotion to detainees' genitals; detainees being watched in the shower; using bribes and threats to force detainees to engage in sexual acts; forcing detainees to engage in sexual acts with each other and in the presence of others including Centre staff; and sexual abuse occurring in the Centre's 'secure unit' and when detainees were taken off site.[57]

2.5 The National Redress Scheme

As discussed in Chapter 17, the National Redress Scheme was created in response to National Royal Commission recommendations. The purpose of the Scheme is to hold institutions accountable for child sexual abuse and to help people who have experienced institutional child sexual abuse to access counselling, a direct personal response and a redress payment. The National Redress Scheme started on 1 July 2018. It will run for 10 years and is only available to people who were born before 30 June 2010 and whose abuse occurred before 1 July 2018.[58]

The National Redress Scheme is administered by the Australian Government. Tasmania's Child Abuse Royal Commission Response Unit (which sits within the Department of Justice) responds to requests for information about the Scheme, with the assistance of other agencies.[59] On receiving a request for information relevant to Ashley Youth Detention Centre, the role of the Department for Education, Children and Young People is to undertake a desktop investigation and provide a summary of material relevant to the National Redress Scheme claim to the Department of Justice.[60] We outline this process in more detail in Case study 7.

As of 20 July 2021, the Department had received 49 National Redress Scheme claims for allegations of child sexual abuse at Ashley Youth Detention Centre (some of which contained multiple allegations).[61] In total, these claims included 53 allegations against Ashley Youth Detention Centre staff members (including youth workers, security guards and contractors), with the alleged period of abuse spanning from 1995 to 2012.[62] Allegations were also raised against other detainees.[63]

Of the 49 National Redress Scheme claims the Department received, 10 claims were made in 2019, 14 claims were made in 2020, 24 claims were made in 2021 and it is unclear when the remaining claim was made.[64]

Secretary Pervan told us that, from 20 July 2021 until 27 May 2022, there were another 49 claims made under the National Redress Scheme (and five civil claims) for incidents dating between 1997 and 2016.[65] Other information in relation to these additional claims suggests that there were 48 National Redress Scheme claims and six civil claims relating to conduct alleged to have occurred over the period 1997 to 2019.[66]

Again, the allegations the Department received indicate a commonality in the methods of abuse allegedly perpetrated by Ashley Youth Detention Centre staff, including abuse during strip searches; abuse through applying products to detainees' bodies and genitals; detainees being watched in the shower; rape; using bribes and threats to force detainees to engage in sexual acts; forcing detainees to engage in sexual acts with each other and in the presence of others including Centre staff; and sexual abuse occurring in the Centre's 'secure unit' and when detainees were taken off site.[67]

2.6 Civil claims

As discussed in Chapter 17, the Tasmanian Government has made several legislative amendments in response to recommendations of the National Royal Commission, which pave the way for more civil claims to be issued against institutions that may be vicariously liable for the conduct of their staff, or liable for failing to protect a child from abuse.

In response to a notice to produce, the Department provided information to our Inquiry about civil claims that relate to allegations of child sexual abuse at Ashley Youth Detention Centre for the period 2000 to 20 July 2021.[68] Secretary Pervan provided further information for the period 20 July 2021 to 27 May 2022.[69] The data indicates that:

- In 2019, one civil claim was issued in relation to Ashley Youth Detention Centre.[70]
- In 2020, four civil claims were issued in relation to Ashley Youth Detention Centre.[71]
- In 2021, one civil claim was issued in relation to Ashley Youth Detention Centre.[72]
- From 20 July 2021 to 27 May 2022, six civil claims were issued in relation to Ashley Youth Detention Centre.[73]

The dates of the incidents raised in these claims up to July 2021 span 1998 to 2010.[74] The additional civil claims the Department received between 20 July 2021 and 27 May 2022 relate to conduct alleged to have occurred between 2002 and 2008.[75] Most of these claims include allegations against staff members, and the allegations involve similar methods of abuse identified in our discussion of the redress schemes above.[76] The allegations in these civil claims include rape, digital penetration, being forced to engage in sexual acts with other detainees and Centre staff (sometimes in the presence of other Centre staff), being photographed while performing sexual acts, using physical abuse and threats, being placed in settings where sexual abuse by other detainees took place, sexual abuse by staff while off site, and the application of products to bodies, including genitals.[77]

We also received evidence that suggests many more civil claims have been issued in relation to physical abuse at Ashley Youth Detention Centre. A briefing for the Minister for Children and Youth that Secretary Pervan cleared on 4 November 2021 states:

> As of 18 October 2021, 42 civil claims [have been made] in relation to physical and/or sexual abuse that involve the Department (or its predecessor). Court proceedings have commenced for 12 of these matters.[78]

Also, on 11 August 2022, a class action was commenced in the Supreme Court of Tasmania on behalf of more than 100 former Ashley Youth Detention Centre detainees, with more claimants being added at the time of writing.[79] The claim of the lead plaintiffs is that the former detainees named as part of the class action suffered serious injuries due to systemic negligence in the management of Ashley Youth Detention Centre over the period from 1961 to 2019. Allegations include that staff:

- performed degrading strip searches
- forcibly applied scabies treatments that caused burns to detainees' bodies, including their genitals
- failed to provide appropriate medical treatment
- used isolation and beatings as punishment.[80]

Lawyers acting for the plaintiffs in the class action, Angela Sdrinis Legal, told us that they act for more than 150 clients who allege abuse at Ashley Youth Detention Centre and Ashley Home for Boys, some of whom are not part of the class action.[81] In a submission to our Commission of Inquiry, Angela Sdrinis Legal told us that these clients' complaints relate to:

- sexual abuse spanning more than 40 years, with many of the same abusers (detainees or employees) committing repeated abuse against numerous children throughout their time at Ashley Youth Detention Centre[82]
- an extensive range of abuse, including rape (54 clients), grooming (11 clients), oral rape (nine clients), object rape (10 clients), forced sexual acts between children (two clients) and contact abuse[83]
- many instances of physical and mental abuse that accompanied the sexual abuse, such as extended periods of isolation and regular beatings[84]
- staff manipulating children into performing sexual acts on each other or on guards, sometimes through threats of physical violence or denial of certain privileges such as personal visits, or to avoid isolation[85]
- staff encouraging children to take part in abuse through perceived rewards or treats, such as cigarettes.[86]

2.7 Direct reports to the Department

As well as civil claims, and claims raised through the redress schemes, the Department also receives complaints and allegations directly from young people who are (or were) detained at Ashley Youth Detention Centre, staff and others with knowledge of alleged misconduct at the Centre. For example, the Department told us that it had received complaints from the then Tasmanian Greens Leader Cassy O'Connor MP in December 2020 and a member of the public in August 2020, as well as referrals from Crime Stoppers reports.[87] The Department may also be alerted to complaints through reports by the Ombudsman, Custodial Inspector and Commissioner for Children and Young People.

In response to our notice to produce, the Department told us the following about complaints (in addition to allegations raised through civil claims and redress schemes) of child sexual abuse by Ashley Youth Detention Centre staff during the period 1 January 2000 to 20 July 2021:

- Several complaints about incidents alleged to have occurred between 2007 and 2016 were physically stored in a filing cabinet at Ashley Youth Detention Centre. Of the approximately 200 complaints the Department reviewed:
    - 10 related to allegations or incidents of child sexual abuse[88]
    - of these 10 complaints, at least six of the allegations were against staff members[89]
    - the allegations include staff members inappropriately touching detainees (including during strip searches), making sexual comments and walking in on a detainee while they were in the shower.[90]
- Another complaint was made to the Department's Client Liaison Officer in January 2021. The detainee alleged that during the period from 2015 to 2016 they were forcibly strip searched and, on a separate occasion, assaulted.[91]

It is not clear to us if any of these complaints relate to staff still working at the Centre.

We also discuss in Case studies 5 and 7 a report in 2020 made by staff member Alysha (a pseudonym) about multiple concerns about the Centre, including allegations of child sexual abuse and staff management of harmful sexual behaviours.[92]

2.8 Observations across data

It is difficult to put a specific number to the allegations of child sexual abuse at Ashley Youth Detention Centre received by the Department. Nevertheless, there have been hundreds of allegations over the years.

Based on the material discussed above, we consider it is likely the Department of Health and Human Services knew of serious allegations of abuse against current staff working at Ashley Youth Detention Centre from at least 2006 when the second phase of the Abuse in State Care Program ended, if not from 2003. By 2006, there were 149 claims involving Ashley Youth Detention Centre or Ashley Home for Boys. As discussed below, staff at the Centre had been relatively stable and many staff moved from Ashley Home for Boys to Ashley Youth Detention Centre in 2000. We discuss the Department's knowledge of allegations of abuse through this program in Case study 7.

3 First-hand accounts of abuse at Ashley Youth Detention Centre

In this section, we summarise the accounts of nine victim-survivors of Ashley Youth Detention Centre and two family members of victim-survivors.

As noted earlier, it was not possible for our Commission of Inquiry to test the veracity of all allegations of abuse, but we identified many common themes in the accounts we heard. We have included these accounts so the Tasmanian Government and the Tasmanian community can get a better sense of the extent and nature of the abuse that has occurred at Ashley Youth Detention Centre as safeguarding reforms are considered and implemented.

The accounts below speak to the circumstances of victim-survivors' residency at the Centre, the alleged abuse that victim-survivors suffered, their attempts and attempts by their family members to report the abuse, the impact the alleged abuse continues to have on them, and the changes they would like to see so other children and young people in detention do not have to experience similar trauma.

Most names used in the following case examples are pseudonyms. The case examples present the accounts of victim-survivors or those of their family members.

3.1 Case example: Ben

3.1.1 Before Ashley Youth Detention Centre

Ben's (a pseudonym) early life was unsettled.[93] His parents separated when he was very young and his father died before Ben was 10 years old.[94] Ben moved in with his mother's new family and he began misbehaving, skipping school, stealing and using drugs.[95] He then ran away from home and was exposed to more serious drugs and crime.[96]

3.1.2 Admissions to Ashley Youth Detention Centre

Ben was 11 years old when he was first detained at Ashley Youth Detention Centre in the early 2000s.[97] He was charged with property offences and he refused to be bailed to his mother's address.[98] With no other address for bail, Ben was sent to Ashley Youth Detention Centre on remand.[99]

Ben described to us his experience of being admitted to the Centre. He recalled that after a three-day period of isolation and observation:

> I was made to strip naked and face a wall with my hands above my head, legs apart. One of these men [a staff member] started to roughly smother some lice cream of some kind up my bum crack all over my bum between my legs and all

> over my genitals and surrounding area, as another one of them done the same to my underarms and my head. I was made to stand there for 5–10 minutes it was really painful and burning me. I complained but was told I'd have it left on there longer if I didn't shut up. Upon the completion of my intake assessment I was taken to my cell/room where I would stay for several long very traumatic weeks.[100]

Ben spent the rest of his childhood, until the late 2000s, in and out of the Centre.[101] From his first admission to when he was aged 18, the longest period Ben spent outside detention was about five months.[102] Ben recalled that he spent most of his time at the Centre on remand.[103] He explained that, most of the time, he was remanded for crimes for which he was eventually acquitted.[104]

3.1.3 Alleged harmful sexual behaviours at Ashley Youth Detention Centre

Ben said that during his first admission he 'witnessed the most violence [he had] ever seen in [his] life'.[105] Ben told us that his first experience of sexual abuse at the Centre happened immediately after his first admission.[106] Ben recalled he was placed in a unit with six much older boys, four of whom physically and sexually abused him.[107] Ben said that after a few weeks, he was moved to a unit with other 'young and vulnerable detainees'.[108]

Ben said that he was physically and sexually abused by older boys at the Centre several times during his admissions.[109] He recalled that this abuse occurred 'every day' during his first admission.[110] Ben said that younger detainees were vulnerable to older male detainees, some of whom were 21 years of age.[111]

Ben told us that he was hospitalised on several occasions during his time at the Centre, including for an injury suffered during an episode of violent sexual abuse by an older boy.[112] He said that some members of staff at the Centre would, on occasion, incite and reward young people for abusing or humiliating other (usually younger or smaller) detainees.[113] Ben told us that young people were encouraged by staff to 'smack their mates' and were offered cigarettes as rewards.[114]

Ben said that he soon learned that the abuse at the hands of older boys 'would be nothing compared to what several of the officers would come to do to me'.[115]

3.1.4 Allegations of abuse by Ashley Youth Detention Centre staff

Ben told us that he and other young people were physically and sexually abused by staff on numerous occasions. He said these incidents often occurred during activities that took place away from Ashley Youth Detention Centre.[116] He told us that these activities were made available to young people as a reward for good behaviour.[117] Ben believed that design changes to the Centre in the early 2000s meant that sexual abuse was more likely to take place away from the Centre's premises.[118] He soon realised that participating in excursions made him more vulnerable to abuse.[119]

Ben recalled one occasion when a staff member violently sexually abused him and two other young people from the Centre during an off-premises activity.[120] The three boys were not yet teenagers.[121] Ben remembered crying in the backseat of the car on the way back to the Centre. He said that the staff member threatened to hurt the boys again if they did not stop crying or if they told anyone what had happened.[122]

After this incident, Ben said he was too scared to be taken off the Centre's premises and would try to avoid these activities. Ben said it was 'hit and miss [whether] we would be abused or not'.[123] Ben explained that missing an outing often meant being left locked inside all day because there were not enough staff left to supervise the young people who stayed on site.[124]

Ben also recalled a multiday camping excursion during which he was sexually, physically and emotionally abused at least once a day.[125] Ben said he was raped three times on this excursion by an Ashley Youth Detention Centre staff member, Stan (a pseudonym). Ben told us that he knew of at least one other young person who was abused on that trip as well.[126] We discuss the Department's response to allegations raised against Stan in Case study 7.

Ben described the effect of the alleged abuse on him:

> By the end of the trip … me and [my friend] were broken. The trip had destroyed us mentally! All we had been enduring had finally caught up to us on this trip that was supposed to be fun and exciting. Once we got back to Ashley everything was harder. I began to do poorly at school and art and all of the other programs run at Ashley. Slowly I started to notice drastic changes in my beliefs, my thoughts, my actions and my behaviour overall—at [this young age] I felt nasty, I felt like violence was the answer to everything and that rage and anger were normal, that flying off the handle over everything was OK.[127]

Ben said that as his behaviour escalated, he was regularly in trouble at the Centre.[128] He told us he was often restrained by staff and that they targeted him for further abuse.[129] Ben believed that some Ashley Youth Detention Centre staff were not 'adequately assessed or screened' for the work, which sometimes involved dealing with the young people's aggressive and violent behaviours.[130] He said that maintenance staff were sometimes called in to resolve incidents and restrain young people.[131] Ben also recalled regular violent abuse by three staff members in particular, which twice resulted in broken bones and other serious injuries to Ben and other young people.[132]

Ben said that the 'sheer scale and volume of sexual and physical acts committed upon [him at Ashley Youth Detention Centre] is astonishing and devastating', so much so it is a 'blur'.[133] He said that the abuse pushed him into a 'dark place'.[134] He recounted an incident where he and two other young people attempted to die by suicide by breaking into a medication cabinet at Ashley Youth Detention Centre and taking the medication they found.[135] Ben said that the incident resulted in a two-hour stand-off with staff, after which the boys were stripped naked, beaten and put into isolation:[136]

> We [were] locked down on 23-hour-a-day lockdowns for weeks on end. Every couple of days we would be belted for the standoff in [the] office and [to] scare us into mercy and [to] never do it again. … I would be on and off the [behaviour management program] all the time … when they would lock us down for 23 hours a day in our cells with one book, one pen and pad, a mattress and bedding.[137]

Ben also recalled a violent beating after an escape attempt, during which he was stripped naked, handcuffed behind his back and had his feet cuffed together.[138] He told us that he was left handcuffed and unable to move off the floor for about five hours, before being placed in lockdown for another three weeks.[139]

Ben was transferred to an adult remand centre in his late teens, where he said he was placed with violent offenders and sex offenders.[140] Ben told us that he continued to suffer physical and sexual abuse there.[141]

3.1.5 Reporting allegations of abuse at Ashley Youth Detention Centre

During his first admission to Ashley Youth Detention Centre, Ben reported the physical and sexual abuse he said he experienced from other young people in detention to staff.[142] Ben said that, in response, he was restrained, taken to an observation cell and stripped naked by senior staff.[143] He recalled that staff members told him that 'if [he] had to suck dick to survive then [he] shouldn't steal tax payers' cars'.[144] Ben said he learned very quickly to keep his mouth shut.[145]

Ben recalled that after he was hospitalised following an episode of violent sexual abuse, it appeared some steps were taken at Ashley Youth Detention Centre to separate the younger, more vulnerable boys from the older boys.[146] He said this involved placing the younger detainees in makeshift container accommodation, where they had to use buckets as toilets.[147] Ben told us that, eventually, young people charged with sexual offences were placed with these younger detainees and the abuse resumed.[148]

Ben described how he and another young person at Ashley Youth Detention Centre made complaints against two staff members.[149] Police investigations began, but Ben and his friend withdrew their complaints because they feared reprisals.[150] Consequently, these staff members returned to work at Ashley Youth Detention Centre.[151] Ben said that soon after this incident, he suffered a medical event, and doctors ordered that he not be moved due to the significant pain he was in.[152] He said that an hour after that medical advice was given, staff at the Centre and police forced Ben into a car so he could attend a meeting at the local police station.[153]

Ben also recalled instances where privileges were taken away from him when he complained about staff members and that favours were granted when he withdrew his complaints.[154] He told us that people external to the Centre visited every four to six weeks to check on the young people.[155] Ben said he was never asked by these visitors if he was being mistreated and that, even if he had been asked, he knew better than to say anything when he was being observed by Ashley Youth Detention Centre staff.[156]

In addition to his fear of repercussions, Ben also believed that the culture at Ashley Youth Detention Centre among young people discouraged reporting abuse.[157] He said:

> I … wanted to be a criminal, and making complaints is not what criminals do. In a way we wanted to be like the people that were abusing us. We wanted to be big and tough. We believed that we only had one way out and that way was violence. There was also no CCTV cameras, so nothing that happened was recorded.[158]

Ben said that staff saw the young people detained at Ashley Youth Detention Centre as 'the scum of society' and that they normalised violence and abuse against young people.[159] He described watching as new staff were absorbed into this system:

> … there was the perception that any staff who didn't follow these rules would not have a job. On countless occasions I witnessed staff new to Ashley be ridiculed by long term staff because they did not join in on restraints. These new staff would quit or get kicked out for not toeing the line. In my opinion they were the sort of people that should have been employed at Ashley. They could have made a difference if they weren't continually pushed out.[160]

In Ben's view, operational leaders of the units wielded the most power over the young people at the Centre.[161] He felt that young people had little access or recourse to Ashley Youth Detention Centre management.[162]

3.1.6 After Ashley Youth Detention Centre

As an adult, Ben said he was approached by representatives of the Abuse in State Care Program.[163] He was told that making a claim would be trauma-informed and that his best interests would be prioritised throughout the process.[164] Ben recounted some of the abuse he suffered while at the Centre to these representatives.[165] A few days later, Ben told us that he was informed that there had been a mistake and that he was ineligible for the program.[166] He was 'shattered'. He added:[167]

> While I don't think they did it on purpose, they should have followed up after this monumental mistake. I felt so worthless, confused, and suicidal after this meeting. To me it was like … there was nothing anyone could do about the horrific sexual and physical abuse I had suffered. This was devastating and has consumed my mind, my thoughts, and my feelings until now. I'd come so far and this [brought] me back so much. It wrecked me.[168]

Ben further recounted that, a few years later, he was visited by lawyers in relation to the National Redress Scheme.[169] He said he was wary about talking to these lawyers because of his experience with the Abuse in State Care Program and that he asked them how they knew he and others had been at Ashley Youth Detention Centre.[170]

Ben is now bringing a civil claim against the State for the abuse he suffered at Ashley Youth Detention Centre.[171] He is frustrated by how long the process is taking:

> The length of time that the process has taken makes me feel betrayed and worthless, and I am starting to question the legitimacy of the process and whether it is worth it for me. … [The Government] are dragging their feet as much as they can. I personally feel like they are weighing up my longevity. They hope that I die of an overdose, die of murder, die in prison – because I chose to go the civil route. I know they won't want to give me a cent. They see it that I've already cost the state money. It doesn't matter what happened to me as a child, it only matters what I have done since then … The process of trying to seek compensation has eaten me up from the inside.[172]

3.1.7 Improving youth detention

Ben wants the Government to acknowledge that it allowed the wrong people to work at Ashley Youth Detention Centre.[173] He wants the Government to ensure people like those who abused him are never employed in institutions like the Centre again.[174] Ben considers that greater scrutiny of youth detention staff is required.[175] In his view, a National Police Check or registration to work with vulnerable people is not enough.[176] He also believes that greater care should be taken when placing young people together in detention to ensure they do not pose a risk of harm to each other.[177]

Ben thinks that more community supports would have prevented him from falling into a life of crime, and that these supports are critical for other youth in crisis and to prevent youth detention.[178] Ben also thinks there is a need for more residential facilities for struggling young people.[179] In his experience, existing residential facilities are wary of taking on young people with a history of violence, mental illness or drug use, which has led to the most vulnerable children ending up back in the community without support, destined to return to Ashley Youth Detention Centre.[180]

3.2 Case example: Eve

3.2.1 Before Ashley Youth Detention Centre

Eve's son Norman (both pseudonyms) had struggled with significant mental health issues from the age of 13, for which he was prescribed medication.[181] Before Norman experienced mental health issues, Eve recalled that Norman was a 'nice, happy, great kid, everyone loved him, got along well with everybody in the community'.[182] After his mental health issues presented, Norman began 'hanging out with a really bad group of people and he made a bad decision' that resulted in criminal charges and a sentence to be served at Ashley Youth Detention Centre.[183]

Norman was admitted to Ashley Youth Detention Centre in the early 2010s when he was 17 years old.[184]

3.2.2 Admission to Ashley Youth Detention Centre

When Norman was first remanded at the Launceston Remand Centre (now Launceston Reception Prison), staff refused to accept Norman's medication from Eve.[185] Eve was told that any medications that Norman required would be provided at Ashley Youth Detention Centre.[186] Norman was transferred to Ashley Youth Detention Centre the next day. When Eve called to ask if Norman had received his medication, staff told her they did not have any medication at the Centre and that Norman would have to wait until after the weekend to see the doctor.[187] On Monday, Eve drove from Hobart to Ashley Youth Detention Centre to supply Norman's medication herself.[188]

Although staff eventually gave Norman his medication, Eve said they questioned Norman's mental health diagnosis and the dosage of his medication. She said they gave him a lower dose than his doctor had prescribed.[189] Staff told Eve that an Ashley Youth Detention Centre psychiatrist would have to review the dosage.[190] Eve also recalled being told that the psychiatrist visited the Centre from the mainland every six weeks.[191] She said that it was impossible for Norman to get an appointment with a psychologist at the Centre, and the Centre refused her attempts to get him access to a local psychologist on the basis that he was under state care.[192] She could not recall how long Norman went without receiving his prescribed dosage of medication.[193]

Eve told us that she advocated for her son through every channel at her disposal. She had her doctor write to the Centre regarding her concerns about Norman's mental illness and wellbeing.[194] She also had the Shadow Minister for Children write to the Minister for Children about Norman's history and her concerns.[195] Further, she contacted the Minister directly but did not receive a response.[196] Eve said she also engaged with Ashley Youth Detention Centre staff but did not find them helpful. She said they would block her attempts to get information about Norman's situation or to help Norman.[197] Where she raised concerns about Norman's welfare, the response was to put Norman on suicide watch in a small cell with observations every three minutes.[198]

Eve said she worried that her advocacy for Norman only made things worse for him:

> If [Norman] rang and told me things, I continued to call Ashley and let them know I had fears for his safety. The outcome of this would be that they would put [Norman] back on three-minute observations. It became a deterrent for him to tell me things. Every time I rang there would be repercussions for him.
>
> Over time the phone calls between [Norman] and I became less frequent and [Norman] stopped telling me things. In the end he said, 'please mum, stop'. My advocating for [Norman] meant there were repercussions for him. He wouldn't even tell me how he was feeling anymore.[199]

Eve initially visited Norman at the Centre every two weeks.[200] However, Norman asked her to stop visiting because, as she learned later, he would have to endure 'cruel' strip searches after each visit:[201]

> So, when I would go and visit, it's a little bit upsetting for a parent to know that, just for a child to come visit its mother in a room, that the guards are going to fossick through their anus and their genitals on their way back out. It wouldn't be something that most people would want to have to happen, and it was—it did feel awful knowing that that did happen every time I visited him, but it wasn't until later on that I found out that there was a lot of bastardisation going on during these searches, I won't go into details, but it was enough to make him not want me to visit anymore.[202]

During Norman's time at Ashley Youth Detention Centre, a detainee died in custody. Eve said Norman heard the detainee being sick in a nearby cell and begging for help, but staff did not assist.[203] Norman told Eve that the other kids heard the detainee whimpering in bed during the night and then the noise stopped.[204] After not showing up for breakfast, the detainee was found dead. Eve said Norman felt really unsafe and was afraid that this sort of thing could happen to him as well.[205] Eve reflected that:

> It really affected him. I remember him distressed on the phone. When you're 17, and you hear a friend die, it's going to affect you for the rest of your life. Despite this, none of the kids got proper counselling.[206]

3.2.3 After Ashley Youth Detention Centre

Eve described her son before he went to Ashley Youth Detention Centre as 'saveable'.[207] She said: 'He was a child that still could have been turned around and had a future, but they changed that and his future's been pretty awful'.[208]

Eve believes that nothing was done at Ashley Youth Detention Centre to help Norman to address his behaviour and that he 'came out ten times worse than he went in'.[209] She said that:

> When he came out, he was a different kid. He wasn't coping. He wasn't acting like himself. He was very angry. He wouldn't speak. There was no happiness in him. He wouldn't tell me what was wrong, but it was clear he was really traumatised.[210]

Eve said that Norman had a lot of bad experiences at Ashley Youth Detention Centre that he does not want to tell her about because he knows how much it will affect her and he doesn't want her to worry about it forever.[211]

Recently, Eve went through the right to information process to try and learn more about Norman's time at the Centre. She believes the records she received show the unwillingness of staff at the time to give her information or constructively address Norman's behaviours. She said the records focus on punishing Norman and satisfying the public perception that young people in youth detention should be treated as 'criminals'.[212]

Eve told us that Norman has recently started engaging with the Sexual Assault Support Service and was talking to them about what happened to him at Ashley Youth Detention Centre more than a decade ago.[213]

3.2.4 Improving youth detention

Eve believes that the detention of young people should be therapeutic rather than focusing on punishment.[214] She stated that Norman's behaviour worsened due to a lack of alternative support for young people with mental health issues and the fact that non-violent young people were detained together with violent young people.[215] She said: 'There needs to be a better way of dealing with children than just destroying them in detention'.[216]

Eve also feels the location of Ashley Youth Detention Centre, a three-hour drive from Hobart, is an issue and that there should be facilities in the north and south of Tasmania so children in detention can stay connected to their families.[217] She told us:

> As a mother that wanted to stay involved and advocate for [Norman], they cut me off. It's detrimental to children to separate them from their families when they are trying to rehabilitate. Family support when they are released from detention is critical.[218]

3.3 Case example: Max

3.3.1 Alleged harmful sexual behaviours at Ashley Youth Detention Centre

Max (a pseudonym) was detained at Ashley Youth Detention Centre from the late 2010s to 2021. He was 12 years old when first detained and, at the time, he was the youngest person in his unit.[219] Max told us that, barely an hour after arriving at his unit, he became the target of bullying by other young people in detention.[220] Max said he asked staff if he could be moved elsewhere because he felt unsafe, but they responded: 'If you don't like coming here, then don't do the crime'.[221] To keep himself safe, Max 'locked [himself] down' in his cell until he was released on bail a few days later.[222]

Max returned to the Centre for breaching his bail conditions.[223] Soon after arriving, Max was placed in a unit with three boys who were much older than him, including Floyd (a pseudonym), who Max knew from the community.[224] As soon as Max found out that Floyd was in the unit, he told staff that he was not safe there and would likely be 'bashed'.[225] Max told us that staff refused to move him, saying he 'had no choice'.[226]

Max said that on the same day, Floyd verbally threatened Max.[227] Max recalled that a staff member, Alan (a pseudonym), was present when Max was threatened, but Alan left the room and sat in the office, watching the boys through a window.[228] Max recalled feeling as though Alan 'had purposely walked away from us'.[229] As soon as Alan left the room, Max was assaulted by Floyd and another boy, Ned (a pseudonym), when Max refused to perform oral sex on Floyd.[230] Alan yelled at the boys to stop fighting but did not physically intervene until other staff arrived to assist.[231]

Max was angry and upset that staff had not listened to his concerns about being placed in a unit with Floyd. He said:

> I was bleeding from the nose. I started saying to the youth workers, 'I told you this would happen'. They just ignored me and didn't say anything. The thing that really pissed me off was that I told all of the youth workers that it was going to happen but they didn't listen to me. [Alan] heard [Floyd] threaten me. They should have been more aware.[232]

Max refused to press charges against Floyd or Ned for the assault because he thought it was a 'dog thing to do'.[233] He also felt it would just make life harder for him at the Centre and put his family at risk because the boys knew where his mother lived.[234] Max said he was aware that the Centre's management took steps to charge other young people for assaults committed at the Centre, and he does not know why this didn't happen in his case.[235] Instead, Max recalled that as punishment, Ned was dropped a 'colour rating' in the Centre's behaviour management program.[236]

Max was moved to another unit, again with boys who were bigger and stronger than him.[237] He said he was picked on because he had got the boys from the previous unit in trouble.[238] Max told us that on one occasion, a boy, Arlo (a pseudonym), tried to insert a table tennis bat into Max's anus.[239] Max said that the staff at the Centre were aware of the incident and dropped Arlo's colour rating in the behaviour management program, but they did not take any other steps to keep Max safe.[240] Eventually, Max was moved to another unit when he refused to go to bed at the same time as the other boys in the unit.[241]

On a later admission to the Centre, when Max was still aged under 15, he was again placed in a unit with Floyd.[242] Fearful, Max asked the staff why he was being placed with Floyd after what had happened; he was told he was 'exaggerating' and that there were no other units available.[243] Max told us that staff threatened to put him into isolation if he did not calm down.[244] Max said that Floyd apologised for what had happened previously, but Max was still afraid.[245] He recalled:

> … I was still scared and thought it was only a matter of time before something else serious happened to me. I don't understand how they could put me back in a unit with someone who nearly raped me. The youth workers knew about it but they weren't even concerned about it.[246]

Desperate to be moved, Max said he intentionally damaged the roof of his cell and was transferred to another unit the next day.[247]

3.3.2 Alleged abuse by Ashley Youth Detention Centre staff

Max recalled that, as he got older, the abuse and assaults by other young people at the Centre stopped, but the frequency of physical and sexual abuse by staff increased.[248]

Max said that the lack of surveillance cameras was a big problem at the Centre and that staff knew how to exploit the 'black spots'.[249] He said that: 'Nine times out of 10 [those black spots are] where everything happens'.[250] He said staff would regularly take young people to these places to 'belt' them, or threatened to do so if the young people did not behave.[251] On one occasion, in the early 2020s, Max recalled being assaulted by staff on a construction site on the Centre's property—Max believes that this was a deliberate attempt to avoid the assault being caught on surveillance cameras.[252]

Max had been told to 'talk before you use actions' to help regulate his behaviour, but, in his experience, Centre staff often did not listen.[253] He recalled one occasion where he had been sent to his room after assaulting a teacher.[254] A staff member asked him what the problem was, to which Max replied that he did not want to talk about it and said that if the staff member did not leave the room Max would hit him.[255] Max told us that the staff member did not leave and Max started towards him, at which point Max was tackled by two other staff who had been outside the room.[256] Max explained that he knew assaulting a staff member was wrong, but he thought the incident could have been avoided if they had listened to him:[257]

> … the way they always say, like, if you've got something, they say talk about it with case management; they say, 'talk about stuff before you do something, like, just try and talk about it, talk before you use actions', so I tried it and it just didn't work, like. So, there was nothing else for me to do.[258]

Eventually, Max felt that the only way he could keep himself safe was to be moved out of the Centre.[259] He continued to act out, including assaulting staff, until he was sent elsewhere in his late teens.[260]

Max said that he was forcibly strip searched by at least three or four staff members in his cell, where there were no cameras.[261] He recalled that on at least two occasions a staff member inserted a finger into Max's anus.[262] On one occasion, he told us that staff handled his genitals and searched between his buttocks.[263]

Max remembered another incident when he was dragged to his room following a stand-off with staff. Max told us that when he refused to be strip searched, staff responded that they could 'do whatever the fuck [they] want'.[264] Max said that none of the other detainees involved in the stand-off were strip searched.[265] He further recalled that, after another incident, staff members ripped his clothes off and started searching him, after which they threw him to the ground and then left him in his cell.[266] Max said he 'felt disgusting after what [the staff] did' and that it made him 'feel like shit knowing that [he] had no power over anything'.[267]

On another occasion, Max recalled that he and another young person were strip searched by Alan and other staff in the breezeway, after they had been caught with cigarettes and drugs.[268] Max told us that he lashed out during the search, at which point Alan punched Max, reminding him that 'there are no cameras up here' in the breezeway, and that 'no one knows what happens up there'.[269]

Max observed that new staff members would quickly adapt to the culture at Ashley Youth Detention Centre.[270] He explained that new staff often started off well, acting nicely towards the young people and not assaulting them, but after a year or so they would 'normally turn into the same as the other ones'.[271]

3.3.3 Reporting allegations of abuse at Ashley Youth Detention Centre

A couple of years after his first admission to Ashley Youth Detention Centre, Max began to engage with the Commissioner for Children and Young People.[272] At first, Max did not want to speak to the Commissioner because he thought it was a 'dog thing to do', but he was encouraged when he saw other young people doing it.[273] Max said that Ashley Youth Detention Centre staff did not like the people in detention speaking to the Commissioner and that, once he started doing this, the staff began treating him even more poorly and made it 'obvious' that they were punishing him.[274] He said that staff thought that by speaking to the Commissioner for Children and Young People, the young people were 'trying to get [them] in trouble'.[275]

Max explained that he did not report the abuse by other young people in detention and staff members at the Centre because he thought that no one would believe him. He recalled that a staff member had told him that making a report to the Commissioner was no use because 'no one will believe you'.[276] Max said that without surveillance footage, he had little hope:

> Because there were no cameras, it was just my word against all of the youth workers. When there are three or four youth workers against one resident, people are always going to believe the youth workers. I'm a criminal and they're government. Everyone is going to believe them. They will just see it as a kid crying wolf.[277]

Max told us he was also scared of the staff at the Centre and how they would react if he were to complain. He felt that the close relationships between staff members meant that they would share information or support one another.[278] He felt that even telling people outside the Centre, including his Youth Justice worker or his lawyer, might result in information getting back to youth detention centre staff.[279] He explained:

> The staff at Ashley are all like family to each other. They all know each other from the outside. They aren't just like work colleagues. They are family and friends or in relationships. That's why you can't tell anyone about another staff member. It always gets back to them and it just ends up worse in the end.[280]

Today, Max thinks that failing to complain about what other young people in detention and staff members did to him made him a target:

> It was like they saw that I wasn't going to be a dog, so they could do these things to me. I look back now and think that I should have done more about it so all of these things would have stopped. I should have told someone. At the time I felt like if I did tell someone I would have been treated even worse.[281]

More recently, Max has told the Commissioner for Children and Young People about his treatment at Ashley Youth Detention Centre and his view of the way staff at the Centre responded to his contact with our Commission of Inquiry. We discuss Max's complaint in Case study 6.

3.3.4 Improving youth detention

Max felt that he 'should have [had] the right to complain' when he was at the Centre, rather than be made to feel as though no one would take him seriously or that he would be harmed if he did so.[282] He thinks that the complaints of young people in detention 'need to be taken seriously' and that more needs to be done to ensure problems are addressed before something serious happens or before it is too late.[283]

Max thinks that if Ashley Youth Detention Centre is replaced, there must be an entirely new workforce employed.[284] He commented: 'You can open a thousand centres but if you keep the same staff there the same stuff is going to happen'.[285]

Max hopes that there will be cameras everywhere in any youth detention centre that replaces Ashley Youth Detention Centre.[286]

3.4 Case example: Warren

3.4.1 Before Ashley Youth Detention Centre

Warren (a pseudonym) told us that, from a young age, he was regularly physically abused by his mother, who struggled to care for him after he was diagnosed with attention-deficit/hyperactivity disorder (ADHD).[287] Warren was taken from his mother's care and made a ward of the State before he was 10 years old.[288] He was placed with numerous foster families and would steal or run away from them in the hope that he would be sent home.[289]

3.4.2 Admissions to Ashley Youth Detention Centre

Warren was first admitted to Ashley Youth Detention Centre in the mid-2000s when he was 13 years old.[290] He was charged with theft and assault while on bail for other offences and was remanded to the Centre for four months.[291] Warren said he was detained at the Centre about 21 times in the 2000s, usually for a couple of months at a time.[292] The longest period he was at the Centre was for about a year, from just before he turned 18 until he was almost 19.[293] Warren's detentions at the Centre were about evenly split between him being on remand and under sentence.[294]

3.4.3 Alleged abuse by Ashley Youth Detention Centre staff

Warren said that initially he did not think the conditions at the Centre were too bad.[295] He said he got along with some of the staff really well and that they would treat him like a human being, rather than just a criminal, and try to help him out and keep him out of trouble.[296] Warren said he also learned how to read and write at the school at Ashley Youth Detention Centre and had the opportunity to learn life skills such as woodworking and being a barista.[297]

Warren also said that some staff would 'bring their bad mood to work' and would be 'physical' with the detainees who they did not like.[298] There was also some violence among the young people detained.[299] Warren said he tried to 'keep out of stuff' by staying in his room a lot and avoiding interactions with other people.[300]

Warren said he was sexually abused at the Centre for the first time when he was 14 years old.[301] He recalled that it happened during his second admission while he was being searched.[302] He told us that strip searches, usually conducted by two staff, were 'degrading and abusive'.[303] Warren said he was forced to strip naked in front of staff and to bend over so they could check for contraband, despite this being contrary to the procedure at the time, which stated that a person in detention only had to expose the top or the bottom half of their body at a time.[304]

Warren said that, starting from his third admission when he was 15 years old, he was abused in his room.[305] He said that three staff members, while giving him medication, forced him to masturbate in front of them.[306] Warren said that the staff would also force him to touch their penises with his hands and perform oral sex on them.[307] Warren also said he was anally raped more than 20 times by one of the staff while other staff members restrained him.[308] He said that the staff would withhold his medication unless he performed sexual acts on them.[309] Warren was supposed to take his medication in the morning and at night. He told us that the sexual abuse would often occur in the morning, and Warren would be required to perform sexual acts on the staff or on himself while they watched, before they would give him his medication.[310] He recalled that such abuse happened to him more than 50 times during his time at Ashley Youth Detention Centre.[311] He also told us that if he did not submit to sexual acts, 'the guards would arrange for my family to be hurt' or that they would 'arrange for older and bigger inmates to bash me'.[312]

Warren said that staff would also physically abuse him by pinning his arms behind his back, hurting his shoulders and ramming his head against the walls.[313]

He said that the staff who abused him were consistently on the same shifts, working together.[314] Warren recalled that the abuse continued throughout his admissions to the Centre until after he turned 18.[315]

Warren said he did not tell anyone what was happening to him at the time.[316] He said that the staff threatened to tell other young people in detention that Warren was informing on them if he disclosed the abuse. He said they also made threats against his family to prevent him from disclosing the abuse.[317]

Warren recalled: 'They would tell me that no one would believe me anyway because I was just a little criminal. I didn't want to say anything because I was afraid of what they could do'.[318]

Warren stated that nobody ever really complained at Ashley Youth Detention Centre because the staff would receive the complaints and tell each other about them.[319] At the time, he did not know of anyone outside the Centre to whom he could complain.[320]

3.4.4 After Ashley Youth Detention Centre

Warren said that since leaving the Centre he has had 'very few achievements' in his life and has struggled with drug use and mental health issues.[321] Warren has also been in and out of prison and has attempted suicide.[322] He said that many of his problems were exacerbated by the abuse he experienced at the Centre.[323]

He said he was almost 30 years old before he began to discuss his experiences at Ashley Youth Detention Centre with his family. He said he has recently engaged with the redress process and counselling, which he has found helpful.[324]

In relation to the impact of his abuse at Ashley Youth Detention Centre, Warren said: 'I have a hard time trusting people. This makes it really hard for me to keep relationships and friendships. I tend to keep to myself and distance myself from people'.[325]

3.4.5 Improving youth detention

Warren told us that many incidents of abuse at Ashley Youth Detention Centre happened in areas that were not covered by closed-circuit television cameras.[326] He thinks that the Centre, or any facility that replaces it, needs more cameras.[327]

Warren also said that the staff need to treat young people in detention better, be better trained and not take their problems out on the people in detention.[328] He said that he never had the same problems with staff in adult prisons that he had with staff at Ashley Youth Detention Centre.[329]

Warren said there needs to be a safe way for young people in the Centre to make complaints, including having someone to speak with who visits from outside the Centre.[330]

3.5 Case example: Charlotte

3.5.1 Before Ashley Youth Detention Centre

Charlotte (a pseudonym) was 12 years old when she first arrived at Ashley Youth Detention Centre in the early 2000s.[331] At the time, Charlotte's family was 'very broken'.[332] Her parents were in jail and Charlotte was living with their friends.[333] Feeling abandoned and alone, Charlotte began running away and fell in with the wrong crowd.[334] She started shoplifting and stealing cars.[335]

3.5.2 Alleged abuse by Ashley Youth Detention Centre staff

Charlotte described her first admission to Ashley Youth Detention Centre as 'the worst time of my life'.[336]

During her first admission, Charlotte said she encountered a staff member, Edwin (a pseudonym), whom she knew from the community.[337] Charlotte described Edwin as 'very sleazy'.[338] She told us that he would often touch her legs under the table and watch her while she showered.[339] Edwin told Charlotte how pretty she was and that he would 'love it if [she] were a bit older'.[340] Charlotte said that Edwin's behaviour made her 'feel yuck' but that she was too scared to report him because she thought her father might hurt Edwin and be sent to jail again.[341] She was also concerned about what Edwin might do if she told anyone about his behaviour.[342]

Charlotte told us that another male staff member at Ashley Youth Detention Centre would also speak and act inappropriately towards her and a friend of hers, who was also in detention. Charlotte said that this staff member would be 'really sleazy, touching our breasts and stuff like that'.[343] She said that on one occasion, he wrote the words 'bite me' across her friend's chest.[344] A female staff member witnessed the incident and reported it.[345] Charlotte wanted to speak to the team leader at Ashley Youth Detention Centre about what had happened, but it was several days before she and her friend could. The team leader shrugged the matter off and responded that the male staff member was no longer at the Centre.[346] Charlotte told us she later found out that the staff member had not been fired. The staff member who had witnessed the assault confirmed to Charlotte that nothing had been done.[347] Charlotte said neither she nor her friend heard anything more about the matter from the Centre's management or the police.[348] Charlotte said she was hurt by the lack of response. She recalled: 'We went to tell someone what happened and nobody cared. We were only little kids'.[349]

Charlotte said that her first admission at Ashley Youth Detention Centre had a significant effect on her.[350] When she was released, Charlotte went to live with friends who had also been detained at the Centre.[351] She began using speed regularly and drinking heavily.[352] She was worried that Edwin would hurt her if she said anything about what had happened at Ashley Youth Detention Centre.[353]

When Charlotte returned to Ashley Youth Detention Centre a second time, Edwin's behaviour was much worse.[354] Charlotte recalled that, on several occasions, Edwin told her that he 'couldn't wait' to go offsite with Charlotte so he could 'do some good things to [her]'.[355]

Charlotte described Edwin as being 'very close' with the male detainees and said that he was known for turning a blind eye to their behaviour.[356] Charlotte recalled that Edwin would regularly bring in cannabis and cigarettes for young people in detention.[357]

On one occasion, Charlotte recalled that Edwin and other staff at the Centre left Charlotte unsupervised with several young people, including older boys.[358] This was not an isolated occurrence. Charlotte recalled that she was regularly left unsupervised with older boys for more than an hour at a time.[359] She told us that, on this occasion, she was sexually abused by an older boy.[360]

Charlotte felt unable to report the abuse because she was sure that friends of the older boy who assaulted her would harm her if she did.[361] Charlotte also felt that even if she did report it, nothing would be done because the young person was a long-term detainee and favoured by staff.[362] Charlotte also said that the staff member responsible for supervision at the time she was detained 'was known to turn a blind eye to pretty much anything'.[363] To keep herself safe, Charlotte isolated herself in her room and her unit.[364] She was depressed and regularly self-harmed.[365]

Charlotte told us she was sexually abused a second time by an older boy from the Centre during an excursion away from the premises.[366] These excursions were common near the end of a young person's sentence and often took place in very remote outdoor places.[367] On this occasion, Charlotte was the only girl in a group of six male young people and supervised only by Edwin.[368] Charlotte said she tried to scream when she was being abused, but no one came to help her.[369] Charlotte did not report the abuse. She explained:

> I just had to leave it like that because, if I said anything, [the older boy] would have got other girls in there to bash me that were in there, and if I said anything to Centre staff, obviously nothing was working anyway, so I just had to keep it to myself.[370]

Charlotte was in her mid to late teens when she was admitted to Ashley Youth Detention Centre a third time.[371] On one occasion during her third admission, staff locked Charlotte and other girls in their cells because they were misbehaving.[372] Staff demanded that Charlotte hand over a lighter that she had, threatening to strip search her if she did not hand it over.[373] Charlotte said she had been strip searched before and was scared about it happening again, so she set fire to her cell and cut her wrists.[374] The fire was ultimately extinguished by the building's sprinkler system.[375] Charlotte said that even though the staff could see her covered in blood in the shower (through a viewing panel in the door), they left her alone in her room for four days in her wet clothes, with no bedding and little food.[376]

Eventually, Charlotte was given new clothes and locked down for another week.[377] Upset and confused, Charlotte attempted suicide again.[378] Charlotte told us that a staff member came into her room after her suicide attempt and slammed her head against the bed base, cutting her scalp.[379] Charlotte told us the staff member said that Charlotte 'deserved it', that she was 'a little bitch that needed a flogging' and that she was 'making more paperwork' for the staff.[380]

3.5.3 After Ashley Youth Detention Centre

Charlotte said that, upon exiting the Centre after her third admission, she reported some of her experiences to her probation officer.[381] Charlotte left Tasmania soon after and, as far as she is aware, her reports were never addressed.[382]

Charlotte has struggled with anxiety, depression and drug use throughout her teenage years and adult life.[383] She is uncomfortable around men and often reacts with fear when somebody touches her.[384] Charlotte attributes these difficulties to the abuse she suffered at Ashley Youth Detention Centre. She explained:

> If it wasn't for how they treated me, I wouldn't be where I am today; using drugs to cover up how I feel and try to forget what happened.
>
> So many times, I've tried to kill myself because of what happened at Ashley. I have lost count.[385]

3.5.4 Improving youth detention

Charlotte thinks that more support should be available to children in detention, including giving young people access to somebody to speak to.[386] She feels that she received more support of this kind in adult prisons than she ever received as a 12-year-old at Ashley Youth Detention Centre.[387]

Charlotte thinks that more cultural support for Aboriginal children, like her, would have made a difference.[388]

Charlotte also noted the lack of educational support she received at Ashley Youth Detention Centre, stating that she still struggles to read and write.[389]

3.6 Case example: Fred

3.6.1 Before Ashley Youth Detention Centre

Fred (a pseudonym) told us he had a tumultuous childhood. He recalled that his father was abusive and physically assaulted Fred and his siblings.[390] Fred's parents separated before he was 10 years old, and he then spent several years moving around the country living with various family members.[391]

Fred had substance abuse issues from his early teens.[392] He told us that, when he was in his mid-teens, his stepfather took out a family violence order against him, and Fred had to move out of the house. Fred became homeless.[393]

3.6.2 Admissions to Ashley Youth Detention Centre

Fred was in his late teens when he was first admitted to Ashley Youth Detention Centre in the mid-2000s.

He was charged with stealing a car and remanded in custody because he was homeless and, therefore, could not give the court a fixed bail address.[394] Fred spent three months on remand in the Centre. He was then given bail and released for six months to an independent living placement organised by Ashley Youth Detention Centre.[395] Fred was eventually sentenced to serve another three months' detention on the same charges. Despite having turned 18 by this time, Fred was sent back to the Centre because he had been charged when he was a child.[396]

Fred was placed in the Franklin Unit at Ashley Youth Detention Centre, which he said housed the young people whom the staff had the most trouble controlling.[397] While Fred was not violent, he believes that he was housed in the Franklin Unit because he would 'push the guard's buttons'.[398]

3.6.3 Alleged abuse at Ashley Youth Detention Centre

Fred told us he was subjected to numerous strip searches on each of his admissions to Ashley Youth Detention Centre. For every strip search, Fred recalled that he had to strip completely naked. Fred told us that he was often restrained by staff during these searches and subjected to intrusive physical search techniques.[399] Fred recalled three or four staff holding him down, putting their knees on him, running their fingers along his buttocks and genitals, taking off his clothing and asking him to 'squat and cough' as part of searches.[400]

Fred described being strip searched when staff suspected that he had received drugs during a visit, although nothing was found.[401] Fred recalled that the staff began threatening him in an attempt to make him hand over the contraband and comply with the search, with one staff member saying, 'I know where your parents live' and 'we'll make your time harder'.[402] Fred said that the strip searches made him feel belittled and disgusting; he described them as 'harrowing'.[403]

Fred told us that violence between the young people at the Centre occurred daily in the Franklin Unit and that it was often encouraged by staff at the Centre, who did little to stop the fights that broke out.[404] Fred said that the young people in the Franklin Unit called the unit the 'gladiator pit' because it felt like the staff treated fights between them as a sport.[405] In Fred's experience, the Franklin Unit staff waited until a fight was almost over, or until there were more staff present, before taking any action to stop the fighting.[406]

Fred said that on at least two separate occasions he was violently abused by other young people while staff stood by and watched. He said staff then punished him, although he was the victim of the abuse, because he was 'an annoyance to the unit'.[407]

Fred told us he was also subjected to physical abuse by the staff. He said the staff, who were physically bigger than Fred and most other young people in the Centre, would hit Fred on the back of his head, push him and jump on him.[408] Fred recalled that once, when some young people from Fred's activity group escaped from the Centre, staff handcuffed him and screamed at him to 'interrogate' him for information about the other boys' whereabouts. He said this reminded him of interrogations shown in films.[409]

Fred told us he witnessed physical and sexual abuse perpetrated against other young people at the Centre. He said he saw a young person at the Centre being raped by another young person, a young person being bashed by other young people, and a staff member dragging a female young person naked from the shower by her hair before placing her on the ground and cuffing her.[410] Fred said that staff generally treated the young people in the Centre roughly, including the younger children who were detained.[411]

3.6.4 Reporting abuse by Ashley Youth Detention Centre staff

While he was at the Centre, Fred made two written complaints about the misconduct of staff. He said the process for making a written complaint was to ask for a complaint form, fill it out and then slide the complaint under his cell door for a passing staff member to collect.[412] Fred told us that neither of his complaints were acknowledged by Ashley Youth Detention Centre staff or gave rise to any follow-up action. Fred said that, after he slid the complaints under his door, he never saw nor heard about the complaints again.[413]

Fred said that he learned he should not speak out or complain because, if he did say something, staff and other young people at the Centre would 'come after him'.[414] Shortly after he made his second complaint, Fred was moved from Ashley Youth Detention Centre to Risdon Prison. Fred said that staff at the Centre told him that being sent to Risdon was his 18th birthday present.[415]

3.6.5 After Ashley Youth Detention Centre

The effect of the abuse Fred endured at Ashley Youth Detention Centre has been significant and ongoing. Fred said he suffers from poor mental health in the form of post-traumatic stress disorder, as well as panic attacks. He feels that his experiences caused him to lose trust in authority figures such as police, prison guards and alcohol and drug counsellors.[416] Fred believes that the physical and sexual abuse he and others suffered at Ashley Youth Detention Centre should not happen to any child:

> The things that happened to me at Ashley and the things I saw have affected my mental health. I have flashbacks. These things shouldn't happen to kids, regardless of how naughty we were or how tough we acted. Especially kids that were younger than me.[417]

Fred believes that his time at Ashley Youth Detention Centre and in the youth justice system failed to address his behaviours. Instead, he said his experiences contributed to him falling into a life of crime: 'They never addressed my behaviours. All I did at Ashley was learn how to be a criminal and meet people who led me further down the wrong track'.[418]

3.6.6 Improving youth detention

Fred thinks that the Tasmanian Government should move towards a model of managing offending behaviour in children through rehabilitation rather than punitive incarceration.[419] He notes that Tasmania has the highest rate of recidivism among young people in youth detention in Australia and he has no doubt this is due, at least in part, to how Ashley Youth Detention Centre treats its young offenders.[420]

Fred firmly believes that Ashley Youth Detention Centre must be closed:

> [The Government should] just close this place down and start again, because it's not—it's systemic, it's grown in that environment. You won't ever get rid of it by putting in new staff members or changing things: tear the place down and start again, the memories are too— just appalling.[421]

3.7 Case example: Oscar

3.7.1 Admission to Ashley Youth Detention Centre

Oscar (a pseudonym) first went to Ashley Youth Detention Centre on remand for a few months in the mid-2000s when he was 14 or 15 years old.[422] He spent another three months on remand at the Centre about a year after his first admission.[423]

3.7.2 Alleged harmful sexual behaviours at Ashley Youth Detention Centre

During his first admission to the Centre, Oscar was initially placed with boys he knew from the community.[424] He was then moved to a unit with boys he did not know.[425] Oscar recalled that on his second day in the new unit, he went to do some laundry and was physically and sexually abused by five boys.[426] Oscar said that a staff member at the Centre was present and watched the abuse.[427] When Oscar asked for the staff member's help, Oscar recalled that the staff member 'just laughed'.[428] Eventually, the boys stopped abusing Oscar. Oscar said the staff member did not say anything about the abuse that had just occurred; he just told Oscar to go back to his room.[429]

Oscar remained in the unit with the same boys.[430] They continued to bully him, hit him when no one was looking and take his canteen food. Oscar explained that he felt like he 'was walking on eggshells all the time. The guards were aware of what was happening but would just turn a blind eye'.[431]

Oscar recalled that when the other boys in the unit found out he was receiving a visitor, they pressured him to have drugs and money brought into the Centre for them.[432] Oscar said that they threatened that if he didn't do this, 'they would bash the shit out of [him]'.[433]

Oscar said that he never spoke to anyone about the abuse he suffered from other young people detained at the Centre, and he never made a complaint: 'I didn't know how to make a complaint and was worried about what would happen if I did. I also didn't want to be a snitch'.[434]

3.7.3 Alleged abuse by Ashley Youth Detention Centre staff

At a visit during his first admission at the Centre, Oscar was given $20, which staff found after Oscar had initially denied being given anything after he left the visitation room.[435] After they found the $20, Oscar told staff that he had not been given anything else during the visit; however, he said they replied: 'We know you're lying to us and you've got other stuff'.[436] Oscar said that staff indicated that they thought Oscar had something hidden in his anus.[437] He recalled that he was then locked in a room near the visitation area that only had a bucket and a desk in it, and he was left there all day:

> At end of the day, they came in and asked me if I'd taken a shit in the bucket. I said I wouldn't go in the bucket. After I refused, they scruffed me and held me down. Then one of the workers who had a glove on stuck his finger up my arse. He said 'I know you've got something in here'. Afterwards, they took me back to my room and locked me in there for the rest of the night and the next day.[438]

Oscar said that he was 'upset and pissed off' after the incident and that he knew the way he had been treated was wrong.[439] Oscar did not want to make a complaint because he 'didn't know who [he] could trust' and was worried what would happen to him if he told the 'wrong' person, because the same staff would always be on the same shifts together.[440] At the time of giving his evidence to our Commission of Inquiry, Oscar still did not want to name the staff involved in that, or any other, incident.[441]

Oscar recalled being regularly strip searched during his time at Ashley Youth Detention Centre, including at admission and after court and visits.[442] The searches would be done in the admissions area, with two staff members watching Oscar: one in front of him and one behind.[443] Oscar also recalled that staff would search his room if they thought he was hiding something.[444] If they did not find anything, they would strip search Oscar in his room's shower bay.[445] Oscar said that during these searches, staff members would sometimes ask him to move his genitals; at other times they would do it themselves.[446] Oscar said that he 'thought it was wrong for them to touch [him]'.[447] Oscar thought he was strip searched in his room like this four or five times while he was at the Centre.[448]

Oscar also recalled being locked in his room on two occasions as punishment for fighting.[449] He said staff would lock him in his room all day and night, only allowing him out once to make a phone call and then making him go to bed at 5.30 pm.[450]

3.7.4 After Ashley Youth Detention Centre

Looking back on his experience at the Centre, Oscar said that he does not trust or get along with many people because of the way he was treated there.[451] Oscar said he tries not to think about what happened to him because it upsets him, and he does not like to talk about it; he is trying to get on with his life.[452]

3.7.5 Improving youth detention

Oscar said there needs to be better background checks on people who are hired to work at Ashley Youth Detention Centre.[453] He said he believes that some of the staff at the Centre should not have been looking after kids.[454] Oscar said he was always worried about what staff members would do if he complained or spoke up about what happened there.[455]

Oscar said he thinks that places such as Ashley Youth Detention Centre should focus on rehabilitation rather than punishment:

> Kids that are in trouble need help to change their behaviours and get a start in life. They should be put into programs and helped to get a job. They shouldn't just be locked up in an institution. Being at Ashley didn't help me in any way. It didn't teach me anything or help me change my behaviours one bit. If anything it made me worse due to the things that happened there and the people I was in with.[456]

3.8 Case example: Simon

3.8.1 Admissions to Ashley Youth Detention Centre

Simon (a pseudonym) was admitted to Ashley Youth Detention Centre seven or eight times from the early to mid-2000s.[457] Simon was only 10 years old when he was first admitted, on remand for stealing.[458]

On the first and each later admission, Simon was detained at the Centre because he was denied bail, remanded in custody and sentenced while he was at the Centre.[459]

3.8.2 Alleged abuse by Ashley Youth Detention Centre staff

Simon told us that strip searches were regularly conducted at the Centre—every time he was admitted, every time he went to and from court, and during random searches of his room.[460] He said that during these searches he had to be naked in front of the staff searching him.[461]

Simon said that, during one search, after he had removed his clothes as requested, the staff asked him to pull his buttocks apart and told him that they would need to hold him down to search him.[462] Simon said he refused and asked the staff to perform a 'normal' search instead.[463] He said that three staff members then came into the room, wrestled him to the ground and spread his buttocks, before putting him in an observation room known as 'the fish tank'.[464] Simon told us that, decades later, he still thinks about that search, how it made him feel abused and how it should never have happened to a child.[465]

Simon said that he was regularly physically abused by Ashley Youth Detention Centre staff, often for minor transgressions such as refusing to go back to his room.[466] Simon told us that staff often responded disproportionately to the actions of the young people in detention; for example, not going to bed on time or 'slipping up [and] doing something simple like a kid does' would lead them to be 'smashed up'.[467] He recalled that staff regularly left him with bruises and grazes.[468] He said that, as well as physically abusing him, staff often called him names such as 'little cunt', which distressed him.[469] Simon told us that he was subjected to verbal abuse 'all the time' while at Ashley Youth Detention Centre.[470]

Simon further recalled staff acting inappropriately towards other young people detained at the Centre. For example, he said that an older staff member would regularly sit and watch young people shower through a viewing panel intended for suicide prevention.[471] Simon said that the staff member became so notorious for this behaviour that he earned the nickname 'dirty old dog' from some young people.[472]

Simon said he was placed in isolation at the Centre two or three times.[473] He recalled being put into isolation as punishment, sometimes for minor transgressions.[474] Simon said he remembers the experience as 'the coldest thing in [his] life that [he has] ever been through', and that it was so cold that it 'felt like it was snowing'.[475] He was only given a horse blanket for warmth.[476] He recalled that, on one occasion, he spent two and a half weeks in isolation.[477]

Simon said he generally did not complain about poor conditions and poor treatment while he was in the Centre because he was afraid that the staff might physically abuse him if he did.[478] He said that, on the occasions he did complain about things the staff did to him, he felt he was not believed because he was a 'criminal' going up against the State.[479]

When Simon was aged 17, he was remanded for robbing a house.[480] When he was told that he was going back to Ashley Youth Detention Centre, he asked to be sent to Risdon Prison instead because he believed he would receive better treatment there.[481] Simon is now in his 30s and has spent more than 15 years of his life in the youth justice and prison system.[482]

3.8.3 After Ashley Youth Detention Centre

Simon said that his experiences at Ashley Youth Detention Centre have affected him into adulthood and he feels they have contributed to his long history of incarceration. He told us that the young people detained at the Centre could not defend or protect themselves and were not appropriately supported to improve themselves. He explained:

> We were only kids and we couldn't stick up for ourselves. The guards and workers at Ashley were disgusting. I've been in [and] out of jail all my life. I was never taught right or wrong to help me change. I was just abused. I don't want what happened to me happening to another kid.[483]

3.8.4 Improving youth detention

Simon said he believes that children and young people who get into trouble should be helped and educated, not punished.[484] He said:

> There needs to be a better place for kids who get in trouble to be sent. A place where the kids actually get help to change their behaviour. Somewhere that makes them realise there are better things out there in life. Kids can't stick up for themselves and should be helped …[485]

Simon said that Ashley Youth Detention Centre could introduce courses and programs to help young people rehabilitate and he believes that he might not be stuck in the prison system now if he had been given that opportunity—he would have had a chance to lead a 'normal' life.[486]

He said Ashley Youth Detention Centre should not be converted into an adult prison after its planned closure, because there is a significant number of adults in prison who spent time at the Centre when they were younger and were assaulted or sexually abused there.[487] Simon said he is concerned that if those adults were sent to a prison on the same site, it could trigger past trauma. He worries that: 'They will put their head down on their pillow at night and think about what happened to them as kids. They will have flashbacks. The whole place should just go'.[488]

Simon said he thinks the Centre should close as soon as possible to avoid causing trauma to more children. He explained: 'I want them to realise they can't treat kids like they did. I don't want other kids to be put [through] what I went [through]. I think the place should be shut down now'.[489]

3.9 Case example: Erin

3.9.1 Admissions to Ashley Youth Detention Centre

When Erin (a pseudonym) was 14 years old, she was living in a women's shelter after acting up at school and becoming estranged from her mother.[490] Erin's behaviour escalated quickly; she was arrested for stealing and remanded at Hobart Remand Centre (now Hobart Reception Prison) in the mid-2010s.[491] She recalled that the court 'didn't know what to do' with her; a placement in foster care, in a shelter or living with her parents were not seen as suitable options for Erin.[492] After two days at the Hobart Remand Centre, Erin was sent to Ashley Youth Detention Centre on remand for three months.[493]

Erin told us that she was initially comforted by the idea of leaving the Hobart Remand Centre and going to the Centre. She said: 'I was relieved. I thought going there would provide me with some security. I thought Ashley would be better, but it turned out to be worse'.[494]

After her first admission, Erin was admitted to Ashley Youth Detention Centre another three times.

3.9.2 Alleged abuse by Ashley Youth Detention Centre staff

Erin said she was strip searched by male staff on her arrival and placed in the female unit.[495] The male detainees yelled at her and banged on her windows.[496] She said she later learned that the males in detention could watch her through the staff office that separated the girls' unit from the boys' unit.[497]

Erin told us that 'if the guards didn't like you, they would do things like leave you in your cell on the weekend'.[498] She said she was once 'unit bound' for a week and only allowed out for an hour or two a day.[499] She stated that this experience has left her traumatised.[500]

Erin recalled frequent strip searches by male staff, during which she would be naked.[501] Erin said she was strip searched each time she was admitted to Ashley Youth Detention Centre and before and after going to court.[502] She said she was also subjected to random strip searches.[503] Erin said she was often strip searched by multiple male staff, who told her they all had to be there for her safety, but Erin felt they treated the strip searches 'like a show'.[504] She described the experience as 'totally violating'.[505] Erin said that she was never given the option of being strip searched by female staff.[506] Erin said that at the time she thought the strip search procedure was normal because she had had the same experience at the Hobart Remand Centre.[507]

Erin described the environment at the Centre as 'hostile'.[508] She said she regularly saw staff physically abuse male detainees.[509] Erin described staff members' attitudes and behaviours towards her as more 'manipulative'.[510] She recalled that staff members

would intentionally cause her to miss meals, leave her in her cell on the weekends and regularly make offensive or inappropriate comments about her body.[511] Erin described being 'treated like an object' by staff.[512] She said that during her detention she was never provided with a bra, was not allowed tampons and was only provided with a certain number of sanitary pads at a time.[513] Erin reflected that '[t]here were no rights or dignity. It was disgusting'.[514]

Erin told us that, about a month after arriving at the Centre, she was feeling unwell and was worried she had appendicitis.[515] She said she told a male staff member and asked to see the nurse.[516] Instead of arranging access to a nurse, she said the male staff member told her to lift her top up, felt around her lower abdomen and drew a shape near her hip, telling Erin it was a 'happy appendix'.[517] Feeling violated and that his actions were 'creepy', Erin reported the incident to a female staff member, who advised Erin to report it to the Ombudsman.[518]

Erin told us that the same male staff member entered her room to collect sheets while she was showering, despite Erin's request that he send a female staff member to collect the sheets, or that he waited until she finished showering.[519]

Erin reported these incidents to the Ombudsman, who responded by letter two weeks later, stating that the matter would be resolved by Ashley Youth Detention Centre management.[520] An internal investigation by management found that the male staff member had not displayed 'inappropriate intent' in either case, but that he should have known his actions might make Erin 'feel uncomfortable and even potentially unsafe'.[521]

Erin said nobody at the Centre spoke to her about her complaint, she did not receive any counselling or other supports, and she was not notified of any outcomes.[522] Erin said that she heard from another staff member that the male staff member was placed on two weeks' paid leave as a result of her complaint, but that this was never confirmed for her by the Ombudsman or by the Centre's management. We discuss the management of Erin's complaint to the Ombudsman further in Case study 7.[523]

Erin told us that when the male staff member returned from leave, she had to continue engaging with him and that he was 'never nice to [her] again'.[524] She said that other staff were angry at her for reporting the incidents, calling her a 'dog' and a 'drama queen'.[525] This made Erin feel as though complaining only created problems:

> After this I felt like it was pointless making complaints or speaking up. I learned that you don't say anything in Ashley, it was more trouble than what it was worth. I would describe the staff at Ashley as being like a pack of animals. Some of them had been working there for 30 years. They all went to school together. They were all from Deloraine, which was a small country town. They all looked after each other.[526]

3.9.3 Alleged harmful sexual behaviours at Ashley Youth Detention Centre

There were few girls at Ashley Youth Detention Centre when Erin was detained. She said that this meant she was often in the company of males in detention when taking part in educational or therapeutic programs.[527] Erin said that, on one occasion, she was left unsupervised in a room with 10 males in detention and was sexually abused.[528] She said that it 'was probably only 2 or 3 minutes but it was enough time for them to do significant damage'.[529]

Erin said she shared what happened to her with another young woman in detention, who then told a female staff member.[530] Erin said that although she asked the staff member not to tell anyone, the staff member reported the incident to management.[531] Erin said she was not offered counselling support or medical treatment, and no one else from the Centre spoke to her about the incident.[532] Instead, she was released a few days later.[533]

Erin returned to Ashley Youth Detention Centre some weeks later on a charge of stealing.[534] She said she was told that the boy who had been predominantly responsible for the sexual abuse during her previous admission had gotten into trouble.[535] Once Erin arrived, the boy's friends began threatening her and she was confined to her room for her safety.[536] She said she also felt targeted by the staff members who had been reprimanded for allowing the incident to occur.[537] She said this treatment reinforced her view that it was better to stay silent. Erin reflected:

> I wasn't offered any support or protection to help me deal with all of this. There was no-one there to support me. This again confirmed to me that you don't say anything at Ashley. If things happen you don't talk, you just go along with it.[538]

Erin was admitted to Ashley Youth Detention Centre two more times, each time for breaching her bail conditions.[539] She said that sexual abuse by male detainees continued during these admissions.[540] Erin told us that staff were aware of what was occurring but that 'they just accepted it', enabling the boys to get away with what they wanted.[541] Erin recalled that she was regularly forced to perform sexual acts on males in detention during scheduled programs while staff members watched.[542] Erin said that eventually she was placed on the contraceptive pill and recalled that she visited the nurse's office each day to receive it.[543]

Erin said she never tried to report sexual abuse again:

> I went along with doing these things because I just thought it was easier. I believed that if I didn't, I would get my head kicked in. It was easier to comply. I didn't make complaints to the staff because I knew if I did things would get worse. Again, I was fearful of being physically assaulted.[544]

3.9.4 After Ashley Youth Detention Centre

Erin said that, after leaving the Centre, she tried to forget her experiences by using alcohol and drugs.[545] Erin has post-traumatic stress disorder, anxiety, depression and low self-esteem. She struggles to trust men, which affects her personal relationships and her children.[546]

Erin said she attributes her poor mental health and wellbeing to the way she was sexualised and sexually abused at Ashley Youth Detention Centre.[547] Reflecting on the impact of her abuse, Erin stated:

> Ashley made me feel like it was normal and it was okay for men to treat me like that. It made me believe that it was what I was used for. I have had horrendous things happen to me that I have just thought I deserved. I believed that it was normal for these things to happen because that's how I was treated at such a young age. Before I went to Ashley, I was never exposed to sexual abuse.[548]

3.9.5 Improving youth detention

Erin expressed her view that Ashley Youth Detention Centre would be much safer for young women in detention if they were kept separate from males in detention, if there were more female staff, and if staff were better trained.[549]

Erin said that children should not be detained for minor offences and that alternative options to institutional detention, such as home detention, are needed.[550]

She also said that a commitment to therapeutic-based systems must be more than mere words; it needs to be evident in the systems and processes in place at Ashley Youth Detention Centre or any new youth justice facility.[551] She recalled that Ashley Youth Detention Centre was said to be operating a 'therapeutic model' when she suffered abuse there.[552] She said: 'Building a new centre and putting a ribbon on it isn't going to change anything. They need to break it right down and make sure it changes'.[553]

3.10 Case example: Jane

3.10.1 Before Ashley Youth Detention Centre

Jane's youngest daughter Ada (both pseudonyms) was bubbly, outgoing and well liked for most of her primary school education.[554] Jane told us that Ada became uncontrollable soon after she started her schooling in Tasmania in the late 1990s, aged 11.[555] Ada spent much of her time trying to fit in with older kids, smoking, drinking and not attending school.[556]

Jane reached out to the Department of Education for assistance, hoping they could encourage Ada to go to school.[557] However, Jane said that the departmental employees sent to speak with her and Ada told Ada to 'not worry about schooling' and to 'focus on [her other] problems instead'.[558]

Jane became concerned that she could no longer keep Ada safe and in school.[559] She described feeling 'betrayed' after she sought help from the Department of Education and two social workers who visited told Ada not to worry about school and to focus on addressing other problems.[560] She was later told by the Department of Education that the social workers were students and that the Department considered Ada's non-attendance a serious concern.[561] Jane recalled that, after finding Ada's behaviour uncontrollable and fearing for her safety, she decided to 'get welfare involved'.[562] She described being assisted to put together an application and ultimately applied to make Ada a ward of the State when Ada was aged 12.[563] At around this time, a psychological assessment found that Ada's behaviour was consistent with that of a primary alcoholic.[564]

3.10.2 Admissions to Ashley Youth Detention Centre

The same year, while she was a ward of the State, Ada was admitted to hospital with severe alcohol poisoning.[565] Jane said that, after five days in hospital, Ada's behaviour was deemed too problematic for the hospital to manage, and Child and Family Services approved Ada's transfer to Ashley Youth Detention Centre.[566] While Jane told us that Ada was admitted to Ashley Youth Detention Centre, we understood her to mean that Ada was admitted to the former Ashley Home for Boys (which was the relevant institution at this time). Jane recalled that Ada's Child and Family Services' case workers agreed that this transfer 'wasn't right' but explained to Jane that Ada had been moved to the Centre because there was nowhere else for her to stay while they considered what to do with her.[567]

The Department told us Ada was admitted to the Centre under section 39(7) of the *Child Welfare Act 1960*.[568] We were told the decision to admit Ada was made to address her complex behavioural and medical needs, was based on expert recommendations and was not a decision that was taken lightly.[569]

Jane told us that Ada resisted being transported to Ashley Youth Detention Centre and was therefore restrained during the trip.[570] Jane said that, once at the Centre, Ada was placed in a single cell with other young people. Jane's recollection was that Ada was subjected to the same rules, such as rules relating to isolation and searches, despite not having been charged with any crime.[571] We were told that Ada was the only female young person detained at Ashley Youth Detention Centre at the time.[572]

Ada was detained at the Centre on and off in the late 1990s and 2000s. Her first admission lasted around two and a half months.[573] Jane told us that, eventually, Ada was transported every day from Ashley Youth Detention Centre to a house, where she was cared for by a case worker or a foster carer. She was then transported back to the Centre every night.[574] Jane recalled she was not allowed to visit Ada during her first admission but visited her at the day home.[575]

Ada was placed with a foster family full-time.[576] A couple of weeks into that placement, Ada ran away for several days until Jane tracked her down and convinced her to go back to the foster home.[577] In response to her running away, Child and Family Services decided that Ada would be detained at Ashley Youth Detention Centre again each night for two weeks and returned to her foster family during the day.[578]

After Ada left Ashley Youth Detention Centre, she returned to Jane's care. Ada was later charged with burglary offences and put on a probation order, with conditions that included not drinking alcohol.[579] The only support the State offered Ada for her alcoholism was counselling. However, Jane stated that Ada, then 13 years old, was left to decide whether she would access counselling.[580] Ada soon breached her probation and was sentenced to a few months' detention.[581]

Jane believes the State set Ada up for failure by neglecting to give her the tools she needed to comply with her probation order. Jane said: '[Ada] had a major drinking problem and they didn't put anything else in place to help her stop. All of these rules had been set up that she would never be able to comply with'.[582]

Jane believes what happened to Ada at Ashley Youth Detention Centre is Ada's story to share, not Jane's.[583] While Jane does not know all the details, Ada has told Jane she had some 'bad times' at the Centre, that she had to be 'tough' when she was there, and that she had to 'fend off some older boys', including males over the age of 18.[584] Ada also told Jane that the increasing number of older people being detained, especially people over the age of 18, created a 'hierarchy' based on age groups and resulted in the older kids causing trouble.[585] While Jane thinks there was more supervision for Ada because she was the only girl at Ashley Youth Detention Centre, she believes the Centre was an entirely unsuitable place for a vulnerable child.[586]

3.10.3 Out of home care

Jane told us the State's decisions for Ada were often inconsistent and poorly communicated to Ada.[587] Jane described one instance where Child and Family Services told Ada she would be placed in independent living on release from Ashley Youth Detention Centre. Jane told us Child and Family Services then changed its mind a week before Ada was released and instead transferred Ada to a women's shelter.[588] Jane said these changes were confusing for Ada, would cause Ada to get angry or upset, and in Jane's opinion, set Ada back.[589]

Jane thinks Ada was not supported well enough as a ward of the State. She described how, on one occasion, when Ada was released from youth detention at the age of 14, Ada had to make her own arrangements to be picked up from the Centre because Child and Family Services had not put any transit arrangements in place for her.[590]

Jane also feels there was poor communication and coordination between the different services with which Ada interacted, including Child and Family Services, the Department of Education, the Department of Justice and police.[591] Jane was particularly frustrated by the State's failure to support Ada in her education:

> They just didn't have the facilities to deal with kids like [Ada] and as a result the system was failing them. There was never a push to get [Ada] back into school. The education department had told her to sort her issues out and not worry about school. There was no education under the care of [Child and Family Services] and as a result [Ada] didn't complete primary school.[592]

Jane recalled that Child and Family Services allowed Ada to do things that Jane and Ada's foster carers would not, given her young age.[593] For example, Jane was aware that Child and Family Services would buy cigarettes for Ada when she was in her early teens.[594] On one occasion, Jane told us that Child and Family Services gave Ada permission and spending money to go on a two-day trip with a female and three males who were much older than her.[595] When Jane confronted Child and Family Services about this, she was told that the trip had been approved because one of the males, a 19-year-old, had a driver's licence.[596] Jane felt that Child and Family Services failed to listen to or consult her about Ada's care, and let Ada do things that she didn't have the maturity to do.[597]

3.10.4 Improving youth detention and out of home care

Jane thought that by making Ada a ward of the State, Ada would be safe and educated.[598] Looking back, Jane feels betrayed by Child and Family Services' decisions to treat Ada like a detainee even though, for much of her time at Ashley Youth Detention Centre, she had not been charged with any crime.[599] Ada now battles an addiction to methamphetamine, which Jane attributes to Ada being caught up in 'the system' and spending time at Ashley Youth Detention Centre.[600]

Jane wants the Tasmanian Government to reduce its reliance on the criminal justice system to work with young people who have complex needs, in favour of alternative interventions and prioritising education.[601] Jane would also like the Government to focus on addressing the cause of youth offending, such as treating Ada's alcoholism.[602]

Jane also believes the various Tasmanian Government departments responsible for children and the out of home care, education and youth justice systems must work together in a child-centred way. She said:

> … these are youth that need help, you know, but [through] a combination of all the services working together and [communicating] … [Ada] didn't finish primary school and she hasn't got an education, and she was extremely bright but she just didn't get that education that I would have liked for her and I think there could have been a lot more done about that.[603]

3.11 Case example: Otis

3.11.1 Admissions to Ashley Youth Detention Centre

Otis (a pseudonym) was detained at Ashley Youth Detention Centre twice in the early 2010s.[604] He was 16 or 17 years old when he was first detained and 17 years old when he was detained a second time. In total, he was detained for several months.[605]

3.11.2 Alleged abuse by Ashley Youth Detention Centre staff

Otis recalled being regularly strip searched at the Centre—on each admission and before and after leaving the Centre's premises.[606] During searches, Otis said staff required him to be naked and instructed him to squat or 'stand like [he was] riding a motorbike'.[607] Otis recalled that staff would then perform an intrusive cavity search, including putting their fingers in his anus.[608] Otis said that if he did not comply with instructions, the staff would hold him down to perform the search and that they sometimes deliberately made it more painful and more sexual.[609] It appeared to Otis that some staff enjoyed strip searching him.[610] Otis recalled that because the strip searches occurred so regularly at the Centre, '[at] the time I just thought the searches were part of what goes on. I thought it was normal. I didn't realise it was illegal like I do now'.[611]

Otis said that, on his second admission to the Centre, he was placed in a unit with young people who were afforded more privileges than most because they were well behaved.[612] These young people were offered extra comforts such as DVD players in their rooms and more exercise time.[613] The unit was not as heavily supervised as other units, and it received more funding.[614] At the start of Otis's admission, the unit did not have any closed-circuit television cameras.[615]

Otis told us that his first experience of sexual abuse was from staff working in that unit, after he opted to stay in his room instead of going to a class, to avoid problems he was having with other young people.[616] Otis said that a staff member entered Otis' room and told him that he would need to do the staff member 'a favour' for letting him stay out of class.[617] Otis said that the staff member then made Otis perform oral sex on him and told Otis that 'it was a secret and he'd look after [Otis] if [Otis] kept it a secret'.[618] Otis recalled that the staff member also told him that if he did not keep it a secret, the staff member would tell the other young people in detention that Otis had 'dobbed' on the other boys.[619]

Otis told us that, after this first incident, he experienced further sexual abuse at the hands of other staff at the Centre.[620] He recalled being made to perform sexual acts on staff and engage in sexual intercourse with staff in his room, in a storeroom, during relaxation therapy group sessions and outside his unit on the Centre's grounds.[621] Otis said that usually, when he was sexually abused, it was just him and the abusing staff member.[622] Otis also recalled a 'gang of perpetrators' that he described as having a 'gang mentality'.[623]

Otis also recalled being sexually abused by Ashley Youth Detention Centre staff during weekly excursions away from the Centre, and witnessing staff sexually abusing other young people in detention during these excursions.[624] Otis said that the abuse started happening outside their rooms, in storerooms or on excursions once cameras were installed in the unit where he was detained.[625]

On some occasions, Otis and other young people were taken off the Centre's grounds to perform community service.[626] Otis said that the staff member accompanying them took advantage of this time to sexually abuse them.[627] He told us that, when he was taken off site during the early 2010s, he would be separated from the group, held in a car and sexually abused.[628] He said because there was no oversight, staff 'would get away with an extreme amount of shit'.[629] Otis described yelling out to another staff member for help following an incident of sexual abuse when he was left alone with one particular staff member when off site.[630] Otis told us that, in response, this staff member physically assaulted Otis and urinated on him.[631] Otis said that staff would also threaten to leave a young person off the grounds or to tell the Centre's management that the young person had 'run away' if they did not submit to the abuse.[632]

Otis said that he and other young people in detention were bribed with cigarettes and alcohol to stay quiet, and they were physically abused if they complained about the sexual abuse.[633] Otis said that it was well known among the young people in detention that going 'off-property' would mean being sexually abused, but that they would come back with cigarettes for everyone.[634]

Otis recalled being sexually abused almost every time he was taken off-property.[635]

3.11.3 Reporting abuse at Ashley Youth Detention Centre

Otis said he felt he could not share the details of his abuse with anyone at the Centre because it would affect his living conditions; the staff who sexually abused him were in control of his television time, his bedtime and his life.[636] He told us that he wanted to stay in his more relaxed unit at the Centre and he was aware that, because he was aged 17 at the time, he had to be well behaved to avoid being transferred to the adult Risdon Prison.[637] Otis said that, when the staff were not content with the sexual acts he was performing, they became physically violent and threatened to take away his bedding or his canteen privileges.[638] Otis believed that his fear of retribution and, in turn, his lack of retaliation, caused staff to continue to sexually abuse him.[639]

Otis said he had heard that young people in detention at Ashley Youth Detention Centre were suffering sexual abuse long before he was admitted to the Centre.[640] He said that sexual abuse was embedded in the everyday behaviour of the place.[641] He said that the young people in detention knew not to 'dob' on anyone:

> We … had a code in Ashley that you don't dob anyone in. The [staff] knew that we had this code, so they knew that we wouldn't speak up. I think they treated us the way they did to show us that they had all the power, and that we had none.[642]

Otis said he eventually reported the abuse to a psychologist at the Centre, although he did not share all the details of his sexual abuse.[643] Otis recalled that the psychologist did not believe him and accused him of being a compulsive liar.[644] He said the psychologist told him not to tell his family about his abuse.[645]

At the time, Otis did not tell his family about the abuse. Otis said: 'I couldn't tell mum about what was happening, and I still haven't been able to tell her some stuff to this day. I got myself into Ashley because I wanted to be a cool kid and do crime. I just didn't expect this stuff to happen'.[646]

3.11.4 After Ashley Youth Detention Centre

Otis said that after being sexually abused at the Centre, he has been confused about his sexuality because he felt that he 'accepted' the abuse from male staff.[647] For example, Otis would sometimes offer himself up to go off-property or to the storeroom, where he knew he would be sexually abused, in the place of a younger person who had not been at Ashley Youth Detention Centre before.[648] Otis said he was prepared to endure the abuse rather than watch others go through it.[649]

Otis said he also continues to feel distressed by the death of a fellow young person in detention at the Centre.[650] Otis said the Centre did not offer any counselling or support to other young people in detention following the death.[651] Otis told us that the circumstances before and after the young person's death were 'handled atrociously' by staff at the Centre.[652] He said the incident 'still haunts' him.[653]

Reflecting on his mental health issues following his time at the Centre, Otis said:

> I was in detention because I did the wrong thing. That should have been my punishment, not the abuse that I had to endure. It's changed who I am as a person. My self-esteem and personality have been affected. It's impacted my mental health. I've lost faith in people. I was failed hard. I'm still suffering to this day for the things that happened to me.[654]

3.11.5 Improving youth detention

Otis said that the sexual abuse of young people in detention was allowed to happen in Ashley Youth Detention Centre because of a lack of oversight.[655] He told us that, in contrast with adult prison, where a strict system of approvals and bookings applies, Ashley Youth Detention Centre staff were allowed to put detained young people in a car and drive them wherever they wanted, with no checks and balances.[656] Otis said he believes the Centre should be run in a more organised manner, where everything requires approval, such as occurs in an adult prison.[657] Otis told us that he wants young

people to be accompanied by at least two staff members at all times when going off-property and for proper approval processes accompanying such trips to be introduced at Ashley Youth Detention Centre.[658]

Otis said that, in the past, he has not been comfortable speaking about his experiences of sexual abuse at the Centre.[659] However, he said that, with the assistance of a counsellor, he has reached a point in his life where he wants to talk about what happened, so others are not subjected to similar abuse.[660] Otis said: 'I want to know who allowed these things to happen. I don't care about money. Money doesn't solve problems … I worry about what will happen if my kids end up in detention like I did'.[661]

3.12 Case example: Brett

3.12.1 Before Ashley Youth Detention Centre

Brett was taken into the care of the Department when he was in his first year of high school because of his father's mental health issues.[662] However, he regularly ran away from his placements because of his experiences, trying to find a way back to live with his father.[663] In Chapter 8, we discuss Brett's experiences of abuse in out of home care. He said he ended up sleeping rough and stole to survive because he had no income.[664]

3.12.2 Admission to Ashley Youth Detention Centre

Brett had just turned 14 when he arrived at Ashley Youth Detention Centre in the late 2000s.[665] He was remanded to the Centre after being charged for an armed robbery he said he committed to finance a plane ticket to the mainland.[666]

3.12.3 Alleged abuse by Ashley Youth Detention Centre staff

Brett said he was strip searched by a staff member on admission, and when Brett resisted taking off his boxer shorts, the worker physically abused him. Forcibly removing Brett's shorts, Brett recalled that the staff member then inserted his finger in Brett's anus, saying, 'Welcome to Ashley, boy, you do as you're told'.[667]

Brett said he went to Ashley Youth Detention Centre six times between the ages of 14 and 17.[668] Brett described his treatment by staff during his time at the Centre as 'horrible'.[669] He recalled constant belittling comments such as being called a 'drug baby' and being told that he wasn't wanted, as well as physical abuse such as being hogtied for minor infractions such as not moving fast enough back to his room.[670] Brett described being kept in isolation in his room, under what was termed an 'Individual Support Program', for up to six weeks at a time.[671]

3.12.4 Reporting allegations of abuse at Ashley Youth Detention Centre

Brett described trying to complain to staff about his treatment in youth detention but stopped because 'it made it 100 times worse' when staff responded by making life even harder. He said was not aware that he could complain to the Ombudsman at that time.[672]

3.12.5 After Ashley Youth Detention Centre

Brett said that his experiences at Ashley Youth Detention Centre led him to distrust the justice system and police—'the ones that are supposed to help are the ones you're trying to escape from'.[673]

Brett said he has been incarcerated multiple times as an adult.[674] He said that he has used drugs to try to 'escape from it all' and attempted suicide.[675]

3.12.6 Improving Ashley Youth Detention Centre

Brett expressed the desire for improved safety at Ashley Youth Detention Centre because of the impact that the experience has had on his life, stating, 'it's wrong … it's destroyed my life and it's destroyed many other lives that I know'.[676] He recommended more cameras in Ashley Youth Detention Centre and that the Centre employ staff 'who understand how to work with children'.[677] He wants children to get help before they get to youth detention.[678]

3.13 Common themes

The accounts of abuse we have outlined here predominantly occurred between the early 2000s and the early 2020s (except in relation to Ada, who was detained at Ashley Home for Boys in the late 1990s and then at the renamed Ashley Youth Detention Centre in the early 2000s). Yet, we observed commonalities in the allegations of abuse made by these victim-survivors and their families, as well as in the allegations made through the Abuse in State Care Program, Abuse in State Care Support Service, National Redress Scheme, civil claims and other complaints. We describe some of the common themes from these accounts below. We urge the Tasmanian Government to reflect on these themes when responding to current and future allegations of abuse, and when planning and implementing reforms relevant to youth detention.

More than two-thirds of victim-survivors in the accounts we have documented were under the age of 14 when they were first detained at Ashley Youth Detention Centre. One of the victim-survivors, Simon, was only 10 years old on his first admission.[679] Most of these children were initially detained at the Centre on remand for relatively minor charges, and some of them were never detained under sentence. In the case of Ada, who was only 12 years old when she was first admitted to the then Ashley Home for Boys, her mother Jane recalled that she was not subject to any criminal charges, although the Department told us she was there on specialist advice. Many of the victim-

survivors were on remand, and some told us that the lack of an adequate bail address was the reason they were remanded to Ashley Youth Detention Centre.

All victim-survivors described being subjected to sexual, physical and other abuse by staff at the Centre or older detainees, or both. We summarise themes in the accounts of alleged abuse by staff below, including in relation to sexual abuse (including through personal searches) and the humiliation and belittling of children and young people. In Case study 3, we closely examine isolation practices at Ashley Youth Detention Centre, including individual accounts of this practice. In Case study 4, we summarise individual accounts of the use of force by staff towards children and young people in the Centre.

Some victim-survivors told us they were forced to share a unit with, or were left unsupervised in the company of, older boys detained at the Centre, despite some pleading with staff that they were not safe. They were subsequently sexually abused, sometimes by groups of older boys. We summarise the accounts of harmful sexual behaviours in Case study 2.

It is incomprehensible to us that children were exposed to such abuse while in the care of the State.

Most of the victim-survivors whose accounts we have reported told us they had experienced trauma before being detained, which contributed to their contact with the justice system and may have made them more vulnerable to sexual abuse once in detention. We heard that victim-survivors came from unsettled, tumultuous and broken family situations. One young person was living in a shelter before her detention at Ashley Youth Detention Centre; another was homeless and two were in out of home care.[680] Victim-survivors spoke of physical abuse in their familial settings and of mental health issues that were triggered or exacerbated by their traumatic circumstances. It makes no sense to us that children and young people living under these pressures were not assessed for, and provided with, support services, rather than being detained, especially in circumstances where they had not been said to have committed an offence. In Chapter 9 of our volume on out of home care and in Chapter 12 of this volume, we discuss the need to support, and advocate for, at-risk children, and to ensure detention is imposed as a last resort.

Many victim-survivors told us that their abuse by staff, or their subjection to the harmful sexual behaviours of other detainees, began as soon as they were admitted to Ashley Youth Detention Centre. As described by Ben, Simon and Erin, when young people first arrived at the Centre, they would undergo an admission process that could involve a period of isolation ranging from a few hours to a week.[681] We were told by Ben and another former detainee whose account is not recorded here that, in addition to the inherently humiliating experience of being strip searched and isolated, there was also a practice of applying scabies cream to young people's naked bodies, causing a burning

sensation.[682] We understand that this practice occurred from the mid to late 1980s until the early 2000s.[683] A staff member described the practice in a statement he made in 2020 to the Department:

> The kids would come in, they would be showered and they would be de-liced … and you would have to paint their bodies with scabies cream … The process involved painting just about every inch of their body, including genitals … The cream would get applied with a paintbrush. Most of the time staff would apply most of it, including to the genital area …[684]

We received evidence from another former detainee of Ashley Youth Detention Centre that, when he was first admitted to the Centre at the age of 13 in the late 1990s, it was midnight, and he was strip searched and 'painted head to toe in anti-scabies lotion' in what he referred to as 'punishment on top of punishment'.[685] He also described a further incident involving the application of scabies cream as follows:

> Once, they said there was an outbreak of scabies, so they line[d] us all up and they painted us all again. The stuff gets left on you, till 3.00 pm the next day when you can shower. It stung, and it's genital torture. It wasn't diagnosed by a doctor, it wasn't completed by a nurse, just a staff member.[686]

Centre staff using strip searches as a tool of control, and as an opportunity to sexually abuse children and young people, was a common theme across the accounts of victim-survivors. We heard that victim-survivors were subjected to aggressive and 'harrowing' strip searches on numerous occasions during their time at Ashley Youth Detention Centre.[687] The mother of one victim-survivor told us that her son asked her to stop visiting him in detention because of the strip searches he had to endure before and after her visits.[688] As a result, her son was further isolated from the support he needed.

Others described being restrained while strip searched, and several victim-survivors detailed being sexually assaulted during 'cavity' searches, including through digital penetration. We also received evidence of male guards performing cavity searches on female detainees by inserting their fingers into detainees' vaginas.[689] Erin described how she was regularly strip searched by male staff members and never provided the option to be searched by female staff.[690]

Some victim-survivors described being stripped naked by staff, verbally abused and left in locked rooms for extended periods as punishment for any number of actual or perceived infractions.

Many, if not all, of these accounts of strip searches are allegations of child sexual abuse by staff.

Female victim-survivors described staff targeting them for humiliation. For example, Charlotte described staff trying to see down her top, making comments about her body and touching her inappropriately.[691] Erin recounted that staff controlled her access to basic amenities such as a bra and sanitary products.[692]

We are particularly concerned by reports that female detainees, who were often alone or in the minority among male detainees at Ashley Youth Detention Centre (and thus especially vulnerable while in detention), said they were targeted for sexual harassment and abuse arising from their gender. We also heard that older boys would harm younger boys.

Several victim-survivors told us that sexual abuse by Centre staff was often perpetrated off site or in areas of the Centre that did not have closed-circuit television, so the abuse was less likely to be detected. Victim-survivors further recalled that if they attempted to avoid off site 'excursions', they were met with reprisals, including having food withheld.[693]

We were told that staff provided children with cigarettes and other privileges, such as more television time, if they submitted to abuse, both on- and off-premises.[694] We heard that this level of manipulation has had lifelong adverse effects on victim-survivors' understanding of their sexuality, their intimate relationships and their capacity to trust, because they believed that accepting such incentives meant they accepted the abuse.[695]

Victim-survivors who spoke to our Commission of Inquiry described being subjected to many forms of humiliating, belittling and threatening conduct at Ashley Youth Detention Centre. We heard evidence that being the target of staff members' derogatory language and verbal threats often happened in conjunction with admission processes, strip searches, isolation and during the perpetration of physical and sexual abuse on Centre premises and off site. Many of the incidents described to us are likely to constitute human rights abuses under instruments such as the United Nations Convention on the Rights of the Child.

One common way that young people described being humiliated and sexually violated at the Centre was being watched by staff while they were showering. Showers at the Centre were visible through observation panels, which were designed so staff could open the panel and check the location and wellbeing of young people, especially if they were at risk of suicide or self-harm.[696] Young people told us that this design was abused.[697]

We also received accounts of young people having insufficient access to toilet facilities while in isolation, including being given only a bucket to use or otherwise being forced to urinate and defecate on their cell floor.[698] The Department told us that none of the rooms at Ashley Youth Detention Centre had toilets until refurbishments in the early 2000s.[699] The Department advised that when a toilet was otherwise unavailable, access to toilet facilities occurred at the request of a detainee while they were in isolation.[700]

Alysha (a pseudonym), former Clinical Practice Consultant, Ashley Youth Detention Centre, told us that, during her employment at Ashley Youth Detention Centre between late 2019 and mid-2020, staff made direct threats of physical violence against detainees.[701] She described a staff member threatening to turn a young person 'into

an owl' if they did not change their behaviour. She recalled being told that this meant the staff member would 'cave the child's face in'.[702] We also received evidence from Alysha of young people being teased about their weight and called names such as 'fat fuck' by staff while being strip searched.[703]

If this conduct did occur, it involves using degrading language to demean the young person and to frighten them as a means of securing their compliance and exercising power and control. The *Youth Justice Act 1997* prohibits any form of psychological pressure intended to intimidate or humiliate children and young people in detention, as well as any form of physical or emotional abuse, or any kind of discriminatory treatment.[704] Young people in detention are entitled to, and deserve, humane treatment and the maintenance of their dignity. Every child has the right not to be humiliated, belittled or threatened.[705]

The sense of utter helplessness that anything could be done about the ways in which young people were treated in detention was palpable across the accounts by victim-survivors, who commonly stated that, after initial attempts to report abuse, things often got worse rather than better for them. Therefore, they learned never to complain again. Victim-survivors told us that reprisals for reporting the abuse included severe violence from staff and other detainees. Consequently, some young people stopped disclosing sexual and physical abuse to other staff members, their parents, community visitors and statutory authorities, such as the Commissioner for Children and Young People.

We are deeply saddened to report that one of the most common themes to emerge from the accounts we have documented was the devastating ongoing trauma that the abuse at Ashley Youth Detention Centre has had on victim-survivors' mental and physical health. We heard that many victim-survivors have attempted suicide, struggle with significant mental health conditions and addictions to drugs and alcohol, and have been incarcerated during their adult lives.

Ben provided a particularly evocative reflection on how the violent sexual abuse that he told us he experienced at Ashley Youth Detention Centre eventually broke him, and his realisation that using violence himself was the only way to survive.[706] His account provides just one illustration of the failure of Ashley Youth Detention Centre to fulfil a core purpose of youth justice—rehabilitation. Instead, through a culture of humiliation, denigration, control, violence and abuse, Ashley Youth Detention Centre seems to have contributed to the antithesis of rehabilitation—further criminalising young people.

Many of the victim-survivors and their family members told us what they wanted to see happen at Ashley Youth Detention Centre and in relation to the youth justice system more broadly. Most commonly, they said they want proper mental health and other supports—not remand—for children when they start offending, and for the Government to reduce its reliance on detaining children and young people overall. They also told us that they want:

- an acknowledgment from the Government about what has happened to them
- a prohibition on staff who have abused children in detention from ever working with children again
- comprehensive background checks on anyone seeking employment at a youth justice facility
- a rehabilitative facility for young people that is more centrally located and ensures detainees have access to a full education
- closed-circuit television throughout a new facility
- female and male young people to be housed separately in detention facilities, with girls to be supervised only by female staff
- a safe and effective process for children to make complaints about their treatment when detained
- more cultural support for Aboriginal young people in detention.

4 Management recognition of the scale of the abuse

Despite a large number of claims and allegations filtering through various redress programs and civil claims, we heard it was only relatively recently that the full scale of allegations—and that many allegations were against current staff—became apparent to senior managers in the Department.

It started to become generally understood in the Department in late 2020 that many of the allegations through redress programs and schemes, civil claims and other sources related to current staff at Ashley Youth Detention Centre. We discuss this development in more detail in Case study 7.

Although he knew about the existence of the Abuse in State Care Program from 2014, Secretary Pervan told us it was in late 2020 that he became aware a significant number of current Ashley Youth Detention Centre staff were named in those records and other redress claims:[707]

> There was a lot of activity in a very short period of time. It would have been towards the end of 2020 where we became aware of the extent of the number of current employees who were implicated from the various redress programs … and the severity of the allegations.[708]

A former Acting Executive Director, People and Culture in the then Department of Communities, explained to us that the 'true picture … as to what may have occurred at Ashley' only came to be understood at the time that various pieces of information (from civil claims, National Redress Scheme applications and Abuse in State Care Program applications) were put together and viewed as a whole.[709]

We were told that when reviewing this information together, it became clear there was a pattern of alleged abuse occurring at Ashley Youth Detention Centre over a lengthy period, and that many allegations related to current employees.[710] At hearings, the former Acting Executive Director, People and Culture described her realisation of the extent of the allegations of abuse around August or September 2020 (soon after she joined the Department) once the various sources of information were viewed in totality:

> Probably up until that point [the point at which she viewed the totality of claims together] I'd only read a few applications, maybe one or two letters of demand, but when you have, I believe, in excess of 300 applications that have come through detailing acts of abuse, and you can see the same names and the same types of abuse, and you can pick up themes and— it's quite confronting.
>
> …
>
> … there is probably too much commonality in some of the methods of abuse, if I may call it that, or the allegations; that, for people that have spanned so many different years, to not believe that they're— it's not a matter of belief, but some of the themes have just repeated so much that it does definitely cause a lot of concern, and I think I've been quite specific in my statement as to a couple of those areas where I think that we see themes coming through now in terms of almost opportunities for abuse when they occurred, such as strip searches; that's probably the main one coming through.
>
> …
>
> But you do have, again, these themes that just continue and again going back to the strip searching one, and it's just how it's described in these applications … a lot of the people didn't even see what happened to them in terms of a cavity search as being a sexual abuse; it was almost like it was an intimidation tactic, and that's how they describe it in their applications, and some of them are so detailed that they are very concerning.[711]

Mandy Clarke, former Deputy Secretary, Children, Youth and Families in the then Department of Communities (between September 2019 to February 2022), told us she was alerted to the possibility of a history of claims made relating to serving staff after a meeting she had with an external lawyer on 31 August 2020 that prompted her (and others) to begin to cross-check records against serving staff.[712] In her statement to us, Ms Clarke said she was shocked and confronted by the allegations and never anticipated that the Department would need to respond to so many historical allegations of abuse involving current employees.[713]

Under questioning at hearings, Pamela Honan, Director, Strategic Youth Services in the then Department of Communities, conceded that there were abusive patterns of behaviour exhibited by Centre staff towards detainees.

> Q [Counsel Assisting]: … [W]ould you accept from the materials that you've reviewed that it's been a place where children have been physically abused? Not all children, but quite a lot?
>
> A [Ms Honan]: There's— absolutely, yep.
>
> Q: That there's been an ongoing pattern of what I would call emotional abuse or disregard in the way in which children have been treated by at least some workers?
>
> A: Yes.
>
> Q: And would you also accept that there's clearly been an ongoing pattern of sexual abuse of some residents by some workers?
>
> A: I would agree.[714]

Ms Honan also conceded ongoing problems with harmful sexual behaviours being displayed by detainees against other detainees.[715]

Secretary Pervan also accepted Counsel Assisting's proposition that it is open to our Inquiry to find that there has been an ongoing pattern of sexual abuse of some detainees by some staff members over the past 20 years.[716] At hearings, Secretary Pervan conceded this in response to questioning by Counsel Assisting:

> Q [Counsel Assisting]: … [W]ould you agree that, having regard to all of the evidence that's available, it's open to the Commission to find that there has been ongoing sexual abuse of some detainees by some officials at Ashley over the last 20 years?
>
> A [Secretary Pervan]: Yes, I would.
>
> Q: And that, whether we describe it as a 'pattern' or 'repeated conduct' or whatever, nevertheless it's clear that it's not isolated incidents; would you accept that?
>
> A: Yes.[717]

Stuart Watson, Manager, Custodial Youth Justice ('Centre Manager'), acknowledged that Ashley Youth Detention Centre had a 'dark past'.[718] He noted it was not for him to draw conclusions about the truthfulness of some allegations made against staff but acknowledged that his reference to a 'dark past' necessarily involved wrongdoing by staff towards detainees.[719]

We note that, in recent times, as discussed in Case Study 7, the Department has conducted some misconduct investigations in response to allegations of abuse at Ashley Youth Detention Centre. However, the Department did not take disciplinary action in respect of the Abuse in State Care Program allegations until late 2020 at the earliest and, in some cases, much later (and only after other allegations had been

raised against staff members). As a result of the time span over which allegations were made against some staff, we can only conclude that some alleged abusers continued to work at the Centre for many years after allegations were first made against them and, as a consequence, had access and opportunity to continue to abuse children and young people in detention during this time.

5 The broader context

The allegations of abuse need to be understood in context, including a longstanding corrosive staff culture, the beliefs of some staff that children and young people in Ashley Youth Detention Centre sometimes or often deserved punishment and make false allegations, and the fact that the Centre is isolated, physically and operationally from the department that oversees its.

5.1 A longstanding corrosive staff culture

It is clear to us that a significant proportion of staff members have worked at Ashley Youth Detention Centre for many years. Victim-survivor Erin, who was at the Centre in the mid to late 2010s and whose experiences we have outlined above, told us that she encountered staff who had worked at the Centre for 30 years.[720] Staff members Ira, Lester and Stan (all pseudonyms), against whom a number of serious complaints of abuse were made (discussed in Case study 7), all began work when the Centre was the Ashley Home for Boys.[721]

In a May 2016 Minute to the Secretary, it was noted that many staff had been working at the Centre for more than 15 years.[722]

Ms Clarke confirmed that a large cohort of the Centre's total staff have worked at the Centre for a very long time and that such staff continually describing 'the old days' could make it challenging for Centre management to redefine the culture in line with a more therapeutic approach.[723] She reflected on this further in hearings, adding:

> … some staff that perhaps dominated decision making that had been there for some time, and that perhaps new staff who brought fresh ideas and new ideas and new way of thinking, their thoughts were not always reflective in that decision; in fact, sometimes they just weren't even being heard …[724]

Information provided in the accounts of victim-survivors, as well as evidence from others, further suggests that the personal connections of staff members at Ashley Youth Detention Centre, beyond their common employment, meant that staff 'looked after each other' and that it was challenging for individual staff members to raise concerns about the misconduct of their colleagues.[725]

A participant in one of our sessions with a Commissioner, who asked to remain anonymous, told us that:

> Most of the staff [at Ashley Youth Detention Centre] were farmhands from around the Deloraine area. Nobody had qualifications. There was a bit of a joke: if you're a member of [a particular club], you've got a job at Ashley. They were all connected through the … club.[726]

Ben, who was first detained at the Centre in the early 2000s, similarly stated that when he was at Ashley Youth Detention Centre it was 'run' by a group of families who would employ other family members and their friends to work there.[727] When he was released from detention, Ben recalled seeing a photo at a club in the local area and could identify more than 50 per cent of the club members in the photo as people connected to Ashley Youth Detention Centre.[728]

As documented throughout this case study, we heard evidence from multiple sources about staff members working together to manipulate, control and abuse children. Warren, who was at the Centre for various periods between 2004 and 2009, described being raped on numerous occasions by different staff members while other staff restrained him and subjected him to verbal abuse.[729] Erin recounted to us that male staff members watched as she was sexually abused by a group of older male detainees.[730] Otis, who was admitted to the Centre in the early 2010s, referred to staff as having a 'gang mentality'.[731] Fred, who was first detained at the Centre in the early 2000s, told us that staff treated violence between young people in detention 'like a sport', either provoking violence or encouraging it when it broke out, rather than stepping in to de-escalate a situation.[732] Max described multiple occasions where a number of staff physically or sexually abused him.[733]

Otis, who told us that he began to 'offer' himself to staff members when he realised that they were targeting younger children to abuse, suggested that sexual abuse at Ashley Youth Detention Centre was not uncommon, at least during the early 2010s when Otis was detained there.[734] We were also told of staff withholding essential medication unless young people submitted to sexual acts, despite repeated requests by young people to staff that they needed this medication.[735] Several accounts allege that physical and sexual abuse was perpetrated by two or more staff acting together. Some victim-survivors stated that other staff saw or heard physical and sexual abuse take place. There were multiple accounts of children's attempts to make reports to staff.

There were also striking similarities in some of the ways that victim-survivors told us they were abused at Ashley Youth Detention Centre, with accounts naming multiple staff over decades using the same tactics, such as abuses perpetrated under the guise of strip searching.

In a submission to our Commission of Inquiry, Ms Sdrinis, who represents more than 300 victims of abuse seeking compensation from the Tasmanian Government

(150 of whom relate to Ashley Youth Detention Centre), raised concerns about 'collusion' among staff at Ashley Youth Detention Centre:[736]

> Numerous clients have described a sense of collusion between staff at [Ashley Youth Detention Centre] that inhibited reporting of abuse. Clients report there were numerous husband/wife teams working as guards … gang members working as security, and security personnel referring friends for shifts at [the Centre].
>
> This created a perceived sense of solidarity between the guards, and an 'us vs them' attitude for staff and residents. This combination of circumstances allowed perpetrators to continue offending for many years, effectively unchecked.[737]

Alysha, who reported allegations against a staff member, Lester, in January 2020 (discussed in Case study 7), told us that:

> Due to the, at times, nepotistic recruitment practices and Tasmania being a small place, speaking up often carries additional considerations such as being friends, community members or parents of children at the same school as someone acting inappropriately. With the Centre being in such a remote location, this issue is additionally compounded as the majority of the staff group live in a small town together. Not only is there fear of professional consequences such as failing to be considered for promotions or being bullied at work, but there are also social considerations that would leave staff ostracized or possibly in danger of reprisal in their own community.[738]

It is further apparent from the accounts of victim-survivors and their families that some new staff were drawn into a culture of degrading children and young people detained at the Centre or ignored the abuse happening around them. While we heard that some staff members who witnessed abuse made attempts to report it, we also heard that some new staff who may have 'started off well' would 'turn into the same as the other ones'.[739]

Ben told us that:

> The hardest thing for me to accept about this abuse is that all of the other staff that weren't doing it to us had to have known. There were times when we did get to leave Ashley to go places and do fun things, but there was always a process. We would have to fill out paperwork. The times we were abused there was no process. We were just told that we were going fishing or caving or something like that, and then just taken off site.[740]

He also told us that staff who did not want to take part in the abuse were sidelined for 'not toeing the line'. He said that these staff, who could have made a difference, were 'continually pushed out'.[741]

In a panel at hearings, Professor Donald Palmer and Dr Michael Guerzoni—both experts in organisational misconduct—described how an organisation's dynamics can foster such indoctrination. Dr Guerzoni, who teaches in the field of criminology (including youth justice), has examined many of the reports into Ashley Youth Detention Centre.[742]

Dr Guerzoni spoke of formal and informal aspects to the socialisation of staff, describing informal components including:

> … the so-called water cooler conversations, lunchtime conversations, barbecue chats and that kind of thing where informal tips on how to do the job or ways of seeing problems and situations which arise within an organisational setting and how to respond to those.[743]

Dr Guerzoni further reflected:

> … it is my understanding that the evidence suggests that new workers at Ashley Youth Detention Centre have been socialised into a punitive culture that is informed by a view that the children in their care are bad people who do not deserve to be treated well.[744]

Dr Guerzoni went on to note that even though Ashley Youth Detention Centre has introduced a range of policies and procedures designed to improve safety, the desired change does not seem to have achieved the intended effect.[745]

Speaking more broadly about cultures within youth detention settings, Professor Palmer said:

> People who become guards in a detention facility very quickly learn from their peers what the culture of that organisation is and it may be; for example, never trust a child and what they say. That might not have been a view that they held before they took the job as a guard in a juvenile detention facility.[746]

Samantha Crompvoets, a sociologist who has examined misconduct in the armed forces, described risks of negative socialisation and misconduct in 'closed' organisations or those that are 'in isolated parts of a network' where distinct norms and behaviours can emerge among a group:

> … when you enter an organisation, you take cues from everyone around you regarding … what is normal and what is not. Part of this is the natural human desire to conform and assimilate. So for organisations or parts of organisations that are closed, it is important that there are checks and balances in place to prevent new employees conforming to the behaviours of the rest of the group.[747]

It seems unlikely that persistent incidents of abuse like this could have happened without some level of staff awareness or collaboration. It also seems unlikely that abuse of this nature and to this extent could have occurred without some other staff knowing about it, or at least harbouring concerns or suspicions.

5.2 A culture of disbelieving detainee complaints

In addition to the broader culture that we heard worked to dehumanise children and young people, we observed a view held by many staff, management and even some external agencies that detainees were sometimes or often unreliable witnesses and concocted false allegations of abuse for monetary gain or retribution against staff.

A youth worker at the Centre, Sarah Spencer, said that she had observed some detainees make statements about their intentions to falsify complaints for redress purposes:

> The government gave these young people, ex-residents whether they went to Risdon, payouts when they said, 'Oh, so and so interfered with me or did this'. No investigation, just gave them 10 grand there, 20 grand there, 30 grand there. We knew about it because they told us all the time. They would leave the Centre saying, 'I'm going to say this when I leave, so and so got this much money for saying this'. Constantly we've lost valuable workers through a lot of unproven allegations with no investigations whatsoever.
>
> ...
>
> It just doesn't make— it's horrific, because they just kept handing them money with no investigation, and now we've got this flood of allegations, and there would be a percentage, I'm not diminishing that, but all of these false allegations take away from the legitimate ones.[748]

Ms Spencer also told us that she believed all young people who reported abuse to her and appropriately escalated all reports of abuse she received.[749]

Fiona Atkins, Assistant Manager, Ashley Youth Detention Centre, told us that staffing levels at the Centre were affected in part by 'the perception of threats from young people about the making of false claims against staff'.[750] In our public hearings, she said:

> Q [Counsel Assisting]: Do you mean that people are worried that they'll be falsely accused of physical or sexual abuse?
>
> A [Ms Atkins]: Some young people have actually voiced that they will say, you know, 'You touched me' or whatever, so that they can get a payout. I have heard that.
>
> Q: And it's your assumption that, if a young person said that, it wouldn't be truthful?
>
> A: Not when they're smiling and laughing in front of me, no.[751]

Mr Watson agreed with Counsel Assisting's proposition that 'a lot of staff' would hold the view that many allegations made by detainees are false.[752] Mr Watson pointed to one factor leading him to this conclusion about such a view among staff:

> Often these people have worked with each other for a long period of time, and I guess, you know, it is the example of, do you really know your neighbour and do you really know what they do?[753]

In reflecting on his opinion of the views of staff later in oral evidence, Mr Watson felt there would likely be mixed views among staff about detainee accusations of abuse, with some thinking that suspensions of staff because of some of these complaints were 'timely'.[754]

Former detainees Max and Warren shared with us that staff told them that reporting abuses was futile because no one would believe them.[755] Otis disclosed some of his abuse to a psychologist at the Centre and told us that he was not believed.[756]

Both the Commissioner for Children and Young People, Leanne McLean, and the Ombudsman, Richard Connock, agreed with Counsel Assisting's proposition that many young people may not have reported their abuse to oversight bodies partly due to fear of not being believed.[757] Mark Morrissey, a former Commissioner for Children and Young People, told us he believed children at the Centre did not have confidence that their reports or concerns would be adequately responded to.[758]

The abuse of children at the Centre became normalised—so much so that some young people at the Centre understood the violence and abuse by staff against them as 'normal' treatment.[759]

We received evidence to suggest that this scepticism of detainee complaints was not confined to the Centre and Department, but also extended to some external agencies. In Case study 7, we discuss attitudes inside Tasmania Police that were dismissive of allegations of abuse at Ashley Youth Detention Centre.[760]

As we have made clear, it was not possible for our Commission of Inquiry to test the veracity of accounts given to us by detainees or to determine the prevalence of any false complaints. We do consider, given the patterns and consistency in allegations over decades, that at least a proportion of these allegations are likely to have occurred. We consider the prevailing views and attitudes of Centre staff, and bodies tasked with protecting children at the Centre, to be relevant to understanding how longstanding and systematic abuses at the Centre were not identified and addressed.

5.3 Isolation of Ashley Youth Detention Centre

It is clear to us that the risk of abuse at Ashley Youth Detention Centre (and the likelihood that it would go unchecked and unreported) was heightened, in part, due to the physical isolation of the Centre, and because of breakdowns in communication and leadership between those working at the site and those in the Department. Ms Honan described her immediate impression of the Centre when she began her role in October 2019:

> [The Centre] operated independently to the broader Division of Children, Youth and Family Services (CFS) and Department of Communities. It was highly autonomous, inward facing and lacked strategic leadership. My impression was that there was

> also a high degree of mistrust and selectivity in what and how information was reported by the Manager up to the executive to ensure the operating of the centre was positively regarded. The relationship with independent statutory bodies appeared to be wary and uncooperative.[761]

At hearings, Ms Honan elaborated on the relationship between the Centre's management and the broader Department, telling us that the Centre operated as a 'satellite' and that it was 'very closed, very wary, and very defensive'.[762] She told us: 'I think what I was being told, but then what I was hearing and seeing on site suggested something quite different'.[763] She also observed that the relationship had 'changed significantly' since 2020 due to many factors, including her weekly physical presence at the Centre and the 'functional alignment' of certain positions that are physically based at the Centre but are also 'professionally supported and interface outside the centre'.[764]

Ms Clarke agreed with Ms Honan's observations that the Centre was operating in a closed environment without a clear passageway to the executive when she began working at the Department in 2019.[765]

In response to questioning at hearings, Secretary Pervan also agreed that the Centre was disconnected from the broader Department and characterised by an insular and inward-looking culture.[766] When we asked him about the cause of the Centre's self-isolation from the rest of the Department, Secretary Pervan said:

> I think it's a broader reflection of cultural norms and history in that there's been a facility on that farm—and Ashley does sit on the edge of a farm that's owned by the Crown—for around 100 years. It was like a lot of our not-good past, a shameful past you might say, that no regard was given to young people …[767]

Secretary Pervan reflected on his role as Secretary and the role of the executive in allowing the self-isolation of the Centre to occur:

> Q [Counsel Assisting]: Doesn't that reflect on the management above Ashley in the hierarchy up to and including you if, if up to 2019 the Ashley management had been permitted to isolate themselves and not participate properly as part of the Department?
>
> A [Secretary Pervan]: There is a reflection there, I'll own that; I was also running the Tasmanian Health System, so it wasn't as if I wasn't aware of the issues at Ashley, and I very much depended on a succession of Deputy Secretaries to be informing me, as I was those conversations with the Commissioner for Children and Young People as to what was happening at Ashley and what I needed to do to remedy it …
>
> It was very difficult to find out exactly what the situation was at Ashley other than noting that it was a facility that was isolated and had isolated itself over a considerable period of time. As with the Deputy Secretary and Director level, there was a succession of Centre managers, and getting to grips with not only what was the problem but what we could actually do about it was incredibly challenging.

> Q: And so the practical effect of that … was that it appears that over a series of years the self-isolation of Ashley from the scrutiny that might be best practice in terms of an open line of communication up through the Director of Custodial Justice and up through the Deputy Secretary to you, that was able to continue so that it was still in place in October 2019?
>
> A: Yes.[768]

It is clear from the Department's evidence that senior members of the Department were aware of the inadequate scrutiny and supervision that occurred due to the Centre's physical location and a culture in which it could self-isolate from the broader Department. We consider this evidence is relevant in understanding how abuses at the Centre continued over a long period without adequate responses from the Department.

6 Observations

Children and young people were supposedly sent to Ashley Youth Detention Centre for rehabilitation from the complex factors that contributed to their offending. In doing so, they entered a highly controlled environment that was largely closed off from the community. They become wholly dependent on staff to care for them, meet their basic needs and protect them from harm. The experiences victim-survivors shared with us paint a harrowing and heartbreaking picture of systematic mistreatment over years—mistreatment that included physical abuse, sexual abuse, verbal abuse, denigration, humiliation, bullying, threats, intimidation, use of isolation and other likely human rights abuses.

While we acknowledge the evidence we received from some staff about the propensity of detainees to falsify claims (or at least state an intention to do so), we can only say that the accounts that we heard from current and former detainees were consistent in terms of the individuals and patterns they described over different periods and varied in ways that suggest a lack of collusion between detainees. Their accounts often were measured and nuanced—particularly in recognising the existence of staff who were not complicit in the behaviour and who recognised their plight for what it was. Many of their accounts, particularly around the culture and dynamics at the Centre, echo the recollections of staff, former staff, some senior managers and oversight agencies. Taken together, all the descriptions of Ashley Youth Detention Centre reveal a toxic and callous environment—a very far stretch from a therapeutic place of rehabilitation and recovery.

Finding—For decades, some children and young people detained at Ashley Youth Detention Centre experienced systematic harm and abuse

Considering all the evidence from victim-survivors and their families, current and former Centre staff, senior management in the Department, the many prior reports and investigations into the Centre, the allegations made through civil and redress scheme claims, the matters considered in Case study 7, and the insight of relevant experts into organisational misconduct, we consider that many children and young people were systematically dehumanised, brutalised and degraded while at Ashley Youth Detention Centre. We do not accept that the mistreatment of detainees occurred only as rare or isolated incidents, or that it always occurred in a highly concealed fashion. We consider it reflected a widespread and, at times, methodical practice, albeit to varying degrees. In this sense, the abuse, including sexual abuse, was systematic.

The broader dynamics at Ashley Youth Detention Centre contributed to a perfect storm that enabled abuses, including sexual abuse, to be perpetrated over a long period. We consider there are complex and varied motivations among staff who harmed children, or who contributed to or ignored harms. We consider at least some staff members were motivated abusers with an abiding sexual interest in children and young people, while other staff members were opportunistic in their abuses, and others again perpetrated abuse as a means of exerting power and dominance over detainees. We also consider it likely some staff felt peer pressure to conform to the poor practices of others (for example, when performing strip searches) and participated reluctantly on this basis, but also to avoid becoming targets for abusive or bullying behaviour from colleagues. We consider some of this behaviour reflects a highly traumatised and dysfunctional workforce.

We accept that not all staff engaged in problematic practices, but we consider many would have been aware of the poor treatment of detainees. As discussed in Chapter 3, cognitive biases (such as wilful blindness) may have contributed to such staff minimising the nature and scale of the behaviour occurring around them, alongside the gradual normalisation of such callous brutality, which operated to erode normal human reactions. Also, a sense that reporting the conduct would be futile—or worse, place them at risk in some way—may have contributed to inaction or people simply leaving their roles.

We acknowledge that some staff did seek to investigate and report abuses, and to escalate such alleged abuses to their superiors, despite feeling discouraged from doing so.

We consider a range of factors are relevant to the culture that enabled systematic abuse of detainees, which includes the following:

- As discussed in Chapter 10, the highly pressured, stressful and occasionally frightening conditions in which staff sometimes had to work, coupled with inadequate professional training and development for some staff, made it more likely for staff to deviate from best practice when seeking to manage the behaviour of detainees. We also consider it likely that difficult—and at times violent—behaviours exhibited by detainees contributed to staff holding negative attitudes towards them.
- Familial and personal connections between some staff created strong social disincentives to challenge, question or report poor behaviour of staff towards detainees.
- The often-longstanding tenure of staff contributed to entrenching problematic attitudes and normalising the poor treatment of detainees. New starters were socialised into this environment, and efforts to promote change towards therapeutic approaches were resisted.
- Staff (and broader community) attitudes that diminished the humanity and credibility of detainees worked to reduce empathy and compassion for them; it heightened scepticism of any complaints or concerns they may have raised in the Centre and beyond.
- While they felt violated, detainees were not always aware that abusive practices likely contravened law, policy or human rights conventions.
- Detainees were disinclined to speak out about abuses for reasons including the stigma and a lack of confidence in reporting processes, the normalisation of their mistreatment and genuine fears for their safety and the safety of their families.

We also consider that the broader context of Ashley Youth Detention Centre contributed to this abuse going unidentified and unaddressed. The physical isolation of the Centre and the culture in which it operated as a 'satellite' from the broader Department enabled conditions in which abuse could be perpetrated and not reported, resulting in delays in action from the Department and an unacceptable level of risk to children. The closed nature of Ashley Youth Detention Centre—and the vulnerability of detainees at the Centre—made it especially necessary for the Department to maintain close supervision over the Centre. Instead, the inadequate scrutiny and apparent inability to address the cultural and physical conditions in which a closed environment was able to flourish meant that inherent risks went unchecked by the executive and abuse could continue.

Case study 2: Harmful sexual behaviours

1 Overview

Over the course of our Commission of Inquiry, we heard from many victim-survivors about their exposure to and experiences of harmful sexual behaviours, often by older male detainees, at Ashley Youth Detention Centre. In this case study, we summarise allegations of harmful sexual behaviours over many years at the Centre. We also consider the Centre's and the Department's responses to these allegations. We recount allegations that staff sometimes actively used the fear of harmful behaviours of children and young people to control other children.

We outline detainees' personal accounts of experiencing harmful sexual behaviours, drawing from the accounts we present in Case study 1. We then focus on a series of incidents involving three young people, Max, Henry and Ray (all pseudonyms), between 2018 and 2022.[769] First, we outline the law and policies during this period. Then, we provide a timeline of incidents involving these three young people. The timeline begins when Max was first admitted to Ashley Youth Detention Centre. It follows the responses of the Centre and the Department to some of the harmful behaviours, including harmful sexual behaviours, of young people in Tasmania's youth justice system.

Throughout this discussion, we highlight specific and systemic failings in the management of Max, Henry and Ray—as well as the children and young people who were displaying harmful sexual behaviours. At the end of the timeline, we highlight some of the systemic problems that were common to the incidents, including:

- staff tensions
- an absence of risk assessments
- a lack of capacity to respond to complex behaviours of children and young people
- the importance of critical incident investigatory skills.

We are particularly concerned about the disrespect and disregard apparently shown to staff who endeavoured to raise or address the risks to young people at Ashley Youth Detention Centre. We received information about unprofessional conduct, silencing in meetings and written complaints being ignored or deflected. We are concerned about apparent efforts to undermine the status and expertise of those professionals raising concerns.

This chapter covers a series of concerning allegations regarding the responses of Ashley Youth Detention Centre staff to harmful sexual behaviours displayed by some young people at the Centre. We acknowledge there have been and are staff at Ashley Youth Detention Centre who have sought to do their jobs lawfully and appropriately. References to 'staff' in this case study are not intended as a reference to all staff at Ashley Youth Detention Centre, unless explicitly stated in a specific context.

In the final section of this case study, we provide our general observations about systemic and operational deficiencies at Ashley Youth Detention Centre, which we consider have contributed to young people being exposed to or experiencing sexual harm by other detainees.

We identify that, over many years, some staff had knowledge of the harmful behaviour, including harmful sexual behaviour, of children and young people against other children. There was often an inadequate response to the risk that such behaviour could occur, as well as inadequate responses when it did occur. Children and young people in detention have too often been exposed to serious harm, including sexual harm, by other children and young people in detention. Some staff have not taken enough steps to protect them.

2 What we heard from victim-survivors about harmful sexual behaviours

In Case study 1, we outline personal accounts of young people's allegations of harmful sexual behaviours at Ashley Youth Detention Centre, including the following:

- In the early 2000s, 11-year-old Ben (a pseudonym) told us he was placed with much older boys who physically and sexually abused him on numerous occasions during his first admission.[770] He had multiple admissions to Ashley Youth Detention Centre and said he was frequently sexually abused by older boys.[771] He said his abuse occurred in the Centre and on outings, where there was less supervision.[772] He told us that, when he told staff early on about the abuse, they essentially blamed him for putting himself in such a position.[773] At other times, he said he was punished for speaking up.[774]
- Charlotte (a pseudonym) told us she was sexually abused by boys at Ashley Youth Detention Centre on several occasions in the mid-2000s when she was in her mid-teens.[775] She told us staff were aware she had a history of experiencing sexual abuse, but she was left alone with groups of boys and was sexually abused more than once.[776] She said she reported the abuse after leaving Ashley Youth Detention Centre but heard nothing more.[777]

- Fred (a pseudonym) told us he was in his late teens in the mid-2000s when he witnessed a detainee raping another boy and was himself physically abused by other boys at Ashley Youth Detention Centre.[778] He said he learned not to speak up because he experienced retribution from staff and residents.[779]
- Oscar (a pseudonym) told us he was in his mid-teens when he was first admitted to Ashley Youth Detention Centre in the middle of the 2000s.[780] He said older boys sexually abused him within days of his admission while a staff member watched on and laughed.[781] He said other boys regularly physically abused him but did not disclose for fear of being labelled 'a snitch'.[782]
- Erin (a pseudonym) first came to Ashley Youth Detention Centre in the mid-2010s.[783] She told us she was left unsupervised with a group of 10 boys, where she was sexually abused.[784] After disclosing the abuse, she said she did not receive any support.[785] Instead, she said she felt shunned by staff who had been reprimanded for allowing it to occur, and was subsequently and targeted and sexually abused by other boys.[786] She said staff witnessed the harmful sexual behaviours and did nothing but put her on the contraceptive pill.[787]
- In the late 2010s, Max was repeatedly placed in units with older boys who posed a risk of harmful sexual behaviours.[788] Consequently, he told us he was physically abused on numerous occasions, threatened with sexual abuse and then sexually abused with a table tennis bat.[789] He said his behaviour became more challenging as he sought to protect himself from other residents and he displayed harmful sexual behaviours himself.[790] Professional services staff came into conflict with operational staff about responding to incidents and protecting Max from harm.[791] We discuss Max's account in more detail in the next section.

As we have made clear, it was not possible for our Commission of Inquiry to test the veracity of all the individual allegations outlined in victim-survivors' accounts. However, we were struck by the many common themes across these accounts. While we do not make findings in relation to any individual allegation, we note the similarities across accounts.

In many of these accounts, younger children were placed with older children who had previously displayed harmful sexual behaviours and received no therapeutic intervention.[792] Although girls were generally placed in separate units from boys, the harmful sexual behaviours they told us about occurred when they were left unsupervised and outnumbered by boys in the Centre.[793]

Victim-survivors told us that some Centre staff were aware of incidents of harmful sexual behaviours but responded in ways that apparently condoned the behaviour—such as dismissing the damage caused by harmful sexual behaviours or responding passively or punishing children and young people for complaining about the harmful sexual behaviour of another child.[794] Victim-survivors told us these responses discouraged them from subsequently reporting harmful sexual behaviours they experienced or witnessed.[795]

3 The exposure to harm of vulnerable children and young people in detention, 2018–22

In this section, we focus on the specific experiences of Max, Henry and Ray from 2018 to 2022. We outline Ashley Youth Detention Centre's response to these young people's vulnerabilities to harmful sexual behaviours (and other harmful behaviours by young people) at the Centre.

Max, Henry and Ray have much in common. Each was detained at Ashley Youth Detention Centre in the past five years and some of their time there overlapped. Each of these three young people were particularly vulnerable to harmful behaviours from other detainees because of their age, experiences of trauma, mental health problems or more than one of these vulnerabilities. At some point during their detention, Max, Henry and Ray were housed in the Centre's Franklin Unit despite protests from several staff and the young people themselves that this unit was not safe for them. All three young people were put at risk of or experienced harmful sexual behaviours by one or both of two detainees in the Franklin Unit, Albert and Finn (both pseudonyms).[796] It is our view that Ashley Youth Detention Centre failed to protect Max, Henry and Ray from harmful behaviours, including harmful sexual behaviours, of other young people. We discuss non-sexual harmful behaviours in this case study because harmful sexual behaviours can be one part of a spectrum of harmful behaviours.

We discuss other experiences that Max says he had in Ashley Youth Detention Centre elsewhere in this report (refer to Case study 1 and Case study 6). In this case study, we consider only those aspects of Max's evidence, and the relevant evidence of others, that relate to his accounts of harmful sexual behaviours and the responses to those behaviours by Centre management and the Department.

First, we discuss the laws, policies and practices relevant to the 2018–22 period. We then outline several incidents of harmful sexual behaviours relevant to Max, Henry and Ray, as well as the varied responses of Centre staff to these incidents at the time.

3.1 The law, policies and practices

In this section, we provide some relevant context about:

- the laws and standards that prohibit bullying and physical and verbal abuse of children and young people in detention
- how decisions were made about where to place young people within Ashley Youth Detention Centre, including what we heard from former staff members about placing young people in the Franklin Unit

- the use of 'Very Close Supervision' orders at Ashley Youth Detention Centre to manage young people whose behaviour is considered a risk to others or to the security of the Centre
- how incidents involving harmful sexual behaviours are reported and investigated at the Centre.

3.1.1 Laws and standards

The *Youth Justice Act 1997* ('Youth Justice Act') prohibits using:

- any form of psychological pressure intended to 'intimidate or humiliate' a child or young person in detention
- any form of physical or emotional abuse
- discriminatory treatment.[797]

It also provides that a child or young person in detention is entitled to have their developmental needs met.[798] In addition, the *Inspection Standards for Youth Custodial Centres in Tasmania* includes several standards designed to protect vulnerable young people from verbal or physical abuse and bullying.[799]

3.1.2 Managing children and young people in detention through placement and supervision

Placement decisions

In Chapter 10, we detail how, prior to 31 May 2022, Ashley Youth Detention Centre staff decided the unit within which to place children and young people at the Centre.[800] To summarise:

- The Centre Support Team generally made week-to-week placement decisions, although these could be changed daily, based on operational factors.[801]
- Placement decisions considered some or all the following factors:
    - age
    - gender
    - safety and security
    - legal status and length of sentence
    - individual needs
    - behavioural issues
    - relationship dynamics between young people and staff
    - the views of staff.[802]

- Due to operational challenges, including staffing numbers, placement decisions sometimes amounted to 'choosing the best out of a poor range of options'.[803]
- Young people could make a formal request for a unit transfer, which the Centre Support Team would consider.[804]

Franklin Unit

Until recently, the Franklin Unit was the most secure unit at Ashley Youth Detention Centre, housing 'the most high risk or dangerous young offenders'.[805] Mr Watson told us that before the Centre's redevelopment in 2022, the Franklin Unit was the only unit with a secure courtyard. It also had concrete (instead of plaster) ceilings.[806] He explained that certain children and young people in detention, such as those who presented an escape risk, were placed there.[807] Mr Watson told us that now all units at Ashley Youth Detention Centre have secure courtyards.[808] We understood his comments to mean Centre staff now have more flexibility in housing children and young people in detention who pose an escape risk.

Madeleine Gardiner, former Manager, Professional Services and Policy, Ashley Youth Detention Centre, recalled that, 'on occasion', youth workers or Centre Support Team members would comment that 'placing certain detainees with other detainees was helpful to manage the behaviour of detainees'.[809] She told us the chair of the Centre Support Team said this was inappropriate and the 'general consensus of the [Centre Support Team] would not support this'.[810] Alysha (a pseudonym), a former Clinical Practice Consultant at Ashley Youth Detention Centre, believes young people were regularly placed in the Franklin Unit to 'manage and punish behaviour that was considered disruptive by Operations staff'.[811] Her opinion is that staff relied on the reputation of the Franklin Unit and the fear of what happened to young people there 'to essentially "scare them into line"'.[812]

Alysha believes the Franklin Unit was operated very differently from other units, specifically in terms of how it was staffed.[813] She said:

> There were 'Franklin staff', whereas [staff in the other units] all seemed to rotate a little unless there was a particular issue for a staff member. None of the staff rotated as they ought to, but the Franklin staff appeared to dictate the rules under which they worked. They would 'refuse' to work in any other units.[814]

Alysha's concern echoes matters departmental staff identified in a 2016 Minute to the Secretary with the subject line 'AYDC–Commissioner for Children letter and emerging concerns' (refer to Case study 3 for more detail).[815] This Minute noted serious concerns about human rights abuses and, among other things, that the Tasmanian Government had previously agreed 'staff at Ashley Youth Detention Centre were to work across teams when requested to do so rather than working solely in the allocated smaller team groups'.[816] We note one of the recent reforms we discuss further in this case study (in response to the 7 August 2019 incident) was to regularly rotate staff through all units.[817]

We asked several past and present Ashley Youth Detention Centre staff about placing young people in the Franklin Unit. The general response was there was no policy or practice (informal or otherwise) of using some detainees as a threat to influence or punish the conduct of other children and young people in detention.[818] We were instead told placement decisions were made according to a range of factors such as age, individual needs and security.

Very Close Supervision

We are aware it is sometimes necessary to place young people in units where staff anticipate incidents might occur.[819] In such situations, a Very Close Supervision order may be applied to the young person.[820]

In August 2019, *Standard Operating Procedure No. 8: Supervision and Movement of Young People* outlined the requirements for Very Close Supervision at Ashley Youth Detention Centre.[821] It stated:

> Very Close Supervision (VCS) is used if a higher level of risk is presented by an individual young person.
>
> Approval for a young person to be placed on and taken off VCS status can only be given by the Centre Support Team (CST), Operations Manager or On Call Manager based on information provided by operational and/or professional staff.
>
> A young person may be classified as requiring VCS if it is assessed they are a serious safety and/or security risk due to:
>
> - Aggressive, subversive and/or inappropriate behaviour.
> - The risk of assault or harm from other young people.
> - Escape or threat of escape.
> - Any other reasons identified by staff that require a higher level of supervision.
>
> The supervising Youth Worker will ensure the young person on VCS remains within five metres at all times whenever the young person is outside of a locked building.[822]

It is unclear from the wording of this Standard Operating Procedure whether a youth worker is required to be within a certain distance of the young person on Very Close Supervision while the young person is inside a building, or if the terms of the supervision only apply outside a locked building. We are aware that some young people have been placed under Very Close Supervision inside and outside a unit.[823]

The Department's Serious Events Review Team (described further in this case study and in Chapter 9) received evidence from a staff member that in practice, Very Close Supervision may not 'guarantee' that a young person would receive one-on-one supervision.[824] Rather, it was suggested that Very Close Supervision was considered more of an 'alert' to staff to be watchful for potential problems, as opposed to a direction

to increase supervision itself.[825] The review concluded that Very Close Supervision 'is problematic and difficult to achieve' even when in use, given the insufficient staffing numbers and the lack of understanding among Ashley Youth Detention Centre staff on how Very Close Supervision operates.[826]

As discussed in the timeline below, Ray was subject to a Very Close Supervision order during a period of his detention at Ashley Youth Detention Centre. However, it does not appear that Albert and Finn were placed on Very Close Supervision orders in response to the incidents outlined below, despite staff being aware of their ongoing sexualised behaviours towards younger detainees.

3.1.3 Incident reporting, referrals and review

Incident reporting, detention offences and conferences

Staff at Ashley Youth Detention Centre must record and report any incident arising from the behaviour of a young person or young people.[827] As discussed in Chapter 10, incident reporting at the Centre occurs in line with the *AYDC Incident Reporting Procedure* ('Incident Reporting Procedure') and the incident report template.[828] The Incident Reporting Procedure came into effect on 1 July 2018.[829] We understand it is still used today.[830] We were told that staff receive incident reporting training during their induction and periodically during refresher training.[831]

The Incident Reporting Procedure states that the aims of incident reporting include to:

- record 'thorough, accurate and objective information' about an incident, including injuries
- provide 'impartial and responsible assessment processes' that ensure the seriousness of an incident is appropriately classified
- 'encourage mutual accountability between young people and staff' for their behaviours and actions
- support consistent decision making
- ensure incident reports are appropriately escalated through management, the Department's executive and Minister, as required
- support 'independent and external oversight of incident management'.[832]

As outlined in Chapter 10, the reporting staff member must also recommend a 'level of seriousness' for the incident for each young person involved against one of the following categories:

- recorded incident
- minor incident
- detention offence.

The Operations Coordinator must sign off on all incident reports, noting any alternative recommendations.[833] There is also a requirement for a 'Management Assessment', which involves the Centre Support Team considering:

- the level of seriousness of the incident
- identifying whether the police, Child Safety Services or a young person's parents should be notified
- whether any other actions, such as an independent investigation, should take place.[834]

Where an incident involves a detention offence or isolation, or the Centre Support Team cannot reach a decision in relation to the seriousness of the incident, the Centre Manager must then review the circumstances of the incident and complete the relevant parts of the Management Assessment, including considering whether any notifications or further actions are required.[835] The Director, Strategic Youth Services, must decide whether any independent investigation of an incident is required.[836]

Under section 140 of the Youth Justice Act, the Secretary must be notified of any detention offences that the offender admits committing. The Secretary must then confer with the offender and any other relevant person before determining how the offence should be dealt with. As outlined in Chapter 10, the Secretary may deal with the offence by:

- taking no action, 'on the undertaking of the offender to be of good behaviour for a period not exceeding 2 months'
- cautioning the offender
- delaying the offender's release from youth detention by no more than three days
- filing a complaint against the offender.[837]

We note that in March 2022, Michael Pervan, the then Secretary of the Department of Health and Human Services (and later the Department of Communities), delegated his functions for dealing with a detention offence to the holders of several other roles, including the:

- Deputy Secretary, Children, Youth and Families
- Director, Youth and Family Violence Services
- Ashley Youth Detention Centre Manager
- Ashley Youth Detention Centre Assistant Manager
- Operations Manager (to a more limited extent)
- Coordinator, Training and Admissions (to a more limited extent).[838]

While we have not received an exhaustive record of previous delegations of these functions, we note that similar delegations were in place (at least in practice) for many years before this.

The Youth Justice Act requires that a conference is held, where practicable, with a young person who has committed a detention offence.[839] *Standard Operating Procedure No. 24: Conferencing* describes conferencing as 'an opportunity for both the offender and victim to enter a restorative discourse and for the offender to take responsibility for their behaviour and to make appropriate reparation'.[840] Standard Operating Procedure No. 24 also provides that sanctions may result from a conference, such as a 'good behaviour bond'.[841]

We understand that for a conference to be held, the offender must admit to the offence and agree to take part in the conference.[842] If possible, the conference should involve the victim, a support person, a guardian and appropriate staff representatives.[843]

As noted throughout the timeline and other sections in this case study, Centre management and staff allocated different levels of seriousness to the incidents involving Max, Henry, Ray, Albert and Finn. Despite detention offences being recorded against Albert and Finn, it is unclear whether conferencing took place.

Senior Quality and Practice Advisor

In line with Ashley Youth Detention Centre's *Referral to a Senior Quality and Practice Advisor Procedure*, clinical staff could seek the advice of a Senior Quality and Practice Advisor from the Department's Children and Youth Services division after an incident had occurred and about managing the behaviours of a detainee.[844] As outlined in Chapter 9 in relation to out of home care, specialised Senior Quality and Practice Advisors, and the Quality Improvement and Workforce Development Team they were in, were abolished during the Strong Families, Safe Kids redesign, which began in 2019.[845] Secretary Pervan told us these roles were substantively replaced with new roles performing similar functions, with the Senior Quality and Practice Advisor functions substantively transitioning to the Senior Development Manager role.[846]

The purpose of making a referral to a Senior Quality and Practice Advisor was to 'access an independent and impartial resource' that would 'provide guidance in relation to ethical considerations and practice, and provide objective, evidence-based recommendations'.[847]

The *Referral to a Senior Quality and Practice Advisor Procedure* required that:

- a referral was made by the Clinical Practice Support Officer or the Multi-Disciplinary Team
- the Multi-Disciplinary Team considered referring complex and critical cases to the Clinical Practice Support Officer in the first instance

- if the Multi-Disciplinary Team considered the matter to be unsuitable for referral to the Clinical Practice Support Officer (due to urgency, complexity or a requirement for independent investigation), the referral could be made to the Senior Quality and Practice Advisor
- the referral had to be endorsed by the Centre Manager
- the referral had to be approved by the Director, Strategic Youth Services.[848]

As we discuss later in this chapter, a referral was made to a Senior Quality and Practice Advisor after an incident involving Ray, Albert and Finn.

Serious Events Review Team

The Serious Events Review Team mentioned throughout this part is:

> … a small team of senior practitioners who undertake reviews when a child [or] young person … known to Children and Youth Services (CYS) has experienced a serious event, such as death, serious injury or 'near miss'.[849]

As described in Chapter 9, Ginna Webster, former Deputy Secretary, Children and Families, Department of Health and Human Services, established the Serious Events Review Team in 2017.[850] We were told this team was established in consultation with then Secretary Pervan.[851]

It is our understanding the Serious Events Review Team was disbanded in May or June 2020, but can be brought together on an ad hoc basis if required (refer to discussion in Chapter 9).[852] The team's former manager explained that its reviews usually involved the following process:

- The Children and Families Executive referred a matter to the Serious Events Review Team for review, along with the terms of reference of the review.[853]
- A Serious Events Review Team reviewer would undertake a comprehensive review of the matter in line with the terms of reference.[854] Their review would include desktop analysis of all relevant data as well as interviews with relevant staff.[855]
- The reviewer would prepare a draft review report, which was provided to a 'Moderation Group' for discussion.[856] The Moderation Group comprised the Manager, Workforce Development; the Manager, Clinical Practice Consultants and Educators; and the Manager, Policy and Director Service Deployment.[857] The Moderation Group was intended to run 'fresh eyes' over all aspects of the report, including editing and analysis.[858]
- The final report would be provided to the Executive of the Department and the Serious Events Review Committee, which comprised representatives internal and external to the Department.[859]

- The Serious Events Review Committee would consider the report and prepare advice to the Secretary.[860]

The former manager also explained the team's role 'was complete upon delivery of the final review reports'.[861] The Children and Youth Services Executive was responsible for implementing any recommendations.[862]

3.2 Max, Henry and Ray

Timeline of Responses to Harmful Sexual Behaviours at Ashley Youth Detention Centre, 2018–2022

On foldout →

3.2.1 Summary

Over an 18-month period in 2018 and 2019, there were at least six reported incidents where Albert or Finn had engaged in sexualised behaviours. These included:

- making sexualised comments
- discussing sexual activities with staff
- simulating sexual acts on other young people
- forcing residents to touch each other's genitals
- exposing their genitals and anus to other young people
- forcibly exposing the genitals and anus of other young people
- placing their hands down their pants in front of other young people.[863]

All but one of these incidents was recorded as a detention offence.[864] Max, Henry and Ray were all placed in the Franklin Unit with Albert or Finn at various times, exposing them to the risk of harm.

We received evidence that Finn's behaviours were serious enough to consider a transfer from Ashley Youth Detention Centre into the adult prison system. A transfer application was drafted in early 2019.[865] That application identified that Finn 'require[d] a high level of secure care because he represents a high risk to the security and safety of himself, other detainees, staff' and the Centre's operations.[866] The application noted 'numerous incidents of inappropriate sexual behaviour' with other residents and other instances of violence and intimidating behaviours while at the Centre.[867] The application also identified that Finn's mental health difficulties contributed to his risk of offending generally.[868] A report prepared by the Centre's psychologist (and included with the draft application) stated that Finn posed 'a High risk of future violence'.[869] The application acknowledged that the Centre did not have the resources to support Finn to address

Timeline of Responses to Harmful Sexual Behaviours at Ashley Youth Detention Centre, 2018–2022

2018

Max is placed with older detainees and experiences harmful sexual behaviours

June

The Serious Events Review Team reviews harmful sexual behaviours experienced by Max

2019

August 6

Henry is placed in the Franklin Unit

August 7

Henry experiences harmful sexual behaviours

August 8

Staff at Ashley Youth Detention Centre become aware of harmful sexual behaviours Henry experienced

August 9

The Centre Support Team discusses the harmful sexual behaviours Henry experienced

August 10

Another incident report is lodged about the harmful sexual behaviours Henry experienced

August 12

The Centre Support Team discusses Albert's and Finn's harmful sexual behaviours

August 13

Staff voice their concerns to the Centre Manager about the management of Albert and Finn

August 14

The Centre Manager notifies the Director, Strategic Youth Services of the incident involving Henry

August 19

The Centre Support Team again discusses the behaviours of Albert and Finn

Max is placed in the Franklin Unit

August 21

Centre management responds to concerns over Max's placement in the Franklin Unit

August 22

A staff member reports the harmful sexual behaviours Henry experienced to Child Safety Services

The Ashley Youth Detention Centre psychologist recommends risk management of harmful sexual behaviours

August 23

The Centre Support Team again discusses the behaviours of Albert and Finn

September 9

The Secretary is briefed about the 7 August 2019 incident involving Henry

September 18

The Ashley Youth Detention Centre psychologist alerts the Centre Manager of Henry's exposure to a risk of harm

September

Ray is admitted to Ashley Youth Detention Centre

October 8

The Ashley Youth Detention Centre psychologist reports harmful sexual behaviours to the Commissioner for Children and Young People

November 13–14

The Ashley Youth Detention Centre psychologist raises more concerns with the Centre Manager about Albert and Finn

November 15

The Ashley Youth Detention Centre psychologist documents her concerns about Albert and Finn in a letter to the Centre Manager

Early December

Behaviour management programs are initiated for Albert and Finn

Staff continue to raise concerns about Albert and Finn

December 6

The Ashley Youth Detention Centre psychologist again reports harmful sexual behaviours to the Commissioner for Children and Young People

December 9–10

The Director, Strategic Youth Services, initiates a review into the 7 August 2019 incident involving Henry

Mid-December

The Serious Events Review Team investigates the 7 August 2019 incident

December

Ray is moved to the Franklin Unit

The Multi-Disciplinary Team raises concerns about Ray's transfer to the Franklin Unit

2020

January 2

An incident occurs involving Ray, Albert and Finn

January 3

The Centre Support Team discusses the incident involving Ray, Albert and Finn

A staff member meets with the Director, Strategic Youth Services to discuss concerns about Ashley Youth Detention Centre

January 5

Ray attempts to escape from Ashley Youth Detention Centre

January 6

The Centre Support Team discusses the incident involving Ray, Albert and Finn

January 6

A referral is prepared to engage a Senior Quality and Practice Advisor

January 7

A management plan is developed for Ray

January 8

The Centre Support Team again discusses the incident involving Ray, Albert and Finn

A staff member reports concerns about the response to harmful sexual behaviours to the Director, Strategic Youth Services

January

The Ashley Youth Detention Centre psychologist informs the Department of Health about the poor response to the behaviours of Albert and Finn

January 20

The Secretary is briefed on concerns regarding Ray

January 28

Ashley Youth Detention Centre engages a Senior Quality and Practice Advisor

March 19

The Serious Events Review Team reports its findings and recommendations about the 7 August 2019 incident involving Henry

May 20

The Commissioner for Children and Young People receives the Serious Events Review Team's report about the 7 August 2019 incident involving Henry

2021

June

The Department responds to the Serious Events Review Team's report about the 7 August 2019 incident involving Henry

Post June

Reforms are implemented in response to the Serious Events Review Team's report

Mid-2021

Ray displays harmful sexual behaviours

December

Max asks to be transferred from Ashley Youth Detention Centre to adult prison

2022

Early

Max asks to be transferred from adult prison back to Ashley Youth Detention Centre

his behaviours, such as access to full-time mental health specialists.[870] We are unaware if the application to transfer Finn was ever lodged. It appears that Finn stayed at Ashley Youth Detention Centre at least until mid-2020 (whether as one uninterrupted admission or on multiple admissions).[871] We discuss the appropriateness of sending young people to adult prison below in relation to Max, but note this detail here because it indicates the Centre was aware of Finn's behaviours.

Max was only 12 years old when he was first admitted to Ashley Youth Detention Centre in the late 2010s.[872] We note that we have received evidence, from Centre staff and Max himself, that Max's behaviour during his 'lengthy history at the centre' could be complex and challenging.[873] Ms Gardiner told us she considered the decision by other staff to place Max in 'a unit with two detainees who had been observed to use sexualised behaviour' may have been made on the basis that '[s]ome staff found [Max] difficult to manage, and I am aware some staff did not like [Max]'.[874] Alysha gave evidence that Max was 'one of the most disliked children by the staff group'.[875]

Max told us he believes the harmful behaviours he experienced when he was first detained at Ashley Youth Detention Centre have had a lasting impact on his behaviour. He said: 'The abuse and how much they could have stopped it but didn't, is the main thing that has caused my behaviour problems'.[876]

On 6 August 2019, Henry was placed in the Franklin Unit with Albert and Finn.[877] Although Henry was technically a few months older than both Albert and Finn, we understand he may have been vulnerable in other ways. We have seen evidence that some Ashley Youth Detention Centre staff expressed concerns about his ability to process and retain information and noted that he was '[e]asily influenced by negative peers'.[878]

Henry was housed with Albert and Finn despite their behaviours being known to managers and staff at the Centre and despite Henry's care plan stating that he was 'vulnerable when with older boys and unable to be safe', as well as identifying that Henry had been the victim of an earlier incident in the Franklin Unit.[879] The care plan further stated that Henry was 'not to reside with [Albert] or [Finn]'.[880] Staff later reported that Henry was placed in the Franklin Unit 'because [Albert] and [Finn] would keep him in line'.[881] On 8 August 2019, Henry requested that he 'move units please anywhere'.[882]

Ray was first admitted to Ashley Youth Detention Centre in the late 2010s.[883] Ray had an extensive history of serious mental illness.[884] We are aware of multiple incidents and concerns during Ray's time in the Centre. In this case study, we focus on Ray's first admission to the Centre because the harmful behaviour he experienced was similar to that of Max and Henry.

When Ray first arrived at Ashley Youth Detention Centre, the Centre's psychologist emailed Operations Management staff with critical information about Ray.[885] The psychologist explained:

> The stability of [Ray's] mental health and the effectiveness of his care and management will strongly depend on his sense of safety and mitigation of stress. Thus, it will be important not only to carefully consider his unit and program placement, but also as far as possible to limit changes to his unit and group placements. Whilst I understand the operational difficulties arising from managing a group of youth all with their own set of complex needs, [Ray is] at a high risk of harm to himself and others.[886]

The psychologist identified that Ray experienced cognitive difficulties, suicidal ideation, hypervigilance, verbal and physical aggression and a 'vulnerability to the influence of others'.[887] To assist Ray during his time at the Centre, the psychologist made several recommendations to Operations Management, which were noted on Ray's care plan.[888] These recommendations included that Ray should be assisted with simple visual checklists outlining his daily schedule, that activities should be broken down so he did not get overwhelmed, and that he responded well to praise for good behaviour and gentle redirection if he was exhibiting signs of distress.[889] The psychologist shared her view that Ray would be suited to placement with a particular young person, and that his interactions would need to be closely monitored because they may rapidly deteriorate.[890]

During his detention, Ray was involved in numerous incidents that involved violence from and against other young people. Some professional services staff at the Centre tried to stop Ray being placed in the Franklin Unit because they considered other young people in that unit posed a significant risk to Ray.[891] Despite this, Ray was placed in the Franklin Unit. After a violent altercation with Albert and Finn, Ray tried to escape from the Centre.[892]

In late 2019, the Centre's psychologist emailed the Centre Manager to advise of a young person in detention disclosing to her that staff had threatened to transfer him to the Franklin Unit, that he felt unsafe, and that he had stated that detainees get 'stood-over, abused and raped' in the Franklin Unit.[893] The identity of the young person who disclosed these concerns to the psychologist is not revealed in the documents, but those concerns related to Albert's and Finn's behaviours.[894]

3.2.2 2018—Max is placed with older detainees and experiences harmful sexual behaviours

Max recounted to us that on his first admission to Ashley Youth Detention Centre he was placed in a unit with three older detainees, including Floyd (a pseudonym) and Ned (a pseudonym).[895] Max told us he warned staff that he would be abused if placed with those detainees, but he was placed in the unit anyway.[896] When the three detainees returned to the unit from the day's activities, Floyd threatened Max.[897]

Max said that once the single staff member supervising the unit walked away into an office, Floyd exposed his penis to Max and told him 'you're going to be sucking this'.[898]

When Max refused, Max told us that Ned began slapping him, at which point Max punched Ned.[899] Ned then began punching Max, knocking him to the ground, before jumping on his head.[900] Max recalled that the supervising staff member shouted at the detainees and called for assistance but otherwise did not intervene to stop the abuse until other staff arrived.[901]

After the abuse, Max recalled he was moved to another unit. But Max was still placed with two detainees who were older and bigger than him, and he recalled that he was bullied and physically and sexually abused further, with the older detainees hitting him and pinching his buttocks.[902] Max recalls that one of the detainees was Arlo (a pseudonym).[903] He could not recall the name of the other detainee, but we know from other evidence available to us, including a Serious Events Review Team report, that the other detainee in the unit with Max and Arlo was Albert.[904]

About a week after he was moved to that unit, Arlo and Albert confronted Max, at which time Max says Arlo sexually abused him with a table tennis bat.[905] We understand that Albert was also involved.[906] Max told us nothing was immediately done to keep him safe after that incident. He remained in the unit with Arlo until he was eventually moved to a different unit for unrelated reasons.[907] An incident report was prepared three days after the incident occurred, but it is not clear to us whether any staff were aware of the incident earlier than this because staff were outside the room responding to a request for help at the time it occurred.[908] The incident report states it was prepared based on CCTV footage. It is also unclear to us how staff became aware of the incident and the existence of the CCTV footage.[909]

On his next admission to Ashley Youth Detention Centre, Max was again placed in a unit with Floyd, the detainee who had sexually abused him previously:

> Before I got taken to the unit, I asked the youth workers who I was going to be with. They told me that it was someone from the North West that I wouldn't know. When I got to the unit I saw that the other person was [Floyd]. [Floyd] was the only other resident in there. I dropped all of my stuff and lost my shit and started screaming 'what's going on here'. The staff called a code black and while they were trying to restrain me, I assaulted one of the staff members. I was saying to the staff 'why the fuck are you putting me back in here when he tried to rape me'. They said that I was exaggerating. They told me that if I didn't calm down I would be put in isolation. After I calmed down, they told me that there was nowhere else I could go so I'd have to stay with [Floyd] in Bronte west.[910]

While Max notes that Floyd apologised to him, Max was still scared and decided that he 'would do something that would get [him] moved from the unit'.[911] Max damaged the ceiling in his room and was moved to another unit.[912]

It is unclear to us how meaningfully Centre staff considered Max's concerns about his unit placement at the time of the previously mentioned incidents. However, we have received evidence that suggests the Multi-Disciplinary Team discussed

Max's relationship with Floyd as an issue relevant to his unit placement in August and September 2018 (after the Serious Events Review Team completed its review, referred to in the next section). At that time, the Multi-Disciplinary Team recommended that Max and Floyd not be placed in the same unit or program group, noting that Max's desire to move units was likely related to his interactions with Floyd and that Max 'does not operate well when housed with' Floyd.[913]

3.2.3 June 2018—The Serious Events Review Team reviews harmful sexual behaviours experienced by Max

The Serious Events Review Team carried out a review into the two instances of harmful sexual behaviours Max experienced. This review was prompted by notifications from Child Safety Services in March and April 2018 following a report from Max's solicitor to Tasmania Police alleging that Ned had sexually abused Max at Ashley Youth Detention Centre.[914] The Serious Events Review Team's report covered the incident involving Floyd and Ned, as well as the incident involving Arlo and Albert.

In relation to the incident involving Floyd and Ned, the Serious Events Review Team investigated it as the 'alleged "rape" of [Max] by [Ned]' because the incident was notified to police in those terms by Max's solicitor.[915] The Serious Events Review Team broadly found that no rape or sexual abuse had occurred.[916]

The Serious Events Review Team's report stated that Max told the investigator that Ned commanded Max to perform oral sex on him before Ned physically abused Max.[917] We note that this is slightly inconsistent with Max's evidence to us that it was Floyd who gave this command while exposing his penis to Max before Ned hit Max. Regardless, the report contained no detailed analysis of the sexualised behaviour and abuse experienced by Max, instead focusing on whether the notified allegation of a rape was substantiated. Indeed, Max's experience of harmful sexual behaviour was met with no significant comment from the investigator other than the finding that 'no sexual assault of [Max] by [Ned] has occurred at [Ashley Youth Detention Centre] on the information available'.[918] We note that the Serious Events Review Team report did not mention Floyd's involvement.[919]

The Serious Events Review Team's report notes that the material the investigator reviewed 'shows a response to the incident as consistent with the current [Centre] procedures', including providing medical care for Max, conversations with Max encouraging him to report the matter to police, involving Max's parents and conferencing with Ned once Max declined to make a formal complaint.[920]

Regarding the incident involving Arlo and Albert, the Serious Events Review Team found a significant issue in the original incident report. The incident report, which was written with reference to the CCTV footage of the incident, stated the following:

- Supervising staff left the three young people unsupervised in the unit after staff attended to a code black emergency in another part of the Centre.

- Arlo and Albert then harassed and abused Max, with Albert jumping on Max's back and making sexually suggestive motions.
- Albert pulled Max's pants down before Max pulled them back up.
- Albert continued to intimidate Max, approaching him with his hand down his pants.
- Arlo removed his erect penis from his pants and encouraged Max to touch it, which Max did.
- Max was obviously upset and appeared to be crying.
- Arlo and Albert made comforting gestures to Max before staff returned to the unit.[921]

The incident report recorded that Arlo and Albert had both perpetrated abuse. Both were 'conferenced' in relation to 'inappropriate sexual behaviour', which meant they were required to meet and discuss the nature and impact of their actions with Centre staff.[922]

The investigator reviewed the CCTV footage as part of preparing the Serious Events Review Team report, finding the following:

- The footage showed staff leaving the young people unsupervised in the unit, Albert jumping on Max's back, Arlo and Albert harassing Max and Albert seemingly comforting Max when he became upset.
- The footage did not show Albert making sexually suggestive motions while on Max's back or Arlo removing his erect penis from his pants, but rather appeared to show him with a table tennis bat in his hand throughout the incident.[923]

The report noted that Arlo had 'accepted full responsibility for the incident' but denied the characterisation of the incident during conferencing, stating that it was a table tennis bat in his hand rather than his penis, and that this was consistent with the investigator's review of the CCTV footage.[924] This was also consistent with Max's characterisation of the incident to the investigator when Max was interviewed, as well as his evidence to us, in that Arlo attempted to sexually abuse him with a 'ping pong bat'.[925] The report also noted Albert 'agreed to having committed the offence' as part of the conferencing process.[926]

The Serious Events Review Team found that neither Arlo nor Albert perpetrated a sexual abuse based on the information available to the investigator:

> In conclusion, the CCTV footage of the incident does not clearly portray sexual motions by [Albert], nor does it clearly show the exposure of a penis by [Arlo]. [Max] now states that [Arlo] had a table tennis bat in his hand. This was also the claim made by [Arlo] during the Conferencing process. There is insufficient information to substantiate sexual assault based on the information available at this point in time.[927]

The investigator acknowledged the incident involving Albert and Arlo was 'likely to be intimidating and frightening for [Max]', but otherwise made no significant findings beyond the factual occurrence and characterisation of the incident.[928]

The limitations of the review were noted in the following comment from the investigator:

> … [a] review of records at [Ashley Youth Detention Centre] found multiple Incident Records referencing 'Inappropriate Sexual Behaviour' involving youth detainees other than the three residents referenced in this Review. By nature of being a youth detention centre and the known pathway to offending behaviour resulting in detention, the residents of [Ashley Youth Detention Centre] are majority male, adolescent and are likely to have dysfunctional backgrounds including exposure to family violence, poor parenting, poor school attendance, interface with child protection services and general trauma history. The result of this can be poor social skills, impulsivity and skills in understanding the impact of behaviour on others. These factors can result in behaviours in a detention centre that are far from ideal within the community, but must be managed on a daily basis within a detention centre setting.[929]

The investigator went on to comment that:

> It is outside the scope of [the Serious Events Review Team] to provide recommendations as to the response of [Ashley Youth Detention Centre] to such behaviours both at a Centre and individual resident level. However, it may be useful to consider expert review, advice and on-going consultation concerning this issue to support [the Centre] to assist residents to develop socially appropriate behaviours for transition to the community.[930]

The Serious Events Review Team's report also stated that Centre management had 'openly acknowledged the action of both Youth Workers leaving the residents unsupervised in the unit was in breach of procedure' and the staff members involved had also acknowledged the error and its role in the incident occurring.[931] Aside from the lack of staff supervision, the report noted that staff and management at the Centre 'appear to have responded to this incident in a manner consistent with their procedures'.[932]

The report further noted that Max later raised concerns about being in a unit with Arlo and that the records reviewed showed 'professional discussion and debate about this' at the Centre.[933] Minutes of a Centre Support Team meeting dated shortly after the incident involving Arlo and Albert and attached to the Serious Events Review Team's report indicated that Max was upset by the incident but did not want to move units at that time.[934] The minutes suggested staff were responding to Arlo and Albert's harmful sexual behaviours and that Max would be offered counselling with the psychologist.[935]

Based on the evidence we received, we are concerned that Max was the victim of harmful sexual behaviours in the incident involving Albert and Arlo. Penetration, or attempted penetration, with a table tennis bat is a serious instance of harmful sexual behaviour. The Serious Events Review Team's conclusion that because

'sexually suggestive motions' were not clearly visible on CCTV meant that harmful sexual behaviours did not occur is not, in our view, a sound one, particularly given the relevant incident report and the accounts from the young people involved supported a conclusion that harmful sexual behaviours involving a table tennis bat had occurred.

The choice of units in which Max was placed, in the context of his victimisation and subjection to harmful sexual behaviours by other young people in detention, continued to be an issue at the Centre for more than 12 months after the incident with Arlo and Albert. In this chapter, we further discuss Max's subsequent subjection to other harmful sexual behaviours while detained in the Franklin Unit.

3.2.4 6 August 2019—Henry is placed in the Franklin Unit

On 6 August 2019, Henry was placed in the Franklin Unit with Albert and Finn.[936] As previously outlined, this was despite a care plan for Henry stating that he was 'not to reside with [Albert] or [Finn]', that Henry was not safe being housed with older boys and that Henry had been the victim of an earlier incident in the Franklin Unit.[937]

There was a lack of evidence to explain why Henry was moved to the Franklin Unit. Documents later prepared by Centre Manager Stuart Watson stated that no risk assessment or Centre Support Team process appeared to have taken place before or after Henry was moved to the Franklin Unit.[938] Whatever the reason for the move, Pamela Honan, Director, Strategic Youth Services, acknowledged in her evidence that 'the decision to place [Henry] into [the Franklin] unit was not properly considered or risk assessed'.[939]

3.2.5 7 August 2019—Henry experiences harmful sexual behaviours

On 7 August 2019, an incident occurred involving Albert, Finn and Henry. We have reviewed the CCTV footage of this incident, which does not contain audio.[940] The CCTV footage shows Henry seated in a common room in the Franklin Unit with Albert, Finn and another resident, Jonathan (a pseudonym).[941] Henry was approached by Finn and Albert, who pulled Henry to the ground. During the incident, Finn and Albert pulled Henry's pants down, exposing Henry's buttocks and then Albert held a bottle near Henry's exposed buttocks. After the incident, Albert and Finn left the room and Henry pulled his pants back up and retied the drawstrings. The incident lasted for approximately 20 seconds and staff members were not present. Jonathan remained in the room throughout the incident.

Finding—In August 2019, Henry (a pseudonym) was exposed to an unacceptable risk of harm and experienced preventable harm at Ashley Youth Detention Centre

Henry was placed in the Franklin Unit despite a care plan for Henry stating that he was 'not to reside with [Albert] or [Finn]', that Henry was not safe being housed with older boys and that Henry had been the victim of an earlier incident in the Franklin Unit.[942]

The behaviours Finn and Albert expressed towards Henry were non-mutual or non-consensual sexual behaviours involving force and fall within accepted definitions of harmful sexual behaviours. Albert and Finn's harmful sexual behaviours towards Henry were preventable.

3.2.6 8 August 2019—Staff at Ashley Youth Detention Centre become aware of harmful sexual behaviours Henry experienced

It appears staff were first alerted to the 7 August 2019 incident the following day when Finn, Albert and another young person at the Centre, Frank (a pseudonym), joked about an attempted rape of Henry with a water bottle.[943] That conversation was not documented until 10 August 2019 (the relevant incident report is described in the next section). Staff identified the incident as likely having occurred on 7 August 2019 and that the matter should be notified to the Operations Coordinator at the Centre, Maude (a pseudonym).[944]

On 8 August 2019, Albert and Finn were involved in other incidents in the Franklin Unit in which they made sexualised gestures and appeared to try to engage other young people in sexualised acts.

On 8 August 2019, Henry asked that he 'move units please anywhere'.[945] A staff member documented at that time that 'staff are keeping a close eye on interactions between the new residents and the three Franklin residents' and that Henry was 'very uncomfortable and a bit nervous'.[946]

3.2.7 9 August 2019—The Centre Support Team discusses the harmful sexual behaviours Henry experienced

The first documented report about the 7 August 2019 incident was lodged on 9 August 2019. That report recorded that a staff member had heard Finn and Albert telling other residents: '[Henry] is a bitch, he won't even come out of his room, we fucked him with a water bottle. He was resisting until we got his pants down'.[947]

An Interim Centre Support Team meeting took place on 9 August 2019. The minutes of this meeting stated:

> Franklin staff noticed [Henry] removing himself from the general population and upon conversation with [Henry] he advised that during his time in Franklin he has been receiving unwanted attention from [Albert] and [Finn]. Footage for the times suggested in the conversation have been reviewed but this shows more attention towards [Jonathan] than to [Henry] as [Henry] is not present.[948]

The Centre Support Team determined that Henry and Jonathan should be immediately moved from the Franklin Unit and asked if they would like their parents notified.[949] The minutes also noted that more information about behaviour and comments staff had heard or seen needed to be recorded before the next Centre Support Team meeting.[950]

Also on 9 August 2019, the Operations Coordinator, Maude, viewed the CCTV footage of the 7 August 2019 incident.[951] Maude included the following description of the CCTV footage in another incident report relating to Albert, which she lodged on the same day:[952]

> [Finn] walks toward [Henry] with [Albert] following. Both boys then grab [Henry] by the legs and pull him off his chair. [Henry] holding on firmly to his track pants, fights against [Finn] & [Albert] trying to pull his trackpants down. [Henry] ends up on his side. [Albert] reaches for the drink bottle and in a swooping manner brings it towards [Henry]'s buttocks. Both [Finn] & [Albert] quickly stand up and move towards the TV room entrance. [Henry] stands up and is seen to be pulling his track pants up which were clearly sitting below his buttocks at the back. During the ordeal it appears [Henry] holds onto the front of his trackpants. [Finn] has his back to the camera and is bent over the top of [Henry]. [Albert]'s face is [noticeable] to the camera and he is also bent over the top of [Henry].[953]

The incident report notes that the behaviour was not unusual or out of character for Albert.[954] We were not provided with a copy of any corresponding incident report specific to Finn or Henry.

Maude recommended the incident be recorded as a detention offence for Albert and Finn.[955] It is unclear whether Maude's viewing of the CCTV footage or completion of the incident report occurred before or after the Centre Support Team meeting on 9 August 2019.

3.2.8 10 August 2019—Another incident report is lodged about the harmful sexual behaviours Henry experienced

An incident report was lodged on 10 August 2019 about the conversation between Albert, Finn and Frank that staff overheard on 8 August 2019.[956] The report noted the following:

- Albert said Henry had 'put himself in his room because he was scared of being raped' and Albert had told Henry that 'he rapes little boys like him'.[957] When the staff member asked whether Albert was joking, Albert laughed and said, 'well yeah obviously—but not really'.[958]

- Frank told Clive (a pseudonym), a youth worker, that Henry had locked himself in his room because 'we tried to rape him'.[959] When asked whether he was joking around, Frank said: 'No, we actually tried to'.[960] We note that Frank was not present at the incident on 7 August 2019.
- Finn, Albert and Frank were talking about 'pulling someone's pants down, a bottle and holding someone down'.[961]
- Finn repeatedly said: 'I don't want to go to prison for rape—I hope they do not check the cameras'.[962]
- Finn stated the incident occurred while one staff member was in the toilet and the other was playing cards with another young person.[963]
- Frank told Clive about another incident of sexual behaviour between young people, stating: 'I told [Finn] that I'd give him a coke if he touched me on the dick and he did'. Finn and Albert confirmed the incident happened as Frank described.[964]
- 'In general, the sexualised talk in Franklin has escalated beyond normal "teenage boy" talk' since Henry and Jonathan were moved to the Franklin Unit.[965]
- Finn told the staff members present: 'Can you please stop putting small boys with long hair in this unit, we have been locked up a long time and we take out our sexual frustrations on them'.[966]

We are not aware of the reason for the two day delay in lodging this incident report.

3.2.9 12 August 2019—The Centre Support Team discusses Albert's and Finn's harmful sexual behaviours

On 12 August 2019, the incident involving Albert and Finn on 7 August 2019, and the subsequent discussions between the young people in detention on 8 August 2019, were again discussed at a Centre Support Team meeting.

The minutes of this meeting stated that there would be 'zero tolerance with this behaviour and talk'.[967] The Centre Support Team was of the view that the level of seriousness of Albert's and Finn's behaviour warranted a 'detention offence' for each of them.[968] It was recorded that conferences would be held with Albert and Finn and that neither would 'progress further than orange [colour level under the behaviour management system] until they attend'.[969] Albert (originally on the yellow colour level) and Finn (originally on the green colour level) were put down to the orange colour level, indicating disapproval of their behaviour under the behaviour management system.[970] Under a section titled 'Positive Words' for each of Albert and Finn, it was commented that each 'had [a] good week aside from their incident reports'.[971]

The minutes also recorded a discussion about Henry's behaviour regarding an unrelated incident on 5 August 2019, but he was moved from the red colour level to the orange colour level and taken off being 'unit bound'.[972] There is no record of the impact of the 7 August 2019 incident on Henry. The only reference to Henry being subjected to harmful sexual behaviours was that '[Henry] was moved back to Bronte [Unit] due to some standover behaviour that [Henry] was subject to in Franklin'.[973] We found the use of the phrase 'standover behaviour' surprising. We are concerned it may indicate a lack of appreciation of the seriousness of what occurred to Henry in the Franklin Unit, particularly because Operations Team staff had heard Finn and Albert talking about 'raping' Henry.[974]

The meeting minutes do not record any dissent in the decision to place Albert and Finn on the orange colour level.[975] Ms Gardiner recalled, however, that she was present at that meeting and had made recommendations that were not followed.[976] In our public hearings, Ms Gardiner told us she had disagreed with the decision to place Albert and Finn on the orange colour level, believing red was the most appropriate colour for this incident.[977] Ms Gardiner further stated that the rationale at the meeting for not placing Albert and Finn on red was because 'they would drop their bundle and that would cause some behaviour problems', creating difficulties for Centre management.[978]

On 12 August 2019, Patrick Ryan, then Centre Manager, prepared and distributed a document titled *AYDC Weekly Report*.[979] Referring to the 7 August 2019 incident, the report stated:

> An incident involving sexualised behaviour in Franklin was considered on the 9 August 2019 and reconsidered at [the Centre Support Team meeting]. Appears to be silly behaviour but [detention offence] for conferencing.[980]

We don't know who received this weekly report.

3.2.10 13 August 2019—Staff voice their concerns to the Centre Manager about the management of Albert and Finn

On 13 August 2019, Ms Gardiner emailed Mr Ryan and some members of the Centre Support Team to reiterate her view that the Centre Support Team's response to Albert and Finn's behaviour was inappropriate. She voiced the following concerns:

- Moving Finn and Albert to the orange (not red) colour level was inconsistent with other Centre Support Team decisions and did not appropriately reflect the nature and seriousness of the offending.[981]
- The rationale for moving Albert and Finn to the orange (not red) colour level was inappropriately influenced by concerns about Albert's and Finn's response to the colour level, and not on Henry's wellbeing. Ms Gardiner criticised the rationale, which she identified as being that 'on Red colour these two residents will "drop

their bundle" or similar', that the Centre would struggle to manage Albert and Finn on red, and that Albert and Finn were long-term residents and would be experiencing some sexual frustration.[982]

- The Centre needed to notify Child Safety Services and the parents of the young people in detention, and to arrange support for all involved.[983] She reminded Mr Ryan and the Centre Support Team that 'in the community this would be [considered] a level of abuse, and we are mandatory reporters'.[984]
- Staff were minimising Finn and Albert's behaviour and needed training in relation to harmful sexual behaviours.[985]

On the same day, the Health and Community Services Union delegate emailed Mr Ryan on behalf of members to raise concerns about Centre Support Team decision making.[986] The email stated that 'conferencing and a slap on the wrist will not be seen by either myself or [union] members as appropriate in this circumstance'.[987] The later Serious Events Review Team report stated that the delegate also noted there were inconsistencies in the Centre Support Team decision making, such as 'awarding more severe consequences for physical assault than were awarded for sexual assault'.[988]

In his response to the delegate, Mr Ryan questioned why the members had approached the union and had not considered using internal mechanisms to address their concerns in the first instance.[989] We are unaware of the steps Mr Ryan took, if any, to address the union's concerns.

3.2.11 14 August 2019—The Centre Manager notifies the Director, Strategic Youth Services of the incident involving Henry

The Serious Events Review Team's report regarding Henry dated 19 March 2020 recorded that, on 14 August 2019, Mr Ryan contacted Greg Brown, the then Director, Strategic Youth Services, via email to notify him of the incident and the differences in opinion among staff about the nature of the incident.[990] The email (as extracted in the report) stated:

> I have viewed the footage, and I do not view it as a sexual assault. But the centre is full of armchair critics and some [youth workers] have gone to their [Health and Community Services Union] delegate who has put his two cents worth in.[991]

We discuss Mr Ryan's description of the incident below.

Henry also had an appointment with the Centre's psychologist on 14 August 2019, during which he revealed he was feeling threatened and had isolated himself in his room for safety.[992] After that appointment, Professional Services Team members noted that Henry was reluctant to talk about the incident, possibly due to fear of retribution.[993] There is no clinical record indicating Henry attended any more individual sessions with the psychologist before his release from the Centre a few months later, but he attended group work, including sessions concerning healthy relationships.[994]

Evidence indicates Henry was offered an opportunity to make a complaint to police but he declined to do so.[995] We do not know when that offer was made.

3.2.12 19 August 2019—The Centre Support Team again discusses the behaviours of Albert and Finn

Another Interim Centre Support Team meeting occurred on 19 August 2019.[996] The minutes of this meeting recorded that Albert and Finn were moved from orange to yellow colour under the behaviour management system.[997] The rationale for this change was not explained in the minutes, but the minutes do record that Finn had 'quickly improved his behaviour following last week's incidents'.[998]

The minutes recorded that the Centre's psychologist 'feels that there is a pattern of behaviour over more than a day with [Finn] & [Albert] that needs to be addressed'.[999] It was noted that the psychologist would continue to work with Albert, but that Finn did not engage with the psychologist.[1000] There was no suggestion of alternative therapeutic supports for Finn. The minutes also stated that 'careful consideration' was to be given to any unit or program placements with Finn and Albert, acknowledging the pair tended to 'buddy up' and display problematic behaviours.[1001]

The minutes of this meeting also suggested that Albert and Finn's sexualised behaviour was affecting other young people in the Franklin Unit. The minutes record that Frank, who remained in the Franklin Unit with Albert and Finn, had been 'intimidated by [others'] behaviour in the unit, which may be why his comments around sexualised behaviour have increased'.[1002]

At this point, neither Albert nor Finn had attended a conference about the 7 August 2019 incident. The minutes acknowledged the need to prioritise conferencing in relation to the incident.[1003]

The Centre's psychologist took her own notes from this meeting, which included the following observations:

> Provided the members of the [Interim Centre Support Team] meeting with a summary of the incidents reviewed on the Franklin video footage. Raised concerns regarding: the seemingly organised nature of the intimidation behaviour; repeated sexualised behaviours including indecent exposure, sexualised harassment and bullying, assaultive behaviour with a threat/intimidation of sexual violence; and non-sexualised bullying/intimidation.[1004]
>
> … Mr Ryan and [a staff member] disagreed with the seriousness of the incidents, describing the incidents as 'horseplay' and comparing them to behaviours observed in the community in various sporting teams. Furthermore, Mr Ryan, [a staff member] and [another staff member] appeared to affirm the risk management and the sanctions taken as proportionate to the nature of the incidents (CST meeting minutes 12/08/2019). However, [one staff member] conceded that should the victims involved in the incident have been female, the response to the incident would have been different, 'would have unleashed a war'.[1005]

> A further concern was raised that in the context of frequent and ongoing moves of residents between units the steps taken to ensure the immediate safety of the victims (i.e. moving them to another unit) may be insufficient to provide them with a perceived sense of and actual safety at [the Centre]. [One staff member] acknowledged the concerns, stating that selection of residents to be placed in a unit with either [Finn] or [Albert] would require special attention whereby younger and more vulnerable residents may be deemed to be at high risk of victimisation.[1006]

Mr Ryan denies describing the incidents as horseplay and comparing them to behaviours of sporting teams.[1007]

In the Ashley Youth Detention Centre Weekly Report, dated 19 August 2019, it was noted that:

> … sexualised behaviour by some residents last week was re-visited this week. Residents have moved units as a practical response. CPR and case conferencing are also practical and theoretical responses.[1008]

The extent of any therapeutic intervention provided to Albert and Finn is unclear.[1009] We do not know the extent to which Albert continued to engage with the psychologist. We are also unaware of what other supports the Centre offered Finn after he declined to engage with the psychologist.

3.2.13 19 August 2019—Max is placed in the Franklin Unit

On or around 19 August 2019, Max was transferred to the Franklin Unit. Max's placement in that unit raised concerns among the Centre's professional services staff. These concerns appear to have arisen because of the presence of other detainees in that unit, namely Albert and Finn. As noted, this was the second time Max had been placed in a unit with Albert, who had previously been involved in an allegation of an incident of harmful sexual behaviour directed at him.

Notably, Max's placement in the Franklin Unit with Albert and Finn occurred about two weeks after Albert and Finn had displayed harmful sexual behaviours towards Henry and at a time when the Centre's management and staff were still considering the seriousness of that incident.[1010]

It is unclear to us why Max was placed in the Franklin Unit. The Centre Support Team meeting minutes from the day the decision was made to transfer Max do not reflect any discussion about his placement in the Franklin Unit.[1011] Rather, those minutes state that Max was requesting a transfer and had been moved between different units (not Franklin) within the Centre.[1012] We infer from this that the decision to place Max in the Franklin Unit was made after that meeting, likely by Operations Team staff without the direct input or consideration of the Centre Support Team.[1013]

3.2.14 21 August 2019—Centre management responds to concerns over Max's placement in the Franklin Unit

On 21 August 2019, Ms Gardiner emailed her concerns about Max's placement in the Franklin Unit to Mr Ryan and the Operations Manager:

> I am raising the serious risk to [Ashley Youth Detention Centre], [Max] and Franklin residents of the placement of [Max] in the Franklin unit with the current residents.
>
> Recently there has been a number of incidents of serious sexually inappropriate behaviour from [Albert] and [Finn] to other residents.
>
> [Max] has been the subject of [Serious Events Review Team] review of incidents where he has reported being sexually assaulted by other residents. One of these incidents was by [Albert].
>
> This unit placement is very inappropriate. It places [Max] at risk of being exposed to further sexual incidents, which he already feels vulnerable to. As well as puts [Albert] and [Finn] in a position of risk of continuing this behaviour, as they have done this in the past.
>
> The decision also put[s] [the Centre] at risk from a significantly concerning incident occurring regarding sexualised behaviour.
>
> I cannot imagine [Max] would feel very safe in this unit – with one resident who has previously been the subject of sexually inappropriate behaviour towards him, and now he is with two residents for who there is evidence of sexually abusive behaviour.
>
> I request this [unit] placement be [reviewed] asap to ensure the safety of residents.[1014]

In her statement to us, Ms Gardiner referred to the placement of Max in the Franklin Unit as an example of some operational staff failing to adequately consult other Centre staff about placements and making placement decisions outside the processes of the Centre Support Team.[1015]

In response to Ms Gardiner's concerns about Max's placement, the Operations Manager appears to have immediately recognised the risk and addressed the issue, transferring Max to another unit.[1016] In his response to Ms Gardiner, the Operations Manager also noted that the decision to place Max in the Franklin Unit had been made by other staff two days prior, while he was on leave.[1017]

Ms Gardiner told us she also raised concerns with Mr Ryan about the risk posed by Operations Team staff making placement decisions without proper consultation. Ms Gardiner stated that Mr Ryan's response was that she should 'read the "Unit Moves" policy'.[1018] Ms Gardiner said that, after reviewing that policy, she told Mr Ryan the policy, as applied in practice, placed young people at risk and needed to be reviewed.[1019]

Mr Ryan has provided us with his own file note of his initial conversation with Ms Gardiner, which records her objection to the placement decisions and processes.[1020] It also records Mr Ryan explaining that the levels of '[Operations Coordinator] and up can use' the relevant procedure to make unit placement decisions.[1021] Mr Ryan's note also records that:

> [Ms Gardiner] suggested that staff need supervision, and to involve [Professional Services and Policy] in unit moves. I explained that an operational decision can be made, if it's based on operations. Thus any discussion on concerns go to the [Operations Coordinator] and/or [the Operations Manager].[1022]

We understood Mr Ryan's note to mean that some Operations Team staff could make decisions about unit moves if there was an operational reason to do so. An example of an operational reason for a unit move might be damage to unit infrastructure that required a young person to be moved to a different unit.

3.2.15 Observations—Placement decisions involving Max

We were concerned by the evidence that Max was placed in the Franklin Unit with Albert and Finn only a matter of weeks after these two young people had engaged in harmful sexual behaviours against Henry, and at a time when Centre management and staff were still considering the seriousness of that incident. We note that before Max's placement in the Franklin Unit he had also been subjected to harmful sexual behaviours by Albert.

Ashley Youth Detention Centre was aware of concerns about Max's safety. As previously outlined, Ms Gardiner had raised concerns soon after the decision was made to place Max in the Franklin Unit, making clear her disagreement with the decision considering Max's vulnerability, the previous behaviour of Albert towards Max and the harmful sexual behaviours engaged in by Albert and Finn. A few days later, Ms Gardiner raised her concerns about Operations Team staff making placement decisions without proper consultation. We are concerned that operational matters were prioritised over protecting young people from the risk of harmful sexual behaviours.

While Max was ultimately placed in a different unit without incident, it appears that no Centre-wide steps were taken to ensure that Max or other vulnerable young people would not be placed in a unit with detainees who were known to engage in harmful sexual behaviours. There should be an integrated, consistent and trauma-informed approach to unit placements in youth detention.

Ms Gardiner's diligence in identifying risks and advocating for Max's safety is to be commended.

Finding—In August 2019, Max (a pseudonym) was exposed to an unacceptable risk of harm at Ashley Youth Detention Centre

Ashley Youth Detention Centre did not adequately consider the risk to Max of him being placed in the Franklin Unit, despite concerns being raised about Max's safety. Max was exposed to an unacceptable risk of harm.

3.2.16 22 August 2019—A staff member reports the harmful sexual behaviours Henry experienced to Child Safety Services

A week after expressing her view that Child Safety Services should be notified of the 7 August 2019 incident involving Henry, Ms Gardiner had received no response from the Centre Support Team or Mr Ryan, so she revisited the matter with Mr Ryan.[1023] On 21 August 2019, Mr Ryan responded, stating there were 'varying views on [the] level of seriousness of the matters' and while he was not 'convinced' a Child Safety Services notification was necessary, he was 'happy to take more argument on it'.[1024] Ms Gardiner responded the next day, stating she would advise Child Safety Services of the incident and leave it to them to determine whether it was to be a notification that required further follow-up.[1025]

On 22 August 2019, Ms Gardiner reported the incident involving Henry to Child Safety Services' Advice and Referral Line.[1026] Advice and Referral Line records indicate Ms Gardiner reported that Albert and Finn were masturbating in the TV room before the incident with Henry.[1027] Ms Gardiner also provided further information about an incident involving another young person on 8 August 2019 (where he was subjected to a resident 'exposing himself and masturbating') and lodged a care concern about Max in relation to his placement with Albert and Finn.[1028]

The records of Ms Gardiner's call with the Advice and Referral Line also suggest there was a discussion about the need to notify police.[1029] On 23 August 2019, Ms Gardiner emailed Mr Ryan, saying that Child Safety Services told her they would make a report to police.[1030]

Mr Ryan told us he had escalated the 7 August 2019 incident and Child Safety Services' report to Mr Brown, who advised him to leave the matter to the police.[1031] Mr Brown said he does not recall advising Mr Ryan to leave the matter to the police.[1032]

There appears to have been confusion, however, between Ashley Youth Detention Centre and Advice and Referral Line staff about who would notify police, with each entity believing the other would make the notification.[1033] By early October 2019, no police notification had been made.[1034] The Advice and Referral Line notified police of the incident on 3 October 2019 after an Ashley Youth Detention Centre staff member

informed them the Centre had not made a referral about the incident.[1035] The Advice and Referral Line file of the incident was closed on 11 November 2019.[1036]

Police records confirm that police were first notified of the incident on referral from Child Safety Services. However, they did not proceed with an investigation because 'no formal complaint' had been made.[1037] We note that the lack of a formal complaint should not be the sole reason for police inaction, particularly when there may be serious barriers for a victim-survivor making a formal complaint.

3.2.17 22 August 2019—The Ashley Youth Detention Centre psychologist recommends risk management of harmful sexual behaviours

Also on 22 August 2019, the Centre's psychologist emailed Ms Gardiner a spreadsheet she had prepared after reviewing footage of incidents in the Franklin Unit.[1038] The spreadsheet summarised incidents of sexualised and non-sexualised threatening and harmful behaviours displayed by Albert and Finn, including the 7 August 2019 incident involving Henry.[1039] The summary does not appear to address all matters or incidents identified in the various incident reports lodged on 9 and 10 August 2019.

In the email to Ms Gardiner, the psychologist noted disagreement about the 'nature and the seriousness of the behaviours' seen in the Franklin Unit.[1040] The psychologist reasoned that this disagreement could be explained by differences in individual and work experience, the extent of staff training and a:

> … general tendency [among Ashley Youth Detention Centre staff] to minimise or dismiss young people's sexually abusive behaviour as experimentation or play, or as a 'phase' that will pass with age … which inadvertently perpetuates the cycle of abuse.[1041]

The psychologist's view was that Finn and Albert had displayed 'concerning and developmentally inappropriate sexual behaviours'.[1042]

The psychologist recommended the following responses:

- further investigation of the incidents
- urgent development of clear risk management strategies, such as increased supervision of the young people who displayed sexually abusive behaviours
- staff training
- more discussion about appropriate therapeutic interventions.[1043]

Ms Gardiner forwarded the psychologist's advice to Mr Ryan on the same day, noting the Centre had 'some work to do to upskill staff in this area. It is a significant risk otherwise' and repeating a request for education/training from a sexual assault service.[1044] Mr Ryan responded to Ms Gardiner, stating that he believed the Department of Education had booked training for Centre staff through the Sexual Assault Support Service for the 2019

school year and encouraged Ms Gardiner to engage the Sexual Assault Support Service for resident programs.[1045] Mr Ryan directed Ms Gardiner to work with the Learning and Development Manager, Strategic Youth Services at the Department of Communities to arrange staff training.[1046]

Ms Gardiner told us she was particularly concerned that:

> … staff in leadership positions were not aware of [harmful sexual behaviours] and this had created a situation of sexual abuse in the Centre, and would create more risk for young people in the future if this was not addressed.[1047]

Over an extended period, Ms Gardiner had contacted several senior staff at the Centre and in the Department to request group training on harmful sexual behaviours, but she said she received no response.[1048]

Mr Ryan provided information to our Commission of Inquiry that during the time he managed the Centre, a number of relevant training programs were provided for staff.[1049] He also made repeated attempts to arrange for the Sexual Assault Support Service to deliver training for Centre staff in relation to harmful sexual behaviours.[1050] He stated that in 2019 the program was implemented for detainees at Ashley School, with the support of the Principal.[1051] However, training for staff was not implemented because, according to Mr Ryan, successive directors did not support the training and Ms Honan noted the request but took no further steps to implement training.[1052]

Mr Brown informed us that sometime between October 2018 and October 2019, at his recommendation, the Department agreed to review staff training programs, including in relation to harmful sexual behaviours, at the Centre.[1053] It is not clear if this review was undertaken, or what the outcome of any such review was.

Ms Honan told us that training for recognising and responding to harmful sexual behaviours is now offered to staff.[1054] Such training will need to be supported by a cultural change of attitudes towards harmful sexual behaviours (refer to Chapter 12).

3.2.18 23 August 2019—The Centre Support Team again discusses the behaviours of Albert and Finn

On 23 August 2019, a further Interim Centre Support Team meeting was held. The meeting minutes reflect that Albert and Finn had progressed to the green colour level. There was no mention of the 7 August 2019 incident involving Henry, progress in relation to conferencing with Albert and Finn, or any actions to address their behaviour.[1055]

Despite the recommendation of the Centre Support Team that Albert and Finn be dealt with by conferencing, it appears that conferencing never took place because of the following factors:

- The Conference Convenor decided to pause the process until a Child Safety Services report was made and responded to.[1056] The Conference Convenor also indicated that if police were notified, she would wait until the end of that process.[1057]
- Police were not notified until 3 October 2019.[1058]
- Henry was subsequently released from Ashley Youth Detention Centre in late October 2019.[1059]
- Child Safety Services did not close their investigation until 11 November 2019.[1060]

Moving Albert and Finn to a green colour level appears to contradict the Centre Support Team decision made on 12 August 2019 that Albert and Finn would not progress beyond orange until a conference had been completed.[1061] While we hold serious concerns about the Behaviour Management System and particularly its use as a tool for punishment, which we discuss in Chapter 12, it is important that if in use it should be applied equally and consistently. It is important that any behaviour management process should be experienced by children and young people in detention as fair, equitable and predictable to support strong relationships between detainees and to promote their sense of security.

We are concerned that Albert and Finn did not appear to receive conferencing or any other therapeutic support for the behaviours they had exhibited. It is also important that the Centre sends a clear message to children and young people displaying or experiencing harmful sexual behaviours that such behaviour is not acceptable.

3.2.19 9 September 2019—The Secretary is briefed about the 7 August 2019 incident involving Henry

In his written statement to us, Mr Ryan confirmed he reviewed the CCTV footage of the 7 August 2019 incident involving Henry.[1062] He described the incident as 'an attempt by two residents to remove the pants of a third resident'.[1063] In a further written statement, Mr Ryan recalled that the footage showed an 'attempt' to pull Henry's pants down and that Henry's 'trousers [were] pulled part way down but his underpants remained on'.[1064] Mr Ryan states that he also showed the footage to Mr Brown, who 'shared my view that it was appropriate to treat this as a sexualised incident, rather than a sexual assault'.[1065]

We asked Mr Brown about what information he received regarding this incident. He could not recall what information he received or when he received it and did not mention viewing the CCTV footage or his interpretation of it at the time.[1066] He subsequently recalled viewing the CCTV footage but, aside from recalling that the footage was 'grainy', he could not recall what it showed.[1067] Mr Brown disputes that he and Mr Ryan shared a view as to how the incident should be described and treated.[1068]

On 2 September 2019, approximately one month after the 7 August 2019 incident involving Henry, Mr Ryan prepared an issues briefing for Michael Pervan, the then Secretary of the Department of Communities, about the incident.[1069] The issues briefing was cleared through Mr Brown on 3 September 2019, then by Ms Honan, who at that time held the role of Acting Deputy Secretary, Children and Youth Services, on 6 September 2019.[1070] The issues briefing confirms that Mr Brown had viewed the CCTV footage of the incident.[1071]

The issues briefing was titled 'Sexualised incident between residents at the Ashley Youth Detention Centre'.[1072] Its stated purpose was to brief the Secretary on the 'sexualised incident' on 7 August 2019 and the related referral to police about the alleged abuse.[1073]

The issues briefing referred to the incident as a 'sexualised incident' and a 'potential sexual assault'.[1074] It described the CCTV footage as showing:

> … the four residents in the [common] room … [Finn] and [Albert] approach [Henry] and grab his legs, pulling him off his chair, and attempting to remove his track pants. [Henry] holds onto his pants and is able to keep them up. [Albert] reaches for a 600-millilitre water bottle and brings it towards [Henry's] buttocks for two to three seconds. The incident then ends.[1075]

We note that Henry's buttocks were exposed, which this description implies was not the case.

The issues briefing also stated:

- Henry had not made a complaint, but staff moved Henry from the Franklin Unit on 8 August 2019 as part of an 'immediate operational response' while an 'inquiry' continued.[1076] Jonathan was also moved from the unit on 9 August 2019 because it was 'considered prudent to do so'.[1077]
- Albert and Finn were reported for a detention offence and referred to the psychologist.[1078] The briefing does not acknowledge that Finn declined to engage with the psychologist.
- Matters were and continued to be monitored via the Centre Support Team and Multi-Disciplinary Team processes.[1079]
- The Professional Services Team and the psychologist considered the incident. Ms Gardiner still 'held concerns that the matter was an assault' and referred the incident to the Advice and Referral Line.[1080]
- Representatives of the Advice and Referral Line agreed the incident was an alleged abuse and advised Centre staff to contact police.[1081]
- The incident had been referred to police.[1082] We note this is incorrect—a police referral was not made until 3 October 2019, almost a month after the Secretary approved the issues briefing.

- To that date, police had 'not been in contact' with the Centre about this matter, 'but historically do so upon receipt of such referrals'.[1083]
- '[N]o further complaints or issues [had] been raised or identified since 8 August 2019'.[1084] We note that the issues briefing does not clarify that the psychologist and the Health and Community Services Union delegate had separately raised concerns about the incident with Mr Ryan.
- Police may charge Albert and/or Finn and the related detention offence reports had been filed pending the outcome of any charges.[1085]
- Various incidents had occurred between Henry, Albert and Finn over the period of 7–8 August 2019, which 'could be described as wrestling and/or adolescent behaviour, or as unwanted attention'.[1086] These incidents were recorded and considered.[1087]

The issues briefing did not invite the Secretary to take any action or make any decision. The Department did not take any further action in response to the issues briefing.

Mr Ryan denied his description in the issues briefing was inaccurate but accepted the description could have been worded better.[1088] When asked about the issues briefing during our public hearings, Mr Ryan emphasised his lack of control over the final product that went before the Secretary. Mr Ryan said it was common that the contents of briefings were changed as they were considered and edited by his superiors, through whom briefings were approved.[1089] He commented that what he 'initially authored isn't exactly what the recipient gets'.[1090]

Mr Ryan provided a draft of the relevant issues briefing, dated 30 August 2019.[1091] The contents of this draft are similar to the final product. Some important differences are that Mr Ryan's draft:

- stated that the allegation was referred to Child Safety Services, which had on-referred the matter to police to consider[1092]
- attached the referral advice provided to Child Safety Services, containing the opinion of its author, Ms Gardiner[1093]
- stated Mr Ryan had considered the incident and CCTV footage and 'suggests the incident is sexualised behaviour, but not an Assault'.[1094]

The description of the incident contained in the draft and final briefing are the same. The two briefs indicate the matter is a 'sexual incident', but the original draft makes it clearer that Mr Ryan did not believe the matter to be 'an Assault'.

The Director, Strategic Youth Services, who has since retired, could not recall many details of the 7 August 2019 incident or the issues briefing. He said:

> I do not recall what information I received and when I received it in relation to this incident. I would be quite sure I would have initially received a phone call outlining basic details and possibly a follow up email. I would generally then receive the incident report and a follow up Issues Brief. I would advise the Deputy Secretary (generally verbally) then follow up with written details through email or an Issues Brief …
>
> I do not recall whether I sought additional information or received additional information or not. In general practice, before clearing an Issues Briefing I would clarify any matters I was not sure about or felt required additional information. I am not sure if I did that on this occasion or not.[1095]

Ms Honan, as Acting Deputy Secretary, stated that she did not conduct any further investigation about the matter before approving the issues briefing.[1096] Ms Honan noted that Mr Ryan and Mr Brown (both of whom had been involved in preparing the issues briefing) had seen the CCTV footage of the incident.[1097] She also acknowledged that the matter had been referred to police and Child Safety Services, and that the young people had been referred to the psychologist about their behaviours.[1098] She told us that, because of these actions, she had 'no reason to doubt the content' of the issues briefing.[1099]

In her statement to us, Ms Honan reflected that she considered the issues briefing of 9 September 2019 appeared to minimise the behaviour of Albert and Finn and did not, as noted in the Serious Events Review Team report, depict an accurate description of the 7 August 2019 incident, and was misleading.[1100]

Department Deputy Secretary Mandy Clarke also agreed the issues briefing minimised the incident and showed a lack of understanding of harmful sexual behaviours.[1101]

Secretary Pervan disagreed the issues briefing minimised the incident overall but acknowledged and accepted the later findings of the Serious Events Review Team that the briefing provided an inaccurate description of the incident.[1102] Secretary Pervan considered that, in this respect, the issues briefing 'painted the incident in a less severe light'.[1103] Secretary Pervan gave evidence that if the issues briefing had been more accurate, he would have initiated the Serious Events Review Team's review sooner.[1104]

It was not until Alysha raised concerns that Ms Honan may not have been fully informed about the incident that a Serious Events Review Team review began in December 2019.[1105] We discuss this review further in this case study.

Finding—The issues briefing to the Secretary about the 7 August 2019 incident regarding Henry minimised the incident and was incomplete, which contributed to a delay in reviewing the incident

The following information was available to Ashley Youth Detention Centre and the Department:

- Albert and Finn forcibly removed Henry from his chair and held him down.
- Albert and Finn's conduct was of a sexual nature.
- Henry's pants were forcibly removed to the extent that his buttocks were exposed.
- Henry was isolating himself in his room, seemingly as a result of the incident and comments from Albert.
- Albert and Finn had discussed a sexual abuse of Henry with other detainees and staff.

This information should have made it clear that an incident of serious harmful sexual behaviour had occurred. It should have been reported as such to the Secretary.

As a result of an insufficient briefing, the Department was not appropriately informed of the severity of the incident and the potential risk to other young people at Ashley Youth Detention Centre. In turn, the incomplete issues briefing likely contributed to the Department delaying action to investigate or otherwise manage the incident.

3.2.20 18 September 2019—The Ashley Youth Detention Centre psychologist alerts the Centre Manager of Henry's exposure to a risk of harm

We were concerned by evidence that in the weeks following the incident, operational decisions meant Henry was again exposed to a risk of harm from Finn. On 18 September 2019, the psychologist raised concerns that Henry had been moved into a program group with Finn, despite the lack of any formal interventions and without consultation with the Multi-Disciplinary Team.[1106] On 20 September 2019, the psychologist requested (via email) that Mr Ryan reverse this decision immediately.[1107] In this email, she stated:

> I believe that some of the reasons provided for the decision (this is secondary information as I was not at the morning meeting in person) were that the investigation is likely to be closed without any further actions due to the insignificant nature of the incident, and that [Henry] and [Finn] have since been in each other's company (for example, in the dining hall) without any issues observed by the youth workers. As I am sure you can appreciate there are a number of issues with such rationale.[1108]

We understand the psychologist's reference to an 'investigation' at this time refers to the internal consideration of the incident within the Centre and the Department, rather than an official investigation such as that subsequently undertaken by the Serious Events Review Team, as we have seen no evidence to suggest that a formal investigation started before December 2019 (discussed in a further section). It is unclear whether Henry was removed from the program with Finn.

Finding—In the weeks following the 7 August 2019 incident, Henry continued to be exposed to risk of harm at Ashley Youth Detention Centre despite widespread knowledge about these risks

Based on the evidence and findings covered in the Serious Events Review Team report into the incident, as well as our own viewing of the CCTV footage of the incident, it appears that Henry experienced serious harmful sexual behaviour on 7 August 2019.[1109]

Ashley Youth Detention Centre did not demonstrate an appreciation of the seriousness of the incident involving Henry on 7 August 2019. Some staff appeared to understand the seriousness of this incident. However, we were concerned that other staff described the matter as a 'sexualised incident'.[1110] This was despite multiple concerns being raised about this, including on:

- 10 August 2019, when another incident report was prepared about Albert and Finn discussing the incident and making further sexualised comments
- 12 August 2019, when the Centre Support Team discussed the sexualised behaviours of Albert and Finn
- 13 August 2019, when Ms Gardiner emailed Mr Ryan and other members of the Centre Support Team emphasising that Albert and Finn's behaviours were inappropriate
- 19 August 2019, when the Centre Support Team again discussed Albert and Finn's behaviour and the psychologist noted a pattern of behaviour that needed to be addressed
- 22 August 2019, when Ms Gardiner reported the incident involving Albert and Finn to Child Safety Services.

This minimisation of the incident resulted in:

- insufficient supports provided to Henry after the incident
- not taking immediate action to protect Henry's safety

- failure to develop a program to address Albert and Finn's behaviour
- delayed reporting to police and Child Safety Services.

We are concerned the advice of staff who had knowledge and understanding of harmful sexual behaviours and the management of such behaviours, appears not to have been given as much sway as the concerns and views of operational staff.

Consequently, young people continued to be placed with Albert and Finn for several months and were at continued risk of sexual harm. We are particularly concerned by evidence that Henry was placed in programs with Finn in the weeks following the 7 August 2019 incident.

3.2.21 September 2019—Ray is admitted to Ashley Youth Detention Centre

In September 2019, Ray was admitted to Ashley Youth Detention Centre. Soon after Ray's admission, the Multi-Disciplinary Team recommended the Centre Support Team place Ray on a Very Close Supervision order until more was known about his history and current mental health.[1111] It does not appear that Ray was placed on a Very Close Supervision order until towards the end of his third month at the Centre (as discussed further in this section).

Approximately one week after his admission, Ray abused another young person and was isolated for 50 minutes.[1112] Ray continued to be involved in a range of physical incidents in the weeks following his admission. Ray was again isolated after at least one other incident.[1113] Ray's mental health difficulties were not reflected in incident forms completed following these incidents.[1114] Conferences were held with Ray regarding some of these incidents.[1115] Following these conferences, Ray was directed to continue to see the psychologist.[1116] In at least two conferences, it was noted that Ray was 'very insightful about his behaviour'.[1117]

A version of Ray's care plan was updated approximately one month after his admission. The care plan noted a recommendation by the Multi-Disciplinary Team that 'a "Key Worker" be identified at each shift to support and monitor [Ray] and to report any behaviour concerns'.[1118] The intention was not 'that a worker be specifically dedicated to [Ray], but rather has a consistent oversight', to help Ray build relationships and create some stability in his environment.[1119] Later emails sent between Professional Services and Operations Team members suggest this recommendation was, at least initially, received positively by at least one Operations Team member.[1120]

We note there were discrepancies in the various incident reports concerning Ray, including forms apparently filled out without reference to the actual events, and some forms that were not filled out appropriately or were incomplete.

3.2.22 8 October 2019—The Ashley Youth Detention Centre psychologist reports harmful sexual behaviours to the Commissioner for Children and Young People

On 8 October 2019, the Ashley Youth Detention Centre's psychologist contacted Leanne McLean, the Commissioner for Children and Young People, to advise her of the 7 August 2019 incident and another incident of harmful sexual behaviour in October 2019 by Albert and Finn.[1121]

3.2.23 13–14 November 2019—The Ashley Youth Detention Centre psychologist raises more concerns with the Centre Manager about Albert and Finn

On 13 November 2019, the psychologist emailed Mr Ryan to advise of a young person in detention disclosing to her that staff had threatened to transfer him to the Franklin Unit, that he felt unsafe and stated that detainees get 'stood-over, abused and raped' in the Franklin Unit.[1122] This conduct referred to Albert and Finn's behaviours.[1123] We are unaware of which young person expressed this concern but based on the timing it appears unlikely to be (but could be) Max, Henry or Ray.

Mr Ryan told us he 'was taken aback by her assertions because they didn't square with [his] understanding of how residents were being treated or the history of complaints which had been received prior'.[1124] In response to this email, Mr Ryan told us he:

- spoke with Digby (a pseudonym), the co-manager of Professional Services (we note Ms Gardiner's employment at the Centre ceased in mid-October 2019), and senior social workers
- convened a 'special meeting' of managers on 20 November 2019 to discuss Albert and Finn's behaviour
- held regular weekly meetings for the remainder of 2019 and into February 2020 to monitor Albert and Finn's behaviour and provide a 'higher level of intervention'.[1125]

It is unclear to us what action was taken in response to the allegations that staff had threatened young people with a transfer to the Franklin Unit, separate from the response to the behaviours Albert and Finn exhibited.

In a meeting on 14 November 2019, the Multi-Disciplinary Team recommended that 'no other residents will be placed in Franklin until a clear plan is in place'.[1126]

3.2.24 15 November 2019—The Ashley Youth Detention Centre psychologist documents her concerns about Albert and Finn in a letter to the Centre Manager

With the support of her supervisors in the Department to raise concerns, the Centre's psychologist sent a letter to Mr Ryan on 15 November 2019.[1127] This letter was also copied to the Director of Nursing, Statewide Forensic Mental Health Services, Department of Health and Barry Nicholson, Group Director, Forensic Mental Health and Correctional Primary Health Services, who were senior health staff in the psychologist's reporting line.[1128]

The letter summarised 'previously voiced concerns' and identified the following concerns associated with the management of Albert and Finn:[1129]

- There was a '[h]igh risk of harm and traumatisation to youth placed in the Franklin Unit, perpetrated by [Albert] and [Finn], on particularly younger residents, those smaller in physical stature and those with disabilities'.[1130]
- There was a 'chronic sense of being unsafe and risk of vicarious trauma to [Centre] residents in general who are aware of the incidents of intimidation and sexualised behaviour in the Franklin Unit and who are also aware of the lack of sanctions associated with these incidents'.[1131]
- Current practice risked reinforcing to Albert, Finn and other young people that this kind of behaviour was an acceptable way 'to get [one's] needs met and is a successful strategy to keep one safe from the abuse of others'.[1132]
- There was 'insufficient and [in]accurate documentation' at the Centre that could lead to courts or community agencies receiving misleading information.[1133]
- There was a range of long-term risks, including 'significant risk of physical and psychological harm, poor staff morale, and the corruption of the system entrusted with the care of some of the most vulnerable youth in the state'.[1134]

To mitigate those risks, the psychologist stated that 'clear interventions and consistent enforceable sanctions' were required as 'a matter of priority'.[1135] The psychologist identified a need to formally assess whether Ashley Youth Detention Centre was sufficiently resourced to address Albert and Finn's specific needs and to prepare a management plan.[1136]

The psychologist also contended there was 'evidence of lack of consultation and adherence to the decisions and recommendations made by the Centre Support Team and Multi-Disciplinary Team'.[1137] She expressed her view that it was essential all professional disciplines across the Centre support implementing the management plan.[1138]

The psychologist recommended that, as an interim measure, other young people should not be placed in the Franklin Unit until safe measures had been implemented 'to ensure their safety with regards to the abolishment of the clear pattern of "ganging-up" and victimisation'.[1139]

Mr Ryan gave evidence that the Director of Nursing and the Nurse Unit Manager had read the psychologist's letter to him, dated 15 November 2019, and did not accept its assertions.[1140]

Emails sent in the week following 15 November 2019 indicate that the Director of Nursing and Mr Ryan spoke about the psychologist's letter. In his statement, Mr Ryan noted an email he had sent to Piers (a pseudonym), who held a leadership role at Ashley Youth Detention Centre at the time, which reads in part that '[the Director of Nursing] states that he has been over [the psychologist's] clinical notes, leading [the Director of Nursing] to state "I believe this to be an operational issue"'.[1141]

In evidence to us, the Nurse Unit Manager disagreed with Mr Ryan's recollection that she reviewed the psychologist's letter at the time, stating that she did not see the psychologist's letter before 4 February 2020.[1142] She did, however, recall a conversation with the Director of Nursing about 'an alleged sexualised behaviour incident which occurred in early August', but could not recall the exact date.[1143] The Nurse Unit Manager told us that during this conversation, she expressed her opinion that she did not interpret the behaviours of Albert and Finn to be 'a serious sexual assault'.[1144] The Nurse Unit Manager told us she formed this opinion after she reviewed the CCTV footage and spoke with the young people in detention (including Henry), who she reported 'all said that they were "just mucking around", and that there was no intent to cause anybody harm'.[1145] The Nurse Unit Manager said that, in hindsight, she believed 'this was probably "bravado" and an attempt to deflect possible retaliation on [Henry's] part'.[1146] The Nurse Unit Manager stated that she would not have done anything differently, but had she been privy to all the information at the time, she could have supported the psychologist in monitoring Henry's wellbeing.[1147]

The Director of Nursing also disagreed with Mr Ryan's recollection, stating that he in fact agreed with the psychologist's concerns.[1148]

Mr Brown could not recall the 7 August 2019 incident and retired from the Department in October 2019.[1149]

There is evidence to suggest that in response to the letter, Mr Ryan told the psychologist that a task team would be created to develop an intervention plan for Albert and Finn.[1150]

In an email to Piers on 22 November 2019, Mr Ryan noted that he had spoken with the psychologist on 21 November 2019 to discuss 'action items' and that 'she appeared pleased'.[1151]

Mr Nicholson also told us the concerns the psychologist raised in her letter of 15 November 2019 were legitimate clinical concerns.[1152] He stated that these concerns should have been taken seriously but were not.[1153]

We return to the discussion between the Department, the psychologist and the Centre below (refer to January 2020).

3.2.25 Early December 2019—Behaviour management programs are initiated for Albert and Finn

In late November 2019, the Multi-Disciplinary Team tasked Alysha and the psychologist with creating and implementing an intensive behaviour management program for Albert and Finn.[1154] In early December 2019, the psychologist and Alysha conducted a review into Albert and Finn's behaviour over the preceding 12 months.[1155]

Alysha told us that as part of their review she and the psychologist reviewed the CCTV footage of the incident and other incidents from 7 and 8 August 2019.[1156] Their review indicated there were five other incidents of intimidating behaviours in that period, including sexualised behaviour.[1157] Albert and Finn were involved in all these incidents.[1158]

Alysha recalled that she and the psychologist also identified a series of incident reports prepared by youth workers that noted conversations in which Finn discussed serious sexual abuse perpetrated by Finn and Albert against younger and smaller boys in the Franklin Unit.[1159] Alysha told us that those incident reports were marked as 'recorded incidents' and left blank in a number of sections, including regarding notifications, CCTV footage, the involvement of other agencies and further action to be taken.[1160] Among these incident reports were documents lodged on 9 and 10 August 2019 in which staff reported discussions between detainees about the 7 August 2019 incident, as well as other harmful sexual behaviours by Albert and Finn.[1161] We understand those reports cover the same incidents as those described above.

Alysha told us that she and the psychologist immediately notified Mr Ryan and Piers about the numerous incidents involving Albert and Finn.[1162] We understand this occurred on or around 6 December 2019.[1163]

Alysha's view was that the 'most urgent' task was to ensure the safety of other children and young people in detention and provide intensive therapeutic interventions for Albert and Finn.[1164] Alysha told us she was concerned the issues documented in the incident reports had not been reported to police and that children were still being placed in the same unit as Albert and Finn.[1165]

Alysha's evidence was that Mr Ryan and Piers ended the review she and the psychologist were conducting.[1166]

We asked Digby, the former co-manager of Professional Services, about the response to concerns raised about Albert and Finn. He responded that he was aware the psychologist, Alysha and another member of staff 'undertook to develop an appropriate tailored management plan to meet the needs of both boys' but that to his knowledge, the plan was never finalised.[1167]

Piers told us that Alysha and the psychologist were restricted from accessing files on advice from Mr Ryan.[1168] Piers recalled the reason for that advice to be:

> Prior to this both staff were freely accessing said files without authority and in some cases, it appeared to have no immediate bearing on their workloads especially in relation to the role that Alysha was employed to do.
>
> In the case of [the psychologist], she was employed by Forensic [Mental] Health and as such being a separate department, there was a protocol to accessing clients' files.
>
> However, to compensate for this, a daily information meeting was started between [the psychologist], Operations Manager and Operations Coordinator to brief on incidents or concerns from previous shifts. She did have unrestricted access to incident reports and [Centre Support Team meeting] minutes.
>
> Both staff were able to move forward with access to any files that they considered important to their work, however they needed to seek authority from their manager to do so.[1169]

In relation to developing a behaviour management plan for Albert and Finn, Mr Ryan told us that although he was aware Alysha and the psychologist were tasked with undertaking a review of Albert and Finn's behaviours, he was not aware they were accessing 'any and every file they wished, against the parameters' set by the managers of the Professional Services Team.[1170] He told us:

> I spoke with [the co-managers of the Professional Services Team] about the unfettered access to files. Both assured me that this was not agreed to with anyone, but that their office was to work with [the psychologist] in preparation of the Plan. Both [managers] felt that … [Alysha] granted access to any file or correspondence sought and that this was against their set parameters. Both indicated that they would speak with all parties involved.[1171]

Mr Ryan denied that he interfered with the development of a behaviour management plan for Albert and Finn.[1172] We understood him to mean that he did not interfere unreasonably or without justification, noting that he did engage with the managers of the Professional Services Team to raise concerns about access to files outside of 'set parameters'.[1173]

3.2.26 Early December 2019—Staff continue to raise concerns about Albert and Finn

Alysha told us that after speaking with Mr Ryan and Piers on 6 December 2019, she notified the Advice and Referral Line of all the incidents involving Albert and Finn.[1174] The psychologist also made a mandatory report to Child Safety Services on 6 December 2019 about the 7 August 2019 incident involving Henry.[1175] On the same day, the psychologist emailed Mr Ryan stating that, following the discovery of the incident reports—which contained allegations of attempted rape and verbal threats of rape, incidents of sexual favours performed for compensation, and that sexual frustration was being taken out on younger residents in the Franklin Unit—she had made mandatory reports to Child Safety Services and the Commissioner for Children and Young People.[1176]

By December 2019, Ms Honan had assumed the role of Director, Strategic Youth Services (now Director, Youth and Family Violence Services).[1177] On 6 December 2019, Mr Ryan forwarded to Ms Honan the psychologist's email about her report to Child Safety Services.[1178] Mr Ryan told Ms Honan that he did not agree with the psychologist's assertions.[1179] He also told Ms Honan that he had urged the psychologist to be cautious until he had checked the Centre Support Team records, but that the psychologist 'declined to wait and said she had no option but to report those findings to [Child Safety Services]'.[1180] He concluded the email by writing that the psychologist had 'strong, emotive opinion in respect to this matter' and that the Director of Nursing and the Nurse Unit Manager had recently disagreed with the psychologist.[1181]

Alysha told us that, on both 5 and 6 December 2019, she called Ms Honan's Executive Officer to tell her about the incident reports and Mr Ryan and Piers' response.[1182] Alysha recalled that she told the Executive Officer she wanted to contact police about the matter immediately, but the Executive Officer told her to wait and to speak with Ms Honan the following week.[1183] On 6 December 2019, Alysha also emailed the Executive Officer, stating:

> I have reached a point where if I lose my job for reporting practices in place, it will be worth it to shine a light on the issues and practices that are currently in place at Ashley. Someone would need to further examine all residents incident reports to get a full picture of the lack of adequate documentation, follow up and interventions put in place to support staff, victims and perpetrators of said incidents.
>
> Please note that it is my understanding there is currently [paper-based] handover and incident reports at Ashley. There are only originals and no copies electronically or paper based.[1184]

Alysha sent photographs of the incident reports to the Executive Officer.[1185]

In her response of the same date, the Executive Officer stated that she appreciated Alysha giving Ms Honan 'an opportunity to discreetly investigate this first before contacting external agencies' and assured Alysha that Alysha had met her duty of care.[1186]

3.2.27 6 December 2019—The Ashley Youth Detention Centre psychologist again reports harmful sexual behaviours to the Commissioner for Children and Young People

On 6 December 2019, the Centre's psychologist again contacted Commissioner McLean after discovering the incident reports related to Henry.[1187] The psychologist provided the Commissioner with the spreadsheet of incidents she had prepared in August 2019.[1188] The psychologist was troubled that nothing had happened to manage Albert and Finn's behaviours, despite her letter of 15 November 2019 to Mr Ryan outlining her concerns.[1189]

On the same day, Commissioner McLean contacted Ms Honan to discuss the psychologist's disclosure.[1190] Ms Honan confirmed she was aware of concerns but did not have all the information.[1191] Ms Honan also confirmed that Mr Ryan had assured the immediate safety of all detainees over the weekend and that she would go to the Centre on the next business day to access information with a view to initiating a Serious Events Review Team review.[1192]

Commissioner McLean expressed support for Ms Honan's approach during that conversation.[1193] Commissioner McLean commented that it seemed to her that the motivation for examining unwanted sexual behaviours among children and young people in detention 'was low' and 'perhaps influenced by a custodial environment'.[1194] We understand this comment to mean Commissioner McLean was concerned that little attention was paid to harmful sexual behaviours at the Centre and that this attitude may have been influenced by a custodial rather than therapeutic attitude in the Centre.

3.2.28 9–10 December 2019—The Director, Strategic Youth Services initiates a review into the 7 August 2019 incident involving Henry

Alysha told us she met with Ms Honan on 9 December 2019.[1195] Alysha recalled that Ms Honan said the Department would conduct an internal investigation and report the matter to the police if necessary.[1196]

On the same day, Commissioner McLean followed up with Ms Honan, who confirmed there was a need for a Serious Events Review Team review.[1197] Commissioner McLean supported initiating a review and advised Ms Honan she would write to the Department about the matter with the potential to refer it to the Custodial Inspector.[1198]

On 10 December 2019, Commissioner McLean wrote to Secretary Pervan to advise him of the psychologist's concerns, enclosing the psychologist's supporting material.[1199] Commissioner McLean further advised of her contact with Ms Honan and of her support for an immediate review.[1200] Commissioner McLean requested that she be kept up to date with the Serious Events Review Team process and advised that she may refer the matter to the Custodial Inspector.[1201]

We have received no evidence that the Custodial Inspector was notified of this incident or any other concerns the psychologist raised. During our public hearings, the Custodial Inspector, Richard Connock, told us he was not sure whether he had been informed at the time that the review was being conducted, but he agreed it was the kind of thing that would have been important for him to have been aware of.[1202]

We note that on 13 December 2019, there was an incident where three young people detained at Ashley Youth Detention Centre accessed a roof, there was a stand-off, and the three young people were subsequently 'unit bound', with allegations of staff falsifying isolation records (we discuss this incident and the Centre's response in Case study 3).[1203]

3.2.29 Mid-December 2019—The Serious Events Review Team investigates the 7 August 2019 incident

The Serious Events Review Team's investigation into the 7 August 2019 incident involving Henry began in December 2019.[1204]

The terms of reference for the review were as follows:

> **Background and Services History**
>
> Review the process applied in recording, investigating, assessing and referral to required services of the alleged incident of sexual assault upon [Henry] in [Ashley Youth Detention Centre] in August 2019.
>
> Determine and comment on the post incident management of this incident both for the alleged perpetrators, victim and other residents' safety and wellbeing.
>
> **Assessment**
>
> Consider and analyse the presence/absence and quality of recorded information and assessments which guided the decisions made with regard to the placement, safety, referral to police/[Tasmanian Health Services], case planning and post incident management of [Henry] and others allegedly involved in this matter.
>
> **Planning, Services and Communication**
>
> Describe and analyse the quality of communication between [Ashley Youth Detention Centre] and other key internal and external stakeholders/service providers in this case.
>
> Make comment on case processes, planning, and service provision and how these have served (or otherwise) to protect and enhance [Henry]'s safety and well-being at this time and over time.
>
> **Compliance with Legislation and Policy**
>
> Determine whether [Ashley Youth Detention Centre] has fulfilled its responsibilities as articulated in the Youth Justice Act 1997, Standard Operating Procedures and agency policy.

Findings and Draft Recommendations

Articulate findings from this review and provide draft recommendations regarding any actions that should be taken to address issues identified in the review, as they relate to the above Terms of Reference.[1205]

Veronica Burton, a former Serious Events Review Team member, conducted the review and wrote the final report. We heard evidence about the difficulties that Ms Burton and others experienced when seeking to access records relevant to the review.

As part of the review, Ms Burton read a wide range of documentation, including electronic and paper files, email communication, meeting minutes and daily diaries, and watched CCTV footage.[1206] She also considered relevant legislation, policies and procedures.[1207] Interviews were conducted with past and current Centre staff, including management.[1208] We note that Mr Ryan said he was unwell and on extended leave during the period Ms Burton carried out the review and was largely unable to participate or contribute to the review process.[1209]

Both Alysha and Ms Burton told us about an occasion during Ms Burton's review where they said Piers prevented Ms Burton from accessing files stored in a filing cabinet and told her that he could not find other files she requested because they had been archived.[1210] Ms Burton told us that some of these records were provided by Stuart Watson when he replaced Mr Ryan as Centre Manager.[1211] Ms Burton recalled that during her review, she was prevented from speaking directly with Henry and therefore, never heard his version of the incident.[1212]

Piers could not recall the Serious Events Review Team attending the Centre to discuss the 7 August 2019 incident.[1213] He said that 'at no time would I have restricted them from accessing any files or reports and would have made available to them what was available to me'.[1214]

Ms Burton also told us that Piers provided her with incident reports about the 7 August 2019 incident.[1215] She believed these reports were not originals and had been rewritten.[1216] Ms Burton told us she received a second set of incident reports from Alysha.[1217] Ms Burton recalled that second set included different details about the incident, including the length of time the detainees were left unsupervised, who the matter was reported to and the severity of the incident.[1218] Ms Burton also told us the second set 'minimis[ed] how the … bottle was used'.[1219] Ms Burton told us that her usual practice was to scan any hard-copy paper files and save them to the secure file system for the Serious Events Review Team and to then file the hard copies.[1220] She stated she does not have 'a clear memory of exactly doing that with those documents, but that was the process that I followed, so I can say with … almost 100 per cent confidence that that's what occurred'.[1221] Ms Burton stated that she no longer had access to the Serious Events Review Team files after leaving the Department.[1222] We have only received one version of the relevant incident report from the Department, which Ms Burton believed to be the version she received from Piers.[1223]

Commenting generally on her engagement with Ashley Youth Detention Centre staff when conducting reviews into incidents at the Centre, Ms Burton told us she depended on the cooperation of Centre management to gain access to records and interviewees.[1224] Her experience was that it was sometimes difficult to access all the information she needed, including interviewing children, without staff assistance, saying 'I couldn't go anywhere in the centre unless somebody took me because every door is locked and I needed somebody to escort me wherever I needed to go'.[1225]

Ms Burton also observed that her access to children and young people in detention was limited because they were usually housed in secure units and so she would 'often only get the staff version of events'.[1226] She said she was often not provided personal information or history about the young people involved.[1227] She expressed concerns to us about an approach at the Centre of a 'clean slate' philosophy that did not view children's history of significant trauma as relevant, noting '[it] is no way to run a therapeutic service'.[1228]

Ms Burton noted that while the Centre had an electronic filing system, it was not in use and 'pretty much everything was paper file'.[1229] Ms Burton told us that she depended on the Centre's management to make paper files available to her and noted that this was different from other agencies, such as Child Safety Services, where Ms Burton would have automatic access to all electronic records.[1230] Ms Burton recalled that in her dealings with Ashley Youth Detention Centre, she often encountered issues of missing documents, a lack of records and, if records were provided, concerns about their accuracy.[1231] For example, Ms Burton recalled that, 'because … file-keeping was so poor', she would often depend on management to identify which staff were rostered on during an incident under review.[1232]

3.2.30 December 2019—Ray is moved to the Franklin Unit

Towards the end of his third month at the Centre, Ray was transferred to the Franklin Unit because the unit he was in had to be evacuated.[1233] At this time, Albert and Finn were still housed in the Franklin Unit.[1234] Minutes of the Centre Support Team meeting held two days after Ray's transfer to the Franklin Unit showed the team did not raise the possibility of transferring Ray out of the Franklin Unit after the incident that caused the transfer.[1235]

We note that at this point, there had been a Multi-Disciplinary Team recommendation that no young people be placed with Albert and Finn until both had received appropriate interventions. That recommendation was made about one month before Ray was placed in the Franklin Unit (on 14 November 2019). The Centre's psychologist reiterated this recommendation following the placement of Henry in the Franklin Unit in the week before Ray's transfer to the Franklin Unit. We also note, as outlined, that when Ray was admitted to the Centre, the psychologist had made a general recommendation about the need to 'carefully consider' Ray's unit placement considering his mental health difficulties.[1236]

3.2.31 December 2019—The Multi-Disciplinary Team raises concerns about Ray's transfer to the Franklin Unit

In the days following Ray's transfer to the Franklin Unit, minutes of a Centre Support Team meeting recorded that Ray had 'settled well into Franklin'.[1237]

Minutes of a Multi-Disciplinary Team meeting held two days later included the following comments, under the heading 'What are we worried about?':

- 'Recent move to Franklin could be a concern for [Ray]'.
- '[Ray] is highly suggestible to external influences'.
- 'There are concerns about the current mix of residents in Franklin'.[1238]

The following comments were made about the recommended next steps for Ray:

- 'Ideally to be moved from Franklin due to [Ray] being easily coerced and his ongoing mental health symptom'.
- 'Reside with peers who are not going to influence [Ray] in an adverse manner'.
- 'Youth workers reporting dysregulation. It is recommended a unit move'.[1239]

Around this time, Ray was made subject to a Very Close Supervision order.[1240] A subsequent issues briefing (discussed below) indicates that this decision was made 'during Centre Support Team and/or [Interim Centre Support Team] meetings', which appears to be backed up by Centre Support Team meeting minutes of this period.[1241] Centre Support Team meeting minutes around this time indicate some discussion about Ray's placement in the Franklin Unit, with a set of minutes noting:

> Concerns regarding [Ray] being housed in Franklin were tabled, but staff felt that by putting [Ray] on [Very Close Supervision] this would eliminate the concerns raised around him possibly being influenced by others in the unit, particularly given his unsettled mental health.[1242]

We asked Mr Ryan about the decision to place Ray in the Franklin Unit. He responded it was a 'difficult' time at the Centre, that there were a 'number of very challenging residents' and that Ray's behaviours were 'extreme'.[1243] He said the options following the Multi-Disciplinary Team's recommendation that Ray be moved from the Franklin Unit were either to move Ray out of the Franklin Unit or to keep him in the Franklin Unit under Very Close Supervision.[1244]

Mr Ryan said that to move Ray from the Franklin Unit to a less secure unit would have had 'ramifications for [Ray] and for other residents and staff'.[1245] Mr Ryan described Ray's continued placement in the Franklin Unit under Very Close Supervision as 'the "least worst" option'.[1246] Mr Ryan also said a separate incident that occurred two weeks after Ray's transfer to the Franklin Unit meant it was 'very difficult to safely move [Ray] from Franklin to a less secure unit'.[1247]

The Very Close Supervision order required a supervising youth worker to always be within five metres of Ray when he was outside a locked building.[1248] We are unclear as to why, in this instance, the Very Close Supervision order seemingly applied only when Ray was outside, given he was likely at the same or increased risk of harm by other young people when inside a unit. However, it appears from the relevant procedure that this was standard practice.[1249] The practice was perhaps directed at managing an escape risk rather than protecting young people from harm.

Minutes of a Centre Support Team meeting held after the Very Close Supervision order was made recorded that he was 'travelling well in Franklin' but that he did 'keep to himself'.[1250]

3.2.32 2 January 2020—An incident occurs involving Ray, Albert and Finn

Approximately three weeks after Ray was transferred to the Franklin Unit, he was involved in a verbal altercation with Albert, after which Ray initiated a physical altercation with Albert.[1251] Finn also took part in this altercation and Ray received multiple punches to the head from Albert and Finn.[1252] This incident occurred indoors.[1253]

Documents prepared in the days following the incident show that Alysha and the psychologist believed Ray was provoked to violence when Albert and Finn made light of Ray's mental health difficulties.[1254] The incident reporting form invited the reporting youth worker to select the option 'the young person was incited/provoked by other young person/s' under the heading 'moderating factors', but this was not selected.[1255]

We have reviewed the CCTV footage of this incident, which does not contain audio.[1256] We consider the CCTV footage matches the account provided in the incident report prepared after the incident, except as noted next.

Immediately before the incident, Ray displayed signs of stress or anxiety. These included signs that the Centre's psychologist had identified to Operations Management at the beginning of Ray's admission.[1257] The incident report stated that each of the three staff members present attempted to stop the incident by speaking to the three young people but that the incident did not end until three more staff members arrived after a 'code black' was called.[1258] It is not apparent from the CCTV footage that any staff member attempted to de-escalate or redirect Ray—for example, by moving him away from other young people—as he began to show signs of distress before the incident. We accept, however, that it was difficult to understand any verbal de-escalation techniques staff might have used without audio available to us.

The arrival of extra staff members cannot be seen in the CCTV footage and appears to have happened outside the room. The CCTV shows that one of the three original staff members eventually intervened to redirect Ray out of the room and away from the incident. It is unclear from the footage why that staff member took several minutes to act in this way, especially when he appears to have finally acted without support or

help from other staff. We were concerned to see that none of the original staff members present appeared to try to remove, restrain or redirect any of the three young people during lulls in the incident, including one instance where Albert left the room entirely (before returning to engage in the incident again). Alysha told us that immediately following the incident involving the three young people:

> … I spoke to Patrick Ryan and [the then Acting Manager, Professional Services and Policy] about the need to report the assault to the police as well as the need to get Ray medically assessed. They insisted that it was a 'fight' between residents and that no police notification was required. He was not assessed by a doctor, nor was this attack reported to the police.[1259]

Alysha believed Ray was concussed, did not attend school due to the concussion and did not get medical care.[1260]

The Nurse Unit Manager's notes from 2 January 2020 in relation to Ray indicate that '[n]il signs of concussion noted … and author advised [Ray] that if he experienced any of these symptoms to notify staff immediately'.[1261] We are unclear whether Ray required any more help or got any further medical assistance.

The incident reports for each of Finn, Albert and Ray include a note that referral to police may be 'pending', but no further comments are made about when or if a referral would occur.[1262] Ms Honan told us the incident was not reported to police '[d]ue to [Ray's] mental health condition and that he was the instigator of this assault and other less serious unprovoked assaults towards detainees'.[1263]

Finding—Ray's (a pseudonym) placement in the Franklin Unit at Ashley Youth Detention Centre in December 2019 was inappropriate and exposed him to preventable harm

Although there was no evidence before us that Ray was subjected to harmful sexual behaviours at Ashley Youth Detention Centre, he was involved in a physical altercation.

We are concerned that Ray was placed in the Franklin Unit in the first place and then not moved once concerns were raised. We hold these concerns because the Centre was aware of:

- Ray's vulnerabilities as outlined by the Centre's psychologist on Ray's admission to the Centre
- concerns raised by the Multi-Disciplinary Team about the decision to place Ray in the Franklin Unit

- the harmful sexual behaviours of detainees in the Franklin Unit, particularly Albert and Finn, which at the time of Ray's placement in the unit had not been properly addressed
- Ray 'keeping to himself' in the Franklin Unit, which could suggest Ray did not feel safe.

We acknowledge the evidence that Ray's behaviour made him a risk to other detainees and that placing Ray in the Franklin Unit with Albert and Finn was the 'least worst' option. However, while we acknowledge that placement decisions at Ashley Youth Detention Centre likely involve a range of difficult decisions, we are not convinced that appropriate consideration was given to Ray's ongoing safety in the Franklin Unit.

It is not apparent to us that the Centre considered transferring Ray to another unit under Very Close Supervision—the options appeared to be seen as Ray either being in a different unit or in the Franklin Unit under a Very Close Supervision order. We note that after the incident Ray was moved to another unit.

We are also not convinced that the Very Close Supervision order—which we understand to have related only to Ray's movements in outdoor areas of the Centre—was enough to ensure Ray's safety if he remained in the Franklin Unit. Having reviewed the CCTV footage of the incident between Ray, Albert and Finn, it does not appear that any youth worker was assigned to supervise Ray inside on that day. More appropriate supervision may have helped avoid the incident.

We are also concerned that Albert and Finn, who appeared to present similar threats to Ray, were not on Very Close Supervision orders.

At our public hearings, Ms Honan agreed the harm that Ray suffered in the incident was entirely preventable.[1264] She also acknowledged there 'could have been other strategies put in place to reduce the likelihood of [the incident] occurring'.[1265] We agree and further consider that earlier de-escalation and intervention to stop the incident once it began would have minimised the degree of harm Ray suffered.

3.2.33 3 January 2020—The Centre Support Team discusses the incident involving Ray, Albert and Finn

Staff logs and minutes of an Interim Centre Support Team meeting held the day after the 2 January 2020 incident say that Ray was moved to another unit on the night of the incident.[1266] A later issues briefing to the Secretary stated that Ray was moved from the Franklin Unit on 2 January 2020 in response to a different incident of property damage the day before the incident.[1267] According to the Ashley Youth Detention Centre daily roll, Ray was not moved to the new unit until a day later (3 January 2020), suggesting that

he spent another night in the Franklin Unit immediately after the incident.[1268] We do not know the reason for the discrepancy in these records, but they appear to be an example of inconsistent and poor record keeping at the Centre.

The minutes of the 3 January 2020 Interim Centre Support Team meeting state:

- 'Staff spoke to residents involved [in the incident in the Franklin Unit] and all agreed that it was over and they were happy to move forward'.
- '[Ray] stated that he wished to stay in [the new unit] and it was decided that he could stay on the terms that there were no problems otherwise he would return to Franklin'.
- '[Albert] and [Finn] both met with [Ray] separately for mediation … and they were all happy to move on from this'.
- Ray was told that 'if he wished to move back to Franklin at any stage that he was welcome to do so'.[1269]

Albert, Finn and Ray's involvement in the incident was classified as a detention offence and all three young people attended conferences in the days after the incident.[1270] It is not clear to us whether the detainees' individual circumstances, including Ray's mental health condition, were considered when determining an outcome for these young people.

3.2.34 3 January 2020—A staff member meets with the Director, Strategic Youth Services to discuss concerns about Ashley Youth Detention Centre

Alysha told us she met with Ms Honan again on 3 January 2020 to discuss her concerns about the Centre's management of harmful sexual behaviours and Ray's safety.[1271] On 6 and 7 January, following this meeting, Alysha emailed Ms Honan copies of Multi-Disciplinary Team meeting minutes in which concerns about Franklin Unit placements were raised, along with a copy of the psychologist's letter to Mr Ryan of November 2020 in which the psychologist highlighted the risk of placing vulnerable people in the Franklin Unit.[1272]

3.2.35 5 January 2020—Ray attempts to escape from Ashley Youth Detention Centre

Three days after the incident involving Albert and Finn, Ray climbed an internal fence in an apparent attempt to escape from the Centre.[1273] We understand that Ray was still the subject of a Very Close Supervision order at that time, requiring a youth worker to be within five metres of Ray while he was outside a locked building.[1274]

The Operations Coordinator on shift, Chester (a pseudonym), emailed the Operations Manager about the incident.[1275] Chester reported that Ray was stopped, 'walked back' to his unit 'unassisted' and was placed in isolation for 30 minutes.[1276] A decision was made to place Ray on 'unit bound' until the next day's Centre Support Team meeting.[1277] We discuss the practice of 'unit bound' in Case study 3. According to Chester's email, this incident immediately followed an earlier one involving Ray, in which he attempted to steal something from an out-of-bounds area.[1278]

In response to a notice to produce, the Department provided us with a copy of what appears to be a complete bundle of all incident reports relating to Ray for the relevant period.[1279] In that bundle, we received a copy of the incident report about the earlier incident.[1280] We have not been provided with a copy of the incident report relating to the escape attempt or associated isolation documents. It is unclear why we did not receive a copy of the incident report and associated isolation documents relating to this incident. This is concerning because we received allegations that staff tackled and handcuffed Ray.[1281]

Alysha told us she spoke to Ray after he returned to the unit.[1282] She recalled that Ray told her he had tried to escape because 'no-one was keeping him safe'.[1283]

3.2.36 6 January 2020—The Centre Support Team discusses the incident involving Ray, Albert and Finn

A Centre Support Team meeting was held four days after the 2 January 2020 incident involving Albert, Finn and Ray.[1284] In relation to Ray, the minutes record that Ray 'is always apologetic after incidents' and notes that work was underway to refer Ray's case to a Senior Quality and Practice Advisor.[1285] The minutes note that Ray had been 'unit bound' since his escape attempt the day before but do not record a decision to remove him from 'unit bound' at that time.[1286] In relation to Finn and Albert, the minutes record separately for both of them that '[he] has had a great week aside from the one incident that let his week down'.[1287]

The Centre's psychologist was present at this meeting.[1288] We have viewed an email sent by a Case Management Coordinator and a member of the Centre Support Team, in the days following this Centre Support Team meeting. In that email, the Case Management Coordinator raised his concerns about how the psychologist's presence was managed.[1289] We understand that some members of the Centre Support Team requested the psychologist's presence because her expertise was required in relation to Ray in particular.[1290] The email recorded that Maude initially declined to allow the psychologist to attend, but when Centre Support Team members 'insisted', Maude agreed on the condition that the psychologist only listen and not speak.[1291] The email also recorded that Mr Ryan agreed with the approach.[1292] Alysha's evidence was also that the psychologist had been allowed to attend on the condition that she not contribute to the discussion.[1293]

We asked Maude for her response to the allegation that she prevented the psychologist from contributing to the Centre Support Team meeting.[1294] Maude did not respond to our request for a statement.

3.2.37 6 January 2020—A referral is prepared to engage a Senior Quality and Practice Advisor

Also on 6 January 2020, Mr Ryan requested that Ray be referred to a Senior Quality and Practice Advisor.[1295] It appears that Ms Honan either approved or directed that a referral be prepared.[1296]

On the same day that Mr Ryan instructed the Case Management Coordinator to prepare a referral to the Senior Quality and Practice Advisor, Alysha emailed Ms Honan requesting a meeting to discuss the incident between Ray, Albert and Finn, and the associated response.[1297] The email said the Multi-Disciplinary Team had 'strongly advised against' placing young people who were 'highly vulnerable, suggestable and at risk' in the Franklin Unit, 'for their own safety'.[1298] The email also notified Ms Honan of Ray's escape attempt, which had occurred when Ray was under Very Close Supervision.[1299] Alysha queried the value of making a referral to a Senior Quality and Practice Advisor when previous recommendations about Ray had not been followed.[1300]

Ms Honan's response to Alysha was that Mr Ryan had asked Ms Honan for her 'opinion about engaging a [Senior Quality and Practice Advisor] … because [staff] were at a loss as to how to manage [Ray]'.[1301] Ms Honan suggested that a referral to the Senior Quality and Practice Advisor would 'shine a light on the adverse responses to the advice of the Professional services staff to the [Operations] Managers'.[1302] We understand Alysha also spoke with a member of the Senior Quality and Practice Advisor team, who shared a similar view to Ms Honan about how a referral could assist with the internal dynamics at the Centre.[1303]

In her emails with Ms Honan of that day, Alysha continually expressed her serious concerns about disregard for the advice of the Professional Services Team and the Multi-Disciplinary Team and failure to comply with policy, including the following:

- Staff were not following the Multi-Disciplinary and Professional Services Teams' advice about how to manage Ray (contrary to the suggestion that staff were simply 'at a loss' about how to manage Ray).[1304]
- Decisions to place Ray and others in the Franklin Unit were directly contrary to advice, and the incident between Ray, Finn and Albert would not have occurred had Multi-Disciplinary Team recommendations been followed.[1305]

- Operational staff had failed to comply with the terms of the Very Close Supervision order, enabling Ray to attempt an escape in the days following the incident with Finn and Albert.[1306]
- The Centre's psychologist had been instructed not to speak at the Centre Support Team meeting in relation to next steps for Ray.[1307]

We understand that the Centre's psychologist reported the incident to Child Safety Services four days after the incident.[1308] The report was made in conjunction with other reports the psychologist made involving Albert and Finn (as discussed earlier).[1309] Specifically, the psychologist reported that Ray had significant mental health difficulties and was placed with Albert and Finn contrary to recommendations.[1310] The psychologist also reported that the response from youth workers was 'very delayed' and that multiple workers were present during the incident but did not intervene.[1311]

The psychologist also raised the matter as part of a broader report of issues to her line manager in the Department (which we discuss further in this case study).

3.2.38 7 January 2020—A management plan is developed for Ray

After the 2 January 2020 incident involving Ray, Albert and Finn, Ms Honan 'formally instructed' Mr Ryan to ask Alysha (in consultation with the psychologist) to 'set out clear strategies to manage [Ray] and also develop some recommendations'.[1312] This was to occur in conjunction with the referral to the Senior Quality and Practice Advisor.[1313]

On 7 January 2020, Mr Ryan instructed Digby, the Manager, Professional Services and Policy, to prepare a management plan for Ray.[1314]

Ray's final management plan, prepared by Digby, provided that:

- Ray was to remain in a specified unit (not the Franklin Unit) 'for the time being' and that the psychologist and others were to be consulted 'if practicable' before a placement decision affecting Ray was made (such as adding others to his unit).[1315]
- Ray was to remain under Very Close Supervision 'until determined otherwise by both [the Multi-Disciplinary Team] and [the Centre Support Team]'.[1316]
- Operations staff were 'to be reminded of their responsibilities' in relation to Very Close Supervision, given Ray's escape attempt.[1317]
- Alysha was to prepare a referral to a Senior Quality and Practice Advisor and provide operational staff with ongoing clinical support.[1318]

Much of the management plan covered recommendations from the psychologist working directly with Ray, which had already been raised with Centre staff at the beginning of Ray's admission and which were listed in his existing care plan.[1319] The management plan also provided that a behaviour chart was to be developed—a task that the psychologist

had undertaken to complete in the days following Ray's admission.[1320] We understand from minutes of a Multi-Disciplinary Team meeting approximately 10 weeks after Ray's admission that the behaviour chart was to be 'reintroduced' for Ray, suggesting its use had been discontinued.[1321] We are unclear about whether its use was intended for a short period or what kind of use Centre staff made of it.

We asked Digby about the 2 January 2020 incident and the responses to it, including the referral to the Senior Quality and Practice Advisor. He responded that he knew 'nothing about this matter'.[1322] This is surprising given his role in preparing the management plan in response to the incident.

3.2.39 8 January 2020—The Centre Support Team again discusses the incident involving Ray, Albert and Finn

On 8 January 2020, another Interim Centre Support Team meeting was held to discuss Ray, Albert and Finn.[1323]

In relation to Albert and Finn, the minutes of that meeting state:

> In the follow up from this incident, both boys participated well in mediation and gave assurances that this behaviour will not occur again. During [Case Plan Review] both residents accepted their part in the incident. Conferencing will take place with all three residents involved in the incident. [The psychologist] and [Alysha] in consulting with staff post incident believe that there was considerable provocation from [Finn] and [Albert] in the lead up to the incident, but these details were not recorded on incidents for [the Centre Support Team]. Following discussion, it was felt that both [Finn] and [Albert] remain red until next [week's] [Centre Support Team meeting] as they still pose a risk with their subversive/inciting behaviour.[1324]

In relation to Ray, the minutes noted he was still an escape risk.[1325] A decision was made at the Interim Centre Support Team meeting to remove him from 'unit bound' (which we understand he had been since 5 January 2020, amounting to four days' 'unit bound') in the interests of his mental health.[1326] Ray was instead placed on an 'individual program with operational staff taking him outside, one-on-one, with no other residents in the yard … when [staff] can operationally schedule it'.[1327] As described in the section on isolation (Case study 3), we are concerned that 'unit bound' and 'individual programs' of this kind amount, in effect, to an isolation practice. We were not provided with details of Ray's individual program as described here and remain unconvinced the individual program was any more supportive of Ray's mental health difficulties than being 'unit bound'. Ray remained under Very Close Supervision.[1328]

3.2.40 8 January 2020—A staff member reports concerns about the response to harmful sexual behaviours to the Director, Strategic Youth Services

On 8 January 2020, an Ashley Youth Detention Centre staff member emailed Ms Honan with concerns about the culture and practices at the Centre.[1329] The email stated: 'I would take this information to the Manager of Ashley; however I feel that my concerns will be overlooked'.[1330] In particular, this staff member outlined their concerns that Albert and Finn continued to engage in sexualised acts against young people, which had been 'minimised by Patrick Ryan to the point where staff and other residents are now at risk of these two young people'.[1331]

The staff member also expressed concern that Operations Team staff and Mr Ryan were ignoring case management and the Centre's psychologist, which was placing the 'centre in danger'.[1332] Ms Honan responded on the same day, saying the information would be taken into consideration.[1333]

3.2.41 January 2020—The Ashley Youth Detention Centre psychologist informs the Department of Health about the poor response to the behaviours of Albert and Finn

In the months before and throughout January 2020, there were many communications and meetings between the Centre's psychologist and her superiors in the Department of Health about the operation of Ashley Youth Detention Centre.[1334]

The psychologist informed her superiors of her various concerns about bullying at the Centre, her professional opinion being ignored (therefore putting children and young people in detention at risk) and the poor management of Albert and Finn's behaviours.[1335] There were also several communications among her superiors at the Department of Health and between the Director of Nursing and Mr Ryan about those issues.[1336]

In various correspondence, Department of Health staff expressed or were reported to have expressed the following views about the psychologist's communications:

- The psychologist had never worked in a custodial setting and had inadvertently got people offside by 'explain[ing] the bullying which has been occurring'.[1337]
- The psychologist was a 'guest' in the custodial setting at Ashley Youth Detention Centre.[1338]
- Placement of young people is an 'operational issue'.[1339]

The Nurse Unit Manager told us that working at Ashley Youth Detention Centre as a health practitioner is not the same as working in the community or any other correctional facility.[1340]

On 13 January 2020, staff from the Department of Health met with the Centre's psychologist to explain the differences between working in a custodial setting and working in the community.[1341] The Nurse Unit Manager and Mr Nicholson, Group Director, Forensic Mental Health and Correctional Primary Health Services, told us there were no specific policies and procedures for Department of Health employees working at Ashley Youth Detention Centre.[1342] We note there has been no specific custodial training provided to Department of Health staff working at the Centre.[1343]

The former Head of Department, Forensic Mental Health Services, Department of Health, explained to us that Department of Health staff are not employees of Ashley Youth Detention Centre and are limited in the performance of their duties while in the prison system.[1344] They said the reality is that custodial staff may refuse to accept medical advice because custodial staff have overall responsibility for children and young people in detention and ensuring the good operation of the Centre.[1345]

Secretary Pervan confirmed that the then Department of Communities retained the 'overall responsibility' for the health, safety and welfare of young people at the Centre during the relevant period.[1346] This is reflected in the memorandum of understanding between the Department and Correctional Primary Health Services.[1347]

3.2.42 Observations—Department of Health's response to concerns of harmful sexual behaviours

We are concerned the Department of Health did not attach enough weight to the issues raised by the Centre's psychologist about the safety of children and young people in detention.

The response to the psychologist's concerns appeared to focus on the role of the psychologist and the Department of Health staff in the Centre, rather than recognising:

- her expertise in harmful sexual behaviours
- the fact that young people in the Centre were displaying these behaviours
- there was a need to protect other children.

We saw little evidence of advocacy from Department of Health staff for the safety of children.

While we accept that the then Department of Communities was ultimately responsible for the operations of the Centre over this period, we consider this a lost opportunity to respond to the concerning behaviours of Albert and Finn.

3.2.43 20 January 2020—The Secretary is briefed on concerns regarding Ray

Approximately three weeks after the incident between Ray, Albert and Finn, Kathy Baker, who was the Acting Secretary of the then Department of Communities for a short period at that time, signed off on an issues briefing to the Secretary titled 'Concern for Ashley Youth Detention Centre (AYDC) resident [Ray] due to recent incidents'.[1348] Mr Ryan prepared the issues briefing, which was cleared through Ms Honan and Mandy Clarke, Deputy Secretary, Children and Youth Services, Department of Communities.[1349]

The issues briefing:

- noted Ray's mental health difficulties and health history[1350]
- briefly noted 'recent' incidents involving Ray, including the incident involving Albert and Finn and the escape attempt[1351]
- stated work was 'underway to identify the triggers and management of [Ray] leading up to and during these incidents, with a referral being made for a Senior Quality and Practice Advisor review'[1352]
- stated that Ray was moved to the Franklin Unit for operational reasons over the period when the incident involving Albert and Finn occurred[1353]
- stated that the Manager, Professional Services and Policy, had prepared an updated management plan for Ray, which became operational in the week after the incident involving Albert and Finn[1354]
- clarified that before the updated management plan, Ray was the 'subject of standard management' through the Centre Support Team, Multi-Disciplinary Team and Case Plan Review[1355]
- stated that Ray was being 'closely monitored and well supported by the on-site Psychologist and Professional Services Team. [Ray] will be reviewed again at [a Centre Support Team meeting] on 20 January 2020 unless an earlier review is required in the interim'.[1356]

The issues briefing did not acknowledge that:

- Professional Services and Health Team staff had raised several concerns about Ray since his admission to the Centre
- moving Ray to the Franklin Unit, and exposing him to Albert and Finn, was contrary to the advice of both the Professional Services Team and the Multi-Disciplinary Team
- while invited to attend Centre Support Team meetings that focused on considering and responding to Ray's behaviours, the psychologist had been actively prevented from taking part in those meetings
- the Senior Quality and Practice Advisor referral was intended to specifically identify failures by Centre staff to follow clear recommendations about Ray's care.

As described above, each of these issues was known within Ashley Youth Detention Centre and the Department at the time the issues briefing was prepared.

Ms Honan told us the purpose of the issues briefing was to outline the complexity of Ray's needs and behaviour and the revised management approach for Ray given the escalation of incidents. She said the matters above were not expressly raised in the issues briefing as they were yet to be analysed and assessed as part of the Senior Quality and Practice Advisor referral relating to Ray.[1357] This is consistent with what Ms Baker told us about her understanding of the issues briefing's purpose.[1358]

While we accept the purpose of the issues briefing guided its content, we are concerned it did not, on the face of it, provide all relevant context for the concerns regarding Ray.

The 'Secretary's notation' on the signed copy of the issues briefing records the following:

1. Thank you for the briefing and the ongoing care provided to [Ray], which is being managed on the advice of the Professional Services Team.
2. What is the timeframe for the [Senior Quality and Practice Advisor] review to be completed?
3. With a possible discharge date of 18 March 2020, can we please start preparing for [Ray's] release and ongoing care for his condition outside of [Ashley Youth Detention Centre][1359]

Given the issues briefing was signed off by Ms Baker, we understand this comment was not prepared or approved by Secretary Pervan.

Finding—The 20 January 2020 issues briefing on concerns regarding Ray at Ashley Youth Detention Centre was inadequate and incomplete

We are concerned the issues briefing to the Secretary about Ray, dated 20 January 2020, gave the impression that Ray's behaviours had only begun to escalate immediately before the issues briefing and that Centre staff had acted in a timely fashion to address issues in a manner consistent with the Professional Services Team's advice.

The briefing did not inform the Secretary that the Centre had been on notice of potential harm due to Ray's vulnerabilities and the previous behaviours of Albert and Finn. It did not notify the Secretary that this potential harm eventuated in the 2 January 2020 incident.

Further, we are concerned the intended scope of the Senior Quality and Practice Advisor referral—being the need to identify and address breakdowns in internal processes and procedures that had caused recommendations of the Multi-Disciplinary Team and psychologist to be ignored—was not made explicit.

3.2.44 28 January 2020—Ashley Youth Detention Centre engages a Senior Quality and Practice Advisor

Ms Honan approved the involvement of a Senior Quality and Practice Advisor, and the Quality Improvement and Workforce Development Team was advised of this, approximately four weeks after the incident involving Ray, Albert and Finn.[1360]

Ms Honan told us the Senior Quality and Practice Advisor's review began in February 2020 but was not completed because of a restructure of the Quality Improvement and Workforce Development Team, staff redeployment and the outbreak of COVID-19.[1361]

3.2.45 19 March 2020—The Serious Events Review Team reports its findings and recommendations about the 7 August 2019 incident involving Henry

The Serious Events Review Team's report on the 7 August 2019 incident involving Henry, Albert and Finn was completed in March 2020.[1362] There were more than 25 findings in the review team's report, which covered decision making, incident management, supervision and support of children and young people in detention, communication, document and file management, workplace culture and staff support, training and supervision, and staffing resources.

The Serious Events Review Team's key findings were:

- There was 'disagreement and conflict' among staff about the seriousness of the incident.[1363]
- The incident in question 'constituted a sexual assault' of Henry.[1364]
- The incident should have been urgently reported to police and Child Safety Services, consistent with best practice principles, legislation and the Department's guidelines.[1365]
- Decision making in relation to the consequences for the offending child or young person in detention was 'flawed and inconsistent with best practice principles, legislation and Departmental guidelines'.[1366]
- There were several issues concerning the completion of incident reports, including a lack of detail and critical information, and no evidence of review or approval as required by internal policy.[1367] The Serious Events Review Team concluded that such failings had 'the potential to expose the staff and young people to an increased risk of harm and the wider service system to internal and external criticism and a loss of credibility'.[1368]
- The Centre Support Team's meeting minutes and the issues briefing provided to the Secretary did not 'accurately portray the incident and, consequently, minimised its severity and indicated a concerning lack of understanding of sexual assault and its possible consequences'.[1369]

- Conferencing with Albert and Finn did not occur, which was a breach of the available guidelines and legislation.[1370]
- Anecdotal evidence suggested 'the behaviour of the offenders may be impacting upon how they are managed by staff on a day to day basis which may in turn be placing residents, staff and the centre at risk'.[1371]
- Centre staff did not have a 'comprehensive understanding of the issues around sexual assault'.[1372]
- A recommendation on Henry's care plan that he not be placed with Albert or Finn had not been observed and, had it been, the incident would not have occurred.[1373]
- Albert and Finn should have been under a higher level of supervision, given their history of abusive behaviour.[1374]
- The use of Very Close Supervision was problematic and difficult to implement due to staff shortages and 'differences of opinion' among staff about when to apply it.[1375]
- The review experienced 'significant difficulties' obtaining information and interviewing staff; the 'provision of information to the review and cooperation with the reviewers was so problematic in this case that it may have been deliberately obstructive'.[1376]
- Communications with executive management 'did not accurately represent the incident and minimised the concerns which could lead to misconceptions, misunderstandings and poorly targeted and ineffective interventions'.[1377]
- '[O]pen and honest communication' appeared to be 'discouraged' at Ashley Youth Detention Centre, and communications were 'disrespectful and inappropriate'.[1378]
- The Centre's filing systems were 'inadequate, incomplete and confusing' and did not 'support services to young people'.[1379]
- There was a 'concerning lack of training, support, debriefing and supervision of staff' at the Centre, contributing to an 'unacceptably high risk of psychological and actual physical harm to staff and young people'.[1380]
- Staffing levels were inadequate.[1381]
- Ashley Youth Detention Centre had a 'toxic workplace culture … characterised by distrust, suspicion, conflict and frustration'.[1382]

The Serious Events Review Team made 17 recommendations to the Department, including that the Department:

- develops a strategy to ensure all Centre staff 'are aware of the governing legislation, policies, procedures and practices', with a particular emphasis on mandatory reporting, record keeping, the Behaviour Development System, case management and Very Close Supervision[1383]
- develops 'specific strategies to address the breaches of policy, procedure and practice that have been identified as part of the review'[1384]
- clarifies and/or develops the policies, procedures and staff responsibilities for moving young people to a different unit[1385]
- ensures there is a procedure for providing support to young people following incidents, including a mechanism for reporting and monitoring that support[1386]
- ensures all staff are aware of grievance procedures and avenues for support when lodging or progressing grievances[1387]
- reviews staff training, 'with a focus on relevance and frequency and applicability to a trauma informed approach'[1388]
- urgently develops a 'mandatory, evidence based, trauma informed training schedule' for staff, covering (at minimum): 'trauma informed care; child development; attachment theory; the impact of trauma on children and young people; positive behaviour management; situational risk assessment; and disability, mental health and drug and alcohol issues in children and young people'[1389]
- provides training to all staff in relation to understanding and responding to sexual abuse, and develops associated guidelines[1390]
- ensures the Children and Youth Services' 'formal supervision model' is implemented at the Centre as a matter of priority[1391]
- develops a strategy to address the 'identified issues related to the toxic culture that currently exists at [the Centre] as a matter of urgency'[1392]
- conducts an inquiry into claims made about the Franklin Unit and the management of Albert and Finn.[1393]

The Serious Events Review Team's report noted that 'the review experienced significant delays due to difficulties in accessing information and arranging interviews with relevant staff'.[1394]

As described earlier in this case study, it was the policy for a Serious Events Review Team report to be considered by the Serious Events Review Committee before being supplied to the Secretary. Ms Burton told us she could not recall her report being

presented to this committee.[1395] Ms Burton believes her report was provided directly to Ms Honan.[1396] Ms Burton also believes that none of the other reports she prepared following reviews of incidents at Ashley Youth Detention Centre were sent to the Serious Events Review Committee.[1397]

In our public hearings, Mandy Clarke, former Deputy Secretary, Children, Youth and Families, Department of Communities, explained that because the Serious Events Review Team's reviews were assessing Ashley Youth Detention Centre and were not focused on the Child Safety Services system, those reviews fell outside the terms of reference of the Serious Events Review Team.[1398] As such, the reviews did not follow the usual process of going to the Serious Events Review Committee.[1399]

There were differences in views about the formal purpose of the Serious Events Review Team. Both Ms Honan and Ms Clarke gave evidence that the Serious Events Review Team was established for the 'particular purpose' of looking into infant deaths.[1400]

The members of the Serious Events Review Team told us that it was established not only to review child deaths but also to review serious injury and near misses across the Division of Children and Families within the Department, including Ashley Youth Detention Centre, and to make recommendations for improving service delivery.[1401]

The former Deputy Secretary for Children, Ginna Webster, who set up the Serious Events Review Team, also told us that its purpose, as directed by her, was to review incidents at Ashley Youth Detention Centre as well as elsewhere within Child Safety Services.[1402]

Secretary Pervan agreed with Ms Clarke's distinction between official Serious Events Review Team reviews and other reviews conducted by members of the Serious Events Review Team, so it was appropriate the Serious Events Review Team report in relation to the 7 August 2019 incident was not provided to the Serious Events Review Committee.[1403] However, Secretary Pervan provided a different explanation for the distinction.[1404] He said that '[b]y the time that Ms Burton was asked to undertake the review, the [Serious Events Review Team] had been disbanded or returned to their substantive positions'.[1405] He explained that the team was used to conduct the review in 'recognition of the [Serious Events Review Team] skills' and the reason the report took the form of a Serious Events Review Team review was 'because that was the template structure that they used'.[1406]

Despite expressing this view, Secretary Pervan went on to agree with Ms Burton's evidence that the Serious Events Review Team was formally dissolved in May or June 2020, after the review of the 7 August 2019 incident had concluded.[1407] Secretary Pervan also told us that while the Serious Events Review Team is now not a standing investigative resource for the Department, it can be reconvened if required to undertake a specific investigation or review.[1408]

3.2.46 Observations—The Serious Events Review Team review

We found the evidence about the process for considering the Serious Events Review Team review confusing. It appears there was general agreement that the Serious Events Review Team reviews relevant to Ashley Youth Detention Centre were not considered by the Serious Events Review Committee, but the reasons given for this varied.

We are concerned the Centre reviews did not go through the usual governance process. We consider this governance process important because it provides a mechanism to ensure problems are broadly acknowledged and shared, and for further accountability when addressing recommended reforms.

We discuss the disbandment of the Serious Events Review Team, and other similar incident review mechanisms, in Chapter 9.

3.2.47 February 2020—Reviewer raises other concerns

During her Serious Events Review Team review of the 7 August 2019 incident involving Henry, Ms Burton observed various other issues at Ashley Youth Detention Centre that were outside the terms of reference for the review. In addition to preparing the Serious Events Review Team's report, Ms Burton sent Ms Honan memorandums outlining those other issues.[1409]

We have received and considered two of these memorandums, one dated 21 February 2020 and another dated 27 February 2020.[1410] These memorandums raise:

- concerns about a poor culture at Ashley Youth Detention Centre, including allegations of physical abuse between staff, bullying and sexual harassment[1411]
- allegations that the Centre's management had refused the psychologist's request to access the files of young people in detention[1412]
- alleged non-consensual sexual activity between a female young person in detention and several male young people in detention when the female in detention was housed with males[1413]
- an allegation of historical sexual abuse of a young person in detention by staff member Lester (a pseudonym)[1414]
- an allegation that Lester recently 'strip searched' a young person, outside the scope of his duties.[1415]

In addition to the above issues, Ms Burton told us she also prepared at least one memorandum for Ms Honan concerning reports that older detainees in the Franklin Unit were being used to 'control' younger detainees 'by whatever means' and that incident reports had been rewritten.[1416] We have not been provided with copies of any memorandums that specifically addressed the use of older detainees to control young detainees, nor any additional memorandums, despite requesting Ms Burton's files from the State.[1417]

Ms Burton told us she sent all memorandums to Ms Honan by email but that she did not receive a response.[1418] We received evidence of at least one such email being sent in late February 2020.[1419]

We asked Ms Honan what action she took in response to the email and memorandum she received from Ms Burton in late February 2020. Ms Honan explained that the concerns about staff culture (including allegations of bullying and sexual harassment) had already been raised and were being investigated at the time.[1420] She further stated that the allegation of non-consensual sexual activity between a female and male detainees had previously been investigated.[1421]

In relation to allegations about Lester, Ms Honan commented that Alysha had previously reported these and they had already been referred to People and Culture at the Department. Ms Honan also told us the allegation that Lester strip searched a young person was investigated and it was found that he 'had not acted inappropriately'.[1422] We discuss the Department's response to allegations about Lester in Case study 7.

We understood Ms Honan's response as suggesting that she considered the memorandums from Ms Burton were matters already known and that they did not require any specific follow-up (separate from processes already underway or concluded at that time).

3.2.48 20 May 2020—The Commissioner for Children and Young People receives the Serious Events Review Team's report about the 7 August 2019 incident involving Henry

Despite Commissioner McLean's request to be kept up to date with the Serious Events Review Team's review of the 7 August 2019 incident involving Henry, it appears she did not receive any update until 18 February 2020, when Secretary Pervan notified her that there had been delays in the Serious Events Review Team's review due to staff absences over the Christmas and New Year period.[1423] Commissioner McLean received a copy of the final review report on 20 May 2020.[1424]

Evidence suggests that between May 2020 and January 2021, Commissioner McLean maintained regular contact with Ms Honan, Ms Clarke and Secretary Pervan, and received quarterly updates on the progress of implementing the Serious Events Review Team's recommendations.[1425] After that period, there does not appear to be any further correspondence in relation to monitoring implementation until May or June 2021. In May or June 2021, Commissioner McLean was provided the 'Response to the Findings of a Serious Event Review Team (SERT) Review in Relation to Former AYDC Resident [Henry]' written by Stuart Watson, Centre Manager, setting out the steps the Department had taken in response to the recommendations.[1426]

3.2.49 June 2021—The Department responds to the Serious Events Review Team's report about the 7 August 2019 incident involving Henry

Fiona Atkins, Assistant Manager at the Centre, told us she was part of the working group within Ashley Youth Detention Centre responsible for implementing the recommendations that resulted from the Serious Events Review Team's review of the 7 August 2019 incident.[1427] In June 2021, more than a year after the Serious Events Review Team's report was finalised, Mr Watson emailed Ms Honan with his final 'response' to the Serious Events Review Team's findings.[1428]

Mr Watson explained that the delay in his response to the Serious Events Review Team review was due to him just taking over the role of Manager at Ashley Youth Detention Centre in March 2020 (which we note was more than a year before), the COVID-19 pandemic, staff shortages and more immediate priorities.[1429] Ms Honan attributed the delay in implementing the recommendations to the 'interdependent' and 'large in scale' nature of the recommendations, which required time to resource and sequence.[1430] She stated that implementation had been progressing for 13 to 16 months, but it was not until the recommendations had 'momentum towards completion' that Mr Watson could complete the response.[1431]

That response summarised how a similar incident would be managed differently and identified the following improvements made to Ashley Youth Detention Centre's processes since the 7 August 2019 incident:

- Reports and CCTV are reviewed by the Operations Manager and then the Centre Support Team (now the Weekly Review Meeting).[1432]
- Case/shift notes are reviewed by Ashley Team Support (formerly Professional Services) staff and feedback provided as part of a continual improvement process.[1433]
- All stakeholders are now included at the conference held following an incident, and the process is facilitated by 'experienced, qualified people that are legislatively aware'.[1434]
- Victim-survivors are given immediate support and post-incident follow-up to ensure safety, health and wellbeing needs are met, and they are informed of their rights to make a formal complaint.[1435]
- Staff are regularly rotated through all units, provided with professional supervision and enter Professional Development Agreements so they are consulted about their work preferences and the reasons behind them.[1436]

We are unaware if the response was provided to anyone in the Department other than Ms Honan and her Executive Officer.

Ms Honan's evidence was that the recommendations of the review have been actioned and that she monitors their progress.[1437]

Ms Clarke said that 'to the best of [her] knowledge the [Serious Events Review Team] recommendations were accepted'.[1438] She told us the Centre's management team was responsible for implementing the recommendations.[1439] She later provided us with a Minute to the Strengthening Safeguards working group dated August 2021 that stated the last of the review's recommendations had been implemented.[1440]

Secretary Pervan told us he had not received a 'briefing on the progress of these issues' and therefore, he did not answer some of our questions about the Serious Events Review Team, including how the Department has ensured the successful implementation of the team's recommendations.[1441] Secretary Pervan told us he understood that the recommendations had been accepted and 'integrated into wider ongoing reforms' at Ashley Youth Detention Centre but that Ms Clarke and Ms Honan were responsible for implementing those recommendations.[1442]

The *Serious Event Review Team Information Sheet*, dated August 2019, stated that the Children and Youth Services Executive was responsible for implementing any recommendations of a review, and the Minister for Human Services and the Secretary were to receive monthly updates.[1443]

The former manager of the Serious Events Review Team told us the Department's executive was not required or expected to report to the Serious Events Review Team on implementing recommendations.[1444] An undated version of the terms of reference for the Serious Events Review Committee, which the former manager of the Serious Events Review Team provided to us, stated that that committee played a role in monitoring 'progress reporting against recommendation implementation'.[1445] We note however, that as discussed above, Secretary Pervan and Ms Clarke explained that reviews of Ashley Youth Detention Centre were not provided to this committee.

Finding—The response to the Serious Events Review Team review of the 7 August 2019 incident did not follow a clear process for implementation and oversight

It appears there was no clear accountability or governance process for reporting against the recommendations of Serious Events Review Team recommendations concerning Ashley Youth Detention Centre. As we observe in relation to the reviews themselves, strong governance structures ensure problems are shared and acted on.

Had a clear formal oversight and accountability process been adopted, there would have been mechanisms for the Secretary and the Minister to be regularly briefed and potentially for a body like the Serious Events Review Committee to provide additional oversight.

We find that acting outside the review structures resulted in a collective lack of ownership in the Department for responding to the Serious Events Review Team's report on the 7 August 2019 incident involving Henry.

3.2.50 Post June 2021—Reforms are implemented in response to the Serious Events Review Team's report

Ms Honan and Mr Watson identified the following improvements made to Ashley Youth Detention Centre practice and procedure following the Serious Events Review Team report:

- A policy review working group was established, led by a senior policy officer, to revise all policies and procedures at the Centre. Finalised procedures are reflected in the electronic practice manual.[1446]
- Training in mandatory reporting, case note and record keeping, the Behaviour Development Plan and Very Close Supervision was updated, delivered to staff and incorporated into the induction for new staff.[1447]
- Case management procedures were under review and were a work in progress. In August 2022, Ms Honan told us she expected this review would be completed by the end of 2022.[1448]
- Moving detainees to a different unit is now determined by the 'Weekly Review Meeting' (previously the Centre Support Team), and an additional risk assessment process is followed if safety concerns arise. Ms Honan told us that the on-call manager must approve any after-hours movement of young people.[1449]
- Case note and incident recording is now electronic and centralised.[1450]
- A new therapeutic practice framework and learning and development framework have been implemented, which are designed to help staff work with young people in a trauma-informed way.[1451]
- Key positions that support operational roles have been reviewed and reclassified to ensure policy development, training and supervision is up to date and delivered by suitably skilled and qualified staff.[1452]
- Recruitment has been centralised through the People and Culture Team.[1453]

- There has been a change in leadership and a 'significant focus' on workplace behaviours.[1454]
- A Senior Business Partner has helped staff to proactively manage complaints and to address conflict and concerns.[1455]
- Security improvements have been made, including securing the courtyards for all units.[1456]
- Workshops have addressed low morale and the Centre's poor workplace culture.[1457]

3.2.51 Mid-2021—Ray displays harmful sexual behaviours

It is notable that in later periods of detention at Ashley Youth Detention Centre, Ray displayed an 'emerging pattern of sexual disinhibition', including making 'sexually inappropriate comments' and engaging in 'increased sexualised talk'.[1458] Eventually, staff raised concerns that he may sexually assault other young people at the Centre. We are not aware of any evidence that he did so. We are concerned, however, by evidence that Ray began displaying similar harmful behaviours in the months following his exposure to violent behaviours at the Centre. A failure to respond appropriately to harmful sexual behaviours may perpetuate the behaviour.

3.2.52 December 2021—Max asks to be transferred from Ashley Youth Detention Centre to adult prison

Beyond the incidents noted above, Max was also involved in other incidents at the Centre that were unrelated to harmful sexual behaviours.[1459] Max's time at the Centre ended in late 2021 with him displaying continuing and increasingly challenging behaviours: 'I just kept going and I would have code blacks called on me every day. I kept hitting staff and stuff like that'.[1460] Max told us he behaved this way in an effort to get transferred from the Centre to an adult prison, despite being under 18:

> Well, I had— as there'd be paperwork of me trying to request to move out of there, I put in request forms, and that's what the [Centre Support Team is] there for, and they just kept coming back saying, 'No, you're not going to be able to move no matter what you do'. So then that made it even worse for me, because like, I felt I had the— I should be allowed to go to an adult prison, not sit in Ashley after everything that's happened to me.
>
> I don't get treated like a kid up there, so why should I be there when just, like, I've had so much trauma and that there I just didn't feel like, like, it wasn't good for me, it wasn't good for my headspace, so I just kept releasing all my anger on all—everyone.[1461]

In a Department Minute to Secretary Pervan dated 22 December 2021 about the proposed transfer of Max to the adult prison system, Max's behaviour was summarised as follows:

> [Max]'s current presentation includes frequent aggressive behavioural outbursts, extensive property damage, threatening/intimidating/assaulting staff, fighting with other residents, and high levels of emotional distress.
>
> [Max] has had 17 incident / detention offences in November and 12 as at 20 December 2021. This includes attempted staff assaults, resident assaults including an assault on a 14-year-old resident, standoffs/riotous behaviour including inciting other young people to join him on three occasions, he has attempted to access staff security equipment on several occasions.
>
> [Max] has increased threats to include threats of sexual assault against staff and other young people including exposing himself to other young people and staff.
>
> [Max] poses a significant risk to staff and other resident safety and cannot be adequately managed to ensure safety of staff and other residents.[1462]

In an email from Ms Honan to Secretary Pervan on 8 February 2022, Ms Honan wrote that Max was transferred to the adult prison system because 'his behaviour was too complex and high risk to manage at [Ashley Youth Detention Centre]'.[1463] Based on Max's evidence, the transfer appears to have been consistent with Max's wishes and stated requests at the time. However, we were also told that Max had been experiencing high levels of emotional distress during this period and frequently changed his mind regarding the transfer.[1464]

Max told us that when he was transferred to adult prison, Ashley Youth Detention Centre staff told him it was his Christmas present.[1465]

A memorandum of understanding between the former Department of Health and Human Services (Children and Youth Services) and Department of Justice (Tasmanian Prison Service) executed in December 2014 governs and facilitates the transfer of young people between the Centre and the Tasmania Prison Service. This memorandum of understanding, which remains in effect, enabled Max's transfer.[1466]

3.2.53 Early 2022—Max asks to be transferred from adult prison back to Ashley Youth Detention Centre

It appears that in early 2022, when he was still under the age of 18, Max asked to return to Ashley Youth Detention Centre.[1467] As part of that process, Max contacted the Commissioner for Children and Young People, Leanne McLean, to advocate for his request.

Commissioner McLean wrote to Secretary Pervan on 17 March 2022, outlining Max's experiences in the adult prison system.[1468] Max had reported to Commissioner McLean that he was being exposed to long periods of isolation, was self-harming (which resulted in further restrictions on his movement) and was being housed with a large number of adults.[1469] Commissioner McLean also noted Max's desire to attend Ashley School.[1470]

Commissioner McLean asked Secretary Pervan that Max be allowed to return to the Centre.[1471] Commissioner McLean noted that she was 'not supportive' of Max's transfer to the adult prison system when the original decision was made.[1472] Secretary Pervan responded to Commissioner McLean's email on 20 March 2022, writing that 'it is my determination that the information provided does not mitigate the significant risk that [Max] continues to present to the safety of other young people and staff at [Ashley Youth Detention Centre]'.[1473]

On 22 March 2022, in response to Secretary Pervan's determination, Commissioner McLean made the following comment about the apparent inability of Ashley Youth Detention Centre to manage or address the challenging behaviours of a young person like Max:

> Thank you for informing me of your decision that [Max] will remain at the [Tasmanian Prison Service], and the information influencing your decision. It is unfortunately an indication of the limitations of our current model, that these types of behaviours cannot be responded to in an appropriate therapeutic fashion within a youth-specific environment.[1474]

Commissioner McLean also asked Secretary Pervan for more information about Max's circumstances, including:

- how he would communicate the determination to Max, and inform Max whether he could seek a review of the decision through the Ombudsman
- what measures were being taken to ensure Max's wellbeing in the adult prison system, raising her concerns as to 'who is responsible for the wellbeing of a child remanded to an adult facility'
- how the decision to remand Max in the adult prison system was made following his earlier arrests, subsequent to his initial transfer from Ashley Youth Detention Centre.[1475]

We asked Secretary Pervan about his decision not to allow Max to return to Ashley Youth Detention Centre once Max was detained in an adult prison, and his response to Commissioner McLean's other queries of 22 March 2022 about how Max would be provided with the appropriate therapeutic supports if he remained in adult prison. Secretary Pervan presented us with his email response to Commissioner McLean, dated 26 April 2022, more than a month after she sent him her queries. Secretary Pervan's email made the following points:

- He had assumed that Commissioner McLean, as Max's advocate, would inform Max of the determination not to transfer Max back to Ashley Youth Detention Centre and any rights he had to review that decision.

- Max's wellbeing in the adult prison system was being supported by visits from his Community Youth Justice Worker and Child Safety Officer, the therapeutic services offered by the Tasmania Prison Service, as well as information provided by Ashley Youth Detention Centre authorities to the Tasmania Prison Service about Max, such as his 'trigger points and associated behaviour management strategies'.
- Upon Max's previous arrest and him being remanded in custody, Secretary Pervan had formed the opinion that it was not practicable to detain Max at Ashley Youth Detention Centre based on the factors considered when Max was first transferred to the adult prison system.[1476]

Secretary Pervan acknowledged the limitations of Ashley Youth Detention Centre to be able to address the needs of children with complex needs and stated that the issue was 'being taken into account in the design of the new facilities that will replace [Ashley Youth Detention Centre]'.[1477]

Finding—Ashley Youth Detention Centre was not equipped to meet the complex needs of children and young people, resulting in at least one young person being transferred to adult prison

Ashley Youth Detention Centre should be able to meet the needs of children displaying complex behaviours. It was not able to in early 2022, resulting in at least one young person being detained in adult prisons.

We remain concerned about how the needs of young people in detention are being met now, given Secretary Pervan's indication that the complex needs of children and young people are being considered in the design for the new facility, which has not yet been built. It is unacceptable that the solution to a young person displaying challenging behaviours in youth detention is to transfer that young person to an adult prison, where they face further risk of sexual abuse.

Max's specific circumstances are complicated somewhat by his admitted desire for such a transfer in late 2021 and his stated intention to escalate his behaviour to compel that outcome. However, once he requested a transfer back to Ashley Youth Detention Centre after experiencing the adult prison system—while still a minor—the Centre should have been in a position to manage and meet Max's needs. In addition, any opportunity for Max to improve his behaviour and receive therapeutic care at Ashley Youth Detention Centre should have been properly assessed.

3.2.54 Observations—Harmful sexual behaviours displayed by Albert and Finn

Ashley Youth Detention Centre was aware that Albert had displayed harmful sexual behaviours as early as January 2018, 17 months before the 7 August 2019 incident with Henry.[1478] Records of multiple other incidents involving Albert and Finn, while not investigated in detail, suggest their behaviours were frequent and persistent and indicated a need for specialist treatment.[1479]

In addition, the Centre was notified, on multiple occasions by different staff, that not enough was being done to manage Albert's and Finn's harmful sexual behaviours and the risks these behaviours posed to other detainees, including Henry:

- On 13 August 2019, Ms Gardiner and the union delegate raised concerns that the Centre's response to the 7 August 2019 incident involving Henry was inappropriate.
- On 22 August 2019, Ms Gardiner advised that she was reporting the incident to Child Safety Services.
- On 18 September 2019, the Ashley Youth Detention Centre psychologist raised concerns about Henry being placed in a program with Finn, given Finn's harmful sexual behaviours towards Henry on 7 August.
- On 13 November 2019, the psychologist again raised her concerns about Albert and Finn's behaviours in an email.
- On 15 November 2019, the psychologist once more raised her concerns in a letter.
- On 6 December 2019, the psychologist advised that she had made mandatory reports to Child Safety Services and the Commissioner for Children and Young People.

Even when attempts were made to address the behaviours of Albert and Finn, these were not progressed. We are concerned that Alysha and the psychologist's review into the behaviours of Albert and Finn was quashed, seemingly by Centre management.

When asked about the management of Albert and Finn, a Case Management Coordinator at the Centre told us:

> They weren't managed appropriately because the senior decision makers were completely dysfunctional. One simple thing that would have helped was to separate [Albert and Finn] as they were a poor influence on each other.[1480]

Ms Gardiner stated that not addressing the needs of Albert and Finn 'placed them at risk for being perpetrators of future sexual assault. [Ashley Youth Detention Centre] had a responsibility for rehabilitation for the detainees, and this was not addressed'.[1481]

In her evidence, Ms Honan expressed concern with the failure of Centre management to act on the advice of Ms Gardiner and the psychologist, saying 'these were highly skilled practitioners, why their advice was disregarded is not okay'.[1482]

Some staff at Ashley Youth Detention Centre raised serious concerns about harmful sexual behaviours, as well as other harmful behaviours, at the Centre. We were concerned that other staff at the Centre did not appear to appreciate the seriousness of Albert and Finn's behaviour and the risk they posed to other children (and staff) and to members of the community after their release if they were not rehabilitated. We also query why Centre staff did not consider moving Albert and/or Finn out of the Franklin Unit.

3.2.55 Observations—The Department of Communities' response to allegations about placement decisions

As described in this case study, we received evidence that the Centre and the Department were made aware of allegations that older detainees were being used to threaten younger detainees. Specifically:

- The psychologist emailed Mr Ryan on 13 November 2019 advising that a young person had reported to her they had been threatened with placement in the Franklin Unit and that detainees get 'stood-over, abused and raped' in that unit.[1483]
- Ms Burton told us she reported the matter to Ms Honan by a memorandum prepared during her review of the 7 August 2019 incident.[1484]
- Ms Honan acknowledged that Alysha reported the matter to her.[1485]

We asked Ashley Youth Detention Centre management and Department officials about the evidence from former Centre staff that misbehaving detainees had been threatened with transfers to the Franklin Unit so their behaviour could be 'sorted out'.[1486]

In his statement to us, Mr Ryan did not answer our question about whether there was, at any time, a practice of using placement decisions to threaten or punish children or young people detained at the Centre.[1487] He did state that he was not aware of any perception among children or young people in detention that they would not be protected against the risk of sexual abuse in the Franklin Unit until the Centre's psychologist told him.[1488]

Mr Watson could not comment on practices before starting work at the Centre in 2020.[1489] He said that a policy or practice of using older detainees to control or influence younger detainees was not presently in use, and he agreed any such practice or policy would be 'totally inappropriate'.[1490]

In response to our question about whether there was a policy or practice of using some young people in detention as a threat to influence or punish the conduct of other detainees (particularly in relation to the Franklin Unit), Mr Brown told us that '[f]rom

memory the [Behaviour Development System] and induction processes were the only policies used to assess where residents were placed'.[1491]

Ms Clarke also told us she had no knowledge of any practice of using placement decisions to punish children or young people in detention.[1492] She confirmed that such conduct 'would warrant a formal investigation'.[1493]

Secretary Pervan denied knowledge of any policy of Centre staff threatening young people with a placement in the Franklin Unit.[1494] He stated that he had not been made aware of concerns with placement decisions until receiving a request for statement from us on 2 August 2022.[1495]

Ms Honan told us she became aware of the possibility of such a practice after Alysha raised the matter with her in late 2019. As described here, Ms Burton told us that during her investigation of the 7 August 2019 incident, she raised with Ms Honan reports that older detainees in the Franklin Unit were being used to 'control' younger detainees.[1496]

Ms Honan said that this issue formed part of the terms of reference of the Serious Events Review Team and Senior Quality and Practice Advisor reviews.[1497] We note that the Senior Quality and Practice Advisor review was never completed and the referral does not raise the issue of using children and young people in detention in the Franklin Unit as a control mechanism.[1498] We are unsure which Serious Events Review Team review Ms Honan was referring to, but note that the terms of reference of the review in relation to the Henry incident in August 2019 did not refer to the allegations that older detainees were used to control or threaten younger detainees.

Finding—The Department should have fully investigated allegations that staff at Ashley Youth Detention Centre used older detainees to threaten or control younger detainees

We are concerned that the allegation that some staff at Ashley Youth Detention Centre used older detainees to threaten or control younger detainees has not been fully investigated, despite this concern first being raised with Centre management in late 2019 and being subsequently raised with Department staff. We would have expected such an investigation to speak to children and young people in detention and staff about their views, particularly children and young people's sense of safety. We remain concerned that some staff who are the subject of those allegations may still be working at Ashley Youth Detention Centre.

3.2.56 6 May 2022—A new unit placement procedure is put in place

In a statement provided to us, dated 27 July 2022, Secretary Pervan attached a copy of the *Unit Commissioning, De-Commissioning and Allocation to a Young Person Procedure* ('Unit Placement Procedure').[1499] The new Unit Placement Procedure acknowledges that decisions about unit placement are 'critical, as placement decisions can affect a young person's health and wellbeing by either increasing or decreasing the risk of immediate or future harm'.[1500] The following 'critical requirements' are identified in the policy to 'ensure the safety of young people':

> All new arrivals will be housed in the admission induction unit.
>
> Male and female detainees will be housed separately. Detainees that identify as transgender will guide their unit placement.
>
> If deemed safe, young people from Aboriginal and Torres Strait Islander backgrounds should room share.
>
> Placement decisions about young people must be made in the best interests of all young people at the Centre.[1501]

We note that the new policy does not refer to harmful sexual behaviours or more broadly that safety should be a paramount consideration in placement decisions. We also consider that the policy lacks clarity on what 'operational considerations' may warrant decisions about unit placement and is generally unclear as to who has what power to make a placement decision in any given context (and who is required to review or may override such a decision). In Chapter 12, we discuss this policy, the importance of clear responsibility for decision making in placing children and young people in detention and the importance of clinically-led responses to safety concerns.

Finding—There is a lack of consistent policy and practice at Ashley Youth Detention Centre on unit placements

There continues to be a lack of clear policy and practice around placement decisions and unit moves at Ashley Youth Detention Centre, including who is responsible for the final decision and reviewing any decision.

This lack of clear process is concerning when children are displaying harmful behaviours and may cause a threat to the safety and wellbeing of other children and young people in the Centre.

There should be clear ultimate decision-making responsibility for placement decisions, which should consider the risks posed by young people who display harmful sexual behaviours.

3.3 System observations—Max, Henry and Ray

It was apparent to us that systemic problems at Ashley Youth Detention Centre contributed to the risk of harmful sexual behaviours among detainees, as well as the failure to appropriately respond when these risks are realised. Combined, the treatment of Max, Henry and Ray—particularly their unit placements—highlighted several systemic problems. We discuss some of these earlier in the case study. Here we focus on others.

3.3.1 Lack of thorough assessment, including risk assessment

It is our view that many staff at Ashley Youth Detention Centre failed to appreciate the risks to Max, Henry and Ray. Consequently, Max, Henry and Ray were subjected to what we consider to be predictable and therefore, avoidable incidents of significant harm.

Henry's placement in the Franklin Unit with Albert and Finn should not have happened given that staff knew Albert and Finn had ongoing and prolonged histories of harmful sexual behaviours. Max's placement in the Franklin Unit should not have happened given that staff were aware that Henry had recently been subjected to harmful sexual behaviours by Albert and Finn. Given Ray's clearly recorded mental health condition on his admission to the Centre, his mental health difficulties over his first months in detention and the escalation in his behaviours in the lead-up to his transfer to the Franklin Unit, Ray should not have been placed with Albert and Finn, who were known to engage in aggressive and violent behaviours.

No risk assessments were undertaken by operational staff with decision-making authority for placements about the suitability of the Franklin Unit for Max, Henry and Ray before these young people were placed in that unit. Rather, where risks had been identified by professional services staff, these were not given appropriate weight. Other operational considerations seem to have influenced the decisions about Max, Henry and Ray's placements.

3.3.2 Staff tensions

It was also apparent to us that tensions between staff and/or teams hindered collaborative decision making about the safety of detainees, which, if addressed, could have significantly mitigated the risks to Max, Henry and Ray.

We observed, on the evidence before us, a dysfunctional relationship or a culture of professional disregard between some operational staff on the one hand and some professional staff on the other hand, particularly during 2019 and early 2020. One staff member described the relationship between some teams as 'caustic'.[1502] We heard of allegations of professional staff being invited to attend meetings but not being allowed to speak. We observed a range of instances where some expert staff recommendations were ignored or their involvement in managing vulnerable detainees was explicitly

denied by both operational staff and management. This meant decisions were being made without consultation and in contradiction to professional advice. In our view, this placed children and young people in detention at risk of sexual harm and ultimately contributed to the harm caused to Max, Henry and Ray. We are concerned that some of these staff tensions reflected a broader divide among staff about the philosophical approach to youth detention and whether a corrections or therapeutic focus was preferable.

The influence of Department employees, including the psychologist, was limited by and subject to the operational decisions of Ashley Youth Detention Centre staff, which prevented concerns about harmful sexual behaviours from being escalated further and prevented clinically-led decision making necessary for a therapeutic response.

We consider the psychologist's repeated reports as indicative of her professional concern. We are concerned that her attempts to raise concerns appear to have been met with a lack of care.

We are also troubled by the alleged conduct of some staff towards other staff who raised concerns about harmful sexual behaviours, including unprofessional conduct, silencing, finger pointing and dismissiveness.

3.3.3 Capacity to identify and respond to harmful sexual behaviours

It was apparent to us that some Ashley Youth Detention Centre staff lacked capacity to recognise and respond to harmful sexual behaviours between detainees. We consider that all staff should receive training on harmful sexual behaviours, particularly senior decision-makers.

If the response of Centre staff to incidents of harmful sexual behaviour is not therapeutic or trauma-informed, problems for young people, staff and the Centre as a whole, now and into the future, will continue with devastating consequences.

Max's experiences at Ashley Youth Detention Centre highlight the ongoing cost of the Centre's failure to meaningfully identify and address harmful sexual behaviours. When Max's long history at the Centre is viewed holistically, we can see that he has become caught in a cycle of trauma and abuse. The 2018 Serious Events Review Team's report into the harmful sexual behaviours Max experienced, while seemingly prepared by the investigator with diligence and in good faith, somewhat and perhaps unintentionally downplayed incidents that caused significant distress to Max. The broad outcome appears to have been a lack of appreciation for the harm caused to Max and an affirmation of the limited response by Centre staff to those incidents. Shortcomings in the response to Max's experiences of harmful sexual behaviours appear to have contributed to Max using violence and harmful sexual behaviours against others.

It is disappointing and concerning that there were seemingly no therapeutic responses available to address the behaviours of Max within the youth custodial context. This is apparently the case despite the best efforts of individuals to have such therapeutic capacity built within the institutional context of the Centre.

3.3.4 Serious Events Review Team

It appears that the Serious Events Review Team's investigation into the incident involving Henry, although delayed, eventually led to several improvements to the Centre's information systems, security systems and responses. These included:

- centralising and digitising incident reporting
- improvements to risk assessments for after-hours unit moves
- improvements to staff training for incident reporting and mandatory reporting obligations.

We note that without that investigation, the actions and decisions of Centre staff regarding harmful sexual behaviours would not have been scrutinised and challenged. The Serious Events Review Team's investigation highlights the importance of having a permanent, experienced and skilled investigative team available to the Department for when serious incidents occur. We note the importance of young people participating in decisions that affect them, including in investigations, is consistent with international obligations and child safe standards.

4 Recent reforms

Ms Honan told us that harmful sexual behaviours would be managed differently if they were to occur at Ashley Youth Detention Centre today. She told us that:

- Placement decisions are now subject to a risk assessment and are more thoroughly scrutinised at Weekly Review Meetings.[1503]
- The Advice and Referral Line would be notified (Ms Honan did not clarify who would make the notification).[1504]
- Clinical staff would better protect and support victim-survivors.[1505]
- There would be a referral to police (Ms Honan did not clarify who would make the notification, but Fiona Atkins, Assistant Manager, Ashley Youth Detention Centre, told us that referrals are made to police 'upon the assessment of the [Centre Support Team] with the [Centre] Manager's support').[1506]
- Incidents involving harmful sexual behaviours would be referred to the Sexual Assault Support Service.[1507]

- Post-management of an incident would be more comprehensive and centralised with the Ashley Incident Management System. All electronic notes and witness statements would be quality assured by the Operations Coordinator and reviewed by the Assistant Manager before being forwarded to the Manager and Director.[1508]
- Staff are now better able to address the behaviours of the kind presented by Albert and Finn due to the current Behaviour Development Program.[1509]
- There is greater support for Operations Team staff from managers and practitioners in relation to enforcing boundaries and reinforcing pro-social behaviours.[1510]
- A Risk Assessment Process Team would be convened to provide recommendations, practical support and advice in managing risk.[1511]
- The Director would be informed about all incidents involving harmful sexual behaviours.[1512]
- All incidents would be reviewed by the Commissioner for Children and Young People and the Custodial Inspector.[1513]
- Young people engaging in harmful sexual behaviours would be referred to services and safety precautions would be placed around them.[1514]

Ms Honan also stated that staff at Ashley Youth Detention Centre would be supported to:

> … call out and address not placate intimidating behaviours. Focus on rewarding positive behaviours when they do occur using the changes within the [Behaviour Development Program] system would have been used to incentivise change. Improvements to incident management reporting and the quality and detail of information now contained in [Weekly Review Meeting] minutes further safeguard the minimisation of incidents and under reporting of them.[1515]

Secretary Pervan told us that where a young person is subjected to harmful sexual behaviours by another young person, they are 'supported therapeutically' by the onsite nurse, medical officer and psychologist, and the young person's care plan is updated and overseen by the Multi-Disciplinary Team.[1516] That said, we received information that the position of onsite psychologist at the Centre has not been filled since November 2021.[1517] Secretary Pervan did not confirm whether mental health support is offered to a young person engaging in harmful sexual behaviours. He did state that Ashley School provides programs on healthy relationships, consent and sexual decision making.[1518]

The Nurse Unit Manager told us that in the event of an incident of harmful sexual behaviour, she would ensure Ashley Youth Detention Centre staff were 'aware' and that 'conferencing is scheduled to address the behaviours of concern'.[1519] She also stated that longer term supports through services such as family planning would be enlisted to 'tailor the delivery of a safe sex education session, which cover aspects of healthy sexual relationships and behaviour, as well as legal boundaries (such as consent)'.[1520]

Ms Honan acknowledged that Ashley Youth Detention Centre is only in the early stages of adopting trauma-informed practice.[1521] Her evidence was that the concept is understood by staff but 'the breakdown is probably in having the skillset and the clinical oversight and guidance about working with that'.[1522] We received evidence from Ms Atkins that Operations Team staff still lack the training, skill and resources to respond to and manage young people displaying harmful sexual behaviours.[1523]

Despite that information regarding the current practice for responding to incidents of harmful sexual behaviour at the Centre, we also received information that the functions and powers of the Commissioner for Children and Young People to review such incidents is limited, and entirely dependent on being notified of such incidents.[1524] Commissioner McLean informed us she has not been formally contacted by the Department to review any harmful sexual behaviour incidents at the Centre, despite making requests to be notified of such incidents.[1525] Further, Commissioner McLean told us that, in situations where she has provided feedback to the Centre and the Department about the way an incident of harmful sexual behaviour has been or should be handled, she is generally not provided with a response to such feedback by the Centre or the Department.[1526] Notably, in a recent instance where Commissioner McLean was contacted by a young person regarding an incident of harmful sexual behaviour at the Centre, she requested advice from the Department in late April 2023 regarding measures taken in response to this incident, however, as at 11 July 2023, had not received a response from the Department.[1527]

5 Harmful sexual behaviours—2022–23

In early 2023, the Tasmanian Legislative Council was conducting its Inquiry into Tasmanian Adult Imprisonment and Youth Detention Matters. Some submissions to that inquiry raised concerns about, among other things, the behaviours of detainees, staff safety and the lack of a clear understanding of therapeutic and trauma-informed care, and questioned if it was appropriate for a detention setting.[1528] In particular, two submissions we read were by retired police officers who had answered a call in late 2022 to work at Ashley Youth Detention Centre to address immediate staffing shortages. They described similar concerns. One described the challenging behaviours of young people in the Centre this way:

> Indecent assaults are common practice with resident on resident fondling and touching and resident on youth worker touching. There were many times where I asked a resident if they wished to make a complaint—the answer was always similar, 'just playing, joking around (normally an expletive), just having fun'. Of the many sexual contacts I witnessed, resident on resident, not one complaint was made.

> In my case I was touched on the breasts on occasions and being asked 'if I liked it', being touched on the backside and in other sexual ways. I was frequently being asked about my sexual activity the night before and on one occasion and in front of other residents and a youth worker (female) a resident asked 'if I liked it up the bum'.
>
> The resident was severely chastised by the other youth worker and me and, as was a common practice, said 'can't you take a joke'. This was the similar response in all inappropriate touching—'only joking'.
>
> I witnessed many vicious assaults—resident on resident and resident on youth worker.[1529]

While not described as such in the submission, this is a description of harmful sexual behaviours. It echoes, for us, comments made in the 2018 Serious Events Review Team report, which said inappropriate sexual behaviour by children and young people in detention 'must be managed on a daily basis' in the Centre and noted that 'it may be useful to consider expert review, advice and [ongoing] consultation concerning this issue to support [the Centre] to assist residents to develop socially appropriate behaviours for transition to the community'.[1530]

We are concerned these sexualised behaviours may have become normalised within the Centre.

Finding—Ashley Youth Detention Centre has been aware of harmful sexual behaviours at the Centre and has not taken steps to protect children and young people from these

While this case study has focused heavily on events from 2018 to 2022, and identified specific failings in relation to those events, we are concerned that these events and the response of the Centre and the Department echo a pattern across many years at Ashley Youth Detention Centre.

We heard too many accounts, from as early as the 2000s, of children and young people being harmed by the sexualised behaviours of other detainees, sometimes facilitated by, or with the knowledge or implicit approval of, staff.

At times staff have failed to respond to known risks of harm, allowing vulnerable children and young people to be placed with or exposed to young people who pose a risk to their safety.

When harmful sexual behaviours did occur, staff or Centre management often failed to respond appropriately—whether by not removing the risks, not supporting the victim-survivor, or punishing them for making a complaint. When some staff raised concerns about the risk of harm to certain children or young people in detention, those concerns were sometimes not given appropriate weight within the culture and operations of the Centre.

We hold serious concerns about allegations that, at times, staff have used unit placement or threats of unit placement with other detainees known to display violence and harmful behaviours to threaten, intimidate or control more vulnerable children and young people.

Notes

Introduction to case studies

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2 The names 'Alysha' and 'Max' are pseudonyms; Order of the Commission of Inquiry, restricted publication order, 18 August 2022.

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6 Statement of Ginna Webster, 29 April 2022, 1 [7], 2 [8].

7 Statement of Ginna Webster, 29 April 2022, 1 [6–7].

8 Statement of Mandy Clarke, 19 August 2022, 1.

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22 Transcript of Patrick Ryan, 7 September 2022, 3568 [36–40]; Statement of Stuart Watson, 16 August 2022, 1 [1–2], [10].

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Case study 1: The nature and extent of abuse in Ashley Youth Detention Centre

25 Refer to, for example, Statement of 'Ben', 29 March 2022, 4 [18]; Statement of 'Max', 19 May 2022, 2 [7–11]; Transcript of 'Charlotte', 24 August 2022, 3202 [22–33]; Statement of 'Charlotte', 31 January 2022, 2; Statement of 'Oscar', 29 July 2022, 2 [6].

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66 Statement of Michael Pervan, 27 July 2022, Annexure 27 ('Description of Allegations or Incidents of Child Sexual Abuse at Ashley Youth Detention Centre or in relation to its Officials Received by the Department from 20 July 2021', Spreadsheet, undated). In Chapter 17, we note that, as at 8 April 2022, 689 National Redress Scheme claims had been made in relation to Tasmanian Government institutions.

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126 Statement of 'Ben', 29 March 2022, Attachment [Ben]–001 (Handwritten Submission to the National Royal Commission, 'Ben', undated) 4. The name 'Stan' is a pseudonym; Order of the Commission of Inquiry, restricted publication order, 18 August 2022.

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179 Statement of 'Ben', 29 March 2022, 11 [51].

180 Statement of 'Ben', 29 March 2022, 11 [51].

181 The names 'Eve' and 'Norman' are pseudonyms; Order of the Commission of Inquiry, restricted publication order, 18 August 2022. Statement of 'Eve', 18 August 2022, 1 [4–5]; Transcript of 'Eve', 19 August 2022, 2868 [40–42], 2869 [32–41].

182 Transcript of 'Eve', 19 August 2022, 2869 [4–8].

183 Transcript of 'Eve', 19 August 2022, 2869 [22–26].

184 Statement of 'Eve', 18 August 2022, 1 [3].

185 Statement of 'Eve', 18 August 2022, 2 [6]; Transcript of 'Eve', 19 August 2022, 2870 [38–45].

186 Statement of 'Eve', 18 August 2022, 2 [6]; Transcript of 'Eve', 19 August 2022, 2870 [38–45].

187 Statement of 'Eve', 18 August 2022, 2 [7].

188 Statement of 'Eve', 18 August 2022, 2 [8]; Transcript of 'Eve', 19 August 2022, 2871 [45].

189 Statement of 'Eve', 18 August 2022, 2 [9].

190 Statement of 'Eve', 18 August 2022, 2 [9]; Transcript of 'Eve', 19 August 2022, 2871 [4–9].

191 Statement of 'Eve', 18 August 2022, 2 [9]; Transcript of 'Eve', 19 August 2022, 2871 [4–9].

192 Statement of 'Eve', 18 August 2022, 5 [27].

193 Statement of 'Eve', 18 August 2022, 2 [9].

194 Transcript of 'Eve', 19 August 2022, 2873 [27–41]; Statement of 'Eve', 18 August 2022, 3 [14].

195 Statement of 'Eve', 18 August 2022, 3 [17].

196 Statement of 'Eve', 18 August 2022, 3 [17]–4 [19].

197 Statement of 'Eve', 18 August 2022, 5 [28].

198 Statement of 'Eve', 18 August 2022, 3 [16]; Transcript of 'Eve', 19 August 2022, 2872 [35]–2873 [6].

199 Statement of 'Eve', 18 August 2022, 4 [20–21].

200 Statement of 'Eve', 18 August 2022, 4 [22].

201 Statement of 'Eve', 18 August 2022, 4 [22–23].

202 Transcript of 'Eve', 19 August 2022, 2876 [2–12].

203 Statement of 'Eve', 18 August 2022, 4 [25].

204 Statement of 'Eve', 18 August 2022, 4 [25].

205 Statement of 'Eve', 18 August 2022, 5 [26].

206 Statement of 'Eve', 18 August 2022, 5 [26].

207 Transcript of 'Eve', 19 August 2022, 2876 [35].

208 Transcript of 'Eve', 19 August 2022, 2876 [35–37].

209 Statement of 'Eve', 18 August 2022, 7 [38].

210 Statement of 'Eve', 18 August 2022, 7 [37].

211 Statement of 'Eve', 18 August 2022, 4 [24].

212 Statement of 'Eve', 18 August 2022, 5 [29]–6 [34]; Transcript of 'Eve', 19 August 2022, 2873 [47]–2874 [29].

213 Statement of 'Eve', 18 August 2022, 7 [39].

214 Statement of 'Eve', 18 August 2022, 7 [40].

215 Statement of 'Eve', 18 August 2022, 7 [41].

216 Statement of 'Eve', 18 August 2022, 7 [42].

217 Statement of 'Eve', 18 August 2022, 7 [43].

218 Statement of 'Eve', 18 August 2022, 8 [44].

219 The name 'Max' is a pseudonym; Order of the Commission of Inquiry, restricted publication order, 18 August 2022. Statement of 'Max', 19 May 2022, 1 [3].

220 Transcript of 'Max', 23 August 2022, 3109 [43]–3110 [2].

221 Statement of 'Max', 19 May 2022, 1 [3].

222 Statement of 'Max', 19 May 2022, 1 [3].

223 Statement of 'Max', 19 May 2022, 1 [4].

224 The name 'Floyd' is a pseudonym; Order of the Commission of Inquiry, restricted publication order, 18 August 2022. Statement of 'Max', 19 May 2022, 2 [6].

225 Statement of 'Max', 19 May 2022, 2 [6].

226 Statement of 'Max', 19 May 2022, 2 [6].

227 Statement of 'Max', 19 May 2022, 2 [7].

228 The name 'Alan' is a pseudonym; Order of the Commission of Inquiry, restricted publication order, 18 August 2022. Statement of 'Max', 19 May 2022, 2 [7–9].

229 Statement of 'Max', 19 May 2022, 2 [9].

230 Restricted publication order ('Ned'), 18 August 2022. Statement of 'Max', 19 May 2022, 2 [10–11].

231 Statement of 'Max', 19 May 2022, 2 [11].

232 Statement of 'Max', 19 May 2022, 2 [11].

233 Statement of 'Max', 19 May 2022, 3 [13].

234 Statement of 'Max', 19 May 2022, 3 [13].

235 Statement of 'Max', 19 May 2022, 3 [15].

236 Statement of 'Max', 19 May 2022, 3 [16].

237 Statement of 'Max', 19 May 2022, 3 [16].

238 Statement of 'Max', 19 May 2022, 3 [16].

239 The name 'Arlo' is a pseudonym; Order of the Commission of Inquiry, restricted publication order, 18 August 2022. Statement of 'Max', 19 May 2022, 4 [17].

240 Statement of 'Max', 19 May 2022, 4 [17].

241 Statement of 'Max', 19 May 2022, 4 [18].

242 Statement of 'Max', 19 May 2022, 4 [20]; Transcript of 'Max', 23 August 2022, 3115 [27].

243 Statement of 'Max', 19 May 2022, 4 [20].

244 Statement of 'Max', 19 May 2022, 4 [20].

245 Statement of 'Max', 19 May 2022, 4 [21].

246 Statement of 'Max', 19 May 2022, 4 [21].

247 Statement of 'Max', 19 May 2022, 5 [22].

248 Transcript of 'Max', 23 August 2022, 3115 [29–34].

249 Transcript of 'Max', 23 August 2022, 3117 [1–12]; Statement of 'Max', 19 May 2022, 6 [28].

250 Statement of 'Max', 19 May 2022, 12 [52].

251 Statement of 'Max', 19 May 2022, 6 [28].

252 Transcript of 'Max', 23 August 2022, 3121 [2–15].

253 Transcript of 'Max', 23 August 2022, 3120 [12–16].

254 Statement of 'Max', 19 May 2022, 8 [36–37].

255 Statement of 'Max', 19 May 2022, 8 [36].

256 Statement of 'Max', 19 May 2022, 8 [37].

257 Transcript of 'Max', 23 August 2022, 3120 [9–25].

258 Transcript of 'Max', 23 August 2022, 3120 [12–17].

259 Statement of 'Max', 19 May 2022, 10 [43]; Transcript of 'Max', 23 August 2022, 3122 [45]–3123 [15].

260 Statement of 'Max', 19 May 2022, 10 [43]; Transcript of 'Max', 23 August 2022, 3122 [45]–3123 [15].

261 Statement of 'Max', 19 May 2022, 6 [27], 10 [42].

262 Transcript of 'Max', 23 August 2022, 3116 [8–14], 3122 [4–8].

263 Statement of 'Max', 19 May 2022, 10 [42].
264 Statement of 'Max', 19 May 2022, 6 [26].
265 Statement of 'Max', 19 May 2022, 6 [26].
266 Statement of 'Max', 19 May 2022, 10 [42].
267 Statement of 'Max', 19 May 2022, 10 [42].
268 Statement of 'Max', 19 May 2022, 6 [29]–7 [31].
269 Statement of 'Max', 19 May 2022, 7 [31].
270 Transcript of 'Max', 23 August 2022, 3123 [33–43].
271 Transcript of 'Max', 23 August 2022, 3123 [24–43].
272 Statement of 'Max', 19 May 2022, 5 [23].
273 Statement of 'Max', 19 May 2022, 5 [23].
274 Transcript of 'Max', 23 August 2022, 3119 [6–26].
275 Statement of 'Max', 19 May 2022, 5 [23].
276 Statement of 'Max', 19 May 2022, 6 [27].
277 Statement of 'Max', 19 May 2022, 7 [32].
278 Statement of 'Max', 19 May 2022, 8 [33].
279 Statement of 'Max', 19 May 2022, 8 [34].
280 Statement of 'Max', 19 May 2022, 8 [33].
281 Statement of 'Max', 19 May 2022, 8 [35].
282 Statement of 'Max', 19 May 2022, 5 [24].
283 Statement of 'Max', 19 May 2022, 12 [54].
284 Statement of 'Max', 19 May 2022, 12 [53].
285 Statement of 'Max', 19 May 2022, 12 [53].
286 Statement of 'Max', 19 May 2022, 12 [52].
287 The name 'Warren' is a pseudonym; Order of the Commission of Inquiry, restricted publication order, 18 August 2022. Statement of 'Warren', 19 May 2022, Attachment [Warren]–001 (Additional statement, 'Warren', 24 November 2021) 1.
288 Statement of 'Warren', 19 May 2022, Attachment [Warren]–001 (Additional statement, 'Warren', 24 November 2021) 1.
289 Statement of 'Warren', 19 May 2022, Attachment [Warren]–001 (Additional statement, 'Warren', 24 November 2021) 1.
290 Statement of 'Warren', 19 May 2022, 2 [7].
291 Statement of 'Warren', 19 May 2022, 2 [7].
292 Statement of 'Warren', 19 May 2022, 2 [12].
293 Statement of 'Warren', 19 May 2022, 2 [12].
294 Statement of 'Warren', 19 May 2022, 2 [12].
295 Statement of 'Warren', 19 May 2022, 2 [8].
296 Statement of 'Warren', 19 May 2022, 2 [8].
297 Statement of 'Warren', 19 May 2022, 2 [11].
298 Statement of 'Warren', 19 May 2022, 2 [9].
299 Statement of 'Warren', 19 May 2022, 2 [10].
300 Statement of 'Warren', 19 May 2022, 2 [10].
301 Statement of 'Warren', 19 May 2022, 3 [15].
302 Statement of 'Warren', 19 May 2022, 3 [15].
303 Statement of 'Warren', 19 May 2022, Attachment [Warren]–001 (Additional statement, 'Warren', 24 November 2021) 1.

304 Statement of 'Warren', 19 May 2022, Attachment [Warren]–001 (Additional statement, 'Warren', 24 November 2021) 1.

305 Statement of 'Warren', 19 May 2022, 3 [15].

306 Statement of 'Warren', 19 May 2022, Attachment [Warren]–001 (Additional statement, 'Warren', 24 November 2021) 2.

307 Statement of 'Warren', 19 May 2022, Attachment [Warren]–001 (Additional statement, 'Warren', 24 November 2021) 2.

308 Statement of 'Warren', 19 May 2022, Attachment [Warren]–001 (Additional statement, 'Warren', 24 November 2021) 2.

309 Statement of 'Warren', 19 May 2022, Attachment [Warren]–001 (Additional statement, 'Warren', 24 November 2021) 2.

310 Statement of 'Warren', 19 May 2022, Attachment [Warren]–001 (Additional statement, 'Warren', 24 November 2021) 2.

311 Statement of 'Warren', 19 May 2022, Attachment [Warren]–001 (Additional statement, 'Warren', 24 November 2021) 2.

312 Statement of 'Warren', 19 May 2022, Attachment [Warren]–001 (Additional statement, 'Warren', 24 November 2021) 2.

313 Statement of 'Warren', 19 May 2022, Attachment [Warren]–001 (Additional statement, 'Warren', 24 November 2021) 1–2.

314 Statement of 'Warren', 19 May 2022, Attachment [Warren]–001 (Additional statement, 'Warren', 24 November 2021) 2.

315 Statement of 'Warren', 19 May 2022, 3 [15].

316 Statement of 'Warren', 19 May 2022, 3 [16].

317 Statement of 'Warren', 19 May 2022, 3 [16].

318 Statement of 'Warren', 19 May 2022, 3 [16].

319 Statement of 'Warren', 19 May 2022, 3 [17].

320 Statement of 'Warren', 19 May 2022, 3–4 [17].

321 Statement of 'Warren', 19 May 2022, Attachment [Warren]–001 (Additional statement, 'Warren', 24 November 2021) 2.

322 Statement of 'Warren', 19 May 2022, Attachment [Warren]–001 (Additional statement, 'Warren', 24 November 2021) 2.

323 Statement of 'Warren', 19 May 2022, Attachment [Warren]–001 (Additional statement, 'Warren', 24 November 2021) 2.

324 Statement of 'Warren', 19 May 2022, 4 [18–19].

325 Statement of 'Warren', 19 May 2022, 4 [20].

326 Statement of 'Warren', 19 May 2022, 4 [21].

327 Statement of 'Warren', 19 May 2022, 4 [21].

328 Statement of 'Warren', 19 May 2022, 4 [22].

329 Statement of 'Warren', 19 May 2022, 4 [22].

330 Statement of 'Warren', 19 May 2022, 5 [23].

331 The name 'Charlotte' is a pseudonym; Order of the Commission of Inquiry, restricted publication order, 18 August 2022. Statement of 'Charlotte', 31 January 2022, 1.

332 Statement of 'Charlotte', 31 January 2022, 1.

333 Transcript of 'Charlotte', 24 August 2022, 3199 [44–45].

334 Statement of 'Charlotte', 31 January 2022, 1; Transcript of 'Charlotte', 24 August 2022, 3199 [45–46].

335 Statement of 'Charlotte', 31 January 2022, 1.

336 Statement of 'Charlotte', 31 January 2022, 1.

337 The name ‘Edwin’ is a pseudonym; Order of the Commission of Inquiry, restricted publication order, 18 August 2022. Statement of ‘Charlotte’, 31 January 2022, 1.

338 Statement of ‘Charlotte’, 31 January 2022, 1.

339 Transcript of ‘Charlotte’, 24 August 2022, 3200 [17–23].

340 Statement of ‘Charlotte’, 31 January 2022, 1.

341 Statement of ‘Charlotte’, 31 January 2022, 1; Transcript of ‘Charlotte’, 24 August 2022, 3200 [13–46].

342 Statement of ‘Charlotte’, 31 January 2022, 1.

343 Statement of ‘Charlotte’, 31 January 2022, 1; Transcript of ‘Charlotte’, 24 August 2022, 3201 [7–8].

344 Statement of ‘Charlotte’, 31 January 2022, 1.

345 Statement of ‘Charlotte’, 31 January 2022, 1; Transcript of ‘Charlotte’, 24 August 2022, 3201 [10–11].

346 Statement of ‘Charlotte’, 31 January 2022, 1; Transcript of ‘Charlotte’, 24 August 2022, 3201 [13–21].

347 Transcript of ‘Charlotte’, 24 August 2022, 3201 [23–26].

348 Statement of ‘Charlotte’, 31 January 2022, 1.

349 Statement of ‘Charlotte’, 31 January 2022, 2.

350 Transcript of ‘Charlotte’, 24 August 2022, 3201 [29–32].

351 Transcript of ‘Charlotte’, 24 August 2022, 3201 [32–37].

352 Statement of ‘Charlotte’, 31 January 2022, 2; Transcript of ‘Charlotte’, 24 August 2022, 3201 [35–41], 3202 [11–13].

353 Transcript of ‘Charlotte’, 24 August 2022, 3201 [44–46].

354 Statement of ‘Charlotte’, 31 January 2022, 2.

355 Statement of ‘Charlotte’, 31 January 2022, 2.

356 Statement of ‘Charlotte’, 31 January 2022, 2.

357 Statement of ‘Charlotte’, 31 January 2022, 2.

358 Statement of ‘Charlotte’, 31 January 2022, 2; Transcript of ‘Charlotte’, 24 August 2022, 3202 [22–33].

359 Statement of ‘Charlotte’, 31 January 2022, 2.

360 Statement of ‘Charlotte’, 31 January 2022, 2; Transcript of ‘Charlotte’, 24 August 2022, 3202 [22–30].

361 Statement of ‘Charlotte’, 31 January 2022, 2.

362 Transcript of ‘Charlotte’, 24 August 2022, 3202 [35–45].

363 Statement of ‘Charlotte’, 31 January 2022, 2.

364 Statement of ‘Charlotte’, 31 January 2022, 2; Transcript of ‘Charlotte’, 24 August 2022, 3202 [47]–3203 [3].

365 Statement of ‘Charlotte’, 31 January 2022, 2; Transcript of ‘Charlotte’, 24 August 2022, 3203 [5–6].

366 Statement of ‘Charlotte’, 31 January 2022, 2; Transcript of ‘Charlotte’, 24 August 2022, 3203 [25–34].

367 Statement of ‘Charlotte’, 31 January 2022, 2.

368 Statement of ‘Charlotte’, 31 January 2022, 2.

369 Statement of ‘Charlotte’, 31 January 2022, 2.

370 Transcript of ‘Charlotte’, 24 August 2022, 3203 [35–39].

371 Statement of ‘Charlotte’, 31 January 2022, 3.

372 Statement of ‘Charlotte’, 31 January 2022, 2; Transcript of ‘Charlotte’, 24 August 2022, 3204 [32–35].

373 Statement of ‘Charlotte’, 31 January 2022, 2–3.

374 Statement of ‘Charlotte’, 31 January 2022, 2; Transcript of ‘Charlotte’, 24 August 2022, 3204 [35]–3205 [1], 3205 [23–35].

375 Statement of ‘Charlotte’, 31 January 2022, 3; Transcript of ‘Charlotte’, 24 August 2022, 3204 [37–44].

376 Statement of ‘Charlotte’, 31 January 2022, 3; Transcript of ‘Charlotte’, 24 August 2022, 3205 [5–14].

377 Statement of ‘Charlotte’, 31 January 2022, 3.

378 Statement of ‘Charlotte’, 31 January 2022, 3.

379 Statement of 'Charlotte', 31 January 2022, 3.

380 Statement of 'Charlotte', 31 January 2022, 3; Transcript of 'Charlotte', 24 August 2022, 3203 [13].

381 Statement of 'Charlotte', 31 January 2022, 3; Transcript of 'Charlotte', 24 August 2022, 3206 [18–21].

382 Statement of 'Charlotte', 31 January 2022, 3; Transcript of 'Charlotte', 24 August 2022, 3206 [18–27].

383 Statement of 'Charlotte', 31 January 2022, 3–4.

384 Statement of 'Charlotte', 31 January 2022, 3; Transcript of 'Charlotte', 24 August 2022, 3206 [29–37].

385 Statement of 'Charlotte', 31 January 2022, 4.

386 Transcript of 'Charlotte', 24 August 2022, 3206 [40]–3207 [2].

387 Transcript of 'Charlotte', 24 August 2022, 3207 [5–9].

388 Transcript of 'Charlotte', 24 August 2022, 3204 [2–11], 3206 [40]–3207 [2].

389 Transcript of 'Charlotte', 24 August 2022, 3207 [12–16].

390 The name 'Fred' is a pseudonym; Order of the Commission of Inquiry, restricted publication order, 18 August 2022. Statement of 'Fred', 24 August 2022, 1 [3].

391 Statement of 'Fred', 24 August 2022, 1 [4–6].

392 Statement of 'Fred', 24 August 2022, 1 [5].

393 Statement of 'Fred', 24 August 2022, 1 [6].

394 Statement of 'Fred', 24 August 2022, 2 [7–8]; Transcript of 'Fred', 25 August 2022, 3341 [27–29].

395 Statement of 'Fred', 24 August 2022, 2 [9].

396 Statement of 'Fred', 24 August 2022, 2 [9].

397 Statement of 'Fred', 24 August 2022, 2 [11].

398 Statement of 'Fred', 24 August 2022, 2 [11].

399 Statement of 'Fred', 24 August 2022, 4 [21–24].

400 Statement of 'Fred', 24 August 2022, 4 [23]; Transcript of 'Fred', 25 August 2022, 3342 [8–14].

401 Statement of 'Fred', 24 August 2022, 4 [24].

402 Statement of 'Fred', 24 August 2022, 4 [24].

403 Transcript of 'Fred', 25 August 2022, 3342 [17–21].

404 Statement of 'Fred', 24 August 2022, 2 [12]; Transcript of 'Fred', 25 August 2022, 3342 [28–29].

405 Statement of 'Fred', 24 August 2022, 2 [12]; Transcript of 'Fred', 25 August 2022, 3342 [28–40].

406 Transcript of 'Fred', 25 August 2022, 3343 [21–26].

407 Statement of 'Fred', 24 August 2022, 2 [13]–3 [14]; Transcript of 'Fred', 25 August 2022, 3343 [45–46].

408 Statement of 'Fred', 24 August 2022, 3 [18].

409 Statement of 'Fred', 24 August 2022, 3 [19]; Transcript of 'Fred', 25 August 2022, 3345 [24–31].

410 Statement of 'Fred', 24 August 2022, 3 [16]; Transcript of 'Fred', 25 August 2022, 3345 [10–15].

411 Statement of 'Fred', 24 August 2022, 3 [18].

412 Statement of 'Fred', 24 August 2022, 5 [25].

413 Transcript of 'Fred', 25 August 2022, 3344 [25–30].

414 Statement of 'Fred', 24 August 2022, 5 [28].

415 Statement of 'Fred', 24 August 2022, 3 [15].

416 Statement of 'Fred', 24 August 2022, 5 [29–30]; Transcript of 'Fred', 25 August 2022, 3346 [17–24].

417 Statement of 'Fred', 24 August 2022, 5 [29].

418 Statement of 'Fred', 24 August 2022, 6 [32].

419 Statement of 'Fred', 24 August 2022, 6 [32].

420 Transcript of 'Fred', 25 August 2022, 3346 [47]–3347 [5].

421 Transcript of 'Fred', 25 August 2022, 3346 [39–44].

422 The name ‘Oscar’ is a pseudonym; Order of the Commission of Inquiry, restricted publication order, 30 August 2023. In relation to this individual, the Commission of Inquiry received the information on the basis that the individual would remain anonymous. Consequently, the State has not been provided with identifying information in relation to this individual and has not had the opportunity to fully consider or respond to the details of the incidents alleged. Statement of ‘Oscar’, 29 July 2022, 1 [3].

423 Statement of ‘Oscar’, 29 July 2022, 1 [4].

424 Statement of ‘Oscar’, 29 July 2022, 1 [5].

425 Statement of ‘Oscar’, 29 July 2022, 1 [5].

426 Statement of ‘Oscar’, 29 July 2022, 2 [6].

427 Statement of ‘Oscar’, 29 July 2022, 2 [6].

428 Statement of ‘Oscar’, 29 July 2022, 2 [6].

429 Statement of ‘Oscar’, 29 July 2022, 2 [6].

430 Statement of ‘Oscar’, 29 July 2022, 2 [8].

431 Statement of ‘Oscar’, 29 July 2022, 2 [8].

432 Statement of ‘Oscar’, 29 July 2022, 2 [9].

433 Statement of ‘Oscar’, 29 July 2022, 2 [9].

434 Statement of ‘Oscar’, 29 July 2022, 2 [7].

435 Statement of ‘Oscar’, 29 July 2022, 2 [9].

436 Statement of ‘Oscar’, 29 July 2022, 2 [9].

437 Statement of ‘Oscar’, 29 July 2022, 2 [9].

438 Statement of ‘Oscar’, 29 July 2022, 2 [10].

439 Statement of ‘Oscar’, 29 July 2022, 2 [11].

440 Statement of ‘Oscar’, 29 July 2022, 2 [11].

441 Statement of ‘Oscar’, 29 July 2022, 2–3 [11].

442 Statement of ‘Oscar’, 29 July 2022, 3 [12].

443 Statement of ‘Oscar’, 29 July 2022, 3 [12].

444 Statement of ‘Oscar’, 29 July 2022, 3 [13].

445 Statement of ‘Oscar’, 29 July 2022, 3 [13].

446 Statement of ‘Oscar’, 29 July 2022, 3 [13].

447 Statement of ‘Oscar’, 29 July 2022, 3 [13].

448 Statement of ‘Oscar’, 29 July 2022, 3 [13].

449 Statement of ‘Oscar’, 29 July 2022, 3 [14].

450 Statement of ‘Oscar’, 29 July 2022, 3 [14].

451 Statement of ‘Oscar’, 29 July 2022, 3 [15].

452 Statement of ‘Oscar’, 29 July 2022, 3 [16].

453 Statement of ‘Oscar’, 29 July 2022, 4 [17].

454 Statement of ‘Oscar’, 29 July 2022, 4 [17].

455 Statement of ‘Oscar’, 29 July 2022, 4 [17].

456 Statement of ‘Oscar’, 29 July 2022, 4 [18].

457 The name ‘Simon’ is a pseudonym; Order of the Commission of Inquiry, restricted publication order, 18 August 2022. Statement of ‘Simon’, 7 July 2022, 1 [4]–2 [7].

458 Statement of ‘Simon’, 7 July 2022, 1 [4].

459 Statement of ‘Simon’, 7 July 2022, 2 [7].

460 Statement of ‘Simon’, 7 July 2022, 2 [8].

461 Transcript of ‘Simon’, 18 August 2022, 2757 [19–20].

462 Transcript of ‘Simon’, 18 August 2022, 2757 [32–37].

463 Statement of 'Simon', 7 July 2022, 2 [9]; Transcript of 'Simon', 18 August 2022, 2757 [33].
464 Statement of 'Simon', 7 July 2022, 2 [9].
465 Statement of 'Simon', 7 July 2022, 2 [9].
466 Statement of 'Simon', 7 July 2022, 3 [11].
467 Transcript of 'Simon', 18 August 2022, 2758 [38–43].
468 Statement of 'Simon', 7 July 2022, 3 [11].
469 Statement of 'Simon', 7 July 2022, 3 [12].
470 Statement of 'Simon', 7 July 2022, 3 [11–12].
471 Transcript of 'Simon', 18 August 2022, 2758 [7–22].
472 Transcript of 'Simon', 18 August 2022, 2758 [17–19].
473 Statement of 'Simon', 7 July 2022, 3 [13].
474 Statement of 'Simon', 7 July 2022, 3 [13].
475 Transcript of 'Simon', 18 August 2022, 2759 [23–27], [45–46].
476 Statement of 'Simon', 7 July 2022, 3 [13].
477 Statement of 'Simon', 7 July 2022, 3 [13].
478 Statement of 'Simon', 7 July 2022, 3 [14].
479 Transcript of 'Simon', 18 August 2022, 2758 [27–31], 2759 [12–18].
480 Statement of 'Simon', 7 July 2022, 2 [7].
481 Transcript of 'Simon', 18 August 2022, 2760 [18–29].
482 Statement of 'Simon', 7 July 2022, 2 [7].
483 Statement of 'Simon', 7 July 2022, 4 [18].
484 Transcript of 'Simon', 18 August 2022, 2761 [27–39].
485 Statement of 'Simon', 7 July 2022, 4 [19].
486 Transcript of 'Simon', 18 August 2022, 2762 [34]–2763 [8].
487 Statement of 'Simon', 7 July 2022, 5 [20].
488 Statement of 'Simon', 7 July 2022, 5 [20].
489 Statement of 'Simon', 7 July 2022, 4 [16].
490 The name 'Erin' is a pseudonym; Order of the Commission of Inquiry, restricted publication order, 18 August 2022. Transcript of 'Erin', 22 August 2022, 3018 [40]–3019 [5].
491 Transcript of 'Erin', 22 August 2022, 3019 [9–44].
492 Transcript of 'Erin', 22 August 2022, 3020 [1–10].
493 Transcript of 'Erin', 22 August 2022, 3019 [43]–3020 [10].
494 Transcript of 'Erin', 22 August 2022, 3020 [12–16].
495 Transcript of 'Erin', 22 August 2022, 3020 [18–35].
496 Transcript of 'Erin', 22 August 2022, 3020 [29–32].
497 Transcript of 'Erin', 22 August 2022, 3020 [34–39].
498 Statement of 'Erin', 18 July 2022, 6 [31]; Transcript of 'Erin', 22 August 2022, 3027 [5–7].
499 Transcript of 'Erin', 22 August 2022, 3020 [41–46].
500 Transcript of 'Erin', 22 August 2022, 3020 [41–47].
501 Transcript of 'Erin', 22 August 2022, 3028 [21–39].
502 Transcript of 'Erin', 22 August 2022, 3028 [22–28].
503 Transcript of 'Erin', 22 August 2022, 3028 [22–28].
504 Transcript of 'Erin', 22 August 2022, 3028 [32–45].
505 Transcript of 'Erin', 22 August 2022, 3028 [41].
506 Transcript of 'Erin', 22 August 2022, 3028 [47]–3029 [1].

507 Transcript of 'Erin', 22 August 2022, 3029 [1–5].

508 Transcript of 'Erin', 22 August 2022, 3027 [3–4].

509 Transcript of 'Erin', 22 August 2022, 3027 [22–25]; File note of telephone conversation from the Commission of Inquiry to 'Erin', 18 July 2023.

510 Transcript of 'Erin', 22 August 2022, 3027 [27–28].

511 Transcript of 'Erin', 22 August 2022, 3027 [4–35].

512 Statement of 'Erin', 18 July 2022, 6 [33]; Transcript of 'Erin', 22 August 2022, 3027 [32–33].

513 Statement of 'Erin', 18 July 2022, 6 [34]–7 [35]; Transcript of 'Erin', 22 August 2022, 3027 [40–41], [10–18].

514 Statement of 'Erin', 18 July 2022, 7 [35].

515 Transcript of 'Erin', 22 August 2022, 3021 [3–6].

516 Transcript of 'Erin', 22 August 2022, 3021 [6–10].

517 Manager Custodial Youth Justice, 'Memo: Complaint to Ombudsman from [Erin]', [date redacted], 2, produced by the Tasmanian Government in response to a Commission notice to produce; Transcript of 'Erin', 22 August 2022, 3021 [10–16].

518 Transcript of 'Erin', 22 August 2022, 3021 [18–24].

519 Manager Custodial Youth Justice, 'Memo: Complaint to Ombudsman from [Erin]', [date redacted], 1, produced by the Tasmanian Government in response to a Commission notice to produce; Transcript of 'Erin', 22 August 2022, 3029 [10–26].

520 Statement of 'Erin', 18 July 2022, Annexure [Erin]–001; Transcript of 'Erin', 22 August 2022, 3021 [18–31].

521 Manager Custodial Youth Justice, 'Memo: Complaint to Ombudsman from [Erin]', [date redacted], 3, produced by the Tasmanian Government in response to a Commission notice to produce.

522 Transcript of 'Erin', 22 August 2022, 3021 [35–39].

523 Transcript of 'Erin', 22 August 2022, 3021 [39–44].

524 Transcript of 'Erin', 22 August 2022, 3021 [46]–3022 [1].

525 Transcript of 'Erin', 22 August 2022, 3022 [3–6].

526 Transcript of 'Erin', 22 August 2022, 3022 [6–16].

527 Transcript of 'Erin', 22 August 2022, 3022 [21–25].

528 Transcript of 'Erin', 22 August 2022, 3022 [25–31].

529 Statement of 'Erin', 18 July 2022, 4 [20].

530 Transcript of 'Erin', 22 August 2022, 3022 [33–38].

531 Transcript of 'Erin', 22 August 2022, 3023 [13–20].

532 Transcript of 'Erin', 22 August 2022, 3023 [20–24].

533 Transcript of 'Erin', 22 August 2022, 3023 [28–30].

534 Transcript of 'Erin', 22 August 2022, 3023 [32–41].

535 Transcript of 'Erin', 22 August 2022, 3023 [32]–3024 [6].

536 Transcript of 'Erin', 22 August 2022, 3024 [8–15].

537 Transcript of 'Erin', 22 August 2022, 3024 [16–18].

538 Transcript of 'Erin', 22 August 2022, 3024 [18–24].

539 Transcript of 'Erin', 22 August 2022, 3024 [31–34].

540 Transcript of 'Erin', 22 August 2022, 3024 [31–45].

541 Transcript of 'Erin', 22 August 2022, 3024 [47]–3025 [3].

542 Transcript of 'Erin', 22 August 2022, 3026 [29–41].

543 Transcript of 'Erin', 22 August 2022, 3025 [4–6].

544 Transcript of 'Erin', 22 August 2022, 3026 [41]–3027 [1].

545 Transcript of 'Erin', 22 August 2022, 3030 [10–16].

546 Transcript of 'Erin', 22 August 2022, 3030 [18–22].

547 Transcript of 'Erin', 22 August 2022, 3030 [21–30].

548 Transcript of 'Erin', 22 August 2022, 3030 [32–41].

549 Transcript of 'Erin', 22 August 2022, 3030 [45]–3031 [12].

550 Transcript of 'Erin', 22 August 2022, 3031 [14–26].

551 Transcript of 'Erin', 22 August 2022, 3031 [28–33].

552 Transcript of 'Erin', 22 August 2022, 3030 [33–35].

553 Transcript of 'Erin', 22 August 2022, 3031 [28–31].

554 The names 'Jane' and 'Ada' are pseudonyms; Order of the Commission of Inquiry, restricted publication order, 18 August 2022. Transcript of 'Jane', 19 August 2022, 2858 [6–13].

555 Statement of 'Jane', 2 June 2022, 1 [4]–2 [6].

556 Statement of 'Jane', 2 June 2022, 1 [4]; Transcript of 'Jane', 19 August 2022, 2858 [38–45].

557 Statement of 'Jane', 2 June 2022, 1 [5]; Transcript of 'Jane', 19 August 2022, 2859 [6–16].

558 Transcript of 'Jane', 19 August 2022, 2859 [28–31].

559 Statement of 'Jane', 2 June 2022, 2 [7].

560 Statement of 'Jane', 2 June 2022, 1 [5].

561 Statement of 'Jane', 2 June 2022, 1–2 [5].

562 Statement of 'Jane', 2 June 2022, 2 [7].

563 Transcript of 'Jane', 19 August 2022, 2860 [4–12]; Statement of 'Jane', 2 June 2022, 2 [7–8].

564 Statement of 'Jane', 2 June 2022, 2 [8].

565 Statement of 'Jane', 2 June 2022, 2 [9].

566 Statement of 'Jane', 2 June 2022, 2 [10].

567 Statement of 'Jane', 2 June 2022, 2 [10]; Transcript of 'Jane', 19 August 2022, 2861 [10–19].

568 Department for Education, Children and Young People, *Procedural Fairness Response*, 1 June 2023, 10.

569 Department for Education, Children and Young People, *Procedural Fairness Response*, 1 June 2023, 9.

570 Statement of 'Jane', 2 June 2022, 3 [11].

571 Statement of 'Jane', 2 June 2022, 3 [11], [15].

572 Statement of 'Jane', 2 June 2022, 3 [11].

573 Transcript of 'Jane', 19 August 2022, 2861 [36].

574 Statement of 'Jane', 2 June 2022, 3 [12]; Transcript of 'Jane', 19 August 2022, 2861 [36–45].

575 Transcript of 'Jane', 19 August 2022, 2862 [27–37].

576 Statement of 'Jane', 2 June 2022, 3 [13].

577 Transcript of 'Jane', 19 August 2022, 2863 [21–27].

578 Statement of 'Jane', 2 June 2022, 3 [14].

579 Transcript of 'Jane', 19 August 2022, 2864 [14–19].

580 Transcript of 'Jane', 19 August 2022, 2864 [25–38].

581 Statement of 'Jane', 2 June 2022, 4 [16–17]; Transcript of 'Jane', 19 August 2022, 2866 [15–17].

582 Statement of 'Jane', 2 June 2022, 4 [16].

583 Statement of 'Jane', 2 June 2022, 5 [26].

584 Statement of 'Jane', 2 June 2022, 5 [26]; Transcript of 'Jane', 19 August 2022, 2865 [32–35], [39–44].

585 Transcript of 'Jane', 19 August 2022, 2865 [31–39].

586 Statement of 'Jane', 2 June 2022, 5 [26]; Transcript of 'Jane', 19 August 2022, 2865 [42–45].

587 Transcript of 'Jane', 19 August 2022, 2866 [7–25].

588 Statement of 'Jane', 2 June 2022, 4 [20]; Transcript of 'Jane', 19 August 2022, 2866 [15–25].

589 Transcript of 'Jane', 19 August 2022, 2866 [11–13].

590 Statement of 'Jane', 2 June 2022, 4 [20].

591 Transcript of 'Jane', 19 August 2022, 2866 [7–8], [30–38].

592 Statement of 'Jane', 2 June 2022, 4 [21].

593 Transcript of 'Jane', 19 August 2022, 2864 [44–47].

594 Statement of 'Jane', 2 June 2022, 5 [23].

595 Transcript of 'Jane', 19 August 2022, 2865 [3–10].

596 Transcript of 'Jane', 19 August 2022, 2865 [10–15].

597 Transcript of 'Jane', 19 August 2022, 2867 [18–31].

598 Transcript of 'Jane', 19 August 2022, 2862 [19–23].

599 Statement of 'Jane', 2 June 2022, 3 [15].

600 Statement of 'Jane', 2 June 2022, 5 [26].

601 Statement of 'Jane', 2 June 2022, 7 [33].

602 Statement of 'Jane', 2 June 2022, 7 [33].

603 Transcript of 'Jane', 19 August 2022, 2866 [40–47].

604 The name 'Otis' is a pseudonym; Order of the Commission of Inquiry, restricted publication order, 18 August 2022; Order of the Commission of Inquiry, restricted publication order, 30 August 2023. Statement of 'Otis', 23 August 2022, 1 [4].

605 Statement of 'Otis', 23 August 2022, 1 [4].

606 Statement of 'Otis', 23 August 2022, 1 [5], 2 [7].

607 Statement of 'Otis', 23 August 2022, 1 [6].

608 Statement of 'Otis', 23 August 2022, 1 [5].

609 Statement of 'Otis', 23 August 2022, 1 [6]–2 [7].

610 Statement of 'Otis', 23 August 2022, 2 [7].

611 Statement of 'Otis', 23 August 2022, 2 [8].

612 Statement of 'Otis', 23 August 2022, 2 [10].

613 Statement of 'Otis', 23 August 2022, 2 [10].

614 Statement of 'Otis', 23 August 2022, 2 [10].

615 Statement of 'Otis', 23 August 2022, 2 [10].

616 Statement of 'Otis', 23 August 2022, 2 [11].

617 Statement of 'Otis', 23 August 2022, 2 [11].

618 Statement of 'Otis', 23 August 2022, 2 [11].

619 Statement of 'Otis', 23 August 2022, 2 [11].

620 Statement of 'Otis', 23 August 2022, 2 [12].

621 Statement of 'Otis', 23 August 2022, 3 [15]–4 [22].

622 Statement of 'Otis', 23 August 2022, 3 [15].

623 Statement of 'Otis', 23 August 2022, 2 [12].

624 Statement of 'Otis', 23 August 2022, 3 [16].

625 Statement of 'Otis', 23 August 2022, 3 [16].

626 Statement of 'Otis', 23 August 2022, 3 [17]–4 [19].

627 Statement of 'Otis', 23 August 2022, 4 [18–19].

628 Statement of 'Otis', 23 August 2022, 3 [17].

629 Statement of 'Otis', 23 August 2022, 4 [21].

630 Statement of 'Otis', 23 August 2022, 4 [19].

631 Statement of 'Otis', 23 August 2022, 4 [19].

632 Statement of 'Otis', 23 August 2022, 3 [17].

633 Statement of 'Otis', 23 August 2022, 3 [17], 4 [19], 4 [21].

634 Statement of 'Otis', 23 August 2022, 3 [17].
635 Statement of 'Otis', 23 August 2022, 4 [18].
636 Statement of 'Otis', 23 August 2022, 4–5 [24].
637 Statement of 'Otis', 23 August 2022, 3 [13].
638 Statement of 'Otis', 23 August 2022, 3 [15].
639 Statement of 'Otis', 23 August 2022, 3 [13].
640 Statement of 'Otis', 23 August 2022, 6 [32].
641 Statement of 'Otis', 23 August 2022, 6 [32].
642 Statement of 'Otis', 23 August 2022, 4–5 [24].
643 Statement of 'Otis', 23 August 2022, 4 [23].
644 Statement of 'Otis', 23 August 2022, 4 [23].
645 Statement of 'Otis', 23 August 2022, 4 [23].
646 Statement of 'Otis', 23 August 2022, 5 [25].
647 Statement of 'Otis', 23 August 2022, 5 [26].
648 Statement of 'Otis', 23 August 2022, 5 [26].
649 Statement of 'Otis', 23 August 2022, 5 [26].
650 Statement of 'Otis', 23 August 2022, 5 [27].
651 Statement of 'Otis', 23 August 2022, 5 [27].
652 Statement of 'Otis', 23 August 2022, 5 [27].
653 Statement of 'Otis', 23 August 2022, 5 [27].
654 Statement of 'Otis', 23 August 2022, 6 [31].
655 Statement of 'Otis', 23 August 2022, 5 [28].
656 Statement of 'Otis', 23 August 2022, 5 [28].
657 Statement of 'Otis', 23 August 2022, 6 [33].
658 Statement of 'Otis', 23 August 2022, 6 [33].
659 Statement of 'Otis', 23 August 2022, 5 [29].
660 Statement of 'Otis', 23 August 2022, 5 [29]–6 [30].
661 Statement of 'Otis', 23 August 2022, 6 [30].
662 Transcript of Brett Robinson, 17 June 2022, 1536 [8–37].
663 Statement of Brett Robinson, 2 June 2022, 1 [6]–2 [7], 3 [14].
664 Transcript of Brett Robinson, 17 June 2022, 1541 [18–33].
665 Transcript of Brett Robinson, 17 June 2022, 1543 [8–14]; Statement of Brett Robinson, 2 June 2022, 3 [17].
666 Transcript of Brett Robinson, 17 June 2022, 1541 [44]–1542 [25].
667 Statement of Brett Robinson, 2 June 2022, 4 [19–20]; Transcript of Brett Robinson, 17 June 2022, 1542 [34]–1543 [1].
668 Statement of Brett Robinson, 2 June 2022, 3 [18].
669 Transcript of Brett Robinson, 17 June 2022, 1543 [18–21].
670 Transcript of Brett Robinson, 17 June 2022, 1543 [23]–1544 [8].
671 Transcript of Brett Robinson, 17 June 2022, 1544 [25–39].
672 Statement of Brett Robinson, 2 June 2022, 6 [31–34].
673 Statement of Brett Robinson, 2 June 2022, 6 [36].
674 Statement of Brett Robinson, 2 June 2022, 7 [37].
675 Statement of Brett Robinson, 2 June 2022, 7 [37].
676 Transcript of Brett Robinson, 17 June 2022, 1545 [24–5].
677 Statement of Brett Robinson, 2 June 2022, 7 [38–39].
678 Statement of Brett Robinson, 2 June 2022, 7 [40].

679 Statement of 'Simon', 7 July 2022, 1 [4].

680 Statement of 'Fred', 24 August 2022, 1 [6]; Statement of 'Jane', 2 June 2022, 2 [7]; Transcript of 'Erin', 22 August 2022, 3019 [1–5]; Statement of Brett Robinson, 2 June 2022, 1 [4].

681 Statement of 'Ben', 29 March 2022, Attachment [Ben]–001 (Handwritten Submission to the National Royal Commission, 'Ben', undated) 2; Statement of 'Simon', 7 July 2022, 1 [5]; Transcript of 'Erin', 22 August 2022, 3020 [43–46].

682 Statement of 'Ben', 29 March 2022, Attachment [Ben]–001 (Handwritten Submission to the National Royal Commission, 'Ben', undated) 1; Anonymous session, 16 February 2022.

683 Submission of Sebastian Buscemi, 28 August 2021, 5; Department of Communities, 'Issues Briefing to the Minister: Update on AYDC Matters Referred by Cassy O'Connor's Office', December 2020, 4, produced by the Tasmanian Government in response to a Commission notice to produce.

684 Tasmania Police, Unsigned 'Statement of Ashley Youth Detention Centre staff member', November 2020, 3 [28–33].

685 Anonymous session, 16 February 2022.

686 Anonymous session, 16 February 2022.

687 Transcript of 'Fred', 25 August 2022, 3342 [17–21].

688 Statement of 'Eve', 18 August 2022, 4 [22]–[23].

689 Submission 086 Angela Sdrinis Legal, 70.

690 Transcript of 'Erin', 22 August 2022, 3028 [21–45], 3028 [47]–3029 [1].

691 Statement of 'Charlotte', 31 January 2022, 1.

692 Statement of 'Erin', 18 July 2022, 6 [33–34].

693 Statement of 'Ben', 29 March 2022, Attachment [Ben]–001 (Handwritten Submission to the National Royal Commission, 'Ben', undated) 3; Statement of 'Otis', 23 August 2022, 3 [15].

694 Statement of 'Otis', 23 August 2022, 3 [17], 4 [19], [21].

695 Statement of 'Otis', 23 August 2022, 5 [26]; Statement of 'Warren', 19 May 2022, 4 [20].

696 Transcript of 'Simon', 18 August 2022, 2758 [7–10]; Statement of 'Erin', 18 July 2022, 7 [37].

697 Transcript of 'Simon', 18 August 2022, 2758 [7–22]; Statement of 'Erin', 18 July 2022, 7 [37–38].

698 Statement of Angela Sdrinis, 5 May 2022, 57.

699 Department for Education, Children and Young People, *Procedural Fairness Response*, 1 June 2023, 13.

700 Department for Education, Children and Young People, *Procedural Fairness Response*, 1 June 2023, 13.

701 The name 'Alysha' is a pseudonym; Order of the Commission of Inquiry, restricted publication order, 18 August 2022. Statement of 'Alysha', 16 August 2022, 55 [278].

702 Statement of 'Alysha', 16 August 2022, 16 [74].

703 Statement of 'Alysha', 16 August 2022, 26 [124].

704 *Youth Justice Act 1997* s 132(d)–(f).

705 *Convention on the Rights of the Child*, opened for signature 20 November 1989, 1577 UNTS 3 (entered into force 2 September 1990), art 37(c).

706 Statement of 'Ben', 29 March 2022, Attachment [Ben]–001 (Handwritten Submission to the National Royal Commission, 'Ben', undated) 4.

707 Department of Health and Human Services, *Review of Claims of Abuse of Children in State Care Final Report – Round 4* (Report, November 2014) 10; Transcript of Michael Pervan, 26 August 2022, 3501 [40–44].

708 Transcript of Michael Pervan, 26 August 2022, 3518 [6–13].

709 Transcript of Jacqueline Allen, 25 August 2022, 3378 [19–37], 3379 [19–33].

710 Transcript of Jacqueline Allen, 25 August 2022, 3378 [19–37]; 3380 [46]–3381 [5].

711 Transcript of Jacqueline Allen, 25 August 2022, 3379 [28]–3380 [42].

712 Statement of Mandy Clarke, 19 August 2022, 9 [29].

713 Statement of Mandy Clarke, 19 August 2022, 5 [6].

714 Transcript of Pamela Honan, 19 August 2022, 2945 [29–42].

715 Transcript of Pamela Honan, 19 August 2022, 2945 [44–47].

716 Transcript of Michael Pervan, 26 August 2022, 3533 [5–10].

717 Transcript of Michael Pervan, 26 August 2022, 3533 [5–15].

718 Transcript of Stuart Watson, 23 August 2022, 3159 [6–14].

719 Transcript of Stuart Watson, 23 August 2022, 3159 [16]–3160 [6].

720 Statement of 'Erin', 18 July 2022, 3 [18].

721 The names 'Ira', 'Lester' and 'Stan' are pseudonyms; Order of the Commission of Inquiry, restricted publication order, 18 August 2022.

722 Children and Youth Services, 'Minute to Secretary: AYDC – Commissioner for Children Letter and Emerging Concerns', 6 May 2016, 7, produced by the Tasmanian Government in response to a Commission notice to produce.

723 Statement of Mandy Clarke, 19 August 2022, 3 [2].

724 Transcript of Mandy Clarke, 25 August 2022, 3400 [31–37].

725 Refer to, for example, Statement of 'Erin', 18 July 2022, 3 [18]; Statement of 'Max', 19 May 2022, 8 [33].

726 Anonymous session, 15 February 2022.

727 Statement of 'Ben', 29 March 2022, 5 [20–21].

728 Statement of 'Ben', 29 March 2022, 5 [21].

729 Statement of 'Warren', 19 May 2022, Attachment [Warren]–001 (Additional statement, 'Warren', 24 November 2021) 2.

730 Transcript of 'Erin', 22 August 2022, 3026 [29–41].

731 Statement of 'Otis', 23 August 2022, 2 [12].

732 Statement of 'Fred', 24 August 2022, 2 [12]; Transcript of 'Fred', 25 August 2022, 3343 [28–37].

733 Statement of 'Max', 19 May 2022, 6 [26], 10 [42].

734 Statement of 'Otis', 23 August 2022, 5 [26].

735 Statement of 'Warren', 19 May 2022, Attachment [Warren]–001 (Additional statement, 'Warren', 24 November 2021) 2.

736 Submission 086 Angela Sdrinis Legal, 60.

737 Submission 086 Angela Sdrinis Legal, 60.

738 Statement of 'Alysha', 16 August 2022, 86 [436].

739 Transcript of 'Max', 23 August 2022, 3123 [24–43].

740 Statement of 'Ben', 29 March 2022, 7 [30].

741 Statement of 'Ben', 29 March 2022, 4 [19].

742 Transcript of Michael Guerzoni, 4 May 2022, 203 [26–30].

743 Transcript of Michael Guerzoni, 4 May 2022, 203 [21–25].

744 Statement of Michael Guerzoni, 29 April 2022, 24–25 [83].

745 Statement of Michael Guerzoni, 29 April 2022, 20–21 [68].

746 Transcript of Donald Palmer, 4 May 2022, 202 [45]–203 [3].

747 Statement of Samantha Crompvoets, 10 September 2022, 10 [38].

748 Transcript of Sarah Spencer, 18 August 2022, 2820 [28–37], [42–46].

749 Sarah Spencer, *Procedural Fairness Response*, 14 July 2023.

750 Statement of Fiona Atkins, 15 August 2022, 15 [48].

751 Transcript of Fiona Atkins, 24 August 2022, 3286 [36–45].

752 Transcript of Stuart Watson, 23 August 2022, 3157 [7–13].

753 Transcript of Stuart Watson, 23 August 2022, 3157 [16–19].

754 Transcript of Stuart Watson, 23 August 2022, 3161 [5–9].

755 Statement of 'Max', 19 May 2022, 6 [27]; Statement of 'Warren', 19 May 2022, 3 [16].

756 Statement of 'Otis', 23 August 2022, 4 [23].

757 Transcript of Leanne McLean and Richard Connock, 24 August 2022, 3310 [16–34].

758 Statement of Mark Morrissey, 9 August 2022, 4 [23].

759 Statement of 'Ben', 29 March 2022, 4 [18]; Statement of Brett Robinson, 2 June 2022, 4 [23].

760 Statement of Peter Graham, 16 August 2022, Attachment D ('Continuation of Positive Registration: Reasons for Decision – [Stan]', 7 July 2022) 5.

761 Statement of Pamela Honan, 18 August 2022, 21 [26.1].

762 Transcript of Pamela Honan, 19 August 2022, 2941 [12–17].

763 Transcript of Pamela Honan, 19 August 2022, 2941 [31–33].

764 Statement of Pamela Honan, 18 August 2022, 21 [26.2–26.3].

765 Transcript of Mandy Clarke, 25 August 2022, 3400 [39]–3401 [4].

766 Transcript of Michael Pervan, 25 August 2022, 3456 [44]–3457 [10].

767 Transcript of Michael Pervan, 25 August 2022, 3457 [17–22].

768 Transcript of Michael Pervan, 26 August 2022, 3489 [21–31], 3489 [37]–3490 [8].

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769 The names 'Max', 'Henry' and 'Ray' are pseudonyms; Order of the Commission of Inquiry, restricted publication order, 18 August 2022.

770 The name 'Ben' is a pseudonym; Order of the Commission of Inquiry, restricted publication order, 18 August 2022. Statement of 'Ben', 29 March 2022, 6 [27]–7 [28].

771 Statement of 'Ben', 29 March 2022, 6 [27]–7 [28].

772 Statement of 'Ben', 29 March 2022, 7 [30]; Statement of 'Ben', 29 March 2022, Annexure [Ben]-001 ('Ben', Handwritten Submission to the National Royal Commission, undated) 3–4.

773 Statement of 'Ben', 29 March 2022, Annexure [Ben]-001 ('Ben', Handwritten Submission to the National Royal Commission, undated) 2.

774 Statement of 'Ben', 29 March 2022, 6.

775 The name 'Charlotte' is a pseudonym; Order of the Commission of Inquiry, restricted publication order, 18 August 2022. Statement of 'Charlotte', 31 January 2022, 2.

776 Statement of 'Charlotte', 31 January 2022, 2; Transcript of 'Charlotte', 24 August 2022, 3202 [22–30].

777 Statement of 'Charlotte', 31 January 2022, 3; Transcript of 'Charlotte', 24 August 2022, 3206 [18–27].

778 The name 'Fred' is a pseudonym; Order of the Commission of Inquiry, restricted publication order, 18 August 2022. Statement of 'Fred', 24 August 2022, 3 [14], [16].

779 Statement of 'Fred', 24 August 2022, 5 [28].

780 The name 'Oscar' is a pseudonym; Order of the Commission of Inquiry, restricted publication order, 30 August 2023. Statement of 'Oscar', 29 July 2022, 1 [3]. In relation to this individual, the Commission of Inquiry received the information on the basis that the individual would remain anonymous. Consequently, the State has not been provided with identifying information in relation to this individual and has not had the opportunity to fully consider or respond to the details of the incidents alleged.

781 Statement of 'Oscar', 29 July 2022, 2 [6].

782 Statement of 'Oscar', 29 July 2022, 2 [7], [11].

783 The name 'Erin' is a pseudonym; Order of the Commission of Inquiry, restricted publication order, 18 August 2022. Transcript of 'Erin', 22 August 2022, 3019 [34–36].

784 Transcript of 'Erin', 22 August 2022, 3022 [25–29].

785 Transcript of 'Erin', 22 August 2022, 3023 [13–30].

786 Transcript of 'Erin', 22 August 2022, 3023 [45]–3024 [18].

787 Transcript of 'Erin', 22 August 2022, 3024 [4]–3025 [6].

788 Statement of 'Max', 19 May 2022, 1 [3], 3 [16]; Transcript of 'Max', 23 August 2022, 3109 [43–45].

789 Statement of 'Max', 19 May 2022, 1 [3], 3 [16], 4 [17]; Transcript of 'Max', 23 August 2022, 3111 [15]–3112 [8], 3113 [39–40].

790 Statement of 'Max', 19 May 2022, 4 [20].

791 Statement of 'Max', 19 May 2022.

792 Statement of 'Ben', 29 March 2022, Annexure [Ben]-001 ('Ben', Handwritten Submission to the National Royal Commission, undated) 2–3; Statement of 'Max', 19 May 2022, 3 [16]; Serious Events Review Team, 'Serious Event Review Report – Review of the matter of [Henry]', 19 March 2020, 8, produced by the Tasmanian Government in response to a Commission notice to produce.

793 Transcript of 'Erin', 22 August 2022, 3022 [25–31]; Ashley Youth Detention Centre, 'Incident Report', 5 June 2019, 2; Transcript of 'Charlotte', 24 August 2022, 3202 [22–30]; Statement of 'Charlotte', 31 January 2022, 2.

794 Statement of 'Ben', 29 March 2022, Annexure [Ben]-001 ('Ben', Handwritten Submission to the National Royal Commission, undated) 2; Transcript of 'Erin', 22 August 2022, 3023 [20–24], 3025 [4–6], 3026 [29–41].

795 Statement of 'Ben', 29 March 2022, Attachment [Ben]-001 (Handwritten Submission to the National Royal Commission, 'Ben', undated) 2; Transcript of 'Charlotte', 24 August 2022, 3202 [35–45], 3203 [35–39].

796 The names 'Albert' and 'Finn' are pseudonyms; Order of the Commission of Inquiry, restricted publication order, 18 August 2022.

797 *Youth Justice Act 1997* s 132.

798 *Youth Justice Act 1997* s 129(1)(a).

799 Refer to, for example, Office of the Custodial Inspector, *Inspection Standards for Youth Custodial Centres in Tasmania* (July 2018) 3 [1.3.3], 40 [8.6], 44 [8.10].

800 After 31 May 2022, the placement and transfer of children and young people in units at Ashley Youth Detention Centre was to be conducted in accordance with the *Unit Commissioning, De-Commissioning and Allocation to a Young Person Procedure* (31 May 2022). The decision-making process and considerations are substantively similar to those previously in place and listed above, with unit allocations and transfer requests now considered by the Risk Assessment Process Team and Weekly Review Meeting respectively, with both reviewed by the Centre Manager.

801 Statement of Operations Manager, Ashley Youth Detention Centre, 1 August 2022, 5 [29]; Statement of Fiona Atkins, 15 August 2022, 11 [39(a)]; Statement of Patrick Ryan, 18 August 2022, 13 [128]; Statement of 'Piers', 16 August 2022, 15 [45(b)]; the name 'Piers' is a pseudonym; Order of the Commission of Inquiry, restricted publication order, 30 August 2023; Statement of 'Digby', 8 August 2022, 16 [56(b)]; the name 'Digby' is a pseudonym; Order of the Commission of Inquiry, restricted publication order, 30 August 2023; Statement of Operations Manager, Ashley Youth Detention Centre, 1 August 2022, 5 [31].

802 Statement of Ginna Webster, 13 January 2023, Annexure 1 (Letter from Secretary Webster to the Ombudsman including appendices, 14 November 2018); Statement of Patrick Ryan, 18 August 2022, 13 [129]; Statement of Operations Manager, Ashley Youth Detention Centre, 1 August 2022, 5 [30], [32]; Statement of Operations Manager, Ashley Youth Detention Centre, 1 August 2022, 5 [29]; Statement of 'Digby', 8 August 2022, 16 [56(a)]; Statement of former Case Management Coordinator, Ashley Youth Detention Centre, 8 August 2022, 4 [59]; Statement of Fiona Atkins, 15 August 2022, 11 [39(c)]; Statement of 'Piers', 15 August 2022, 16 [45(c)].

803 Statement of 'Digby', 8 August 2022, 16 [56].

804 Statement of Ginna Webster, 13 January 2023, Annexure 1 (Letter from Secretary Webster to the Ombudsman including appendices, 14 November 2018) 157–160.

805 Statement of 'Alysha', 16 August 2022, 27 [130]; the name 'Alysha' is a pseudonym; Order of the Commission of Inquiry, restricted publication order, 18 August 2022.

806 Statement of Stuart Watson, 16 August 2022, 8 [49a]; Transcript of Stuart Watson, 23 August 2022, 3179 [16–21].

807 Statement of Stuart Watson, 16 August 2022, 8 [49a].

808 Statement of Stuart Watson, 16 August 2022, 8 [49a].

809 Statement of Madeleine Gardiner, 15 August 2022, 32 [55].

810 Statement of Madeleine Gardiner, 15 August 2022, 32 [55].

811 Statement of 'Alysha', 16 August 2022, 51 [262].

812 Statement of 'Alysha', 16 August 2022, 47 [241].

813 Statement of 'Alysha', 16 August 2022, 27 [130].

814 Statement of 'Alysha', 16 August 2022, 27 [130].

815 Children and Youth Services, 'Minute to Secretary: AYDC – Commissioner for Children Letter and Emerging Concerns', 6 May 2016, 1, produced by the Tasmanian Government in response to a Commission notice to produce.

816 Children and Youth Services, 'Minute to Secretary: AYDC – Commissioner for Children Letter and Emerging Concerns', 6 May 2016, 5, produced by the Tasmanian Government in response to a Commission notice to produce.

817 Stuart Watson, 'Response to the Findings of a Serious Event Review Team (SERT) Review in Relation to Former AYDC Resident [Henry]', 31 May 2021, 3-4, produced by the Tasmanian Government in response to a Commission notice to produce.

818 Statement of Operations Manager, Ashley Youth Detention Centre, 1 August 2022, 5 [30], [31]; Statement of 'Digby', 8 August 2022, 17 [57]; Statement of 'Piers', 15 August 2022, 17 [47]; Statement of former Case Management Coordinator, Ashley Youth Detention Centre, 8 August 2022, 4 [60].

819 Serious Events Review Team, 'Serious Event Review Report – Review of the matter of [Henry]', 19 March 2020, 16, produced by the Tasmanian Government in response to a Commission notice to produce; Email from 'Piers' to 'Alysha', 22 January 2020, produced by the Tasmanian Government in response to a Commission notice to produce.

820 Serious Events Review Team, 'Serious Event Review Report – Review of the matter of [Henry]', 19 March 2020, 16, produced by the Tasmanian Government in response to a Commission notice to produce.

821 Ashley Youth Detention Centre, 'Standard Operating Procedure #8: Supervision and Movement of Young People', 2015, 5–6, produced by the Tasmanian Government in response to a Commission notice to produce.

822 Ashley Youth Detention Centre, 'Standard Operating Procedure #8: Supervision and Movement of Young People', 2015, 5–6, produced by the Tasmanian Government in response to a Commission notice to produce.

823 Refer to, for example, Ashley Youth Detention Centre, 'Multi-Disciplinary Team Minutes: Signs of Safety Assessment Map', 19 February 2020, 1, produced by the Tasmanian Government in response to a Commission notice to produce.

824 Serious Events Review Team, 'Serious Event Review Report – Review of the matter of [Henry]', 19 March 2020, 24, produced by the Tasmanian Government in response to a Commission notice to produce.

825 Serious Events Review Team, 'Serious Event Review Report – Review of the matter of [Henry]', 19 March 2020, 24–25, produced by the Tasmanian Government in response to a Commission notice to produce.

826 Serious Events Review Team, 'Serious Event Review Report – Review of the matter of [Henry]', 19 March 2020, 24–25, 32, produced by the Tasmanian Government in response to a Commission notice to produce.

827 Children and Youth Services, 'Procedure: AYDC Incident Reporting', 1 July 2018, produced by the Tasmanian Government in response to a Commission notice to produce.

828 Children and Youth Services, 'Procedure: AYDC Incident Reporting', 1 July 2018, produced by the Tasmanian Government in response to a Commission notice to produce.

829 Children and Youth Services, 'Procedure: AYDC Incident Reporting', 1 July 2018, 1, produced by the Tasmanian Government in response to a Commission notice to produce.

830 Statement of Michael Pervan, 27 July 2022, 59 [161].

831 Statement of Pamela Honan, 18 August 2022, 34 [56].

832 Children and Youth Services, 'Procedure: AYDC Incident Reporting', 1 July 2018, 1, produced by the Tasmanian Government in response to a Commission notice to produce.

833 Children and Youth Services, 'Form: AYDC Incident Reporting', undated, 4, produced by the Tasmanian Government in response to a Commission notice to produce.

834 Children and Youth Services, 'Form: AYDC Incident Reporting', undated, 5, produced by the Tasmanian Government in response to a Commission notice to produce.

835 Children and Youth Services, 'Form: AYDC Incident Reporting', undated, 5, produced by the Tasmanian Government in response to a Commission notice to produce.

836 Children and Youth Services, 'Form: AYDC Incident Reporting', undated, 5, produced by the Tasmanian Government in response to a Commission notice to produce.

837 *Youth Justice Act 1997* s 140(3).

838 Statement of Michael Pervan, 27 July 2022, Annexure 2 ('Instrument of Delegation', Department of Communities, 9 March 2022).

839 *Youth Justice Act 1997* s 140(3).

840 Ashley Youth Detention Centre, 'Standard Operating Procedure #24: Conferencing', November 2014, 1, produced by the Tasmanian Government in response to a Commission notice to produce.

841 Ashley Youth Detention Centre, 'Standard Operating Procedure #24: Conferencing', November 2014, 3, produced by the Tasmanian Government in response to a Commission notice to produce.

842 *Youth Justice Act 1997* s 140(2)(b)(i); Ashley Youth Detention Centre, 'Standard Operating Procedure #24: Conferencing', November 2014, 1, produced by the Tasmanian Government in response to a Commission notice to produce.

843 Ashley Youth Detention Centre, 'Standard Operating Procedure #24: Conferencing', November 2014, 1, produced by the Tasmanian Government in response to a Commission notice to produce.

844 Children and Youth Services, 'Procedure: Referral to a Senior Quality and Practice Advisor (SQPA)', 6 November 2019, 1, produced by the Tasmanian Government in response to a Commission notice to produce.

845 Statement of Michael Pervan, 6 June 2022, 52 [232]; Transcript of Michael Pervan, 17 June 2022, 1624 [43]–1625 [13]; Transcript of Claire Lovell, 4 July 2022, 2296 [17–20].

846 Michael Pervan, *Procedural Fairness Response*, 21 July 2023, 2 [7]–3 [9]; Department for Education, Children and Young People, *Child Safety Services Careers* (Web Page) <https://www.decyp.tas.gov.au/about-us/employment/child-safety-services-careers/>.

847 Children and Youth Services, 'Procedure: Referral to a Senior Quality and Practice Advisor (SQPA)', 6 November 2019, 1, produced by the Tasmanian Government in response to a Commission notice to produce.

848 Children and Youth Services, 'Procedure: Referral to a Senior Quality and Practice Advisor (SQPA)', 6 November 2019, 2, produced by the Tasmanian Government in response to a Commission notice to produce.

849 Children and Youth Services, 'Information Sheet: Serious Event Reviews', 29 August 2019, 1, produced by the Department for Education, Children and Young People in response to a Commission notice to produce.

850 Statement of Ginna Webster, 13 January 2023, 48 [80.1].

851 Statement of former Manager, Serious Events Review Team, 11 November 2022, 13 [59].

852 Transcript of Michael Pervan, 26 August 2022, 3527 [15–21].

853 Statement of former Manager, Serious Events Review Team, 11 November 2022, 16 [76]. Refer also to Children and Youth Services, 'Information Sheet: Serious Event Reviews', 29 August 2019, which states that referrals to the Serious Event Review Team were made by the Secretary or Deputy Secretary.

854 Statement of former Manager, Serious Events Review Team, 11 November 2022, 4 [17], 16 [77].

855 Statement of former Manager, Serious Events Review Team, 11 November 2022, 16 [78–82].

856 Statement of former Manager, Serious Events Review Team, 11 November 2022, 16 [83].

857 Statement of former Manager, Serious Events Review Team, 11 November 2022, 16 [83].

858 Statement of former Manager, Serious Events Review Team, 11 November 2022, 16 [83].

859 Statement of former Manager, Serious Events Review Team, 11 November 2022, 4 [17], 15 [72], 16 [84].

860 Statement of former Manager, Serious Events Review Team, 11 November 2022, Annexure 10 (Flow chart: 'Serious Events Review – Governance', undated).

861 Statement of former Manager, Serious Events Review Team, 11 November 2022, 10 [45].

862 Children and Youth Services, 'Information Sheet: Serious Event Review', 29 August 2019, 2, produced by the Department for Education, Children and Young People in response to a Commission notice to produce.

863 Refer to, for example, Ashley Youth Detention Centre, 'Incident Advice in relation to [Albert]', 17 February 2018, produced by the Tasmanian Government in response to a Commission notice to produce; Ashley Youth Detention Centre, 'Incident Advice in relation to [Albert]', 25 February 2018, produced by the Tasmanian Government in response to a Commission notice to produce; Ashley Youth Detention Centre, 'Incident Advice in relation to [Albert]', 31 January 2018, produced by the Tasmanian Government in response to a Commission notice to produce; Ashley Youth Detention Centre, 'Incident Report in relation to [Albert]', 10 August 2019, produced by the Tasmanian Government in response to a Commission notice to produce; Ashley Youth Detention Centre, 'Incident Report in relation to [Finn]', 11 March 2019, produced by the Tasmanian Government in response to a Commission notice to produce; Ashley Youth Detention Centre, 'Incident Report in relation to [Finn]', 23 March 2019, produced by the Tasmanian Government in response to a Commission notice to produce.

864 The only incident that was not recorded as a detention offence may be found at Ashley Youth Detention Centre, 'Incident Report in relation to [Finn]', 24 March 2019, produced by the Tasmanian Government in response to a Commission notice to produce.

865 Patrick Ryan, 'Schedule 1: Application to transfer person from Ashley Youth Detention Centre', 15 April 2019, produced by the Tasmanian Government in response to a Commission notice to produce.

866 Patrick Ryan, 'Schedule 1: Application to transfer person from Ashley Youth Detention Centre', 15 April 2019, 4, produced by the Tasmanian Government in response to a Commission notice to produce.

867 Patrick Ryan, 'Schedule 1: Application to transfer person from Ashley Youth Detention Centre', 15 April 2019, 4–5, produced by the Tasmanian Government in response to a Commission notice to produce.

868 Patrick Ryan, 'Schedule 1: Application to transfer person from Ashley Youth Detention Centre', 15 April 2019, 4, produced by the Tasmanian Government in response to a Commission notice to produce.

869 Psychologist, Ashley Youth Detention Centre, 'Violence Risk Assessment', 5 April 2019, 3, produced by the Tasmanian Government in response to a Commission notice to produce.

870 Patrick Ryan, 'Schedule 1: Application to transfer person from Ashley Youth Detention Centre', 15 April 2019, 6, produced by the Tasmanian Government in response to a Commission notice to produce.

871 Ashley Youth Detention Centre, 'Multi-Disciplinary Team Minutes: Signs of Safety Assessment Map [Finn]', 10 June 2020, produced by the Tasmanian Government in response to a Commission notice to produce.

872 Statement of 'Max', 19 May 2022, 1 [3].

873 Statement of 'Alysha', 16 August 2022, 25 [121]; Statement of 'Max', 19 May 2022, 3 [14], 11 [48].

874 Statement of Madeleine Gardiner, 15 August 2022, 32 [55].

875 Statement of 'Alysha', 16 August 2022, 25 [121].

876 Statement of 'Max', 19 May 2022, 3 [14].

877 Serious Events Review Team, 'Serious Event Review Report – Review of the matter of [Henry]', 19 March 2020, 8, produced by the Tasmanian Government in response to a Commission notice to produce.

878 Ashley Youth Detention Centre, 'Multi-Disciplinary Team Minutes: Signs of Safety Assessment Map [Henry]', 14 February 2019, produced by the Tasmanian Government in response to a Commission notice to produce; Ashley Youth Detention Centre, 'Multi-Disciplinary Team Minutes: Signs of Safety Assessment Map [Henry]', 12 September 2019, produced by the Tasmanian Government in response to a Commission notice to produce.

879 Ashley Youth Detention Centre, 'Care Plan in relation to [Henry]', 3, produced by the Tasmanian Government in response to a Commission notice to produce.

880 Ashley Youth Detention Centre, 'Care Plan in relation to [Henry]', 3, produced by the Tasmanian Government in response to a Commission notice to produce.

881 Transcript of Veronica Burton, 22 August 2022, 3093 [30–33].

882 Ashley Youth Detention Centre, 'Client Request in relation to [Henry]', 8 August 2019, produced by the Tasmanian Government in response to a Commission notice to produce.

883 The name 'Ray' is a pseudonym; Order of the Commission of Inquiry, restricted publication order, 18 August 2022. Ashley Youth Detention Centre, 'Care Plan in relation to [Ray]', 25 October 2019, 1, produced by the Tasmanian Government in response to a Commission notice to produce; Custodial Youth Justice, 'File Cover Sheet', September 2019, 1, produced by the Tasmanian Government in response to a Commission notice to produce.

884 Ashley Youth Detention Centre, 'Care Plan in relation to [Ray]', 25 October 2019, 1, produced by the Tasmanian Government in response to a Commission notice to produce; Transcript of 'Alysha', 22 August 2022, 3057 [21–25].

885 Email from Psychologist, Ashley Youth Detention Centre to Ashley Operations Management et al, 24 September 2019, 1–2, produced by the Tasmanian Government in response to a Commission notice to produce.

886 Email from Psychologist, Ashley Youth Detention Centre to Ashley Operations Management et al, 24 September 2019, 1, produced by the Tasmanian Government in response to a Commission notice to produce.

887 Email from Psychologist, Ashley Youth Detention Centre to Ashley Operations Management et al, 24 September 2019, 2, produced by the Tasmanian Government in response to a Commission notice to produce.

888 Ashley Youth Detention Centre, 'Care Plan in relation to [Ray]', 25 October 2019, 1, 3–5, produced by the Tasmanian Government in response to a Commission notice to produce.

889 Ashley Youth Detention Centre, 'Care Plan in relation to [Ray]', 25 October 2019, 1, produced by the Tasmanian Government in response to a Commission notice to produce.

890 Email from Psychologist, Ashley Youth Detention Centre to Ashley Operations Management et al, 24 September 2019, 1–2, produced by the Tasmanian Government in response to a Commission notice to produce.

891 Email from 'Alysha' to Pamela Honan, 6 January 2020, produced by the Tasmanian Government in response to a Commission notice to produce; Ashley Youth Detention Centre, 'Multi-Disciplinary Team Minutes: Signs of Safety Assessment Map [Ray]', 18 December 2019, 1, produced by the Tasmanian Government in response to a Commission notice to produce.

892 Statement of 'Alysha', 16 August 2022, 23 [108]; Ashley Youth Detention Centre, 'Centre Support Team Minutes', 6 January 2020, 3–4, produced by the Tasmanian Government in response to a Commission notice to produce; Ashley Youth Detention Centre, 'Interim Centre Support Team Minutes', 8 January 2020, 1, produced by the Tasmanian Government in response to a Commission notice to produce.

893 Email from Psychologist, Ashley Youth Detention Centre to Patrick Ryan et al, 13 November 2019, produced by the Tasmanian Government in response to a Commission notice to produce.

894 Email from Psychologist, Ashley Youth Detention Centre to Patrick Ryan et al, 13 November 2019, produced by the Tasmanian Government in response to a Commission notice to produce; Statement of Patrick Ryan, 18 August 2022, 21 [208].

895 The names 'Floyd' and 'Ned' are pseudonyms; Order of the Commission of Inquiry, restricted publication order, 18 August 2022. Statement of 'Max', 19 May 2022, 2 [5–6].

896 Statement of 'Max', 19 May 2022, 2 [5–6].

897 Statement of 'Max', 19 May 2022, 2 [7].

898 Statement of 'Max', 19 May 2022, 2 [10]; Transcript of Max, 23 August 2022, 3111 [32]–3112 [8].

899 Statement of 'Max', 19 May 2022, 2–3 [10–11]; Transcript of Max, 23 August 2022, 3111 [32]–3112 [8].

900 Statement of 'Max', 19 May 2022, 2–3 [10–11]; Transcript of Max, 23 August 2022, 3111 [32]–3112 [8].

901 Statement of 'Max', 19 May 2022, 2–3 [10–11]; Transcript of Max, 23 August 2022, 3112 [10–25].

902 Statement of 'Max', 19 May 2022, 3 [16].

903 The name 'Arlo' is a pseudonym; Order of the Commission of Inquiry, restricted publication order, 18 August 2022.

904 Serious Events Review Team, 'Serious Event Review Report – Review of the matter of [Max]', 19 June 2018, 9–12, produced by the Tasmanian Government in response to a Commission notice to produce.

905 Statement of 'Max', 19 May 2022, 4 [17].

906 Serious Events Review Team, 'Serious Event Review Report – Review of the matter of [Max]', 19 June 2018, 10, produced by the Tasmanian Government in response to a Commission notice to produce.

907 Statement of 'Max', 19 May 2022, 4 [17–18].

908 Serious Events Review Team, 'Serious Event Review Report – Review of the matter of [Max]', 19 June 2018, 9–10, produced by the Tasmanian Government in response to a Commission notice to produce.

909 Serious Events Review Team, 'Serious Event Review Report – Review of the matter of [Max]', 19 June 2018, 9–10, produced by the Tasmanian Government in response to a Commission notice to produce.

910 Statement of 'Max', 19 May 2022, 4 [20].

911 Statement of 'Max', 19 May 2022, 4 [21]–5 [22].

912 Statement of 'Max', 19 May 2022, 5 [22].

913 Ashley Youth Detention Centre, 'Care Plan and Multi-Disciplinary Team Minutes [Max]', 23 August 2018, 2–3, produced by the Tasmanian Government in response to a Commission notice to produce; Ashley Youth Detention Centre, 'Care Plan and Multi-Disciplinary Team Minutes [Max]', 20 September 2018, 4, produced by the Tasmanian Government in response to a Commission notice to produce.

914 Serious Events Review Team, 'Serious Event Review Report – Review of the matter of [Max]', 19 June 2018, 3, 9, produced by the Tasmanian Government in response to a Commission notice to produce.

915 Serious Events Review Team, 'Serious Event Review Report – Review of the matter of [Max]', 19 June 2018, 9, produced by the Tasmanian Government in response to a Commission notice to produce.

916 Serious Events Review Team, 'Serious Event Review Report – Review of the matter of [Max]', 19 June 2018, 9, produced by the Tasmanian Government in response to a Commission notice to produce.

917 Serious Events Review Team, 'Serious Event Review Report – Review of the matter of [Max]', 19 June 2018, 9, produced by the Tasmanian Government in response to a Commission notice to produce.

918 Serious Events Review Team, 'Serious Event Review Report – Review of the matter of [Max]', 19 June 2018, 9, produced by the Tasmanian Government in response to a Commission notice to produce.

919 Serious Events Review Team, 'Serious Event Review Report – Review of the matter of [Max]', 19 June 2018, 9, produced by the Tasmanian Government in response to a Commission notice to produce.

920 Serious Events Review Team, 'Serious Event Review Report – Review of the matter of [Max]', 19 June 2018, 9, produced by the Tasmanian Government in response to a Commission notice to produce.

921 Serious Events Review Team, 'Serious Event Review Report – Review of the matter of [Max]', 19 June 2018, 10, produced by the Tasmanian Government in response to a Commission notice to produce.

922 Serious Events Review Team, 'Serious Event Review Report – Review of the matter of [Max]', 19 June 2018, 10, produced by the Tasmanian Government in response to a Commission notice to produce.

923 Serious Events Review Team, 'Serious Event Review Report – Review of the matter of [Max]', 19 June 2018, 11, produced by the Tasmanian Government in response to a Commission notice to produce.

924 Serious Events Review Team, 'Serious Event Review Report – Review of the matter of [Max]', 19 June 2018, 10–11, produced by the Tasmanian Government in response to a Commission notice to produce.

925 Serious Events Review Team, 'Serious Event Review Report – Review of the matter of [Max]', 19 June 2018, 11, produced by the Tasmanian Government in response to a Commission notice to produce; Statement of 'Max', 19 May 2022, 4 [17].

926 Serious Events Review Team, 'Serious Event Review Report – Review of the matter of [Max]', 19 June 2018, 10–11, produced by the Tasmanian Government in response to a Commission notice to produce.

927 Serious Events Review Team, 'Serious Event Review Report – Review of the matter of [Max]', 19 June 2018, 12, produced by the Tasmanian Government in response to a Commission notice to produce.

928 Serious Events Review Team, Serious Event Review Report – Review of the matter of [Max]', 19 June 2018, 13, produced by the Tasmanian Government in response to a Commission notice to produce.

929 Serious Events Review Team, 'Serious Event Review Report – Review of the matter of [Max]', 19 June 2018, 13, produced by the Tasmanian Government in response to a Commission notice to produce.

930 Serious Events Review Team, 'Serious Event Review Report – Review of the matter of [Max]', 19 June 2018, 13, produced by the Tasmanian Government in response to a Commission notice to produce.

931 Serious Events Review Team, 'Serious Event Review Report – Review of the matter of [Max]', 19 June 2018, 11, produced by the Tasmanian Government in response to a Commission notice to produce.

932 Serious Events Review Team, 'Serious Event Review Report – Review of the matter of [Max]', 19 June 2018, 13, produced by the Tasmanian Government in response to a Commission notice to produce.

933 Serious Events Review Team, 'Serious Event Review Report – Review of the matter of [Max]', 19 June 2018, 13, produced by the Tasmanian Government in response to a Commission notice to produce.

934 Serious Events Review Team, 'Serious Event Review Report – Review of the matter of [Max]', 19 June 2018, 11, produced by the Tasmanian Government in response to a Commission notice to produce.

935 Serious Events Review Team, 'Serious Event Review Report – Review of the matter of [Max]', 19 June 2018, 16, produced by the Tasmanian Government in response to a Commission notice to produce.

936 Serious Events Review Team, 'Serious Event Review Report – Review of the Matter of [Henry]', 19 March 2020, 8, produced by the Tasmanian Government in response to a Commission notice to produce.

937 Ashley Youth Detention Centre, 'Care Plan in relation to [Henry]', 3, produced by the Tasmanian Government in response to a Commission notice to produce.

938 Stuart Watson, 'Response to the Findings of a Serious Event Review Team Review in Relation to AYDC Resident [Henry]', 31 May 2021, 1, produced by the Tasmanian Government in response to a Commission notice to produce.

939 Statement of Pamela Honan, 18 August 2022, 38 [60.1].

940 Department of Communities, 'CCTV Recording of 7 August 2019', 7 August 2019, produced by the Tasmanian Government in response to a Commission notice to produce.

941 The name 'Jonathan' is a pseudonym; Order of the Commission of Inquiry, restricted publication order, 18 August 2022.

942 Ashley Youth Detention Centre, 'Care Plan in relation to [Henry]', 3, produced by the Tasmanian Government in response to a Commission notice to produce.

943 The name 'Frank' is a pseudonym; Order of the Commission of Inquiry, restricted publication order, 18 August 2022. Ashley Youth Detention Centre, 'Incident Report in relation to [Albert], [Finn] and [Frank]', 10 August 2019, 2, produced by the Tasmanian Government in response to a Commission notice to produce.

944 The name 'Maude' is a pseudonym; Order of the Commission of Inquiry, restricted publication order, 18 August 2022. Ashley Youth Detention Centre, 'Incident Report in relation to [Albert], [Finn] and [Frank]', 10 August 2019, 2, produced by the Tasmanian Government in response to a Commission notice to produce.

945 Ashley Youth Detention Centre, 'Client Request', 8 August 2019, produced by the Tasmanian Government in response to a Commission notice to produce.

946 Ashley Youth Detention Centre, 'Client Request', 8 August 2019, produced by the Tasmanian Government in response to a Commission notice to produce.

947 Ashley Youth Detention Centre, 'Incident Report in relation to [Albert] and [Finn]', 9 August 2019, 2, produced by the Tasmanian Government in response to a Commission notice to produce.

948 Serious Events Review Team, 'Serious Event Review Report – Review of the Matter of [Henry]', 19 March 2020, 11, produced by the Tasmanian Government in response to a Commission notice to produce.

949 Serious Events Review Team, 'Serious Event Review Report – Review of the Matter of [Henry]', 19 March 2020, 11, produced by the Tasmanian Government in response to a Commission notice to produce.

950 Serious Events Review Team, 'Serious Event Review Report – Review of the Matter of [Henry]', 19 March 2020, 11, produced by the Tasmanian Government in response to a Commission notice to produce.

951 Ashley Youth Detention Centre, 'Incident Report Form in relation to [Albert] and [Finn]', 9 August 2019, 2, produced by the Tasmanian Government in response to a Commission notice to produce.

952 Ashley Youth Detention Centre, 'Incident Report in relation to [Albert] and [Finn]', 9 August 2019, produced by the Tasmanian Government in response to a Commission notice to produce. Note that the incident report records the date of the incident as 7 September 2019, which we presume to be a typographical error on the basis that the report indicates the CCTV footage was viewed and the report was signed on 9 August 2019, and on the basis that the incident date of 7 August 2019 is confirmed in other documentary and witness evidence.

953 Ashley Youth Detention Centre, 'Incident Report in relation to [Albert] and [Finn]', 9 August 2019, 2, produced by the Tasmanian Government in response to a Commission notice to produce.

954 Ashley Youth Detention Centre, 'Incident Report in relation to [Albert] and [Finn]', 9 August 2019, 4, produced by the Tasmanian Government in response to a Commission notice to produce.

955 Serious Events Review Team, 'Serious Event Review Report – Review of the Matter of [Henry]', 19 March 2020, 11, produced by the Tasmanian Government in response to a Commission notice to produce.

956 Ashley Youth Detention Centre, 'Incident Report in relation to [Albert], [Finn] and [Frank]', 10 August 2019, 3, produced by the Tasmanian Government in response to a Commission notice to produce.

957 Ashley Youth Detention Centre, 'Incident Report in relation to [Albert], [Finn] and [Frank]', 10 August 2019, 2, produced by the Tasmanian Government in response to a Commission notice to produce.

958 Ashley Youth Detention Centre, 'Incident Report in relation to [Albert], [Finn] and [Frank]', 10 August 2019, 2, produced by the Tasmanian Government in response to a Commission notice to produce.

959 The name 'Clive' is a pseudonym; Order of the Commission of Inquiry, restricted publication order, 18 August 2022. Ashley Youth Detention Centre, 'Incident Report in relation to [Albert], [Finn] and [Frank]', 10 August 2019, 2, produced by the Tasmanian Government in response to a Commission notice to produce.

960 Ashley Youth Detention Centre, 'Incident Report in relation to [Albert], [Finn] and [Frank]', 10 August 2019, 2, produced by the Tasmanian Government in response to a Commission notice to produce.

961 Ashley Youth Detention Centre, 'Incident Report in relation to [Albert], [Finn] and [Frank]', 10 August 2019, 2, produced by the Tasmanian Government in response to a Commission notice to produce.

962 Ashley Youth Detention Centre, 'Incident Report in relation to [Albert], [Finn] and [Frank]', 10 August 2019, 2, produced by the Tasmanian Government in response to a Commission notice to produce.

963 Ashley Youth Detention Centre, 'Incident Report in relation to [Albert], [Finn] and [Frank]', 10 August 2019, 2, produced by the Tasmanian Government in response to a Commission notice to produce.

964 Ashley Youth Detention Centre, 'Incident Report in relation to [Albert], [Finn] and [Frank]', 10 August 2019, 2, produced by the Tasmanian Government in response to a Commission notice to produce.

965 Ashley Youth Detention Centre, 'Incident Report in relation to [Albert], [Finn] and [Frank]', 10 August 2019, 3, produced by the Tasmanian Government in response to a Commission notice to produce.

966 Ashley Youth Detention Centre, 'Incident Report in relation to [Albert], [Finn] and [Frank]', 10 August 2019, 3, produced by the Tasmanian Government in response to a Commission notice to produce.

967 Ashley Youth Detention Centre, 'Centre Support Team Minutes', 12 August 2019, 6, produced by the Tasmanian Government in response to a Commission notice to produce.

968 Ashley Youth Detention Centre, 'Centre Support Team Minutes', 12 August 2019, 6, produced by the Tasmanian Government in response to a Commission notice to produce.

969 Ashley Youth Detention Centre, 'Centre Support Team Minutes', 12 August 2019, 6, produced by the Tasmanian Government in response to a Commission notice to produce.

970 Ashley Youth Detention Centre, 'Centre Support Team Minutes', 12 August 2019, 6, produced by the Tasmanian Government in response to a Commission notice to produce.

971 Ashley Youth Detention Centre, 'Centre Support Team Minutes', 12 August 2019, 6, produced by the Tasmanian Government in response to a Commission notice to produce.

972 Ashley Youth Detention Centre, 'Centre Support Team Minutes', 12 August 2019, 3, produced by the Tasmanian Government in response to a Commission notice to produce.

973 Ashley Youth Detention Centre, 'Centre Support Team Minutes', 12 August 2019, 3, produced by the Tasmanian Government in response to a Commission notice to produce.

974 Ashley Youth Detention Centre, 'Incident Report in relation to [Albert], [Finn] and [Frank]', 10 August 2019, 2, produced by the Tasmanian Government in response to a Commission notice to produce.

975 Transcript of Madeleine Gardiner, 22 August 2022, 3010 [20–24].

976 Statement of Madeleine Gardiner, 15 August 2022, 27–28 [50].

977 Transcript of Madeleine Gardiner, 22 August 2022, 3010 [7–10].

978 Transcript of Madeleine Gardiner, 22 August 2022, 3009 [42]–3010 [5], [26–29].

979 Serious Events Review Team, 'Serious Event Review Report – Review of the matter of [Henry]', 19 March 2020, 12, produced by the Tasmanian Government in response to a Commission notice to produce.

980 Serious Events Review Team, 'Serious Event Review Report – Review of the matter of [Henry]', 19 March 2020, 12, produced by the Tasmanian Government in response to a Commission notice to produce.

981 Email from Madeleine Gardiner to Patrick Ryan et al, 13 August 2019, 3–4, produced by the Tasmanian Government in response to a Commission notice to produce; Transcript of Madeleine Gardiner, 22 August 2022, 3009 [42]–3010 [5].

982 Email from Madeleine Gardiner to Patrick Ryan et al, 13 August 2019, 3–4 produced by the Tasmanian Government in response to a Commission notice to produce; Transcript of Madeleine Gardiner, 22 August 2022, 3009 [42]–3010 [5].

983 Email from Madeleine Gardiner to Patrick Ryan et al, 13 August 2019, 4, produced by the Tasmanian Government in response to a Commission notice to produce.

984 Email from Madeleine Gardiner to Patrick Ryan et al, 13 August 2019, 4, produced by the Tasmanian Government in response to a Commission notice to produce.

985 Statement of Madeleine Gardiner, 15 August 2022, 27–28 [50]; Email from Madeleine Gardiner to Patrick Ryan, 22 August 2019, 2, produced by the Tasmanian Government in response to a Commission notice to produce.

986 Serious Events Review Team, 'Serious Event Review Report – Review of the Matter of [Henry]', 19 March 2020, 12, produced by the Tasmanian Government in response to a Commission notice to produce.

987 Serious Events Review Team, 'Serious Event Review Report – Review of the Matter of [Henry]', 19 March 2020, 12, produced by the Tasmanian Government in response to a Commission notice to produce.

988 Serious Events Review Team, 'Serious Event Review Report – Review of the Matter of [Henry]', 19 March 2020, 12, produced by the Tasmanian Government in response to a Commission notice to produce.

989 Serious Events Review Team, 'Serious Event Review Report – Review of the Matter of [Henry]', 19 March 2020, 12, produced by the Tasmanian Government in response to a Commission notice to produce.

990 Serious Events Review Team, 'Serious Event Review Report – Review of the Matter of [Henry]', 19 March 2020, 13, produced by the Tasmanian Government in response to a Commission notice to produce.

991 Serious Events Review Team, 'Serious Event Review Report – Review of the Matter of [Henry]', 19 March 2020, 13, produced by the Tasmanian Government in response to a Commission notice to produce.

992 Statement of Nurse Unit Manager, Ashley Youth Detention Centre, 11 November 2022, 33–34 [144], 35 [150]; Ashley Youth Detention Centre, 'Patient Consultation Summary List: [Henry]', 25 March 2021, 14, produced by the Tasmanian Government in response to a Commission notice to produce.

993 Letter from Mandy Clarke to Leanne McLean, 19 May 2020.

994 Statement of Nurse Unit Manager, Ashley Youth Detention Centre, 11 November 2022, 36 [152], 37–38 [162]; Ashley Youth Detention Centre, 'Patient Consultation Summary List: [Henry]', 25 March 2021, produced by the Tasmanian Government in response to a Commission notice to produce.

995 Letter from Mandy Clarke to Leanne McLean, 19 May 2020.

996 Ashley Youth Detention Centre, 'Centre Support Team Minutes', 19 August 2019, produced by the Tasmanian Government in response to a Commission notice to produce.

997 Ashley Youth Detention Centre, 'Centre Support Team Minutes', 19 August 2019, 5–6, produced by the Tasmanian Government in response to a Commission notice to produce.

998 Ashley Youth Detention Centre, 'Centre Support Team Minutes', 19 August 2019, 5–6, produced by the Tasmanian Government in response to a Commission notice to produce.

999 Ashley Youth Detention Centre, 'Centre Support Team Minutes', 19 August 2019, 6, produced by the Tasmanian Government in response to a Commission notice to produce.

1000 Ashley Youth Detention Centre, 'Centre Support Team Minutes', 19 August 2019, 6, produced by the Tasmanian Government in response to a Commission notice to produce.

1001 Ashley Youth Detention Centre, 'Centre Support Team Minutes', 19 August 2019, 6, produced by the Tasmanian Government in response to a Commission notice to produce.

1002 Ashley Youth Detention Centre, 'Centre Support Team Minutes', 19 August 2019, 5, produced by the Tasmanian Government in response to a Commission notice to produce.

1003 Ashley Youth Detention Centre, 'Centre Support Team Minutes', 19 August 2019, 6, produced by the Tasmanian Government in response to a Commission notice to produce.

1004 Ashley Youth Detention Centre, 'Patient Consultation Summary List: [Henry]', 25 March 2021, 15, produced by the Tasmanian Government in response to a Commission notice to produce.

1005 Ashley Youth Detention Centre, 'Patient Consultation Summary List: [Henry]', 25 March 2021, 15, produced by the Tasmanian Government in response to a Commission notice to produce.

1006 Ashley Youth Detention Centre, 'Patient Consultation Summary List: [Henry]', 25 March 2021, 15, produced by the Tasmanian Government in response to a Commission notice to produce.

1007 Patrick Ryan, *Procedural Fairness Response*, 12 July 2023, 2 [6].

1008 Serious Events Review Team, 'Serious Event Review Report – Review of the Matter of [Henry]', 19 March 2020, 13, produced by the Tasmanian Government in response to a Commission notice to produce.

1009 Letter from Psychologist, Ashley Youth Detention Centre to Patrick Ryan, 15 November 2019, 3–6, produced by the Tasmanian Government in response to a Commission notice to produce; Statement of Patrick Ryan, 18 August 2022, Annexure PR-56 (Email from 'Piers' to 'Maude' et al, 21 November 2019); Transcript of Veronica Burton, 22 August 2022, 3101 [17–22]; Statement of Fiona Atkins, 15 August 2022, 21–22 [96(e)]; Transcript of Pamela Honan, 19 August 2022, 2952 [30–42], 2953 [26–37]; Statement of Nurse Unit Manager, Ashley Youth Detention Centre, 11 November 2022, 37 [161].

1010 Statement of 'Alysha', 16 August 2022, 38–40 [198].

1011 Ashley Youth Detention Centre, 'Centre Support Team Minutes', 19 August 2019, 1, produced by the Tasmanian Government in response to a Commission notice to produce.

1012 Ashley Youth Detention Centre, 'Centre Support Team Minutes', 19 August 2019, 1.

1013 Refer also to email from Operations Manager to Madeleine Gardiner, 21 August 2019, produced by the Tasmanian Government in response to a Commission notice to produce.

1014 Email from Madeleine Gardiner to Patrick Ryan and Operations Manager, 21 August 2019, produced by the Tasmanian Government in response to a Commission notice to produce.

1015 Statement of Madeleine Gardiner, 15 August 2022, 29 [53(a)].

1016 Email from Operations Manager to Madeleine Gardiner, 21 August 2019, produced by the Tasmanian Government in response to a Commission notice to produce.

1017 Email from Operations Manager to Madeleine Gardiner, 21 August 2019.

1018 Statement of Madeleine Gardiner, 15 August 2022, 29 [53(a)].

1019 Statement of Madeleine Gardiner, 15 August 2022, 29 [53(a)].

1020 Statement of Patrick Ryan, 19 August 2022, Annexure PR-51 (File Note, Patrick Ryan, 22 August 2019).

1021 Statement of Patrick Ryan, 19 August 2022, Annexure PR-51 (File Note, Patrick Ryan, 22 August 2019).

1022 Statement of Patrick Ryan, 19 August 2022, Annexure PR-51 (File Note, Patrick Ryan, 22 August 2019).

1023 Email from Madeleine Gardiner to Patrick Ryan, 21 August 2019, produced by the Tasmanian Government in response to a Commission notice to produce.

1024 Email from Patrick Ryan to Madeleine Gardiner, 21 August 2019, produced by the Tasmanian Government in response to a Commission notice to produce.

1025 Email from Madeleine Gardiner to Patrick Ryan, 22 August 2019, produced by the Tasmanian Government in response to a Commission notice to produce.

1026 Department of Communities, 'CARDI Conversation Summary Report in relation to [Henry]', 25 March 2022, 2, produced by the Tasmanian Government in response to a Commission notice to produce; Email from Madeleine Gardiner to Patrick Ryan, 23 August 2019, produced by the Tasmanian Government in response to a Commission notice to produce.

1027 Department of Communities, 'CARDI Conversation Summary Report in relation to [Henry]', 25 March 2022, 2, produced by the Tasmanian Government in response to a Commission notice to produce.

1028 Department of Communities, 'CARDI Conversation Summary Report in relation to [Henry]', 25 March 2022, 3, produced by the Tasmanian Government in response to a Commission notice to produce.

1029 Department of Communities, 'CARDI Conversation Summary Report in relation to [Henry]', 25 March 2022, 2, 6, produced by the Tasmanian Government in response to a Commission notice to produce.

1030 Email from Madeleine Gardiner to Patrick Ryan, 23 August 2019, produced by the Tasmanian Government in response to a Commission notice to produce.

1031 Patrick Ryan, *Procedural Fairness Response*, 15 May 2023, 4 [27].

1032 Greg Brown, *Procedural Fairness Response*, 17 July 2023, 10 [49]; Greg Brown, *Procedural Fairness Response*, 17 July 2023, Annexure 1 (Statement of Greg Brown, 17 July 2023) 1 [6].

1033 Department of Communities, 'CARDI Conversation Summary Report in relation to [Henry]', 25 March 2022, 1–2, 8–9, produced by the Tasmanian Government in response to a Commission notice to produce; email from Madeleine Gardiner to Patrick Ryan, 23 August 2019, produced by the Tasmanian Government in response to a Commission notice to produce.

1034 Email from former Operations Coordinator to former Director, Strategic Youth Services, Department of Communities, 1 October 2019, produced by the Tasmanian Government in response to a Commission notice to produce.

1035 Department of Communities, 'CARDI Conversation Summary Report in relation to [Henry]', 25 March 2022, 8, produced by the Tasmanian Government in response to a Commission notice to produce.

1036 Department of Communities, 'CARDI Conversation Summary Report in relation to [Henry]', 25 March 2022, 9, produced by the Tasmanian Government in response to a Commission notice to produce.

1037 Tasmania Police, 'Table of Allegations and Incidents of Child Sexual Abuse', 20 July 2021, produced by Tasmania Police in response to a Commission notice to produce.

1038 Email from Psychologist, Ashley Youth Detention Centre to Madeleine Gardiner, 22 August 2019, produced by the Tasmanian Government in response to a Commission notice to produce; Psychologist, Ashley Youth Detention Centre, 'Incident Log', 21 August 2019, produced by the Tasmanian Government in response to a Commission notice to produce.

1039 Email from Psychologist, Ashley Youth Detention Centre to Madeleine Gardiner, 22 August 2019, 1, produced by the Tasmanian Government in response to a Commission notice to produce; Psychologist, Ashley Youth Detention Centre, 'Incident Log', 21 August 2019, produced by the Tasmanian Government in response to a Commission notice to produce.

1040 Email from Psychologist, Ashley Youth Detention Centre to Madeleine Gardiner, 22 August 2019, produced by the Tasmanian Government in response to a Commission notice to produce.

1041 Email from Psychologist, Ashley Youth Detention Centre to Madeleine Gardiner, 22 August 2019, produced by the Tasmanian Government in response to a Commission notice to produce.

1042 Email from Psychologist, Ashley Youth Detention Centre to Madeleine Gardiner, 22 August 2019, produced by the Tasmanian Government in response to a Commission notice to produce.

1043 Email from Psychologist, Ashley Youth Detention Centre to Madeleine Gardiner, 22 August 2019, produced by the Tasmanian Government in response to a Commission notice to produce.

1044 Email from Madeleine Gardiner to Patrick Ryan, 22 August 2019, produced by the Tasmanian Government in response to a Commission notice to produce.

1045 Email from Patrick Ryan to Madeleine Gardiner, 22 August 2019, produced by the Tasmanian Government in response to a Commission notice to produce.

1046 Email from Patrick Ryan to Madeleine Gardiner, 22 August 2019, produced by the Tasmanian Government in response to a Commission notice to produce.

1047 Statement of Madeleine Gardiner, 15 August 2022, 49 [92(c)].

1048 Statement of Madeleine Gardiner, 15 August 2022, 28 [50], 49 [92(b)]; Email from Madeleine Gardiner to former Director, Strategic Youth Services, Department of Communities, 5 September 2019, produced by the Tasmanian Government in response to a Commission notice to produce.

1049 Patrick Ryan, *Procedural Fairness Response*, 15 May 2023, 2 [14]; Patrick Ryan, *Procedural Fairness Response*, 15 May 2023, Annexure 1 ('Ashley Youth Detention Centre Program Summary Table 2018–19', undated).

1050 Statement of Patrick Ryan, 18 August 2022, 3 [22]–4 [32].

1051 Statement of Patrick Ryan, 18 August 2022, 4 [32].

1052 Statement of Patrick Ryan, 18 August 2022, 20 [195–199].

1053 Greg Brown, *Procedural Fairness Response*, 17 July 2023, 10 [50]; Greg Brown, *Procedural Fairness Response*, 17 July 2023, Annexure 1 (Statement of Greg Brown, 17 July 2023) 1 [7].

1054 Statement of Pamela Honan, 18 August 2022, 13 [12.5–12.6].

1055 Serious Events Review Team, 'Serious Event Review Report – Review of the matter of [Henry]', 19 March 2020, 13, produced by the Tasmanian Government in response to a Commission notice to produce.

1056 Statement of Madeleine Gardiner, 15 August 2022, 46 [89(a)]; Statement of Madeleine Gardiner, 15 August 2022, Annexure MG-26 (Email from Ashley Professional Services to Madeleine Gardiner and Patrick Ryan, 23 August 2019).

1057 Statement of Madeleine Gardiner, 15 August 2022, 46 [89(a)]; Statement of Madeleine Gardiner, 15 August 2022, Annexure MG-26 (Email from Ashley Professional Services to Madeleine Gardiner and Patrick Ryan, 23 August 2019).

1058 Department of Communities, 'CARDI Conversation Summary Report in relation to [Henry]', 25 March 2022, 8, produced by the Tasmanian Government in response to a Commission notice to produce.

1059 Statement of Nurse Unit Manager, Ashley Youth Detention Centre, 11 November 2022, 36 [152].

1060 Department of Communities, 'CARDI Conversation Summary Report in relation to [Henry]', 25 March 2022, 9, produced by the Tasmanian Government in response to a Commission notice to produce.

1061 Ashley Youth Detention Centre, 'Centre Support Team Minutes', 12 August 2019, 6, produced by the Tasmanian Government in response to a Commission notice to produce.

1062 Statement of Patrick Ryan, 18 August 2022, 19 [183].

1063 Statement of Patrick Ryan, 18 August 2022, 19 [181].

1064 Statement of Patrick Ryan, 7 September 2022, 1 [1].

1065 Statement of Patrick Ryan, 7 September 2022, 1 [2].

1066 Statement of Greg Brown, 28 November 2022, 32 [93].

1067 Greg Brown, *Procedural Fairness Response*, 17 July 2023, 12 [63]; Greg Brown, *Procedural Fairness Response*, 17 July 2023, Annexure 1 (Statement of Greg Brown, 17 July 2023) 2 [10].

1068 Greg Brown, *Procedural Fairness Response*, 17 July 2023, Annexure 1 (Statement of Greg Brown, 17 July 2023) 2 [11].

1069 Department of Communities, 'Issues Briefing to Secretary: Sexualised Incident between Residents at the Ashley Youth Detention Centre', 9 September 2019, produced by the Tasmanian Government in response to a Commission notice to produce.

1070 Department of Communities, 'Issues Briefing to Secretary: Sexualised Incident between Residents at the Ashley Youth Detention Centre', 9 September 2019, 2, produced by the Tasmanian Government in response to a Commission notice to produce.

1071 Department of Communities, 'Issues Briefing to Secretary: Sexualised Incident between Residents at the Ashley Youth Detention Centre', 9 September 2019, 2 produced by the Tasmanian Government in response to a Commission notice to produce.

1072 Department of Communities, 'Issues Briefing to Secretary: Sexualised Incident between Residents at the Ashley Youth Detention Centre', 9 September 2019, 1, produced by the Tasmanian Government in response to a Commission notice to produce.

1073 Department of Communities, 'Issues Briefing to Secretary: Sexualised Incident between Residents at the Ashley Youth Detention Centre', 9 September 2019, 1, produced by the Tasmanian Government in response to a Commission notice to produce.

1074 Department of Communities, 'Issues Briefing to Secretary: Sexualised Incident between Residents at the Ashley Youth Detention Centre', 9 September 2019, 1, produced by the Tasmanian Government in response to a Commission notice to produce.

1075 Department of Communities, 'Issues Briefing to Secretary: Sexualised Incident between Residents at the Ashley Youth Detention Centre', 9 September 2019, 1, produced by the Tasmanian Government in response to a Commission notice to produce.

1076 Department of Communities, 'Issues Briefing to Secretary: Sexualised Incident between Residents at the Ashley Youth Detention Centre', 9 September 2019, 2, produced by the Tasmanian Government in response to a Commission notice to produce.

1077 Department of Communities, 'Issues Briefing to Secretary: Sexualised Incident between Residents at the Ashley Youth Detention Centre', 9 September 2019, 2, produced by the Tasmanian Government in response to a Commission notice to produce.

1078 Department of Communities, 'Issues Briefing to Secretary: Sexualised Incident between Residents at the Ashley Youth Detention Centre', 9 September 2019, 2, produced by the Tasmanian Government in response to a Commission notice to produce.

1079 Department of Communities, 'Issues Briefing to Secretary: Sexualised Incident between Residents at the Ashley Youth Detention Centre', 9 September 2019, 2, produced by the Tasmanian Government in response to a Commission notice to produce.

1080 Department of Communities, 'Issues Briefing to Secretary: Sexualised Incident between Residents at the Ashley Youth Detention Centre', 9 September 2019, 2, produced by the Tasmanian Government in response to a Commission notice to produce.

1081 Department of Communities, 'Issues Briefing to Secretary: Sexualised Incident between Residents at the Ashley Youth Detention Centre', 9 September 2019, 2, produced by the Tasmanian Government in response to a Commission notice to produce.

1082 Department of Communities, 'Issues Briefing to Secretary: Sexualised Incident between Residents at the Ashley Youth Detention Centre', 9 September 2019, 1–2, produced by the Tasmanian Government in response to a Commission notice to produce.

1083 Department of Communities, 'Issues Briefing to Secretary: Sexualised Incident between Residents at the Ashley Youth Detention Centre', 9 September 2019, 2, produced by the Tasmanian Government in response to a Commission notice to produce.

1084 Department of Communities, 'Issues Briefing to Secretary: Sexualised Incident between Residents at the Ashley Youth Detention Centre', 9 September 2019, 2, produced by the Tasmanian Government in response to a Commission notice to produce.

1085 Department of Communities, 'Issues Briefing to Secretary: Sexualised Incident between Residents at the Ashley Youth Detention Centre', 9 September 2019, 2, produced by the Tasmanian Government in response to a Commission notice to produce.

1086 Department of Communities, 'Issues Briefing to Secretary: Sexualised Incident between Residents at the Ashley Youth Detention Centre', 9 September 2019, 2, produced by the Tasmanian Government in response to a Commission notice to produce.

1087 Department of Communities, 'Issues Briefing to Secretary: Sexualised Incident between Residents at the Ashley Youth Detention Centre', 9 September 2019, 2, produced by the Tasmanian Government in response to a Commission notice to produce.

1088 Transcript of Patrick Ryan, 7 September 2022, 3636 [46–47], 3637 [15–19].

1089 Transcript of Patrick Ryan, 7 September 2022, 3634 [43–46].

1090 Transcript of Patrick Ryan, 7 September 2022, 3635 [34–35].

1091 Statement of Patrick Ryan, 19 August 2022, Annexure PR-50 ('Sexualised Incident between Residents at the Ashley Youth Detention Centre', Draft Issues Briefing to Secretary, Strategic Youth Services, 30 August 2019).

1092 Statement of Patrick Ryan, 19 August 2022, Annexure PR-50 ('Sexualised Incident between Residents at the Ashley Youth Detention Centre', Draft Issues Briefing to Secretary, Strategic Youth Services, 30 August 2019) 1–2.

1093 Statement of Patrick Ryan, 19 August 2022, Annexure PR-50 ('Sexualised Incident between Residents at the Ashley Youth Detention Centre', Draft Issues Briefing to Secretary, Strategic Youth Services, 30 August 2019) 3.

1094 Statement of Patrick Ryan, 18 August 2022, Annexure PR-50 ('Sexualised Incident between Residents at the Ashley Youth Detention Centre', Draft Issues Briefing to Secretary, Strategic Youth Services, 30 August 2019) 2.

1095 Statement of Greg Brown, 28 November 2022, 32 [93–94].

1096 Statement of Pamela Honan, 18 August 2022, 35 [59.1].

1097 Statement of Pamela Honan, 18 August 2022, 35 [59.1].

1098 Statement of Pamela Honan, 18 August 2022, 35 [59.1].

1099 Statement of Pamela Honan, 18 August 2022, 35 [59.1].

1100 Statement of Pamela Honan, 18 August 2022, 24 [31.2].

1101 Statement of Mandy Clarke, 19 August 2022, 17 [69.1]–18 [69.2].

1102 Statement of Michael Pervan, 23 August 2022, 56 [229(i)].

1103 Statement of Michael Pervan, 23 August 2022, 56 [229(i)].

1104 Transcript of Michael Pervan, 26 August 2022, 3525 [22–36].

1105 Statement of Pamela Honan, 18 August 2022, 23 [30.2]; Transcript of Pamela Honan, 19 August 2022, 2949 [9–13].

1106 Email from Psychologist, Ashley Youth Detention Centre to Patrick Ryan et al, 18 September 2019, 1–2, produced by the Tasmanian Government in response to a Commission notice to produce.

1107 Email from Psychologist, Ashley Youth Detention Centre to Patrick Ryan et al, 20 September 2019, 1, produced by the Tasmanian Government in response to a Commission notice to produce.

1108 Email from Psychologist, Ashley Youth Detention Centre to Patrick Ryan et al, 20 September 2019, 1, produced by the Tasmanian Government in response to a Commission notice to produce.

1109 Serious Events Review Team, 'Serious Event Review Report – Review of the matter of [Henry]', 19 March 2020, produced by the Tasmanian Government in response to a Commission notice to produce. Refer also to Transcript of Chris Gunson SC, Counsel for the State of Tasmania, 19 August 2022, 2983 [28]–2984 [42].

1110 Transcript of Patrick Ryan, 7 September 2022, 3628 [14–17].

1111 Ashley Youth Detention Centre, 'Multi-Disciplinary Team Minutes: Signs of Safety Assessment Map [Ray]', 19 September 2019, 1, produced by the Tasmanian Government in response to a Commission notice to produce.

1112 Ashley Youth Detention Centre, 'Incident Report in relation to [Ray]', 26 September 2019, produced by the Tasmanian Government in response to a Commission notice to produce; Ashley Youth Detention Centre, 'Authorisation for Use of Isolation in relation to [Ray]', 26 September 2019, produced by the Tasmanian Government in response to a Commission notice to produce.

1113 Ashley Youth Detention Centre, 'Incident Report in relation to [Ray]', 28 September 2019, produced by the Tasmanian Government in response to a Commission notice to produce; Ashley Youth Detention Centre, 'Incident Report in relation to [Ray]', 1 October 2019, produced by the Tasmanian Government in response to a Commission notice to produce; Ashley Youth Detention Centre, 'Incident Report in relation to [Ray]', 2 October 2019, produced by the Tasmanian Government in response to a Commission notice to produce; Ashley Youth Detention Centre, 'Incident Report in relation to [Ray]', 2 October 2019, produced by the Tasmanian Government in response to a Commission notice to produce; Ashley Youth Detention Centre, 'Incident Report in relation to [Ray]', 3 October 2019, produced by the Tasmanian Government in response to a Commission notice to produce; Ashley Youth Detention Centre, 'Incident Report in relation to [Ray]', 5 November 2019, produced by the Tasmanian Government in response to a Commission notice to produce; Ashley Youth Detention Centre, 'Incident Report in relation to [Ray]', 8 November 2019, produced by the Tasmanian Government in response to a Commission notice to produce; Ashley Youth Detention Centre, 'Incident Report in relation to [Ray]', 24 November 2019, produced by the Tasmanian Government in response to a Commission notice to produce; Ashley Youth Detention Centre, 'Incident Report in relation to [Ray]', 27 November 2019, produced by the Tasmanian Government in response to a Commission notice to produce.

1114 Ashley Youth Detention Centre, 'Incident Report in relation to [Ray]', 28 September 2019, 3, produced by the Tasmanian Government in response to a Commission notice to produce; Ashley Youth Detention Centre, 'Incident Report in relation to [Ray]', 1 October 2019, 3–4, produced by the Tasmanian Government in response to a Commission notice to produce; Ashley Youth Detention Centre, 'Incident Report in relation to [Ray]', 2 October 2019, 3, produced by the Tasmanian Government in response to a Commission notice

to produce; Ashley Youth Detention Centre, 'Incident Report in relation to [Ray]', 2 October 2019, 3, produced by the Tasmanian Government in response to a Commission notice to produce; Ashley Youth Detention Centre, 'Incident Report in relation to [Ray]', 3 October 2019, 3–4, produced by the Tasmanian Government in response to a Commission notice to produce; Ashley Youth Detention Centre, 'Incident Report in relation to [Ray]', 5 November 2019, 3, produced by the Tasmanian Government in response to a Commission notice to produce; Ashley Youth Detention Centre, 'Incident Report in relation to [Ray]', 8 November 2019, 4, produced by the Tasmanian Government in response to a Commission notice to produce; Ashley Youth Detention Centre, 'Incident Report in relation to [Ray]', 24 November 2019, 3–4, produced by the Tasmanian Government in response to a Commission notice to produce; Ashley Youth Detention Centre, 'Incident Report in relation to [Ray]', 27 November 2019, 3–4, produced by the Tasmanian Government in response to a Commission notice to produce.

1115 Ashley Youth Detention Centre, 'Conference Convenor Report in relation to [Ray]', 17 October 2019, produced by the Tasmanian Government in response to a Commission notice to produce; Ashley Youth Detention Centre, 'Conference Convenor Report in relation to [Ray]', 13 November 2019, produced by the Tasmanian Government in response to a Commission notice to produce; Ashley Youth Detention Centre, 'Conference Convenor Report in relation to [Ray]', 4 December 2019, produced by the Tasmanian Government in response to a Commission notice to produce; Ashley Youth Detention Centre, 'Conference Convenor Report in relation to [Ray]', 4 December 2019, produced by the Tasmanian Government in response to a Commission notice to produce; Ashley Youth Detention Centre, 'Conference Convenor Report in relation to [Ray]', 4 December 2019, produced by the Tasmanian Government in response to a Commission notice to produce.

1116 Refer to, for example, Ashley Youth Detention Centre, 'Conference Convenor Report in relation to [Ray]', 2 October 2019, 2, produced by the Tasmanian Government in response to a Commission notice to produce; Ashley Youth Detention Centre, 'Conference Convenor Report in relation to [Ray]', 4 December 2019, 2, produced by the Tasmanian Government in response to a Commission notice to produce; Ashley Youth Detention Centre, 'Conference Convenor Report in relation to [Ray]', 4 December 2019, 2, produced by the Tasmanian Government in response to a Commission notice to produce.

1117 Ashley Youth Detention Centre, 'Conference Convenor Report in relation to [Ray]', 4 December 2019, 2, produced by the Tasmanian Government in response to a Commission notice to produce; Ashley Youth Detention Centre, 'Conference Convenor Report in relation to [Ray]', 4 December 2019, 2, produced by the Tasmanian Government in response to a Commission notice to produce.

1118 Ashley Youth Detention Centre, 'Care Plan in relation to [Ray]', 25 October 2019, 4, produced by the Tasmanian Government in response to a Commission notice to produce.

1119 Email from Ashley Professional Services to 'Chester', 8 October 2019, produced by the Tasmanian Government in response to a Commission notice to produce. 'Chester' is a pseudonym; Order of the Commission of Inquiry, restricted publication order, 18 August 2022.

1120 Email from 'Chester' to Ashley Professional Services, 8 October 2019, produced by the Tasmanian Government in response to a Commission notice to produce.

1121 Email from Psychologist, Ashley Youth Detention Centre to Leanne McLean, 8 October 2019, produced by the Tasmanian Government in response to a Commission notice to produce.

1122 Email from Psychologist, Ashley Youth Detention Centre to Patrick Ryan et al, 13 November 2019, produced by the Tasmanian Government in response to a Commission notice to produce.

1123 Statement of Patrick Ryan, 18 August 2022, 21 [208].

1124 Statement of Patrick Ryan, 18 August 2022, 21 [206].

1125 Statement of Patrick Ryan, 18 August 2022, 21 [207–210]; Statement of Patrick Ryan, 18 August 2022, Annexure PR-56 (Compiled emails and other documents relating to planning and meetings in relation to 'Albert' and 'Finn').

1126 Ashley Youth Detention Centre, 'Multi-Disciplinary Team Minutes: Signs of Safety Assessment Map [Albert] and [Finn]', 14 November 2019, 2, produced by the Tasmanian Government in response to a Commission notice to produce.

1127 Letter from Psychologist, Ashley Youth Detention Centre to Patrick Ryan, 15 November 2019, produced by the Tasmanian Government in response to a Commission notice to produce.

1128 Email from Psychologist, Ashley Youth Detention Centre to Patrick Ryan, 15 November 2019, produced by the Tasmanian Government in response to a Commission notice to produce; Letter from Psychologist, Ashley Youth Detention Centre to Patrick Ryan, 15 November 2019, 2, produced by the Tasmanian Government in response to a Commission notice to produce.

1129 Email from Psychologist, Ashley Youth Detention Centre to Patrick Ryan, 15 November 2019, produced by the Tasmanian Government in response to a Commission notice to produce.

1130 Letter from Psychologist, Ashley Youth Detention Centre to Patrick Ryan, 15 November 2019, 1, produced by the Tasmanian Government in response to a Commission notice to produce.

1131 Letter from Psychologist, Ashley Youth Detention Centre to Patrick Ryan, 15 November 2019, 1, produced by the Tasmanian Government in response to a Commission notice to produce.

1132 Letter from Psychologist, Ashley Youth Detention Centre to Patrick Ryan, 15 November 2019, 1, produced by the Tasmanian Government in response to a Commission notice to produce.

1133 Letter from Psychologist, Ashley Youth Detention Centre to Patrick Ryan, 15 November 2019, 1, produced by the Tasmanian Government in response to a Commission notice to produce.

1134 Letter from Psychologist, Ashley Youth Detention Centre to Patrick Ryan, 15 November 2019, 1, produced by the Tasmanian Government in response to a Commission notice to produce.

1135 Letter from Psychologist, Ashley Youth Detention Centre to Patrick Ryan, 15 November 2019, 1–2, produced by the Tasmanian Government in response to a Commission notice to produce.

1136 Letter from Psychologist, Ashley Youth Detention Centre to Patrick Ryan, 15 November 2019, 2, produced by the Tasmanian Government in response to a Commission notice to produce.

1137 Letter from Psychologist, Ashley Youth Detention Centre to Patrick Ryan, 15 November 2019, 2, produced by the Tasmanian Government in response to a Commission notice to produce.

1138 Letter from Psychologist, Ashley Youth Detention Centre to Patrick Ryan, 15 November 2019, 2, produced by the Tasmanian Government in response to a Commission notice to produce.

1139 Letter from Psychologist, Ashley Youth Detention Centre to Patrick Ryan, 15 November 2019, 2, produced by the Tasmanian Government in response to a Commission notice to produce.

1140 Statement of Patrick Ryan, 18 August 2022, 22 [215]; Statement of Patrick Ryan, 18 August 2022, Annexure PR-56 (Email from Patrick Ryan to 'Digby', 6 December 2019).

1141 Statement of Patrick Ryan, 18 August 2022, Annexure PR-56 (Email from Patrick Ryan to 'Piers', 22 November 2019).

1142 Statement of Nurse Unit Manager, Ashley Youth Detention Centre, 11 November 2022, 35–36 [151].

1143 Statement of Nurse Unit Manager, Ashley Youth Detention Centre, 11 November 2022, 35–36 [151].

1144 Statement of Nurse Unit Manager, Ashley Youth Detention Centre, 11 November 2022, 35–36 [151].

1145 Statement of Nurse Unit Manager, Ashley Youth Detention Centre, 11 November 2022, 33 [144].

1146 Statement of Nurse Unit Manager, Ashley Youth Detention Centre, 11 November 2022, 33 [144].

1147 Statement of Nurse Unit Manager, Ashley Youth Detention Centre, 11 November 2022, 39 [169].

1148 Statement of Director of Nursing, Statewide Forensic Mental Health Services, Department of Health, 3 November 2022, 18 [99].

1149 Statement of Greg Brown, 28 November 2022, 32 [93–94], 33 [95–96]; Greg Brown, *Procedural Fairness Response*, 17 July 2023, 13 [66].

1150 Statement of former Head of Department, Forensic Mental Health Services, Department of Health, 6 September 2022, 16 [76].

1151 Statement of Patrick Ryan, 18 August 2022, Annexure PR-56 (Email from Patrick Ryan to 'Piers', 22 November 2019).

1152 Transcript of Barry Nicholson, 19 August 2022, 2929 [26–34].

1153 Transcript of Barry Nicholson, 19 August 2022, 2930 [2–12].

1154 Statement of 'Alysha', 16 August 2022, 27 [132].

1155 Statement of 'Alysha', 16 August 2022, 27 [134].

1156 Statement of 'Alysha', 16 August 2022, 33 [167].

1157 Letter from Psychologist, Ashley Youth Detention Centre to Patrick Ryan, 15 November 2019, 3, produced by the Tasmanian Government in response to a Commission notice to produce.

1158 Letter from Psychologist, Ashley Youth Detention Centre to Patrick Ryan, 15 November 2019, 3, produced by the Tasmanian Government in response to a Commission notice to produce.

1159 Statement of 'Alysha', 16 August 2022, 28 [135].

1160 Statement of 'Alysha', 16 August 2022, 28 [136].

1161 Statement of 'Alysha', 16 August 2022, 28 [137], 29 [142–143].

1162 Statement of 'Alysha', 16 August 2022, 29–30 [144].

1163 Statement of 'Alysha', 16 August 2022, 31 [154–155].

1164 Statement of 'Alysha', 16 August 2022, 30 [147].

1165 Statement of 'Alysha', 16 August 2022, 30 [147].

1166 Statement of 'Alysha', 16 August 2022, 30 [148].

1167 Statement of 'Digby', 8 August 2022, 24.

1168 Statement of 'Piers', 15 August 2022, 30 [103(d)].

1169 Statement of 'Piers', 15 August 2022, 30 [103(d)].

1170 Statement of Patrick Ryan, 18 August 2022, 24 [225–226], [228].

1171 Statement of Patrick Ryan, 18 August 2022, 24 [228].

1172 Statement of Patrick Ryan, 7 September 2022, 24 [227].

1173 Statement of Patrick Ryan, 7 September 2022, 24 [228].

1174 Statement of 'Alysha', 16 August 2022, 30 [149].

1175 Department of Communities, 'CARDI Conversation Summary Report in relation to [Henry]', 25 March 2022, produced by the Tasmanian Government in response to a Commission notice to produce.

1176 Email from Psychologist, Ashley Youth Detention Centre to Patrick Ryan, 6 December 2019, 1–2, produced by the Tasmanian Government in response to a Commission notice to produce.

1177 Statement of Pamela Honan, 18 August 2022, 1 [1.1].

1178 Email from Patrick Ryan to Pamela Honan, 6 December 2019, produced by the Tasmanian Government in response to a Commission notice to produce.

1179 Email from Patrick Ryan to Pamela Honan, 6 December 2019, produced by the Tasmanian Government in response to a Commission notice to produce.

1180 Email from Patrick Ryan to Pamela Honan, 6 December 2019, produced by the Tasmanian Government in response to a Commission notice to produce.

1181 Email from Patrick Ryan to Pamela Honan, 6 December 2019, produced by the Tasmanian Government in response to a Commission notice to produce; Statement of Patrick Ryan, 18 August 2022, 12 [121].

1182 Statement of 'Alysha', 16 August 2022, 30 [150–151], [154–156].

1183 Statement of 'Alysha', 16 August 2022, 30 [151]; Email from Executive Officer to 'Alysha', 6 December 2019, produced by the Tasmanian Government in response to a Commission notice to produce; Statement of Pamela Honan, 18 August 2022, 23 [30.1].

1184 Email from Executive Officer to 'Alysha', 6 December 2019, produced by the Tasmanian Government in response to a Commission notice to produce.

1185 Email from 'Alysha' to Executive Officer, 6 December 2019, produced by the Tasmanian Government in response to a Commission notice to Produce.

1186 Email from Executive Officer to 'Alysha', 6 December 2019, 1, produced by the Tasmanian Government in response to a Commission notice to produce.

1187 Email from Psychologist, Ashley Youth Detention Centre to Leanne McLean, 6 December 2019; Letter from Leanne McLean to Michael Pervan, 10 December 2019, 1; Commissioner for Children and Young People, 'File Note', 6 December 2019.

1188 Email from Psychologist, Ashley Youth Detention Centre to Leanne McLean, 6 December 2019; Letter from Leanne McLean to Michael Pervan, 10 December 2019, 1.

1189 Commissioner for Children and Young People, 'File Note', 6 December 2019.

1190 Commissioner for Children and Young People, 'File Note 8/12/19 re Ashley Disclosures re Inappropriate Sexual Behaviour/Assault and AYDC Response', 8 December 2019, 1.

1191 Commissioner for Children and Young People, 'File Note 8/12/19 re Ashley Disclosures re Inappropriate Sexual Behaviour/Assault and AYDC Response', 8 December 2019, 1.

1192 Commissioner for Children and Young People, 'File Note 8/12/19 re Ashley Disclosures re Inappropriate Sexual Behaviour/Assault and AYDC Response', 8 December 2019, 2.

1193 Commissioner for Children and Young People, 'File Note 8/12/19 re Ashley Disclosures re Inappropriate Sexual Behaviour/Assault and AYDC Response', 8 December 2019, 2.

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1214 Statement of 'Piers', 15 August 2022, 30 [104(a)].

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Psychologist, Community Forensic Mental Health Service, Department of Health, 22 August 2022, 2 [8]–3 [13]; Statement of former Head of Department, Forensic Mental Health Services, Department of Health, 6 September 2022, 14 [64], 21 [110].

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1341 Statement of former Head of Department, Forensic Mental Health Services, Department of Health, 6 September 2022, 17 [85].

1342 Statement of Nurse Unit Manager, Ashley Youth Detention Centre, 11 November 2022, 4 [13]; Statement of Barry Nicholson, 18 August 2022, 6 [48].

1343 Statement of Director of Nursing, Statewide Forensic Mental Health Services, Department of Health, 3 November 2022, 4 [18].

1344 Statement of former Head of Department, Forensic Mental Health Services, Department of Health, 6 September 2022, 23 [120]–24 [124].

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1346 Statement of Michael Pervan, 27 July 2022, 47 [88].

1347 Statement of Michael Pervan, 27 July 2022, Annexure 27 ('A Memorandum of Understanding between the Correctional Primary Health Services and Children, Youth and Families - Ashley Youth Detention Centre', Department of Communities, May 2021). While this memorandum is dated May 2021, we understand there has been a memorandum in place since 2011 (Statement of Barry Nicholson, 18 August 2022, 6 [46]).

1348 Department of Communities, 'Issues Briefing to Secretary: Concern for Ashley Youth Detention Centre (AYDC) Resident [Ray] Due to Recent Incidents', 20 January 2020, produced by the Tasmanian Government in response to a Commission notice to produce.

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1360 Email from former Executive Officer, Strategic Youth Services to Quality Improvement and Workforce Development, 28 January 2020, produced by the Tasmanian Government in response to a Commission notice to produce.

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1362 Statement of Pamela Honan, 18 August 2022, 35 [59.2].

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1364 Serious Events Review Team, 'Serious Event Review Report – Review of the Matter of [Henry]', 19 March 2020, 31, produced by the Tasmanian Government in response to a Commission notice to produce.

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Commission of Inquiry into the Tasmanian Government's Responses to Child Sexual Abuse in Institutional Settings

Who was looking after me? Prioritising the safety of Tasmanian children

Volume 5: Children in youth detention
Book 2

August 2023

Commission of Inquiry into the Tasmanian Government's Responses to Child Sexual Abuse in Institutional Settings Report

Volume 5
Children in youth detention (Book 2)

The Honourable Marcia Neave AO
President and Commissioner

Professor Leah Bromfield
Commissioner

The Honourable Robert Benjamin AM SC
Commissioner

August 2023

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Please be aware that the content in this report includes descriptions of child sexual abuse, attempted suicide and self-harm, and may be distressing or raise issues of concern for some readers.

We encourage readers to exercise discretion in their engagement with this content and to seek support and care if required.

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Book 3

CHAPTER 12

The way forward: Children in youth detention

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Case study 3: Isolation in Ashley Youth Detention Centre

1 Overview

The inappropriate isolation of children and young people in detention is a breach of their human rights. It is well recognised that isolating a child or young person adversely affects their mental health and wellbeing. In recognition of the harm isolation can cause, the *Youth Justice Act 1997* ('Youth Justice Act') and Ashley Youth Detention Centre policies and procedures outline strict requirements for when isolation can be used in the Centre. It must never be used as punishment.

We heard about multiple practices at the Centre that involved at least some isolation of young people. However, these practices were not formally labelled as 'isolation' or responded to in line with the requirements for the use of isolation. Examples of the labels used were:

- routine Centre-wide 'time out' or 'quiet time'
- 'unit bound'
- 'individualised programs'

- ‘segregation’
- non-association
- the ‘Blue Program’.

As outlined below, it appears to us that at least occasionally, these isolation practices involved locking a young person alone in their unit or their room and operated outside the isolation procedures. The evidence indicates these practices also involved segregating young people for days or weeks at a time from:

- the routine of the Centre
- programs and education
- their peers.

Irrespective of the name used, and perhaps slight differences between each practice, from a child’s perspective, these were isolation practices. The effect on their mental health and wellbeing would have been the same. For this reason, we refer to these practices as isolation practices.

Often, these isolation practices were connected to the Behaviour Development System at Ashley Youth Detention Centre. As discussed in Chapter 10, the Behaviour Development System (now known as the Behaviour Development Program) is an incentive-based behaviour management protocol that allocates privileges or restrictions to a young person based on a colour coding—green, yellow, orange or red—that corresponds with their level of ‘good’ or ‘bad’ behaviour as judged against a set of criteria. As described in Chapter 10 and below, isolation practices were often used with ‘bad’ colour ratings corresponding to ‘bad’ behaviour.

The inappropriate use of isolation practices over many years speaks to organisational factors the National Royal Commission identified as relevant to the risk of child sexual abuse in youth detention. We discuss these factors in Chapter 10, but particularly relevant in this context are:

- the use of strict rules, discipline and punishment
- cultures of disrespect for children
- cultures of humiliating and degrading treatment of children
- cultures where children’s voices are not encouraged, and their welfare is not prioritised
- group allegiance among staff and among managers.[1531]

When isolating young people at Ashley Youth Detention Centre is unauthorised, unregulated and unreported, the risk of, and opportunities for, the physical and sexual

abuse of young people increases. Such belittling and dehumanising practices also reduce the likelihood of children and young people making disclosures of child sexual abuse because their sense of what is right and wrong, trust in adults at the Centre, and self-worth have been undermined.

We also heard about other forms of isolation—such as 'restrictive practices' and 'lockdowns'—that involved all children in the Centre being restricted to their units or rooms for operational reasons. These practices were often a result of staff shortages rather than targeted actions to manage specific children. We are conscious these practices are isolation by another name, are human rights abuses, and have the same impact as other isolation practices on children's health and wellbeing, although we do not address them in this case study. We discuss our concerns about staff shortages and our recommendations for increasing staffing numbers in Chapter 12.

In this case study, we briefly summarise the law and policies relating to isolating children and young people in detention, highlighting that the use of isolation is intended to be strictly regulated and monitored. We then outline what we heard about detainees' experiences of isolation, drawing from the victim-survivor accounts we provide in Case study 1. We then discuss how various forms of isolation practices were adopted over many years at Ashley Youth Detention Centre, often, we suspect, with the knowledge of Centre management, the Department, and the Tasmanian Government at the time. We conclude with several findings about the inappropriate isolation of children and young people at the Centre, namely that:

- the use of isolation as a form of behaviour management, punishment or cruelty and contrary to the Youth Justice Act has been a regular and persistent practice at Ashley Youth Detention Centre since at least the early 2000s, and the conditions that enabled this practice still exist today
- the Department, and sometimes the Tasmanian Government, have been on notice about potentially unlawful isolation practices at Ashley Youth Detention Centre since at least 2013, and have not taken sufficient action
- there was a consistent failure to include the voices of children and young people detained at Ashley Youth Detention Centre in any reviews, investigations or policy changes relating to isolation
- Ashley Youth Detention Centre and the Department failed to support children and young people in detention who were subjected to isolation practices.

This case study covers a series of concerning allegations against Ashley Youth Detention Centre staff. We acknowledge there have been and are staff at the Centre who have sought to do their jobs lawfully and appropriately. References to problematic practices by 'staff' in this case study are not intended as a reference to all staff at the Centre, unless explicitly stated in a specific context.

2 The law and policies

As outlined in Chapter 10, disciplinary measures involving 'placement in a dark cell, solitary confinement or any other punishment that may compromise the physical or mental health or wellbeing of the child' violate article 37 of the United Nations Convention on the Rights of the Child and are strictly prohibited.[1532]

The Youth Justice Act and Ashley Youth Detention Centre's isolation policy, the *Use of Isolation Procedure* dated 1 July 2017 ('Isolation Procedure'), recognises the seriousness of isolating a child or young person by limiting the practice to certain situations.[1533] Overall, these instruments show there are strict requirements for subjecting a child to isolation in the Centre to protect them from the harm this practice causes. We understand similar strict requirements have existed in previous iterations of isolation procedures. In this section, we outline the requirements set out in these instruments as context for the isolation practices discussed in subsequent sections. We also show that when practices that amount to isolation are not recognised as such, these protections are not provided to children and young people in detention.

The Youth Justice Act defines 'isolation' as 'locking a detainee in a room separate from others and from the normal routine of the detention centre'.[1534] What constitutes the 'normal routine' of a detention centre is not defined in the Youth Justice Act. Tasmanian courts have not substantively considered it.

Combined, the Youth Justice Act and the Isolation Procedure provide that:

- Isolating a detainee is only permissible if their behaviour poses an immediate threat to the safety of themselves, another person or property, or it is in the interest of the security of the Centre, and when all other reasonable steps have been taken to 'prevent the harm'.[1535] Isolation as a form of punishment does not satisfy one of these purposes.
- Isolation should be for the 'minimum time necessary to ensure the safety of individuals or property', with a goal of reintegrating the young person 'into the group as safely and as quickly as possible'.[1536]
- There are strict requirements about who in the Centre can authorise isolation, being the Centre Manager or their delegate, and for what time periods.[1537]
- There are strict requirements for the level of supervision and observation of children and young people in isolation.[1538]

Below, we discuss several occasions where isolation or related practices were used in response to Centre-wide 'incidents'. The Isolation Procedure offers examples of situations where isolation might be authorised in the interests of Centre security. These examples include:

- to prevent or control a security breach, including incidents such as, but not limited to:
    - a riot
    - a power failure
    - a perimeter breach
    - an escape or attempted escape
- to allow order or control to be restored to the Centre (or to prevent its anticipated loss).[1539]

These examples suggest that isolation must only be used in the interests of the security of the Centre in the most serious of situations. The Isolation Procedure explains that such incidents 'may result in more than one young person requiring isolation at a time, or the entire Centre being locked down'.[1540]

The Isolation Procedure requires that an authorisation of isolation must be given at the time the decision to isolate the young person is made; that is, not before the decision, afterwards, or on the condition that certain events occur.[1541] The Centre Manager must be satisfied 'that isolation is a reasonable intervention under the circumstances', and that its use will comply with both the Youth Justice Act and the Isolation Procedure.[1542] The Centre Manager must assess and determine the conditions for the care and treatment of the young person while in isolation. They must also consider the particular needs and circumstances of the child or young person.[1543]

The Centre Manager sets the conditions of isolation, including the period of isolation and the observation schedule.[1544] Other conditions may include specifying items that are safe and therapeutic to be left with the young person, for example, 'playing cards, reading material or drawing material', and access to a support person, cultural advisor, or youth worker.[1545]

Once isolation is authorised, the Operations Coordinator at the Centre must ensure, among other things, the young person is advised:

- why they are being isolated
- their period of isolation
- how they can seek help while they are isolated.[1546]

The Youth Justice Act does not prescribe a maximum period of isolation. The Isolation Procedure sets out tiered maximum isolation periods. It requires the Centre Manager to 'seek to set the shortest period of isolation that is appropriate in the circumstances'.[1547] The Isolation Procedure prescribes the following periods of isolation:

- an initial period of no more than 30 minutes, which an Operations Coordinator can authorise
- an extension of the initial period to three hours (including the first 30 minutes), which the Centre Manager (or their delegate) must authorise.[1548]

The Isolation Procedure allows for the period of isolation to be extended to a maximum of 12 hours.[1549] To extend isolation beyond three hours, the Centre Manager must:

- review the observation records prepared during the isolation period
- consult with the Correctional Primary Health Services nurse and/or medical practitioner and available members of the Multi-Disciplinary Team
- consult with the Director, Strategic Youth Services on the outcome of the discussion with the Correctional Primary Health Services nurse, medical practitioner and/or Multi-Disciplinary Team members[1550]
- complete the 'Authorisation for Extension of Isolation' form, noting any new conditions of the isolation or change to conditions.[1551]

The Youth Justice Act and the Isolation Procedure require the Centre Manager to set a schedule for observing young people in isolation, with observations to occur at intervals of no more than 15 minutes.[1552] The Isolation Procedure requires shorter intervals where there are particular concerns about a young person's wellbeing.[1553] For example, young people who may be at risk of self-harm must be subject to observation intervals in line with the relevant suicide and self-harm procedure.[1554]

At the time of the 2019 roof incident that we discuss later in this case study, the relevant instrument of delegation provided that the power to isolate a detained young person under section 133(2) of the Youth Justice Act (and therefore to extend the period of isolation) was delegated to the Operations Manager or the Director, Strategic Youth Services, only 'if the Detention Centre Manager is on leave, is uncontactable, or is unable for any other reason to perform the relevant function'.[1555] The Operations Coordinator and youth workers 'performing the duties of the Operations Coordinator' also had the power to isolate a detained young person for up to 30 minutes (but no more).[1556]

In 2021, the delegation instrument was revised. The most critical change regarding isolation was that the Assistant Manager could exercise, without any conditions, the Centre Manager's power to isolate a young person under section 133(2) of the Youth Justice Act.[1557]

In addition, the Isolation Procedure places obligations on the staff member(s) observing the isolated young person, including to:

- speak to the young person
- assess whether their mental health has deteriorated

- assess if the young person still poses an immediate threat to themselves, others, or the security of the Centre
- record their observations.

If circumstances change, they must take appropriate steps.[1558] Any engagement between the young person and the observing staff member(s) does not bring the isolation period to an end or restart the time limits.[1559]

Consistent with the legislative requirement that isolation only be used as a short-term tool to address immediate safety or security concerns, the Isolation Procedure requires consideration to be given to ending isolation as soon as the young person's behaviour has sufficiently settled, or isolation is no longer necessary in the interests of the security of the Centre, irrespective of the set isolation period.[1560]

At the end of a period of isolation, the Operations Coordinator must check the 'Authorisation for Isolation Form' to determine what post-isolation conditions have been set.[1561] If considered necessary, the Operations Coordinator or Centre Manager must put a post-isolation plan in place to address matters such as:

- the implementation of post-isolation conditions
- the level of observation required for the young person as they resume their normal routine
- a review of behaviour goals and strategies to prevent further periods of isolation.[1562]

Debriefings with other young people and staff should also occur if required.[1563]

The Operations Coordinator or youth worker must also inform the young person when their isolation has ended.[1564]

3 What we heard from victim-survivors about isolation practices at Ashley Youth Detention Centre

We heard evidence about isolation practices at Ashley Youth Detention Centre from young people who had been detained there, and their families. Those young people described the circumstances in which isolation was used at the Centre, the length of isolation incidents, and the conditions under which they were held in isolation. The accounts we received referred to various periods of detention during the past two decades, when individuals were aged between 11 and 17 years. As noted earlier, it was not possible for our Commission of Inquiry to test the veracity of all allegations of abuse, but we identified many common themes in the accounts we heard.

Some experiences shared by victim-survivors included their recollections of:

- different degrees or kinds of isolation, ranging from being held in a cell alone to being confined to a unit[1565]
- long periods of isolation, including for several weeks[1566]
- inappropriate isolation used for a range of reasons, including as part of the induction process, as punishment for bad behaviour or self-harm, against victims of assault or as retribution for making complaints[1567]
- being isolated, or isolating themselves, to keep themselves safe from other young people[1568]
- poor isolation conditions, often with limited or no access to therapeutic programs, education and health care, or without appropriate bedding and sufficient food[1569]
- handcuffs and physical restraints being used to place a young person in isolation, or while they were in isolation[1570]
- isolation traumatising and confusing young people, contributing to long-term negative effects on a young person's mental health and wellbeing.[1571]

We heard that many new arrivals to the Centre were isolated as part of the induction process. Ben (a pseudonym) told us that when he first arrived at the Centre in the early 2000s, he was placed in a 'holding cell' for 72 hours of mandatory observation, where he was given only a mattress and a thin blanket.[1572] Simon (a pseudonym) told us that when he arrived at the Centre for the first time in the mid-2000s, he was locked in a cell for two days.[1573] Erin (a pseudonym), who was at the Centre in the mid-2010s, some years after Ben and Simon, described how she was 'unit bound' by herself for about a week each time she was admitted as 'part of the normal introduction', and that she was only allowed out for one or two hours per day during that time.[1574] She said this experience resulted in 'massive trauma', that now she 'can't deal with being trapped inside' and that she 'found the COVID lockdowns really hard'.[1575]

We were told that, besides being a feature of the admissions process, isolation was sometimes used to punish young people. Simon described how he was placed in isolation two or three times after committing detention offences, refusing to go to bed when directed or not listening to staff.[1576] He recalled that staff members would say he was being isolated as punishment for those behaviours.[1577]

We heard concerning evidence about isolation being used against detainees as punishment for complaining or when a young person was assaulted.[1578] Fred (a pseudonym), who first went to the Centre in the mid-2000s, described two incidents where he was 'locked down' as punishment after being assaulted by other young people. He told us this was a 'pretty normal' response to assaults.[1579] Fred said that 'several' times it was only him who was 'locked down', not those who had assaulted

him, and that he was told this was because he 'was an annoyance to the unit'.[1580] Erin also described being kept in her room because of threats of assault made against her by other young people.[1581]

Brett Robinson, who was detained at Ashley Youth Detention Centre in the late 2000s, described his experience in a similar way:

> When you were locked down, they would come in to your cell at 8.00 am in the morning, take all of your bedding away and then give it back to you at the end of the day. You were not able to do any programs or school. You weren't allowed to watch TV. They would take out any excess stuff that was considered a privilege. You'd be left with a book or two and maybe a puzzle.[1582]

Erin told us that sometimes when staff locked young people in their room over the weekend, they would make the isolation worse by disorienting them:

> They would tell you that it was six o'clock in the morning when it was actually ten o'clock. They would leave a curtain up over your door so you couldn't see the sun and didn't know what was going on around you. You'd miss out on your lunch and they wouldn't let you out of your cell until one o'clock in the afternoon. They did these things to mess with you and make your life really hard.[1583]

Some victim-survivors told us that, while in isolation in the early to late 2000s, they would often only be allowed an hour a day to make a phone call or to exercise.[1584] One witness described how, in the mid-2000s, they only had access to a bucket as a toilet.[1585] Another said, in the early to mid-2000s, staff members would first 'bash' him up before placing him in a 'freezing cold' cell.[1586]

We also heard young people were sometimes physically restrained when being placed in isolation, or once in isolation.[1587] Brett Robinson, who was first admitted to the Centre in the late 2000s said:

> I was hog tied and left in my cell, then put into lockdown. I [brought] it up in the weekly meeting. The staff responded by saying, 'If you want to misbehave, then there are steps put in place to deal with you'. When the workers who hog tied me came back on shift, they just laughed and said, 'What did you think was going to happen?'[1588]

Two witnesses told us that, after attempting suicide, they were held in isolation, were subjected to further physical or psychological abuse by guards and were not provided with any counselling assistance. Ben, who was at the Centre from the early to mid-2000s, said that after stealing medical supplies with other young people and attempting suicide, he was stripped naked, flogged and 'locked down on 23-hour-a-day lockdowns for weeks on end'.[1589] Ben recalled that, once he was released from lockdown, he was on and off the 'non-association program', which meant being locked down for 23 hours a day with a book, pen, pad, mattress and bedding.[1590]

Charlotte (a pseudonym), who was first admitted to the Centre in the early 2000s, told us that, after a confrontation with a staff member at the Centre, she was locked in her cell for four days.[1591] At the start of her isolation, she set her cell on fire and attempted suicide. She recalled:

> After about 10 minutes the room filled up with smoke … The sprinklers went off, but no one came for ages. Then they just opened the viewing panel in the door. They could see me in the shower with blood on my arms and just left me there. I was in that room alone for 4 days … I got water and toast for tea. I was wet from the sprinkler … I didn't have any bedding. I had to wear the wet, burnt, smelly clothes. When they finally came to get me a few days later they … stripped me down to nothing with 2 female staff. … Then they finally gave me some clothes and left me alone again all night until the next day. Then I was sent back to the unit and locked down for a week …[1592]

Charlotte said she was upset, hungry and confused during her isolation and again attempted suicide.[1593]

We heard of a family member's perception that her attempts to limit the use of isolation practices on her child seemed to make things worse for him. Eve (a pseudonym) described how her son Norman (a pseudonym), who was first admitted to the Centre in the early 2010s, was 'in lockdown all the time', with limited exercise and sunlight.[1594] She was concerned these practices were having a negative effect on Norman's mental health.[1595] Eve said trying to raise the issue with management at the Centre appeared to have negative consequences for Norman. One such consequence was being placed on frequent self-harm observations.[1596]

These accounts were deeply troubling to us, particularly given the consistency across accounts and the patterns that emerged, because they suggested that during the early 2000s to at least the mid-2010s, unlawful and harmful isolation practices were part of how children and young people detained at the Centre were commonly treated.

4 Practices that involve isolation

Two of the most common isolation practices we heard about that operated outside the formal policy framework for isolation at Ashley Youth Detention Centre were 'unit bound' and the 'Blue Program'. We heard about these isolation practices, which often operated outside the policy framework, being used up to early 2020 (noting we also heard about restrictive practices for operational reasons, which amount to isolation, due to the COVID-19 pandemic and staff shortages from 2020 to 2023).

4.1 The practice of 'unit bound'

The unit bound practice appears to have a long history at Ashley Youth Detention Centre. However, we could not identify a specific policy on unit bound or any formal definition of the practice.

We received confusing evidence about what constituted unit bound. One long-term staff member told us the unit bound practice was governed by a 'combination' of policies and procedures.[1597] Two other long-serving staff members told us the policy that governed the Behaviour Development System also governed the use of the unit bound practice.[1598] Madeleine Gardiner, former Manager, Professional Services and Policy at Ashley Youth Detention Centre, said she was 'not aware' of a specific policy relevant to unit bound, and the practice appeared to be based on a 'case-by-case' assessment of the security risk associated with the young person being in the shared areas of the Centre.[1599]

We put a series of questions to past and present staff of the Centre about the:

- rationale or criteria for the use of the unit bound practice
- nature of its operation
- difference between being unit bound and being in isolation under the Centre's Isolation Procedure.

The responses we received were, at best, inconsistent.

In her evidence to us, Fiona Atkins, Assistant Manager, Ashley Youth Detention Centre, described the unit bound practice as a temporary response to a young person's escape risk, that is, where they had attempted to escape, actually escaped or said they intended to escape from the Centre.[1600] This rationale was echoed by some other Centre staff.[1601] Another staff member described a sliding scale of risk. They said a young person would be isolated in their room when they presented as a risk to themselves, others or the Centre, but the unit bound practice would be used in cases of lesser risk, where separating a young person from others was still considered necessary for safety.[1602] Another staff member said repeated threats or attempts to assault other young people were identified as possible reasons for using the unit bound practice.[1603]

We understand a decision to place a young person on unit bound was usually made by the Centre Support Team at the Centre.[1604] Ms Gardiner said the decision to put a young person on unit bound was made by the Operations Manager, the Centre Manager, the Operations Coordinator, or the Centre Support Team.[1605] The Centre Support Team also decided a young person's rating under the Behaviour Development System, either during weekly meetings or at ad hoc interim meetings.

In terms of the practical operation of the unit bound practice, Ms Atkins said being unit bound meant the young person had access to unit-based activities, underpinned by an 'individualised program' prepared by a program coordinator.[1606] It appears the nature and content of any 'individualised program' was a matter of discretion. There was a degree of inconsistency in the evidence we received as to the extent to which the young person would have access to common areas of the unit, Ashley School, the gym and outdoor areas.[1607]

Samuel Baker, Principal of Ashley School, told us that a young person's colour level (sometimes referred to as status or rating) on the Behaviour Development System affected the number of hours of face-to-face schooling they received each day, and the nature and content of that schooling. He said young people who were unit bound due to a red colour rating could not attend woodwork, art and 'fit gym'—because equipment in those classes could be used as a weapon—but could continue to attend all other classes.[1608] Those young people were required to remain unit bound when school activities, such as woodwork, were scheduled.[1609] We also heard from staff at the Centre that young people who were unit bound were not permitted to attend school until they agreed to not behave in the ways that caused them to be placed on unit bound.[1610]

There was a lack of clarity in responses about the degree to which young people who were unit bound were physically isolated from their peers. Pamela Honan, Director, Strategic Youth Services, described the unit bound practice as one 'where a young person is allowed out of their room but they are still contained within the confines of a locked unit'.[1611] Ms Honan acknowledged she was unclear whether young people on unit bound were allowed to associate with other young people within the confines of the unit. She agreed the unit bound category appeared to be 'a form of isolation by another name'.[1612] Ms Gardiner was more certain in her characterisation. She contended that unit bound involved 'isolating people from the general routine of the Centre' or the 'general activities of the Centre', as well as from their peers.[1613]

4.2 The Blue Program

We understand that from early 2011 to December 2013, Ashley Youth Detention Centre had what was commonly referred to as a Blue Program.[1614] It was also formally reintroduced for a short period (at least three months) in 2019 with the knowledge of the Department (refer to Section 9 of this case study). As will become apparent throughout this case study, the Blue Program appears to have been adopted informally at other times, possibly as the unit bound practice.

One version of the Behaviour Development System (dated 2013) referred to the blue category in that system as 'full segregation' and outlined that:[1615]

> This colour level is for those young people who are unable to function under the normal provisions of the BDS [Behaviour Development System] and require an intensive level of supervision, such as full segregation from other young people. Refer Intensive Support Program ISP …
>
> Young people on this level would currently pose an immediate threat to the security and safety of the Centre including both staff and young people. This would include such things as attempt[ed] or complete absconding, assaultive behaviour, possession of a lethal weapon or facsimile of a lethal weapon or persistent history of contraband possession and/or use. Their behaviour may also be considered to be a primary source of inciting other young people to behave in a way that is subversive and/or disruptive to the order of the Unit/Centre.[1616]

Evidence received from staff at the Centre suggests the Blue Program involved at least some form of isolation. At our public hearings, Sarah Spencer, a youth worker at Ashley Youth Detention Centre, acknowledged the Blue Program 'involved a lot of isolation'.[1617] One staff member told us that a young person on the Blue Program was 'in isolation for up to [eight] hours at a time'.[1618]

Some previous staff told us the Blue Program and 'unit bound' were essentially the same practice. However, it is important to note that unit bound practices were not limited to periods when the Blue Program was officially in operation. As Ms Gardiner explained:

> My understanding is that 'Unit Bound' and being on colour 'Blue' on the [Behaviour Development System] was the same, which I learnt from an email from Patrick Ryan [Centre Manager] on [4 September 2019] … that was a response to the Commissioner for Children explaining that for a young person to be 'Unit Bound' was part of the Blue colour of the Behaviour Development System (BDS). This definition of Blue and 'Unit Bound' was never communicated clearly to myself until this time. My understanding and observation of the 'Unit Bound' or 'Blue colour' was that a young person was not in isolation but was confined to the unit for parts of the day, they did not participate in the general activities of the Centre, and they received individual timetabling of activities. I understood that the young person was escorted to use the gym or other areas of the Centre, when it was possible to do this, to ensure the safety of the Centre was not compromised. I am not completely clear on the parameters of 'Unit Bound' practices, as there was no policy/procedure at the time regarding a detainee being 'Unit Bound' and as can be seen in the response to the Commissioner for Children, this practice was used at the discretion of the Centre Manager, to maintain safety and security of the Centre.[1619]

Alysha (a pseudonym), former Clinical Practice Consultant, who started working at Ashley Youth Detention Centre after the Blue Program ceased official operation (for the second time) in 2019, noted that staff continued to conflate the Blue Program with the unit bound practice.[1620] Alysha observed that:

> Whilst the blue category was not part of the systems practice manual while I was at the Centre, it was regularly referred to and seemingly accepted as a standard practice despite occasionally being acknowledged as something that should

> not be said. I was present at [Centre Support Team] meetings where Operations staff would discuss putting children 'on the Blue Program'. It would be noted that 'we can't say that anymore', so the meeting minutes would reflect that the child was either 'unit bound' or on an 'individual support program'. [1621]

Ms Spencer also told us staff referred to the Blue Program, even though it was not officially in operation. When asked if the Blue Program was reintroduced in 2019, she said:

> I don't know that I'm officially aware of that. I don't think so. As in, how recent? …
>
> I don't think so. I think there was some isolation around a riot, but I don't believe that it was an official Blue Program. People around the Centre may have used that word just because that's what they related it to because of their previous history, but I don't think it was officially called that, I think it was just in regards to managing these particular young people that had a pretty serious riot.[1622]

5 Concerns raised about the Blue Program in 2013

On 12 September 2013, Deputy Chief Magistrate Michael Daly delivered judgment in the case *Lusted v ZS*.[1623] The judgment included significant criticism of the operations of Ashley Youth Detention Centre, in particular the use of isolation and similar practices. Following the sentencing of the young person in that case (referred to as 'ZS' or 'Z') for assaulting a staff member at the Centre, Deputy Chief Magistrate Daly thought it appropriate and necessary to make further comments regarding Z's experiences at the Centre while on remand. The need for these comments arose because during proceedings, Z disclosed he had been locked in his room for three weeks as punishment for destroying property.[1624]

The comments of Deputy Chief Magistrate Daly in *Lusted v ZS* are relevant to the use of isolation and similar practices at Ashley Youth Detention Centre. Deputy Chief Magistrate Daly expressly stated in *Lusted v ZS* that the Court's understanding of 'the colour scheme' (being the Blue Program and the Behaviour Development System) was minimal.[1625] The Court received no information of 'practical value' about the system beyond the experiences of the young person in question in the case.[1626] However, Deputy Chief Magistrate Daly noted it would be a 'very serious issue of grave concern' if a young person had been isolated outside the 'strict provisions of [section] 133' of the Youth Justice Act.[1627]

Deputy Chief Magistrate Daly issued a series of questions to the then Secretary of the Department on 26 July 2013 about whether Z's experiences at the Centre may have constituted abuse or neglect.[1628] These questions related to factual issues, such as whether Z had been confined to his room and the circumstances of that confinement, and clarification about whether that confinement and the Blue Program constituted isolation for the purposes of the Youth Justice Act.[1629]

Child Protection Services, on behalf of the Secretary, responded to these questions on 30 July 2013. Part of its response was as follows:

> [The Blue Program] does not involve the isolation of a young person. Neither is it a punishment. It is a Program put in place where a young person is able to function under the normal provisions of the Behaviour Development System and requires an intensive level of supervision and support. It may limit the access for the young person involved to some areas of the facility and it may involve periods of segregation from other residents.[1630]

It is apparent to us that the response did little to clarify the specific experiences of Z or the broader issue. The response appears to suggest that because the Blue Program was part of the Behaviour Development System, which was part of the 'routine' of the Centre, a young person under the Blue Program was not in isolation. The response provided no clarification on what meaningful distinction, if any, existed between confinement or 'segregation' of a young person under the Blue Program in response to adverse behaviours and the use of isolation as punishment. Indeed, after seeking further clarification, to which the Department provided no response, Deputy Chief Magistrate Daly stated in his judgment that the Secretary's initial response was 'so vague that it was of no practical value' and 'wholly inadequate'.[1631]

Consequently, Deputy Chief Magistrate Daly said in his decision that:

> In relation to Z's isolation, for the purposes of this exercise it is open to me to conclude that what happened to Z while in the custody of the Secretary was that he was placed in isolation in a manner unauthorised by the *Youth Justice Act 1997*, [section] 133. Further, on the material before me, I fear that unauthorised isolation may [be] a normal part of the management of youths in detention or on remand.[1632]

Deputy Chief Magistrate Daly was further critical of the Secretary's approach to addressing concerns raised by authorities outside Ashley Youth Detention Centre regarding the use of isolation, as well as the use of practices that are substantively isolation being applied outside the statutory framework.

We note these criticisms are highly relevant to subsequent events at the Centre in the years that followed the decision of *Lusted v ZS*.

5.1 Our observations

We conclude that from 2013, the Department and, we presume, the Tasmanian Government were made aware and put on notice of isolation practices that contravened Tasmanian law and human rights principles to which Australia was a signatory, with concerns raised that these were not one-off but routine practices.

6 Concerns raised about unit bound and similar practices in 2016 and 2017

During his time as Commissioner for Children and Young People, Mark Morrissey raised the issue of isolation with the Department, including what he viewed as substantively similar practices referred to by other names.

In April 2016, in a letter to the then Secretary of the Department, Michael Pervan, Mr Morrissey raised concerns that isolation was being used as a form of punishment against young people in detention.[1633] Specifically, Mr Morrissey relayed complaints he had received from two young people in detention that they had been kept in isolation for a week as punishment for their involvement in an incident at the Centre.[1634] In the letter, Mr Morrissey expressed his clear disapproval of the practice. He stated that it 'would be reasonable to conclude' that the young people had been isolated 'contrary to various international and national standards'. He also noted that concerns about isolating young people in detention had previously been raised in 2013 (in relation to the isolation of Z, discussed above).[1635]

Later in April 2016, a Minute to the Secretary with the subject line '[Ashley Youth Detention Centre] – Commissioner for Children letter and emerging concerns' was drafted by staff in Children and Youth Services and provided to Secretary Pervan. Secretary Pervan approved the Minute on 6 May 2016.[1636] The Minute noted that:

- the Commissioner for Children and Young People had formally advised the Secretary of concerns relating to the use of isolation as a punishment at Ashley Youth Detention Centre
- the Deputy Secretary, Children and Youth Services, had previously raised concerns surrounding staff capability at the Centre
- the Director, Services to Young People (this role later became Director, Strategic Youth Services), had also recently identified major challenges at the Centre, including in relation to the culture of the Centre, which was considered to influence how staff members responded to the behavioural issues of young people in detention.[1637]

In the Minute, Secretary Pervan was advised that the then Deputy Secretary and Director had undertaken an informal preliminary assessment of the matters raised by the Commissioner for Children and Young People, and 'consider[ed] it likely that the claims of the children and the concerns of the Commissioner are accurate'.[1638] Further, the then Director had determined that:

- many staff at Ashley Youth Detention Centre had been in their roles 'in excess of 15 years'

- there was a negative culture at the Centre, with some staff subscribing to a punitive approach when dealing with young people
- the delivery of therapeutic care to young people, and adherence to their human rights, had not evolved at the Centre so as 'to meet the requirements of a modern detention centre and community expectation'
- the Centre's internal complaints mechanism framework was inefficient, not transparent, and did not include a formal register or a review process for complaints.[1639]

The Minute appeared to suggest considerable concern about the practices of current staff. It recommended with some urgency, that a 'profiling of required skill base' for staff be undertaken with human resources involvement 'to ensure rules surrounding staffing and any profiling of positions affords natural justice and procedural fairness and are undertaken in line with rules of the State Service'.[1640] We infer from these statements that the authors were recommending an effective spill of staff positions, which is an exceptional recommendation for a Deputy Secretary and a Director within a Department to make. The Minute also recommended establishing an ongoing mandatory training calendar.

The Minute stated the issues identified regarding isolation practices 'have remained embedded at [the Centre] for a significant period' and that '[c]onsistent concerns have been raised over a number of years, by a number of stakeholders'.[1641] The Minute stated that in June 2013, the Secretary at that time had instigated a 'Taskforce' for Ashley Youth Detention Centre to identify and implement changes that would 'improve the day to day lives of the young detainees'. The Minute stated that the Taskforce made 16 recommendations, including 'removing "quiet time" for residents twice a day where they are confined to their room'.[1642]

The Minute further noted that in 2015, a review into the governance and management arrangements at the Centre identified shortfalls in leadership, culture and the capacity of staff.[1643] In response to the review, the Government had agreed to multiple actions, including that the practice of 'Time Out'—which the Minute stated 'equates to Isolation at law'—be ceased, and that staff at the Centre were to 'work across teams when requested to do so rather than working solely in the allocated smaller team groups'.[1644]

The Minute recommended that Secretary Pervan approve and resource an immediate 'change management process' at the Centre to introduce a therapeutic model and associated training for staff, as well as new governance structures to ensure the Centre's operations met legislative requirements.[1645]

The Minute further recommended to Secretary Pervan that immediate action be taken to:

- review policies and procedures relating to 'time out', isolation and behaviour management in line with best practice across other jurisdictions, legislative requirements, and requirements under various national and international human rights treaties and conventions
- consider a formal change management model to help Centre staff understand where '[d]etention in Tasmania needs to move to'
- review and amend the internal complaints framework to direct all complaints from young people to the then Director in the first instance, who could record complaints in a formal register and review and monitor systemic issues at the Centre
- develop a formal register in relation to incidents of isolation to ensure compliance with the law
- investigate whether young people in detention were receiving the same level of education as young people engaged in mainstream education
- develop programs that create pro-social pathways after school hours and on weekends for young people in detention
- implement outstanding actions from previous reviews relevant to the treatment of young people in detention.[1646]

The Minute concluded that, should immediate efforts to reform the Centre not occur, there was a significant risk to the reputation of the Department and the Minister, as well as a 'strong prospect of litigation for human right breaches or failures to comply with legislative obligations'.[1647] The Minute emphasised to the Secretary that:

> Without purposeful effort to support true quality of care in detention for the youth of Tasmania under strong and contemporary leadership, it is unlikely that significant change requirements could succeed.[1648]

We note that, in an undated letter to Mr Morrissey in response to issues raised in his letter of 6 April 2016, Secretary Pervan did not substantively address the issue of isolation. Secretary Pervan observed the matters raised in Mr Morrissey's letter were not isolated incidents but likely to be 'systemic and embedded within all interactions between the staff and young people'.[1649] In his letter to Mr Morrissey, Secretary Pervan did not relate the Department's observations there were likely human rights breaches occurring at the Centre. We consider this a missed opportunity to transparently recognise the potential harm being done to children and young people at the Centre. Such recognition and engagement are important to enable a Commissioner for Children and Young People to perform their function appropriately.

On 9 November 2016, Mr Morrissey emailed the Acting Deputy Secretary, Children and Youth Services, and other departmental officials after reviewing the Ashley Youth Detention Centre daily roll and noticing two young people were listed as 'unit bound'.[1650] Mr Morrissey sought clarification regarding the conditions the young people experienced while being unit bound, particularly whether they were locked in their rooms, separated from other young people (young people who were in the same unit and in the Centre more broadly), excluded from school or other programs and made to eat meals separately.[1651]

On 10 November 2016, the Acting Deputy Secretary, Children and Youth Services replied to Mr Morrissey, stating the term 'unit bound' was used to describe the placement of a young person on a 'separate routine'.[1652] A separate routine was defined in the Ashley Youth Detention Centre Standard Operating Procedure as follows:

> A young person may be placed on a Separate Routine where their behaviour presents a risk to others or to the security of the Centre but which can be managed without resort to isolation. It may involve restrictions on contact with other specific young people or certain programs and areas of the Centre. It may also entail closer supervision and/or restriction to a particular Unit. This strategy can be used to deal with risks such as threats of harm to self and others, threats of escape and subversive and inciting behaviour. A Separate Routine can only be approved by the [Centre Support Team] or [Interim Centre Support Team], must be reviewed at least twice a week and must be discontinued as soon as the level of risk permits.[1653]

The 10 November 2016 response to Mr Morrissey noted the terms 'unit bound', 'separate routine' and 'individual program' were often used interchangeably, and they had not 'been considered a form of isolation as a Youth Worker is always present'. However, the response noted other jurisdictions had interpreted being separate from other children and young people in detention to be isolation.[1654] The Acting Deputy Secretary, Children and Youth Services noted:

> At this stage Individual Programs provide [Ashley Youth Detention Centre] staff with the flexibility to manage quite challenging behaviours, safely, without resorting to isolation. As more work is done to increase the range of therapeutic responses available to staff, the need for Individual Programs delivered as a Separate Routine will be reviewed.[1655]

The Acting Deputy Secretary, Children and Youth Services further observed that, at that time, a revised policy regarding isolation was being prepared for the Centre, which would require a 'significant amount of policy work' to define 'normal routine', including 'separate routine' and 'induction routine'.[1656] He invited the Commissioner for Children and Young People's involvement in this process.

On 11 November 2016, Mr Morrissey wrote to the then Minister for Human Services, copying in Secretary Pervan. This letter addressed several issues, including the use of isolation at Ashley Youth Detention Centre and the Commissioner for Children and Young People's 'concerns about a lack of clarity around what isolation is and around the current legislative prohibition on its use as a punishment'.[1657]

Mr Morrissey noted that, at Ashley Youth Detention Centre:

> ... there may be a view that if a young person is locked up with a youth worker, then, regardless of anything else, that will in and of itself negate categorisation of treatment as isolation. I have indicated my disagreement with such an approach.[1658]

Mr Morrissey expressed the view that a practice should be considered isolation if a young person was separated *from other young people* and from the normal routine of the Centre.[1659] He supported this view by referring to the approach taken in Victoria, where legislation defined isolation in similar terms to the Youth Justice Act.

Mr Morrissey was similarly direct in expressing his concern about the Centre's 'resort to practices similar to if not identical to isolation but which are referred to by other terminology'.[1660] He noted the need to clarify different, seemingly interchangeable terms such as 'unit bound', which may amount to isolation where a young person was the sole occupant of the unit to which they were confined.[1661]

On 18 November 2016, Secretary Pervan responded to Mr Morrissey's concerns, copying in the Minister for Human Services.[1662] Secretary Pervan stated:

- procedures at the Centre relating to restrictive practices, including isolation, were under review
- the draft revised Isolation Procedure had 'a much greater focus on isolation as a prohibited action, except for in very specific circumstances'
- isolation should be a 'last resort'.[1663]

He indicated the use of isolation was, at least partially, a result of a lack of therapeutic responses:

> As more work is done to increase the range of therapeutic responses available to staff it is expected that the use of isolation as a strategy to manage unsafe behaviours should reduce. To this end, staff have undertaken refresher training in Non Violent Crisis Intervention (NVCI) and are currently participating in Trauma Informed Care training.[1664]

Secretary Pervan's response also acknowledged Mr Morrissey's concerns regarding practices that are 'similar to isolation, but which are referred to by other terminology' and referred to the 'work' to define 'normal routine and separate from others', including potentially needing to make legislative changes.[1665] The response did not substantively address Mr Morrissey's concern that isolation may be used under a different name and with significantly fewer protections in place to prevent harm to young people in detention.

On 4 January 2017, Mr Morrissey again emailed the Acting Deputy Secretary, Children and Youth Services (copying in Secretary Pervan) seeking clarification regarding a complaint from a young person at the Centre about isolation practices.[1666]

Mr Morrissey stated it appeared the young person was, in effect, being held in isolation despite such isolation being alternatively defined as 'unit bound', and that this was causing 'significant distress':

> I have been provided with a copy of [the young person's] individual program and note that he is unit bound—he takes his meals in the Unit, does not participate in the normal routine of the Centre and does not mix with any of the other boys. He is the sole resident of his Unit …
>
> If [the young person] is being kept separate from the normal routine and from the other detainees, please advise how this does not amount to 'isolation' as defined in the new Procedure governing Isolation …[1667]

The Acting Deputy Secretary, Children and Youth Services responded later the same day.[1668] Beyond providing details of the individual young person's circumstances (the young person had rejoined regular programs at the Centre that day), he disagreed the circumstances constituted isolation but did not elaborate on why.[1669] The Acting Deputy Secretary did note the 'individual program' standard operating procedures and arrangements would need to be reviewed.[1670]

On 11 January 2017, Mr Morrissey again emphasised in an email to the Acting Deputy Secretary, Children and Youth Services that, in his view, these practices constituted isolation:

> I believe that what is occurring is actually isolation, based on the content of the revised SOPs [Standard Operating Procedures]. My reason for saying this is that [the young person] was also on his own—essentially unit bound, separate from other detainees—and on individual program. The old SOP dealing with isolation referred to 'separate routine'—which appears to be how [the young person] was treated.[1671]

On 19 January 2017, Mr Morrissey sent another email to the Acting Deputy Secretary, Children and Youth Services regarding the same young person. It appears this young person was again being held separately from other young people at the Centre and was 'very upset and escalating'.[1672] Mr Morrissey noted he had raised 'on a number of other occasions' that isolation is 'highly counterproductive to a therapeutic approach' and 'often will directly contribute to escalating distress and behaviour issues'.[1673] His frustration at the continued practice of isolating this young person, seemingly in preference to alternative therapeutic options for de-escalating and managing behaviour, was evident from his correspondence.[1674]

6.1 Our observations

It is our conclusion that, during 2016 and early 2017, the Department and the Tasmanian Government were again made aware and put on notice of routine isolation practices that potentially contravened Tasmanian law and human rights principles to which Australia was a signatory. The Department had internally acknowledged the veracity of these concerns through the 2016 Minute, which appeared to us to be an urgent call to action from the Deputy Secretary, Children and Youth Services and the Director at the time to address routine human rights abuses the Centre.

We were deeply troubled that, despite the 2016 Minute's internal recognition that unlawful isolation practices were likely occurring, we saw no evidence of action taken to remedy the ongoing human rights abuses being perpetrated against the young person for whom Mr Morrissey had repeatedly advocated. The Department failed to act in the best interests of this young person and any other children subjected to potentially unlawful isolation practices during this period.

We note some in the Department appeared to take the view that the reference to 'separate from others' in relation to isolation under the Youth Justice Act meant that a young person in detention would not be in isolation if a youth worker was present. We share Mr Morrissey's view that 'separate from others' should be taken to mean separate from other young people in detention, particularly given that Victoria adopted this approach in relation to the same phrasing in its legislation.

We note that this view by the Department had resonances with its 30 July 2013 response to Deputy Chief Magistrate Daly, which appeared to focus closely on the term 'routine' in the definition of isolation. It appeared to suggest that because the Blue Program was part of the Behaviour Development System, which was part of the 'routine' of the Centre, a young person in detention under the Blue Program was not in isolation.

We note how the Youth Justice Act is interpreted and applied remains relevant given that the Tasmanian (and Victorian) legislative definitions of 'isolation' continue to refer to locking a young person in detention in a room separate *from others* and from the normal *routine* of the Centre. We consider a plain language description of the daily experience of a child or young person on the Blue Program or who is unit bound would help determine whether a child is in isolation under the Youth Justice Act.

7 Continuing concerns in 2017

On 19 February 2017, Mr Morrissey wrote to the Custodial Inspector, Richard Connock, requesting his opinion on whether the practices that Mr Morrissey had been discussing with departmental officials for several months amounted to isolation.[1675] Mr Morrissey observed to Mr Connock that 'the interpretation of what constitutes isolation remains an irresolute issue'.[1676]

On 2 June 2017, Mr Morrissey wrote to Ginna Webster, who was Deputy Secretary, Children and Youth Services at the time, again raising the issue of isolation and concerns over the use of definitions. He noted no progress appeared to have been made since January 2017:

> My primary concern relates to the use of separate routine for the young people. I have formed a general view that it is indeed likely to be isolation. Separate routines at times extend for considerable periods. A therapeutic strategy for these young people may be able to offer less isolating options.[1677]

At that time, Mr Morrissey also noted he had not received a reply from Mr Connock in response to his request for an opinion in February.[1678] Mr Morrissey told us he left the role of Commissioner for Children and Young People in October 2017, after deciding the momentum for influencing reforms in the role had stalled, and that it was time for a change.[1679] In Chapter 18, we discuss Mr Morrissey's belief that on a number of occasions the independence of his role was undermined. It is unclear if Mr Connock ever provided a formal response or opinion on the issue to Mr Morrissey. While Mr Connock recalls being in regular contact with Mr Morrissey at around this time, he told us he had no recollection of the email.[1680] We are pleased to note that on 1 July 2017, a new Isolation Procedure was introduced by Ms Webster, as delegate of the Secretary of the Department, under section 124(2) of the Youth Justice Act.[1681] This is the procedure outlined in Section 2 and it clearly identifies that isolation should be used as a last resort and as a short-term tool to address immediate safety or security concerns. In the following section, we note ongoing concerns about formal isolation practices under this procedure. In Chapter 12, we identify further improvements to the Isolation Procedure.

8 Reviews of unit bound and similar practices in 2018 and 2019

A subsequent report by Mr Connock, titled *Custody Inspection Report: Inspection of Youth Custodial Services in Tasmania, 2018* was published in August 2019.[1682] The inspection of Ashley Youth Detention Centre for this report occurred in February 2018, seven months after the introduction of the new Isolation Procedure.[1683] In the report, Mr Connock considered the isolation practices that engaged the Centre's official Isolation Procedure.[1684] Mr Connock identified serious failures regarding the use of official isolation, including the failure to:

- regularly review and monitor instances of isolation
- meet minimum observation requirements while young people are held in isolation
- keep proper records regarding young people being held in isolation, including:
    - it appeared staff were copying and pasting different incident reports
    - documentation intended to explain or justify the use of isolation was incomplete.[1685]

The report did not discuss other isolation practices, such as unit bound practices or segregation, being used at the Centre outside the formal isolation safeguards.

8.1 Our observations

We conclude the Department and the Tasmanian Government were made aware in 2019 that, despite implementing a new policy and staff training in response to issues raised over the previous six or more years, formal isolation practices at the Centre continued to raise concerns for oversight bodies.

9 The reintroduction of the Blue Program in March 2019

9.1 The decision to reintroduce the Blue Program

On the evening of 7 March 2019, staff of Ashley Youth Detention Centre were notified by email from Patrick Ryan, Centre Manager at the time, that the Blue Program was being reintroduced for three months, at which point a decision on its continued use would be made.[1686] Greg Brown, then Director, Strategic Youth Services in the Department, was forwarded this email soon afterwards.[1687] Mr Brown was in this role between December 2017 and October 2019. Reference to the Blue Program in this section refers, unless noted otherwise, to the form of the program that was reintroduced in 2019.

The details of the Blue Program were set out in a series of documents Mr Ryan distributed to staff.[1688] In these documents, the Blue Program was described as a program to be used where a 'young person **persistently** breaks the rules of the Centre and is at risk to themselves or others' [emphasis in original].[1689]

Examples of situations that may attract a blue colour code were identified as attempts to escape, violent or assaultive behaviour, possession of a weapon and other behaviours that are 'disruptive to the order of their Unit or the Centre broadly'.[1690]

The relevant policy documentation stated:

> Whilst on Blue colour, which puts them outside normal Centre routine, the young person must be able to participate in an intensive support program that permits them to continue with their education, work, recreation or therapeutic activities until they are able to participate effectively in normal programming and normal Centre routine …
>
> Being placed on Blue colour is **not** the isolation of a young person, but a management tool used to manage the behaviours of individuals who consistently refuse to adhere to the rules and good order of the Centre or are unable to assimilate with the broader [Ashley Youth Detention Centre] community [emphasis in original].[1691]

The documentation also listed the following key practice under the program:

> A young person is fully segregated from Ashley School, daily programs and activities, other young people in their Unit (subject to risk assessment) and the normal routine of the Centre.[1692]

The process for placing a young person on the Blue Program involved initial consideration by the Centre Support Team or Interim Centre Support Team (an ad hoc meeting of the Centre Support Team), followed by Mr Ryan or his delegate ratifying the decision.[1693] The Centre Support Team or Interim Centre Support Team would then decide the 'nature of the intensive support program' for the young person while on the Blue Program, including the extent of any restrictions on the movement of that young person.[1694] A young person's eligibility to take part in Centre activities and programs in their unit was subject to a risk assessment.[1695]

Communications to staff and young people at the Centre emphasised the Blue Program was not a 'punishment option for difficult behaviour but rather an opportunity to maintain safety and security, as well as allowing the young person time to settle and be re-integrated back into normal routine'.[1696]

Mr Ryan confirmed to us that when young people on the Blue Program were in their room, their door was locked and there was no other person in the room with them.[1697] However, he disagreed the Blue Program was isolation of the kind prohibited by the Youth Justice Act.[1698] Instead, he stated it was 'working under a program' and that the program was part of 'normal routine', accordingly bringing it in line with the Centre's Isolation Procedure and the requirements of the Youth Justice Act.[1699]

Mr Ryan's evidence was that the reintroduction of the Blue Program followed two significant events of property damage at Ashley Youth Detention Centre. The first occurred on 25–26 February 2019 and the second on 6–7 March 2019.[1700] Mr Ryan explained these incidents had 'raised serious concerns for the wellbeing of the residents as well as staff'.[1701] Mr Ryan told us, 'immediate steps needed to be taken to better deal with serious incidents' and described the reintroduction of the Blue Program as a temporary 'circuit breaker' in response.[1702]

We were provided with various Centre Support Team meeting minutes for the period following the reintroduction of the Blue Program. Those minutes indicate that children sometimes remained on the Blue Program for long periods. For example, the minutes of 12 March 2019 show that on that date, three young people were on the Blue Program.[1703] Minutes of Centre Support Team meetings held over the following two weeks show that one of those young people remained on the Blue Program up to at least 25 March 2019 (at least 18 days).[1704] Another of those young people remained on the Blue Program until at least 1 April 2019 (at least 25 days), at which point he was moved to the red colour level and placed on unit bound.[1705] Over this period, Mr Ryan provided Mr Brown with email updates detailing the number of young people on the Blue Program, and providing their names, where relevant.[1706]

Mr Brown told us in his statement that he did not recall when he was briefed about the Blue Program, but he noted Mr Ryan 'would have briefed me verbally through phone calls or at meetings and followed up with emails or even an Issues Brief'.[1707]

Regarding the reintroduction of the Blue Program, Mr Brown said:

> From memory it was reintroduced by the Manager [Ashley Youth Detention Centre] as a result of an incident involving a number of residents but I cannot recall any specific details. I do not recall whether I had any involvement in its reintroduction outside of being briefed by the Manager and me then briefing the Deputy Secretary and/or Secretary. If I had a role in its operation or implementation it would have only been a decision-making delegation, but I do not recall any.[1708]

Mr Brown told us he did 'not recall having any concerns about the use of isolation/unit bound/blue program'.[1709]

9.1.1 Our observations about the reintroduction of the Blue Program

It is our view that, in March and April 2019, the Department was aware, or should have been aware, that a behaviour management approach had been reintroduced. A magistrate, a Commissioner for Children and Young People, and a 2016 departmental Minute to the Secretary had previously identified this approach as a likely human rights violation amounting to unlawful isolation. As outlined in the following section, the new Commissioner for Children and Young People was raising concerns about isolation practices prior to and while the Blue Program was being reintroduced.

While the Department confirmed it was aware of the reintroduction of the Blue Program in 2019, Secretary Pervan told us he does not recall being notified of matters concerning the reintroduction of the Blue Program in or around 2019. He said he only became aware of these matters through our Commission of Inquiry.[1710]

We consider that, despite reassurances that the Blue Program was not to be used as punishment, the excessive time children and young people were unit bound (18 or 25 days) may have reasonably felt like punishment to those young people.

9.2 Concerns raised by the Commissioner for Children and Young People in 2019

The reintroduction of the Blue Program involved, in part, what appears to be a concerning chain of correspondence between the Centre's management and Leanne McLean, Commissioner for Children and Young People, following her appointment to that role in November 2018. The relevant aspects of that correspondence are described below.

On 4 March 2019, before the 6–7 March 2019 incident, Commissioner McLean wrote to Mr Ryan and Mr Brown stating that several young people at Ashley Youth Detention Centre were unit bound. Commissioner McLean requested a copy of the policy or procedure that guided the decision to place the children on unit bound.[1711] Mr Ryan responded (copying in Mr Brown), requesting a few days to collate the information.[1712]

On 7 March 2019 at 5.57 pm, Mr Ryan notified staff at the Centre that the Blue Program had been reintroduced temporarily.[1713] Approximately 30 minutes later, at 6.26 pm, Mr Ryan responded to Commissioner McLean's request for information, noting:

- the unit bound activities she had identified formed part of the response to the 25–26 February 2019 incident
- the Behaviour Development System had previously recorded unit bound practice 'within the Blue Program' and the Blue Program was reintroduced in a temporary capacity
- Mr Ryan would provide a copy of the revised Behaviour Development System the next day.[1714]

On 7 March 2019, at 6.35 pm, Mr Ryan instructed the then Assistant Manager of Ashley Youth Detention Centre, Piers (a pseudonym), to 'amend the [Behaviour Development System] with the stuff I sent in the other email', stating that once that was complete, Mr Ryan would forward a copy of the Behaviour Development System to Commissioner McLean.[1715]

We note that Mr Ryan's response to Commissioner McLean gave the impression the Blue Program had been temporarily reintroduced in response to the 25–26 February incident. However, we question the accuracy of this for two reasons:

- Mr Ryan only emailed staff on 7 March 2019 that the Blue Program had been reintroduced temporarily, which was days after the 25–26 February 2019 incident and after Commissioner McLean's email.
- Mr Ryan instructed Piers to 'amend' the Behaviour Development System on 7 March 2019 before its release to Commissioner McLean.

When this inconsistency was put to Mr Ryan during our public hearings, he did not accept the correspondence suggested that he was implementing a program that was not otherwise reflected in the Behaviour Development System at the time.[1716] Instead, he stated his instructions to Piers merely reflected his desire to ensure the version of the Behaviour Development System provided to Commissioner McLean was current.[1717] He explained this was because there were 'a number of different copies' of the Behaviour Development System at the Centre at the time.[1718]

Mr Brown was copied into the email correspondence between Mr Ryan and Commissioner McLean.[1719] We are not aware of any separate response made by Mr Brown to that correspondence.

At best, this explanation during our hearings indicates a dysfunctional record and policy management system at the Centre, where the applicable policy was difficult to determine or locate. Such poor record keeping creates a risk of the incorrect or inconsistent application of the Centre's policies, many of which give operational effect to important legislative obligations.

At worst, the correspondence with Commissioner McLean suggests an attempt to mislead her as to the formal status and use of the Blue Program and the authorisation for placing children and young people on 'unit bound'.

Mr Ryan gave evidence that the reintroduction of the Blue Program followed 'consideration through consultation and meetings', including with the Centre Support Team and the Multi-Disciplinary Team at the Centre.[1720]

Given the timeframes involved, it is difficult to conclude the program was given thorough consideration before its reintroduction. Centre staff had, at most, approximately one week following the end of the first incident referred to by Mr Ryan (25–26 February 2019) to consider the appropriateness of the Blue Program. Further, Mr Ryan suggested the 6–7 March 2019 incident also contributed to the decision to reintroduce the program. If so, it appears the decision was reached only a matter of hours following the conclusion of that incident, as Mr Ryan's directive on the Blue Program was issued on the evening of 7 March 2019.

Ms Gardiner, who jointly held the Professional Services and Policy Manager role with another staff member at Ashley Youth Detention Centre in March 2019, denied being formally consulted on the matter.[1721] She asserted that, instead, she learned about the

reintroduction of the Blue Program along with other staff when the email was sent to Ashley Youth Detention Centre staff on the evening of 7 March 2019.[1722] She considered any consultation with the Centre's Professional Services Team about the reintroduction of the program was minimal, and she was not aware that any consultation occurred with other senior managers at the Centre.[1723]

We have considered the Multi-Disciplinary Team and Centre Support Team meeting minutes available for the period 1 February 2019 to 10 March 2019. We have been unable to identify in those minutes any discussion of the reintroduction of the Blue Program. We also considered the draft meeting minutes of a Behaviour Development System Review Committee at the Centre, which met at least three times between November 2018 and February 2019.[1724] Draft minutes of a meeting that Committee held on 19 February 2019 noted attendees unanimously supported establishing a working group to consider whether the Behaviour Development System was 'consistent with the [Ashley Youth Detention Centre] "therapeutic direction"'.[1725] Otherwise, there was no suggestion in minutes available to us that this Behaviour Development System Review Committee was asked to consider or consult on the reintroduction of the Blue Program.

We received evidence that the other Manager, Professional Services and Policy, Digby (a pseudonym) (who held that role jointly with Ms Gardiner) was the person responsible for the Behaviour Development System and was involved in preparing the relevant Blue Program documentation.[1726] Digby had made Mr Ryan aware of the Blue Program's problematic history.

In an email to Mr Ryan dated 7 March 2019, Digby stated:

> Just briefly the Blue Colour Category was first introduced in early 2011 to cater for the deep Red residents who had to be managed intensively for a period of time. It was rescinded in December 2013 (although fondly remembered by some staff) because it had become more broadly used (for some residents who didn't really need it) and was considered in some quarters to be a punishment option.[1727]

In April 2019, Mr Ryan prepared a draft Issues Briefing to the Minister updating the Minister on matters relating to the February and March incidents.[1728] That draft Issues Briefing noted:

> The [Ashley Youth Detention Centre] Behaviour Development System was amended to reintroduce the Blue Program as an interim measure for three months. The program is an individual intensive support program and affords some segregation from other residents. It was reintroduced after the second incident and was considered through the Centre Support Team (CST) meeting following. [1729]

This briefing and Mr Ryan's response to the Commissioner for Children and Young People appear inconsistent. The Issues Briefing suggests the Blue Program was reintroduced after the 7 March 2019 incident, whereas Mr Ryan's response to the Commissioner suggests the Blue Program was introduced in response to the 25–26

February 2019 incident. Mr Ryan disagreed the documents were inconsistent and told us the Blue Program was only reintroduced after the 7 March 2019 incident.[1730]

We were not provided with a final version of this Issues Briefing. It is unclear to us what information was provided to the Deputy Secretary, Secretary or Minister about the reintroduction and operation of the Blue Program.

This was the second Commissioner for Children and Young People and the third external party to raise concerns about the Blue Program with the Department, in addition to the Custodial Inspector's concerns about formal isolation practices.

9.3 Attempts to reform the 2019 Blue Program

We understand concerns were raised within the Centre about the Blue Program at the time of its reintroduction in 2019. Ms Gardiner's evidence was that she and other members of her team considered the Blue Program to be lacking any therapeutic benefit.[1731] Ms Gardiner told us she:

> … considered the [Blue Program] highly unsuitable for a young person who was displaying highly aggressive/violent and dysregulated behaviour. Whilst in the short term the security and safety risk of the Centre needed to be addressed, the content and delivery of the program was not trauma informed, developmentally appropriate or designed to meet the needs of the cohort of young people in the Centre.[1732]

She noted her concern the Blue Program interfered with the rights of young people to educational opportunities secured under the Youth Justice Act and international standards.[1733]

On 16 March 2019, Ms Gardiner emailed Mr Ryan with suggestions 'to improve the program to provide support to young people to [meet] their developmental and trauma needs'.[1734] Those suggestions included:

- reviewing the content of the individual programs from a literacy perspective, to ensure they could be understood appropriately by young people (noting the generally low literacy among young people at the Centre)
- reducing the 'cognitive heavy' content of the programs, which Ms Gardiner considered unhelpful in a context where young people were on the program because of assaultive or threatening behaviour, suggesting a level of distress
- adopting adjunct programs that address trauma and complement trauma-informed practices, such as programs that can 'calm the brainstem and limbic system'
- consulting with the Health Team at the Centre and the Australian Childhood Foundation for help in program development
- ensuring youth workers were appropriately skilled and trained to deliver the content of the individual programs.[1735]

Ms Gardiner recalled Mr Ryan's initial reaction to her suggestions as 'being open to improvement'.[1736] Mr Ryan responded to Ms Gardiner's email positively, stating he saw her role as 'guiding residents and staff'.[1737] He noted, however, there would 'need to be some "selling" of [Ms Gardiner's suggestions] to staff'.[1738]

Ms Gardiner described how her Professional Services Team then developed a series of measures to improve the Blue Program content and delivery, based on trauma-informed practice and attachment theory, and building on the work of the Australian Childhood Foundation.[1739] She said her team worked 'a bit on the run', given the program had already been put in place.[1740] She recalled that, on a daily basis, her team would develop individual programs for each of the young people on the Blue Program, which involved roughly hourly alternations between therapeutic program content, such as psychological support or education, and 'calming regulation activities', such as using the gym one-on-one with a youth worker or more meditative activities, such as puzzles.[1741]

Ms Gardiner considered the modified Blue Program, as developed by her and her team, was positive in the sense that it appeared to work by bringing children quickly off the program and back into the Centre's general activities. However, she did not have sufficient time to evaluate its success.[1742]

Ms Gardiner conceded the version of the Blue Program as modified by her team still involved a degree of isolation, where children might be left alone every second hour or so (in between therapeutic program delivery). However, she considered, on balance, that young people had more contact with others than on the original planned 2019 Blue Program.[1743]

We were interested to hear Mr Ryan's view that he thought Ms Gardiner considered the reintroduction of the Blue Program 'was the best thing that could have happened in the circumstances …'.[1744] Based on the evidence available, it is difficult to reach a conclusion that Ms Gardiner supported the reintroduction of the Blue Program; rather, she appears to have worked to improve the Blue Program once it was in use.

At this time, even with the improvements Ms Gardiner implemented, the evidence available to us showed the Blue Program often (if not always):

- segregated children from other children and young people in detention
- denied children and young people the right to take part in the usual educational programming offered through Ashley School
- involved children and young people being locked in their rooms for hours at a time
- sent children and young people to bed at an excessively early time for an adolescent
- locked children and young people in their room from this early time until the morning.

It remains unclear to us what, if any, opportunities children and young people had to take part in activities with other young people in their unit. However, we consider it likely they were segregated from other children and young people all or most of the time.

9.4 Departmental correspondence about the Blue Program

We were given a draft email from Mr Brown dated 21 May 2019 intended for Ginna Webster—who, at that time, had become the Secretary of the Department—that refers to the 'Blue Program', 'unit bound', 'reflection activities' and 'individualised programs', but not isolation:

> In March the Blue Program was reintroduced in response to two major incidents at [Ashley Youth Detention Centre] and following the incidents the Centre was unsettled. Three residents were put on Blue after the major incidents.
>
> The 'old' Blue Program (developed over 20 years ago) had the resident unit bound and used some reflection activities. Whilst it contained [an] excellent sense of security and structure for residents and staff, some of the theories it was developed from have been superseded by more contemporary theory and it does need to have a thorough review to ensure it aligns with a therapeutic model of care.
>
> With its reintroduction, it was quickly identified that the reflection activities were not supporting the residents to progress i.e. 'move up colours' on the Behaviour Development System (BDS) used by the Centre. As a result, elements of the program were changed and an active support program was introduced. This became a daily schedule for Blue residents in the unit, with daily psychology, case management and education programs, as well as scheduled exercise and gym sessions. This resulted in two of the Blue residents progressing up the colours at the next week, and progress was much improved. The Professional Services and Policy (PS&P) staff developed daily individualised program timetables and documents to support the Blue Program, so it was an increased support program.
>
> Due to complex presentations and behaviour by the Blue residents, [the Centre] initiated a [Senior Quality Practice Advisor] referral for further advice regarding the Blue program to ensure [the Centre] was considering all available therapeutic options for the residents on Blue, however the referral was declined by [Quality Improvement and Workforce Development]. Notwithstanding this, a review of the reintroduction of the Blue Program is to be undertaken in the near future. The review will consider how the program aligns to therapeutic care, and supports young people who are displaying highly dis-regulated behaviour, as occurred in the recent major incidents.[1745]

We are concerned this correspondence—and specifically the reference to the young people 'progressing up the colours at the next week'—suggests that they were on the Blue Program or unit bound for days.[1746]

Secretary Webster told us she did not recall receiving this email, although she accepted it was possible she did. She also noted that nothing in the email indicates that the Blue Program was correlated to a form of isolation.[1747]

9.5 Further concerns raised by the Commissioner for Children and Young People in 2019

We received evidence of a further attempt by Commissioner McLean, in late 2019, to clarify the nature of isolation practices at Ashley Youth Detention Centre.

On 22 August 2019, Commissioner McLean wrote to Secretary Webster seeking clarification about the difference between unit bound and formal isolation, and how a decision about placing a young person on unit bound was reached.[1748]

Commissioner McLean raised the following concerns:

- The Behaviour Development System did not clarify when and how a decision was made for a young person to be unit bound.[1749]
- The colour allocated to a young person did not appear to necessarily result in a young person being unit bound, 'suggesting that a decision to confine a young person to their unit is not solely covered by the [Behaviour Development System]'.[1750]
- It was unclear whether it was mandatory for a young person who was unit bound to be provided with an individual program.[1751]

Commissioner McLean requested a copy of the policy or procedure governing decisions to confine a young person to their unit, and the criteria relevant to such a decision, as well as clarification of the difference between isolation and unit bound.[1752]

Commissioner McLean's request was forwarded to Mr Brown, who then asked that Mr Ryan and Ms Gardiner prepare a draft response and associated Issues Briefings.[1753] On 4 September 2019, Mr Ryan emailed a staff member at the Centre a draft Issues Briefing to the Secretary regarding Commissioner McLean's request, for forwarding to Mr Brown.[1754] The draft Issues Briefing to the Secretary contained the following observations:

- Young people on unit bound were 'from time to time confined to their unit … as a result of the governing Behaviour Development System' used at Ashley Youth Detention Centre.[1755]
- Commissioner McLean's statement that it appeared a decision to place a young person on unit bound was 'not solely covered' by the Behaviour Development System was partially correct.[1756] Mr Ryan explained that 'there is an element of discretionary decision making for resident movement' and that the colour rating

held by a young person 'can determine an activity the resident may or may not participate in, ratified at Centre Support Team meetings'.[1757]

- Regarding individual programs, Mr Ryan explained the Program Assessment Team terms of reference, 'holds a strong premise and rationale of addressing programs for young people diversely and/or individually'.[1758]
- Mr Ryan confirmed there was 'not one policy or procedure that governs decision making processes' at Ashley Youth Detention Centre.[1759] Instead, the Behaviour Development System provided direction complemented by Centre Support Team, Multi-Disciplinary Team and Program Assessment Team processes.[1760]

Regarding the difference between isolation and unit bound, Mr Ryan explained in the draft Issues Briefing:

> As previously mentioned, being 'unit bound' refers to residents who are from time to time confined to their unit as a result of the governing Behaviour Development System (BDS) and related procedures used at [the Centre]. Each of these are underpinned by [the Centre] striving to provide a safe and secure environment for young people in detention. 'Isolation' is described in the *Use of Isolation Procedure* and the *Youth Justice Act 1997* as 'locking a detainee in a room separate from others and from the normal routine of the Centre'. Being 'unit bound' is within the normal routine of the Centre, in that it is programming and/or an Individual Timetable for a resident. The resident is not locked in a room within the unit, nor kept from other residents. 'Unit bound' is generally reserved against the Programmed day of 9 am to 4.30 pm, and outside opportunities of exercise and visits are always availed.[1761]

In his email to the staff member, Mr Ryan commented: '[o]n reflection, I'm happy that there is no prescription for "unit bound". It's good, tactical work across many areas of the Centre when we do "unit bound" a resident'.[1762]

At this time, Mr Ryan also prepared a draft Issues Briefing to the Minister and a draft response to Commissioner McLean.[1763]

The final Issues Briefing to the Minister, prepared by Mr Ryan, reviewed by Mr Brown and cleared by Secretary Pervan broadly reflected the matters Mr Ryan raised in the Issues Briefing to the Secretary.[1764] Secretary Pervan was newly appointed to Secretary of the Department at this time, having ceased responsibility for youth justice for a brief period from 9 May 2018 to 2 September 2019 because of a restructure.

In Secretary Pervan's response to Commissioner McLean on 11 September 2019, he stated no unit bound procedure was in place.[1765] He explained to Commissioner McLean:

> There is no separate Unit Bound Procedure in use at [the Centre]. The term refers to residents who are from time to time confined to their residential unit as a result of the governing Behaviour Development System (BDS) and related procedures used at [the Centre]. Each of these are underpinned by [the Centre] striving to provide a safe and secure environment for young people in detention.

> In any detention centre, there is an element of discretionary decision making for resident movement. The [Behaviour Development System] affords a colour status to a resident, which can determine an activity the resident may or may not participate in, ratified at Centre Support Team meetings. Work Health and Safety Risk Assessments complement the decision-making process. Multi-Disciplinary Team and Program Assessment Team meetings also complement and aid the decision-making process.[1766]

Secretary Pervan also offered the following distinction between unit bound and isolation to Commissioner McLean:

> 'Isolation' is described in the Use of Isolation Procedure and the Youth Justice Act 1997 as 'locking a detainee in a room separate from others and from the normal routine of the Centre'. Being 'unit bound' is within the normal routine of the Centre, in that it is specific programming and/or an Individual Timetable for a resident. The resident is not locked in a room within the unit, nor kept from other residents. 'Unit bound' is generally reserved against the programmed day of 9 am to 4.30 pm, and outside opportunities of exercise and visits are always availed.[1767]

Mr Brown is identified as the departmental contact in the Secretary's letter to Commissioner McLean and was copied into the correspondence.[1768] We understand Commissioner McLean raised concerns about unit bound with Centre management at least once more.[1769]

9.6 Our observations

We observe that Commissioner McLean was the second Commissioner for Children and Young People to find it necessary to make persistent requests for clarification about the Blue Program and the practice of making young people in the Centre unit bound, and to question whether this amounted to isolation.

In our view, all formal correspondence regarding the Blue Program lacked a plain language description of the daily experience of children and young people in detention who were on the Blue Program, and the number of hours on average they were confined to their room or unit and segregated from other young people in the Centre. Clarity regarding these matters is material to Commissioner McLean's concern about whether the Blue Program was a form of isolation.

We are also very concerned that the Blue Program was reintroduced despite prior internal and external conclusions that the Blue Program did amount to a form of isolation. There was a missed opportunity in the Department to scrutinise why the Blue Program had previously ceased before accepting its reintroduction. This missed opportunity meant a further cohort of children and young people detained at the Centre were subjected to the isolation practices inherent in the Blue Program.

Finally, we assume that Commissioner McLean (like Mr Morrissey before her) was asking questions and raising concerns about the Blue Program because of her engagement with children and young people detained at the Centre. There is no evidence in any departmental documentation provided to our Commission of Inquiry that children and young people detained at the Centre were ever given an opportunity to provide their experience of the Blue Program.

Failing to consider the benefits of engaging with and hearing the voice of children and young people about the Blue Program, particularly following the clarifications the Commissioner for Children and Young People requested, was a further missed opportunity by the Department that may have helped to identify the isolating features of the Blue Program and their impacts on children and young people more clearly.

We conclude that, because of these missed opportunities, isolation practices that were potentially outside the standards set by law, policy and international conventions continued at Ashley Youth Detention Centre for significant periods throughout 2019.

10 Roof incident December 2019

In December 2019, several young people in detention gained access to the roof of buildings at Ashley Youth Detention Centre. In this section, we consider this incident and the Centre's response of placing the children in isolation or related practices. We discuss allegations that isolation records were falsified after these young people were isolated. While the handling of this matter raises multiple questions about many practices, including the use of restraints and incident management procedures, we focus here on the use of isolation. Our summary of events relies heavily on a subsequent independent investigation of this matter.[1770]

We note the Centre's Isolation Procedure (effective 1 July 2017), discussed earlier, is relevant to how this incident was managed.[1771] At the time of the 2019 roof incident, the relevant instrument of delegation provided that the power to isolate a detained young person under section 133(2) of the Youth Justice Act (and therefore to extend the period of isolation), was delegated to the Centre's Operations Manager or the Director, Strategic Youth Services, only 'if the Detention Centre Manager is on leave, is uncontactable, or is unable for any other reason to perform the relevant function'.[1772]

10.1 The incident

Around noon on Friday 13 December 2019, three young people detained at Ashley Youth Detention Centre—Arlo, Elijah and Joseph (all pseudonyms)—accessed the roof of Ashley School, where they threatened staff with items dislodged from the roof.[1773] During the next approximately three hours, staff members at the Centre negotiated with Arlo, Elijah and Joseph to come down from the roof.[1774]

During this period, Ashley School and its offices were evacuated, and some young people were moved around the Centre while restrained with handcuffs.[1775] Mr Ryan, the Centre Manager, provided updates to Ms Honan, the Director, approximately every half hour.[1776] By this time, Ms Honan had assumed the role of Director from Mr Brown. Mr Ryan notified police of the incident but their attendance was not requested.[1777] Welfare checks were carried out for staff, and there was some evidence to suggest the same was done for young people not involved in the incident.[1778] Other young people were kept in their designated units, but routines and programs that could be carried out safely within each unit continued, as well as very limited access to the gym if available.[1779]

At approximately 4.00 pm, negotiations with Arlo, Elijah and Joseph were successful. They were escorted in handcuffs to a unit that had been emptied of other young people.[1780] Each had minor injuries to their feet or hands.[1781] No staff or other young people were injured.[1782] The Centre returned to normal operations and routine soon after.[1783]

10.2 The Centre's response: isolation and unit bound

Immediately following the incident, Arlo, Elijah and Joseph took showers and were given food.[1784] An Operations Coordinator, Chester (a pseudonym), authorised an initial period of isolation for Arlo, Elijah and Joseph, for approximately 30 minutes.[1785] The Acting Operations Manager, Maude (a pseudonym), extended the initial period of isolation by two-and-a-half hours.[1786] The three young people were then sent to bed (that is, continued to be locked in their rooms alone), consistent with the 7.30 pm bedtime for young people on the 'red' colour in the Behaviour Development System.[1787]

The immediate isolation after the incident was noted in an email to Ms Honan.[1788] Ms Honan also received a further email that the Operations Manager (whom we understand to have been Acting Operations Manager, Maude) was considering extending the initial 30-minute isolation period.[1789] Ms Honan was last substantively updated at 5.11 pm on 13 December 2019 by being copied into an email from Mr Ryan to Centre staff thanking them for their work.[1790] In that email, Mr Ryan stated that 'rehabilitation continues to occur after the incident, this evening and into next week'.[1791]

Before Mr Ryan left the Centre for the weekend, he spoke with Maude and Chester.[1792] In her evidence to the investigation of the incident, Maude stated she told Mr Ryan at this time that 'individual programs' would likely be used for Arlo, Elijah and Joseph over the weekend, and the Centre Support Team would review these programs on Monday 16 December 2019.[1793] Her evidence was that Mr Ryan gave no instructions about the use of isolation and instead, he said he would leave the issue to Maude and Chester to manage.[1794] In his evidence to the investigation of the incident, Chester shared Maude's recollection of these conversations.[1795]

On the morning of Saturday 14 December 2019, an acting Operations Coordinator and a youth worker at the Centre prepared 'individual programs' for each of the three young people involved in the incident.[1796] Arlo, Elijah and Joseph were placed on a rotating program of exercise, in-room activities and in-unit activities, separated from one another and from the other young people in detention.[1797] Their programs included multiple hours alone in their rooms each day, with intervals of being within their unit, and an option of one hour of exercise in the gym 'if available'.[1798] The periods in their room ranged from one hour to three or four hours, with different activities offered.[1799] We understand the programs involved no contact with other children and young people.[1800] Professional Services Team members generally did not work on weekends and had no input into the individual programs.[1801]

The individual programs continued over the weekend until the morning of Monday 16 December 2019.[1802] Neither Mr Ryan nor the On-Call Manager were contacted over the weekend to authorise any periods of isolation.[1803]

Maude reported that, on the morning of Monday 16 December 2019:

> … staff weren't keen for the three residents to leave their unit until their attitude had shifted and staff were satisfied that they were going to follow appropriate direction and work with the staff and not against them. There was concern about them causing more damage. The three residents were unit bound at that time although they could access the unit common-room.[1804]

On the same morning, a Centre Support Team meeting was held, during which the individual programs for Arlo, Elijah and Joseph were discussed.[1805] The Program Coordinator at the time raised concerns about the individual programs during that meeting, later saying:

> … [the individual programs were] in no way therapeutic or considered and it seemed to me that the young people involved had not had time outside and only very limited time out of their rooms; it was also clear that there were lengthy periods of isolation.[1806]

Notably, the minutes of that Centre Support Team meeting stated that '[f]rom observations over the weekend, it would appear that the boys have little remorse for their actions'.[1807]

Evidence provided to us indicates that Arlo, Elijah and Joseph each remained unit bound up to and including 24 December 2019 (at least 11 days).[1808] There is also evidence to suggest the three young people may have been offered time outside the unit occasionally during that period, possibly with a peer.[1809] While Interim Centre Support Team meeting minutes of 19 December 2019 suggest a decision was taken that day for Arlo, Elijah and Joseph to come off unit bound, this is inconsistent with the evidence of the daily rolls.[1810]

10.2.1 Our observations of isolation practices in December 2019

From our analysis, it appears that in December 2019, three young people at the Centre were subjected to isolation practices for at least 11 days that potentially did not comply with Tasmanian law or policy or international human rights standards. Again, we consider that irrespective of intent, being unit bound for this length of time may have reasonably felt like punishment to the young people involved.

10.3 December 2019 Issues Briefing

On Monday 16 December 2019, Mr Ryan prepared an Issues Briefing for the Minister about the roof incident. Between 16 and 20 December 2019, this briefing was passed through Ms Honan, Mandy Clarke (then Deputy Secretary, Children, Youth and Families) and Secretary Pervan, before being noted by the Minister on 7 January 2020.[1811] The Issues Briefing provided a summary of the events of 13 December 2019, noted injuries to each of Arlo, Elijah and Joseph, and provided estimates of the cost of damage to the Centre's property.[1812] The Issues Briefing commented that staff 'responded immediately and appropriately'—an assessment that could be considered premature, given the Issues Briefing stated a full review of the incident would follow.[1813]

The Issues Briefing did not disclose that the three young people had been isolated immediately following the incident or placed on individual programs, which, in our view, amounted to isolation, over the weekend following the incident.

We asked Secretary Pervan whether he considered the Issues Briefing sufficiently informed the Minister about the sanctions imposed on the three young people. Secretary Pervan responded that the sanctions were not 'central' to the Issues Briefing 'in the circumstances'.[1814] He said the content of an Issues Briefing was 'guided by the request' for the Issues Briefing, and there were regular opportunities for the Minister to ask any follow-up questions, including through 'daily dialogue' between the Department and Ministerial advisers and more formal regular meetings.[1815] Secretary Pervan did not confirm the Minister was advised at this time of the use of isolation, but stated he considered it 'highly unlikely' that the Minister was not made aware of these matters in the days following the event.[1816] We are unaware of any other correspondence or meeting minutes that might be evidence of an update to the Minister on these issues, or a request for such an update. We did not seek confirmation from the relevant Minister on this issue.

Ms Clarke gave evidence that she considered the Issues Briefing provided 'sufficient information in relation to the description of the actual event itself'.[1817] She thought the possible reason for the lack of information about how the young people were managed after the incident was a lack of knowledge about the matter among 'Department executives'.[1818]

We are unclear about the usual process for reporting isolation to the Department.

We know that Centre management made some reports to Ms Honan that identified isolation had been used in response to the 2019 roof incident. However, we are not aware the Centre Manager routinely reported all uses of isolation to the Director, as opposed to doing so only where it formed part of a response to a critical incident on site. Further, we are unaware of any notification by Centre management or Department staff to the Deputy Secretary or Secretary of the use of isolation or unit bound in response to this incident. We are concerned the evidence shows there was no requirement to formally report, in writing, all uses of isolation to senior Department officials.

We were advised by Ms Honan that the Issues Briefing included an overview of the incident that had occurred on the weekend based on immediate information available to Ms Honan at the time.[1819] Ms Honan said that when she cleared the briefing, 'the information contained in it was correct and the immediate containment and management of the standoff, appeared compliant with the Restraint (Handcuffing) and Isolation policy and procedures'.[1820] Ms Honan also told us she was not consulted about any periods of isolation or the use of handcuffs in the management of the incident.[1821]

We understand it is normal practice for management at the Centre to perform an internal review following a significant incident, as had been foreshadowed in the above Issues Briefing. The review was incomplete as of 20 February 2020, when Secretary Pervan appointed an independent investigator to investigate the incident and associated response.[1822]

10.4 Concerns raised by staff about the incident

In late December 2019 and in January 2020, staff at the Centre raised concerns through multiple channels about the immediate response to the 2019 roof incident.

During this time, Ms Honan received communications from staff members who alleged that (among other things):

- isolation had been used without authorisation in response to the 2019 roof incident[1823]
- staff had been asked to backdate or sign isolation forms for practices that had occurred over the weekend in question[1824]
- operations staff had failed to appropriately consult with the Professional Services Team during the incident, placing the three young people involved in the incident at a high risk of harm.[1825]

Regarding the use of isolation without authorisation and the falsification or backdating of isolation records for the weekend of 14–15 December 2019, the allegations included:

- On Monday 16 December, Mr Ryan stated to the then Assistant Manager, Piers, that the isolation forms for the weekend were incomplete, and Mr Ryan directed Piers to ask the Operations Coordinators on shift that weekend to complete them.[1826]

- In the week beginning Monday 16 December, Piers began to pressure Maude to get other staff to sign isolation forms for 14–15 December.[1827] This included staff who had not been involved in the decision to isolate the young people.[1828] Maude reported to the independent investigation into the 2019 roof incident that those staff had declined to sign the forms because they thought the forms were forgeries, as isolation had not been appropriately authorised.[1829] Maude alleged that Piers told her '[y]ou're just going to have to put on your steel-capped boots and get the staff to sign them'.[1830]
- Chester and a youth worker prepared some detail for the isolation forms, with reference to the individual programs that had been prepared.[1831]
- Chester eventually signed some isolation forms that had been prepared in the days following Monday 16 December, but told Maude he was uncomfortable about doing so.[1832]

In her statement to us, Ms Honan described her initial inquiries of staff about the post-incident management, particularly as it related to the completion of isolation paperwork. On 16 January 2020, as the internal review had not been completed, Ms Honan asked Mr Ryan to provide copies of the isolation forms, daily logs, individual programs and other notes prepared and produced in the period from 13 to 19 December 2019.[1833] She sought an independent investigation because of the seriousness of the concerns and the number of staff who would need to be interviewed to understand what had occurred.[1834] We discuss this independent investigation in the next section.

In addition, a psychologist working at Ashley Youth Detention Centre wrote to the Head of Department, Statewide Forensic Mental Health Services, Tasmanian Health Service (who was responsible for the Health Team at the Centre), raising the following concerns:

- Arlo, Elijah and Joseph had been out of their room for only approximately two-and-a-half hours a day on the Saturday and Sunday following the incident.[1835]
- Aside from verbal threats to a staff member who had not been on site since the incident, there appeared to be no reason to continue to isolate the young people, and that the apparent 'lack of remorse' on behalf of the young people seemed to motivate the decision to keep them isolated.[1836]
- Attempts by the psychologist to obtain information about isolation decisions in the days following the incident had been disregarded by Mr Ryan and Piers.[1837]
- Centre management had asked operations and professional services staff to backdate documentation, or sign documentation containing misleading and/or false information about the isolation decisions.[1838]

The former Head of Department, Statewide Forensic Mental Health Services, who received the psychologist's notification, told us she understood that the psychologist was interviewed by a representative of the Department of Communities in mid-January 2020.[1839] We understand the psychologist was told an investigation would follow.[1840] The psychologist's notification to the Tasmanian Health Service about this issue was one of many concerns the psychologist raised with their superiors at this time. We discuss other concerns that the psychologist held about the Centre's responses to harmful sexual behaviours in Case study 2.

10.5 The independent investigation of the incident

On 18 February 2020, Ms Clarke cleared a Minute to the Secretary requesting approval to appoint an investigator to investigate the December 2019 roof incident and associated post-incident management.[1841] The Minute identified a series of 'potential issues relating to the incident's management, both during and post the incident', including:

- the alleged use of physical force when moving young people around Ashley Youth Detention Centre, including the use of handcuffs[1842]
- concerns about the management of the response[1843]
- allegations that senior staff members directed operations and professional services staff to retrospectively sign documents authorising the isolation of Arlo, Elijah and Joseph, where no such authorisation had been sought[1844]
- the falsification of isolation records, including records of a young person's program activities and observations during periods of isolation.[1845]

The Minute noted the investigation may give rise to consideration of a subsequent breach of the State Service Code of Conduct investigation.[1846]

On 20 February 2020, Secretary Pervan approved the appointment of an independent investigator to investigate the incident and associated response.[1847] The scope of the investigation was to:

- prepare a chronology of the events during and immediately after the incident
- detail the management strategies for other young people at the Centre during the incident, including the methods used to move them around the Centre
- examine the involvement of operations and professional services staff throughout the incident and in the post-incident management
- identify procedures, legislative provisions and any other relevant directions or guidelines relevant to the incident, and to assess compliance with these in the identified period

- assess the effectiveness of the management response to the incident
- identify whether Arlo, Elijah and Joseph were subject to a period of unapproved isolation following the incident and, if so, to detail:
    - the processes used to implement and maintain that isolation
    - the decision-making and approval processes followed
    - the basis for that isolation
    - the programs provided to the young people during the period of isolation, and the involvement of operations and professional services staff in decisions relating to isolation
    - whether the period of isolation complied with the Centre's policies and procedures, the legislative framework and any other relevant direction or guidelines
    - the preparation of documentation to support the isolation of young people.[1848]

While the investigator was not instructed to consider whether there had been a breach of the State Service Code of Conduct, the investigation appears to have been ordered with a view to consider whether there had been any behaviour that should be the subject of disciplinary action.[1849]

The investigator took statements or obtained answers to questions from Centre staff members significantly involved in the incident.[1850] The substantive report summarised the statements and attaches the full statements. Despite requesting them, we were not provided with the full statements.[1851] The investigator did not interview young people at the Centre.

The investigator's final report is dated 26 March 2021 and addressed to Secretary Pervan.[1852] While the report did not contain formal recommendations, it noted a range of matters for the Secretary's consideration.

Regarding the use of isolation, the independent investigator made the following observations:

- The initial 30-minute period of isolation was appropriately authorised by the Operations Coordinator in line with the Isolation Procedure and relevant delegation instrument.[1853]
- The extension of the initial period of isolation was likely to have been inconsistent with the Isolation Procedure and delegation instrument.[1854] The investigator considered that Maude had authorised the extension 'in good faith' but, in fact, she was only entitled to authorise the extension if Mr Ryan was on leave, uncontactable or unable to authorise it for some other reason.[1855] The investigator noted Mr Ryan's view that he was 'uncontactable' if his 'door was closed' or he was 'on the toilet'—a view the investigator disagreed with.[1856]

- Arlo, Elijah and Joseph were in fact isolated over the weekend, despite on-duty youth workers having a 'misinformed/misguided' view that no isolation was taking place and instead, the young people were simply on 'individual programs'.[1857] Accordingly, isolation of the young people over the weekend occurred without appropriate authorisations under the Isolation Procedure.[1858]
- The evidence from Maude and Chester was that Mr Ryan was aware individual programs would likely be used to manage Arlo, Elijah and Joseph over the weekend and that Mr Ryan provided no instructions to staff about isolation.[1859] Mr Ryan contended that Operations Coordinators knew that approvals were required for the continuation of isolation.[1860]
- There was scope to conclude Centre management should have more actively ensured professional services staff were available out of hours to help prepare weekend programs for Arlo, Elijah and Joseph.[1861]
- Young people not otherwise involved in the incident had been confined to their units for the duration of the incident, with some suggestions they had been given access to in-unit programs where possible.[1862]

A key issue that emerged from the report regarding isolation was that several staff understood themselves to be carrying out the Blue Program, or a program that mirrored the Blue Program in form and substance.[1863]

Mr Ryan and Piers denied that Mr Ryan had instructed staff to use the Blue Program for Arlo, Elijah and Joseph over the weekend.[1864] However, the youth workers 'had the Blue Program in mind' when preparing the individual programs for Arlo, Elijah and Joseph.[1865] An Operations Coordinator who worked over the weekend said he understood the young people to effectively be on the Blue Program:

> The [Centre] used to run a Blue Program for very bad behaviour with any resident involved being placed under isolation and doing lots of activities in their room with specifically prepared individualised programs. In January/February 2019 Patrick brought the Blue Program back in for a short period of time (or at least what was called an Individualised Program Routine) because of a particular event that had taken place that involved five residents in one standoff and about four or five others in another.
>
> Over the weekend of 14 and 15 December I was under the impression that the Blue Program (or at least the Individualised Program Routine) that had been reintroduced by Patrick would apply. The terminology Blue Program wasn't used; however, that is what I, and I believe the other staff involved over the weekend, thought was to occur with individualised programs for the three residents.[1866]

Statements received from staff members, and internal correspondence the investigator obtained, stated staff did not think isolation forms were needed because these had not been required in the past for the Blue Program.[1867]

Regarding the appropriate management of the young people over the weekend, the investigator invited Secretary Pervan to consider:

- whether Mr Ryan and Piers should have been more 'actively' involved in ensuring weekend programming for Arlo, Elijah and Joseph was appropriate, including whether Mr Ryan did enough to make sure that weekend staff understood that any use of isolation was to be in line with the Isolation Procedure[1868]
- whether relevant delegations concerning the Isolation Procedure were appropriately followed, including whether it was appropriate for Mr Ryan to contend that he was 'uncontactable'[1869]
- whether it was reasonable to confine the young people not directly involved in the incident to their units, noting that the young people 'would not seem to have been locked down (potentially meaning isolated) as that term is understood'[1870]
- the extent to which Professional Services Team members were now available after hours and over the weekend to assist with program management.[1871]

The investigator also suggested the Department perform a complete review of isolation routines at the Centre, specifically regarding how isolation periods were extended.[1872]

Regarding the concerns raised about the subsequent falsification or backdating of isolation documents, the investigator observed the following:

- It was a 'significant issue' that Chester signed the various isolation forms when he had acknowledged his view was that no isolation had occurred over the weekend.[1873]
- It was clear Chester and Maude had felt pressure to complete or backdate isolation forms because of Piers' and Mr Ryan's actions.[1874]
- Piers disagreed that Mr Ryan placed pressure on him to have the isolation forms completed.[1875]
- Piers acknowledged he had pressured Maude when he conceded he may have told her to 'tough it up a little bit'.[1876]
- Mr Ryan and Piers had pressured Maude and, in turn, Chester to complete the isolation documentation.[1877]

The investigator noted Mr Ryan's and Piers' actions occurred in situations where they would likely have been aware the appropriate authorisations had not been sought. He said:

> … it is difficult … to understand why Ryan (through [Piers]), and [Piers] himself, pressed for the completion of [isolation documentation] when, on the balance of probabilities, both would have been aware that isolation was not conducted in accordance with [the Isolation Procedure] …

> It is also difficult … to understand why [Maude] was pressured, and in turn pressed [Chester], to complete (backdated) isolation forms when on the balance of probabilities it was known by Ryan and [Piers] that isolation was not conducted in accordance with [the Isolation Procedure].[1878]

Regarding potential breaches of the State Service Code of Conduct, the report concluded:

> In my view, you need to bring your mind to whether there were any breaches of the State Service Code of Conduct by Ryan, [Piers], [Maude] or [Chester] in the context of the completion of the isolation documentation [referenced in the body of the report].
>
> In the context of the involvement of [Maude] and [Chester] in the completion of the related isolation documentation, in my view you should consider whether there are mitigating circumstances associated with the pressure that the evidence suggests to me was being applied by Ryan and [Piers]—more [Piers] but through Ryan in my assessment—to [Maude] and, in turn, [Chester] to have isolation documentation completed.[1879]

By the time the report was delivered, on 26 March 2021, Piers and Maude had been suspended from employment for reasons unrelated to the 2019 roof incident or the findings of the report, and Mr Ryan had left the Centre for an alternative role.[1880] Chester remained working at the Centre.[1881]

In summary, the report of the independent investigator, which was addressed to Secretary Pervan, raised concerns about the carrying out of isolation routines at the Centre, specifically in relation to how isolation periods were extended. It provided evidence the Blue Program was still believed to be used in practice, if not in name. It also raised serious questions about whether formal isolation procedures were being followed and identified isolation records had been amended retrospectively.

Once more, there was a missed opportunity to hear directly from children and young people affected in a critical incident investigation, which at the very least, would have alerted children and young people at the Centre that some action was being taken to assess the appropriateness of their treatment during and following the December 2019 roof incident. We suspect that, if asked, Arlo, Elijah and Joseph would have believed they were unit bound as punishment for their involvement in the roof incident. We saw no evidence there was an acknowledgment or apology by the Department for the extended, and potentially unauthorised, isolation that Arlo, Elijah and Joseph experienced over the weekend, or an assessment of potential harm caused.

10.6 The Department's response to the independent investigation

On 22 December 2021, Secretary Pervan cleared an Issues Briefing to the Minister for Children and Youth, which provided updates on a series of concerns raised about Ashley Youth Detention Centre in 2020, via the Office of Cassy O'Connor MP.[1882]

Relevantly, the Issues Briefing, as cleared by Secretary Pervan, stated that regarding:

- the lack of authorisation to put children into isolation after the December 2019 roof incident and the alteration of documents, 'the incident has been externally investigated' and the 'investigation has been finalised and appropriate action taken'[1883]
- the allegation that Mr Ryan had directed or pressured other staff to forge or backdate paperwork in relation to isolation records, '[t]his incident has been independently investigated and finalised, per the above information'.[1884]

It is not clear to us that 'appropriate action' had been taken in relation to the matter, nor that the matter had been 'finalised'. We understand that various disciplinary processes related to the matters raised in the independent investigation report remained underway at the time of this Issues Briefing. We were advised the Department had either 'acted or is waiting to take action' against each of Mr Ryan, Maude and Chester regarding the roles they played in the December 2019 roof incident.[1885] A summary of the status of each matter, as we understand it, is set out next.

10.6.1 Department's response to Mr Ryan

In October 2021, the Department decided not to engage with Mr Ryan regarding the matter, due to health and wellbeing concerns.[1886] On 17 February 2022, Department representatives met with Mr Ryan to discuss concerns raised in the independent investigator's report, including that Mr Ryan had:

- failed to apply the instrument of delegation appropriately under the Youth Justice Act[1887]
- applied pressure on employee/s to complete isolation authorisation forms, knowing the Isolation Procedure had not been followed and approval for isolation had not been sought[1888]
- applied pressure on employee/s to incorrectly complete isolation authorisation forms, to show retrospective compliance with the Isolation Procedure.[1889]

Mr Ryan denied the allegations. The Department concluded Mr Ryan's 'actions (or inactions) most likely did not breach any internal practice guide, process or procedure'.[1890] The Department determined to not take any further action in relation to

the matter.[1891] The reason given for not pursuing an Employment Direction No. 5—Breach of Code of Conduct investigation was that it was 'unlikely an investigation focused on the *State Service Act 2000* would yield any further information [than] has already been obtained'.[1892]

This view appears inconsistent with the original purpose and scope of the independent investigation and calls into question the necessity and usefulness of carrying out a lengthy investigation in the first place.

In a letter to Mr Ryan dated 4 April 2022, Secretary Pervan advised:

> Whilst I do consider that more could have been done in relation to ensuring that correct policies and procedures were followed in relation to the events from 13 to 16 December 2019, I do not consider that further action is required by me given you are no longer assigned duties at [the Centre].
>
> ...
>
> I consider it important that I take this opportunity to document expectations in relation to your new role as Manager Silverdome.
>
> I would like to remind you of existing policies and procedures, specifically in relation to delegations, which are available on Communities Tasmania's intranet. I would like to outline to you that it is important that you obtain written clarification if, at any time, you require clarification in relation to these.[1893]

10.6.2 Department's response to Chester

In or around late 2021, representatives of the Centre and the Department's People and Culture team met with Chester to discuss allegations that he had:

- backdated and signed isolation authorisation documents relating to the December 2019 roof incident, knowing that they were incorrect and to retrospectively show compliance with the Isolation Procedure[1894]
- prepared backdated isolation authorisation documents for staff who worked between 13 and 16 December 2019, to retrospectively show compliance with the Isolation Procedure.[1895]

We were advised that, as of August 2022, the Department's People and Culture team was still waiting to finalise Chester's statement due to his significant absences from work since the meeting.[1896]

10.6.3 Department's response to Maude

We were told the Department has concerns that Maude pressured Chester to backdate and sign isolation authorisation forms relating to the December 2019 roof incident, knowing they were to retrospectively show compliance with the Isolation Procedure.[1897] We understand those concerns had not been put to Maude as Maude was suspended from her employment for other reasons.[1898]

10.6.4 The Department's response to system issues

Ms Honan advised us that the report of the independent investigation into the December 2019 roof incident was not shared with her until 19 May 2021, some weeks after its 26 March 2021 completion.[1899] She stated that no specific action was taken in response to the findings, on the basis that 'many of the issues and considerations identified … had been addressed or were [a] work in progress as previous recommendations in [Serious Event Review Team] reviews'.[1900] She identified these steps as including:

- changes to incident reporting and review
- changes to leadership and collaboration across teams
- clarification of the isolation process
- supporting staff to work in compliance with policy and procedures.[1901]

Ms Honan noted that such an incident would now be managed in a completely different way, and that:

- all staff, including managers, are 'now informed' about procedures concerning the use of force, isolation and delegation and would obtain necessary authorisations consistent with those procedures[1902]
- incident reporting is now managed electronically and is centralised, 'requiring more timely and comprehensive details with multiple review delegations' and resulting in greater transparency and accountability[1903]
- the unit bound practice and Blue Program are no longer in use at Ashley Youth Detention Centre.[1904]

At our public hearings, Ms Honan expressed confidence the unit bound practice and Blue Program were no longer in use at the Centre.[1905] When asked what gave her such confidence, she said:

> I think there's several aspects to it. One of them is that the staff that were authorising it and condoning it as a legitimate practice are no longer there. The staff that are there, i.e. the new managers have—it's been very clear with them and from them with staff. There is much clearer documentation and accountability around practices and procedures, and as an independent, I guess, litmus test and validation that these practices are no longer used we're fortunate to have the Commissioner for Children have an advocate that's also on site three days a week often, sometimes a little less but often frequently; the Commissioner herself is up there on a monthly basis and I have every confidence that the young people would speak up if this was a practice that was occurring.[1906]

Secretary Pervan noted a key response to the December 2019 roof incident was to replace the Isolation Procedure with a 'new directive', although he did not describe what that new directive entailed.[1907] He also identified the following steps taken in response to the December 2019 roof incident:

- the development of an *Ashley Youth Detention Centre Practice Framework* ('Practice Framework') and *Learning and Development Framework* (we discuss these documents in Chapter 12)
- 'upgrade[s]' to the training coordinator role
- the development of new policies and procedures in line with the Practice Framework
- the provision of oversight and risk assessment activities by the Multi-Disciplinary Team alongside the 'development of appropriate safety planning and behaviour management'.[1908]

Secretary Pervan did not provide further detail about what these developments involved in practical terms.

We are aware that in December 2021, the instrument dealing with delegation of authorities and powers at the Centre was revised. Critically, the revised delegation instrument provides as follows:

- The Assistant Manager of the Centre is a delegate who may exercise the Centre Manager's power to isolate a young person under section 133(2) of the Youth Justice Act.[1909] That delegation is not subject to any conditions.[1910]
- The Director, Strategic Youth Services or the Centre Operations Manager may exercise the Centre Manager's power to isolate a young person under section 133(2) of the Youth Justice Act, only if the Centre Manager and the Assistant Manager are 'on leave, uncontactable, or unable for any other reason to perform the relevant function'.[1911]
- An Operations Coordinator may exercise the Centre Manager's power to isolate a young person in line with section 133(2) of the Youth Justice Act. However, the delegation does not extend to authorising isolation for a period of more than 30 minutes.[1912]
- A youth worker may exercise the Centre Manager's power to isolate a young person in line with section 133(2) of the Youth Justice Act. However, the delegation is only to be exercised if the delegate is performing the duties of the Operations Coordinator and does not extend to authorising isolation for a period of more than 30 minutes.[1913]

10.7 Our observations

We note, with concern, the following aspects of the immediate response to the December 2019 incident, including that:

- The Operations Team seemed to understand the purpose of isolating Arlo, Elijah and Joseph to be punishment, despite isolation as punishment being prohibited under the Youth Justice Act and the Isolation Procedure.[1914]
- A number of staff believed isolating Arlo, Elijah and Joseph over the weekend after the incident was being carried out under the Blue Program.[1915] Mr Ryan denied he had instructed staff to use the Blue Program for Arlo, Elijah and Joseph.[1916] However, the independent investigator found the youth workers 'had the Blue Program in mind' when preparing the individual programs for Arlo, Elijah and Joseph.[1917] This suggests the Blue Program remained in use (at least informally) at the Centre until at least the end of 2019.
- One youth worker, with more than a decade's experience at the Centre, told the independent investigator his understanding of isolation procedures was 'very blurred'.[1918] It is concerning that a youth worker with this degree of experience was not clear on how isolation practices should work at the Centre.

We are concerned that some problems with the Isolation Procedure remain. Revisions to the delegation instrument in 2021 expand the number of delegates who may exercise the power to isolate a young person under section 133 of the Youth Justice Act. However, this revised version of the instrument does little to clarify the circumstances in which the Centre Manager or Assistant Manager are 'on leave, uncontactable, or unable for any other reason to perform the relevant function'. It is unclear why such clarifications have not been made, given this was one of the issues raised in the 2019 investigation. It is concerning, too, that this phrase is a condition of many other delegated powers, including in relation to searches.

Despite the claims of clearer documentation or improved training and understanding about isolation procedures, we also query the extent to which the Isolation Procedure and associated delegations reflect current practice. Specifically, we note that Stuart Watson, Centre Manager, stated that extensions of periods of isolation beyond three hours may be approved by the Director.[1919] Fiona Atkins, Assistant Manager, Ashley Youth Detention Centre, similarly expressed the view that extensions of isolation periods beyond three hours require authorisation from the Director.[1920] These responses do not reflect:

- the Isolation Procedure, which only requires that the Centre Manager consult the Director[1921]

- the wording of the Authorisation for Extension of Isolation form, which states that '[e]xtensions beyond [three] hours from initial time of Isolation requires that the Detention Centre Manager (or Delegate) review and consult with [the Multi-Disciplinary Team] and Director'[1922]
- the conditions of the 2021 delegation instrument, which provides that the Director may only exercise the power to isolate a young person under section 133(2) of the Youth Justice Act in instances where the Centre Manager and Assistant Manager are 'on leave, uncontactable, or unable for any other reason to perform the relevant function'.[1923]

We commend an approach that seeks to ensure that extensions of isolation periods beyond three hours receive a high level of authorisation and oversight, given the serious nature of such a practice. However, we are unaware of any written requirement that complements the Isolation Procedure or the 2021 delegation instrument and requires the Director's approval to extend a period of isolation.

We are concerned that despite revisions to the delegation instrument, a common understanding of who has the power to authorise isolation, and in what circumstances, appears to remain elusive to Centre management and Department officials.

11 Roof incident March 2020

In March 2020, there was another incident where young people at the Centre gained access to a roof. Ms Honan, Director, Strategic Youth Services, told us this incident threatened the safety of staff and other young people because of the number and unpredictability of the young people involved.[1924] The Centre's response again involved isolation. We discuss the incident and response next in relation to isolation practices. Other concerns were raised regarding this incident, including allegations of harmful sexual behaviours and workplace health and safety concerns, but we have focused on isolation practices. We were unable to find consistent evidence in relation to the allegations of harmful sexual behaviours, and therefore do not address those matters.

The incident and the response demonstrate continued confusion about appropriate ways to respond to children and young people and the use of isolation practices. We understand the relevant isolation policy at the time of the incident was the Isolation Procedure, which is presently in force and described in Section 2.[1925]

11.1 The incident

On Friday 6 March 2020, staff and young people at Ashley Youth Detention Centre were threatened by four young detainees, who also caused property damage.[1926]

At approximately 2.30 pm, four young people jumped the inner yard fence at the Centre and climbed onto shipping containers at the back of the Ashley School building.[1927] A request for assistance ('code black') was called and available staff responded by positioning themselves to block possible exit routes from the space.[1928] Staff began to negotiate with the young people but were unsuccessful.[1929]

The young people made a hole in the roof of a shipping container and found items stored inside they could use as weapons.[1930] They threatened to harm any staff member who approached them and threw small objects at staff.[1931] Eventually, the young people jumped from the roof of the shipping container armed with hammers and metal bars, and staff moved inside the Centre to keep safe.[1932] The young people then gained entry to the stores building and, while armed with makeshift weapons, climbed onto the roof of the Bronte Unit and continued to threaten staff from there.[1933]

At that time, three staff members and four other young people were inside the Bronte Unit.[1934] A decision was made to evacuate the Bronte Unit.[1935] Staff and two of the young people inside the unit were evacuated first.[1936] When staff returned to evacuate the two remaining young people, staff found they had entered the roof cavity of the unit with the help of the four young people who had broken through the external roof.[1937]

The incident report suggests police were notified, asked to attend and arrived on site at about 4.30 pm.[1938] At approximately 5.00 pm, two young people left the roof and again attempted to gain access to the stores building, where they were restrained by police.[1939] Both were temporarily placed in the admissions holding cell before being escorted to their respective rooms.[1940] Both young people were seen by the Centre's nurse.[1941]

The four remaining young people stayed on the roof for about five hours more.[1942] They continued to make threats, as well as sexual comments, to staff and police, and were still armed with makeshift weapons.[1943] One young person gained access to a circular saw.[1944] The four young people then broke into the Bronte Unit's staff office, accessing the security drawer.[1945] At approximately 6.30 pm, police with shields were moved into the Centre.[1946] A member of the Professional Services Team attempted to contact the families of the young people involved in the incident.[1947]

At about 10.00 pm, one young person came down from the roof, escorted by police.[1948] The three remaining young people made a series of demands, including for pizza and bottles of Coke.[1949] They also asked for guarantees about the unit they would be moved to, that they would not spend any time in their rooms, and that they would be allocated a 'yellow' colour status under the Behaviour Development System.[1950] The young people received the requested food and drink and were assured that they would be placed in the unit of their choice once they came down from the roof.[1951]

By 11.00 pm, all remaining young people had come down from the roof.[1952] They were escorted by police to their unit with no injuries, and their families were notified of the safe conclusion of the incident.[1953]

We understand that all young people detained at Ashley Youth Detention Centre who were not involved in the incident were confined to their units during the incident—about eight-and-a-half hours.[1954]

We note this incident occurred just before the 11 March 2020 announcement by the World Health Organization that COVID-19 was a pandemic.[1955]

11.2 Disagreement about the Centre's response

Mr Ryan was the Centre Manager on the day of the incident. He told us he was very stressed at the time and, aside from a few hours the following Wednesday, after days off and sick leave, this major incident occurred on his last day of employment at Ashley Youth Detention Centre.[1956]

Soon after the March 2020 roof incident, Stuart Watson took over as Acting Manager of Ashley Youth Detention Centre.[1957] He was appointed permanently to the position of Manager, Custodial Youth Justice ('Centre Manager'), in March 2021.[1958]

Towards the end of and immediately following the incident, there was a dispute between Ms Honan and the Centre's management about how the young people involved in the incident should be managed over the following days. We understand that Mr Ryan as Centre Manager, Mr Watson, then the Assistant Manager, Piers, then the Acting Operations Manager and Ms Atkins, as On-Call Manager over the weekend, were involved in telephone discussions with Ms Honan. We received different accounts of this discussion.

Mr Ryan told us he shared many phone calls and emails with Ms Honan as the incident unfolded and once it had concluded.[1959] This included an email from Mr Ryan to Ms Honan on the day of the incident, Friday 6 March.[1960] Mr Ryan added he called meetings with senior staff during the incident about planning for the weekend, and he told senior staff to raise the plans with Ms Honan.[1961] Mr Ryan stated Ms Honan provided no support in relation to how the young people could be managed, but he did not elaborate on this.[1962]

Ms Honan's evidence was that, at about 9.00 pm on the evening of the incident (before it had concluded), Mr Ryan and Ms Honan corresponded about the planned approach to the young people over the weekend.[1963] She provided us with copies of some of that correspondence.[1964] Ms Honan explained that Mr Ryan proposed 'a combination of rolling isolation and unit bound practices for the proceeding [three] day, long weekend for all of the young people involved in the standoff'.[1965] This is evidenced by copies of 'program forecasts' that Mr Ryan provided to Ms Honan on the evening of 6 March 2020,

which he described as involving 'multiple [i]solations', whereby '[e]ach resident would be effectively in and out of their room, but collectively [isolated for] more than 3 hours per day'.[1966] Ms Honan told us she considered this to be a similar response to that used after the December 2019 roof incident, except the approach was provided to Ms Honan to 'endorse'.[1967] Ms Honan's evidence was that Mr Ryan gave no reasons for the need to use isolation and unit bound procedures in this way.[1968] In her view, there were too many 'unknown factors' at that time, as the incident was still ongoing, making the proposal 'premature'.[1969]

Ms Honan emailed Mr Ryan, stating: '[h]aving … compare[d] [Mr Ryan's proposed response] to the isolation procedure … the more uncomfortable I am with it'.[1970] Ms Honan proposed an alternative approach, which included a combination of placing the young people on 'red' colour 'once the initial immediate isolation procedure is expired' and '[r]estricted activity and closer supervision but not constrained to rooms'.[1971] She requested that Mr Ryan reassess the situation the next morning.[1972] Ms Honan said she received a further proposal from Mr Ryan at 10.21 pm on the night of 6 March 2020, asking her to endorse it.[1973] Ms Honan told us that at the time she would not endorse the proposal and instead told Mr Ryan he should rely on the expertise of the Centre's management and the Professional Services Team to determine the best way forward.[1974]

During a later discussion about the incident with Department officials, Digby (a pseudonym), a former Manager, Professional Services and Policy, said the discussion centred on Ms Honan's proposal of a 'reset' based on a therapeutic approach and his and others' focus on 'de-escalation and restoration, which is a critical part of any therapeutic approach'.[1975] He expressed concern the direction being proposed was 'a new way for which there had been no training, no guidelines, policies or procedures, no practice experience'.[1976]

During our hearings, Mr Watson said he also considered the plan proposed by Mr Ryan and others was inappropriate.[1977] Mr Watson stated the correct approach would have been to have rehabilitation at front of mind.[1978] He explained the starting point should be that if the young person was non-violent, non-aggressive and non-threatening, they should be out of their room.[1979] He considered this approach gave young people a chance to rehabilitate and 'move forward'.[1980]

Ms Honan conceded to us that appropriate management of young people was not her area of expertise, and that four or five staff employed at the Centre in addition to Mr Ryan did have the expertise and operational knowledge required to inform the approach.[1981] We note the Isolation Procedure provides that, for isolation periods extending beyond three hours, the Centre Manager or their delegate should 'consult' with various professionals at the Centre and speak with the Director about the outcome of those consultations. This suggests there is no expectation the Director would have specialist knowledge to inform isolation decisions.

It seems apparent there was no agreed policy or procedure being used to guide the response. However, we agree with the observations of Ms Honan that, when read alongside the Isolation Procedure, the proposed approach was concerning and there was no clear rationale for isolation at that time.

11.3 The Centre's response: isolation and unit bound

The evidence available to us indicates the six young people involved were all unit bound for at least four days after the incident, with some unit bound for as long as seven days.[1982]

Ms Honan's evidence was that the eventual approach taken towards the young people involved in the incident partly reflected her suggestions.[1983] She considered the Isolation Procedure was followed appropriately in the days following, as decisions to isolate the young people were 'based on immediate risk and safety assessment[s]' and were authorised by herself and the On-Call Manager where extensions beyond three hours were required.[1984]

According to Mr Watson, the young people were not punished but were dropped to 'red' on the Behaviour Development System.[1985]

The day after the incident, Ms Atkins, Coordinator, Admissions and Training at Ashley Youth Detention Centre at that time, emailed Ms Honan regarding 'continued and ongoing risks … if all young people are to associate'.[1986] Ms Atkins highlighted, among other things, that:

- there were several young people who had intended to take part in the incident and there was talk among the young people of retribution for those who did not get involved
- at that stage, staff had indicated that if 'all young people' were to be allowed out of their rooms, six staff would 'walk off', leaving the Centre significantly understaffed
- one young person was believed to have a weapon at that time
- significant damage to the Bronte Unit meant it could not be used in the near future.[1987]

Ms Honan responded to Ms Atkins' email, welcoming the new information, classifying it as serious, and stating that it 'change[d] the position significantly'.[1988] She noted she 'absolutely support[ed] the staff concerns'.[1989]

We understand all young people were locked in their rooms until at least 3.00 pm on Saturday 7 March 2020.[1990] The next day, Sunday, a fight broke out between some young people who had been involved in the incident and some who had not.[1991] The related incident report stated that before the fight, young people not involved in the roof incident had been:

> … [expressing] resentment towards the residents who had caused them to be unjustly locked in their rooms for 8 hours on Saturday morning [7]th of March [and] saying it was unfair [the] roof incident didn't come with consequences as many had consequences in the past for … similar behaviour.[1992]

Staff held a debrief meeting in the days following the 2020 roof incident, which was also attended by an external counsellor.[1993] Mr Watson, Mr Ryan, Ms Atkins and Ms Honan did not attend this meeting, but Piers did.[1994] In the debrief, staff commented that management had handled the situation well, praised how staff supported one another during the incident and commended the Professional Services Team's response over the weekend following the event.[1995] The debrief minutes identified there was a '[h]istory of [young people] doing stand offs with no consequence for [their] action[s]'.[1996] The minutes also indicated that the staff felt that the overall understanding of the Isolation Procedure could be improved.[1997]

The debrief minutes contained a series of other recommendations and observations. Specifically, the staff sought an explanation from management or the Director about why the decision was made to lock down all the young people in the Centre and not just the young people involved in the incident.[1998]

11.4 The Department's response to the incident

We are not aware of a formal investigation being conducted specifically into the isolation of children and young people after the March 2020 roof incident. We understand there was an internal review of 'the serious incident on 6 March 2020 itself,' but this was more limited than the investigation into the 13 December 2019 roof incident discussed in Section 10 (which considered the extended series of events following the incident, including staff responses).[1999]

11.5 Reforms since March 2020

Ms Honan gave evidence there had been changes at Ashley Youth Detention Centre since the March 2020 incident.[2000] She highlighted changes to the Practice Framework, which outlines a model of care provided at the Centre. Ms Honan reflected that the Practice Framework in place at the Centre at the time of the 2020 roof incident had grown organically and she considered that there were not 'many people that had any clarity about … the practice framework across the Centre, and they had selectively picked pieces out of it or operated almost autonomously … under intuition'.[2001] She acknowledged youth workers did not understand or use the Practice Framework in appropriate ways.[2002]

Soon after the incident, Adjunct Associate Professor Janise Mitchell, Deputy Chief Executive Officer, Australian Childhood Foundation, in partnership with Southern Cross University, prepared a report for the Department titled *Through the Fence and into*

Their Lives: Ashley Youth Detention Centre Trauma Informed Practice Framework, dated April 2020.[2003] We discuss this report in Chapter 10 but note here that it proposes a 'scope of works and methodology for the further development and implementation of an integrated and tailored practice framework'.[2004]

Ms Honan also discussed the siloed nature of the working relationship between the Operations Team and the Professional Services Team, and considered that if staff were to respond to a similar event today, they would do so in a more collaborative way.[2005] She further stated a more trauma-informed practice at the Centre had 'evolved' from the recommendations of the *Through the Fence* report.[2006]

On 26 March 2021, Secretary Pervan received the report of the independent investigation into the December 2019 roof incident, which we describe in Section 10.

11.6 Our observations regarding the March 2020 roof incident

It is apparent from the evidence available to us, including the concerns Ashley Youth Detention Centre staff raised with Ms Honan, that there was a high level of stress and tension among staff following the March 2020 roof incident, as well as a lack of understanding about the decisions made in response to the incident and the reasons for them. It appears the lack of understanding was partly due to insufficient training in responding to major incidents (which we have not discussed here). There was also a lack of understanding of the therapeutic framework intended to guide the response.

Of particular concern, the minutes of an all-staff meeting following the incident recorded the view that staff needed to improve their understanding of, among other things, the Isolation Procedure and that associated training was required.[2007] Most of the staff who attended this debrief had (at that point) been working at the Centre for a substantial number of years, some for more than a decade.[2008] As we noted earlier in our system observations of the December 2019 roof incident, it is alarming that staff members who had worked at the Centre for a significant period felt the need to improve their understanding of important procedures such as the Isolation Procedure.

We were also left with an overwhelming sense that a clear and measured response to the March 2020 roof incident was hampered by workplace tensions. The distress and concerns of staff about the response to the incident were no doubt heightened by the lack of any cohesive or communicated response plan by management and disagreement between senior decision makers.

This degree of dysfunction at the Centre at a senior level and in relation to long-term staff members' ignorance of key procedures relevant to managing young people in detention after incidents of this kind, has put children and young people in detention at risk. It is unacceptable that experienced staff members at the Centre and the

Department do not have the knowledge or skills to respond decisively, lawfully and effectively to incidents that threaten the security of the Centre. It is also not acceptable that management cannot provide decisive, lawful and effective guidance to staff when confronted with an incident of this nature because they are engaged in disputes among themselves about what constitutes a lawful and appropriate response.

We found it difficult to know whether, after these 2020 reforms by the Department, the necessary cultural change had occurred to stop what appeared to have been a systematic use of isolation outside parameters set by international conventions since the Centre was established. We acknowledge Secretary Pervan's evidence of policy change and workforce development to address the issue but note these were strategies that had been trialled repeatedly in the past and failed to create sustained change. We also recognise the evidence of Ms Honan that the changes that gave her confidence inappropriate isolation practices were no longer occurring were that 'the staff that were authorising it and condoning it as a legitimate practice are no longer there'. We were also somewhat reassured by the regular presence at the Centre of the Commissioner for Children and Young People and her advocate, until we received further evidence from the Commissioner in July 2023 (refer to discussion in Section 13).

12 The Department's response to the use of isolation at Ashley Youth Detention Centre

In response to our requests for information, as well as during our public hearings, Secretary Pervan provided several explanations to us about the use of isolation practices—historically and recently—at Ashley Youth Detention Centre.

We asked Secretary Pervan to comment on whether it was appropriate to isolate a young person in detention in the manner described in *Lusted v ZS*.[2009] He responded that '[u]nder no circumstances is the isolation of a young person as described in the case of *Lusted v ZS* appropriate'.[2010] He observed that the staff member who acted to isolate the young person in that case was relying on an 'incorrect' interpretation of the Youth Justice Act.[2011]

Secretary Pervan was also asked whether the isolation of Z, as described in *Lusted v ZS*, was accurately recorded in the isolation register. He responded:

> No. Records from 2013 were stored in physical hard copy files in a locked filing cabinet and in excel spreadsheets which were stored on an external hard drive. The information on the forms during this period was minimal and often not populated or signed off. With respect to this case, the records appear incomplete and have been inaccurately recorded in the isolation register. This may not have

> been classified as 'isolation'. A practice developed known as the 'Blue Program' which was known to be for purported restricted movement and unit bound. The 'Blue Program' was not a formalised or approved program and was not contained in any policy or procedure documents from the time. It does appear, however, that it had some level of acceptance among [Centre] staff as being operationally utilised at that time.[2012]

In a further request for statement, we asked Secretary Pervan to explain the meaning of 'unit bound'. He explained that:

> … unit bound is … the situation where a resident, as a result of decisions made in response to the specific needs and behaviours of the resident, is not scheduled for activities outside the unit and therefore remains within the unit. The resident is not locked into their rooms nor kept from contact with other residents although there may be restrictions on contact with specific residents. Unit bound is not a formal status, and there is no specific policy governing it, but is a description of the current circumstances of the resident.[2013]

Secretary Pervan added that when a young person is unit bound, they continue to have an educational program, which is monitored through the Multi-Disciplinary Team.[2014] Depending on risk assessment, some aspects of the educational program (for example, the Ashley School woodworking program, which involves sharp tools) may not be available.[2015] He continued:

> In the past, 'unit bound' has been used interchangeably with the terms 'separate routine' and 'individual program', both of which appeared on early versions of the isolation procedure and have been, at times, used in a manner similar to the Blue Program …[2016]

In the next paragraph of his statement, Secretary Pervan explained:

> [The Blue Program] … was intended to be for tightly restricted movement and unit bound detainees. A Blue Program appears to have been in place in 2013 and a version of the Blue Program was put into place as a category within the framework of the Behaviour Development System. It was inserted into a draft (Version 2.8) for a period in 2019 and implemented within [the Centre]. Neither the Blue Program nor the Blue category were approved by the Department. The Blue category of the [Behaviour Development System] was implemented within [the Centre] without agency approval. The Blue Program and the Blue category are both based on incorrect interpretations of policies and procedures to manage behaviours. They are unlawful (in my personal view) and inconsistent with approved practice.[2017]

When discussing the present status of the unit bound practice and the Blue Program, Secretary Pervan said:

> In short, the use of the Blue Program and unit bound have been ceased and replaced by a Use of Isolation procedure that is monitored and enforced. I am also aware that the Commissioner for Children and Young People monitors the use of isolation and is regularly provided with data to enable that monitoring.[2018]

In the same statement, Secretary Pervan commented on how decisions are made regarding the use of isolation practices. He said:

> I do not have concerns in regard to how decisions are made in relation to the use of isolation, where isolation is recognised as isolation. There should be no decision made to implement a Blue Program or category under the Behaviour Development System.
>
> As stated above, 'unit bound' is a term to describe the circumstances in which some restrictions on the participation of the resident outside their unit have been put into place as a result of the [Multi-Disciplinary Team]. I do not have concerns about the procedure for the operation of the Multi-Disciplinary team or the decisions made by that team. It may be however that the term 'unit bound' should perhaps be replaced with another term which has less historical associations and better describes the current program for the young person concerned.[2019]

In a discussion about whether isolation could constitute torture, Secretary Pervan stated:

> Without wanting to go to a specific case, only because I don't have that detail in front of me, as I understand—and it's a superficial understanding—the definition of 'torture' in that document goes to intent, and there was, I believe, looking at the past, a use of restrictive practice to—it would be argued by the staff involved it was used as a disciplinary measure, but yet the intent was to cause people to feel bad, it wasn't for their safety, it wasn't for any other purpose but to punish them. [2020]

In his written evidence to our Commission of Inquiry, Secretary Pervan stated unequivocally that both the Blue Program and unit bound were no longer in use at Ashley Youth Detention Centre. However, he expressed his faith in the discretion of the Multi-Disciplinary Team at the Centre to limit the participation of a young person in activities of the Centre and advocated for a new term for the practice. This raises significant concerns that unit bound practices, in some form, continue to be used at the Centre, despite representations to the contrary.[2021] We hold serious concerns that practices substantively similar to unit bound, and involving isolation of a young person within the plain meaning of the term, may still be continuing at the Centre, given the long-term and systematic use of unit bound over previous years.

In her evidence to us, Ms Atkins, Assistant Manager at Ashley Youth Detention Centre, referred to *Standard Operating Procedure No. 15* as current policy. This procedure states, in part, the following:

> Separate Routine
>
> A young person may be placed on a Separate Routine where their behaviour presents a risk to others or to the security of the Centre but which can be managed without resort to isolation. It may involve restrictions on contact with other specific young people or certain programs and areas of the Centre. It may also entail closer supervision and/or restriction to a particular Unit. This strategy can be used to deal with risks such as threats of harm to self and others, threats of escape and

> subversive and inciting behaviour. A Separate Routine can only be approved by the [Centre Support Team] or [Interim Centre Support Team], must be reviewed at least twice a week and must be discontinued as soon as the level of risk permits.[2022]

We note the description of 'separate routine' in the Centre's current procedure reflects the exact wording quoted to Mr Morrissey by the Acting Deputy Secretary, Children and Youth Services, in November 2016, when he sought clarification on the use of unit bound practice on two young people. As discussed above, that response from the Acting Deputy Secretary acknowledged:

- the terms 'unit bound', 'separate routine' and 'individual program' were often used interchangeably
- separating a young person from other young people at the Centre was concerning
- a revised policy was being prepared to resolve the different 'designations' being given to essentially the same practice.

Critically, the Isolation Procedure at Ashley Youth Detention Centre does not appear to have been revised to resolve the different designations, nor to articulate that what is, in substance and effect, a practice of isolation (even if it is part of a broader program that is not associated with the Isolation Procedure) must accord with legislative requirements. Further, there do not appear to be any safeguards currently in place, besides the consideration of the Multi-Disciplinary Team, to ensure that young people are only held in isolation while being unit bound or on 'separate routine' in line with the Youth Justice Act.

We note the contradictory evidence of Secretary Pervan regarding the potential use of unit bound and the Standard Operating Procedure regarding 'separate routine', which suggests the policy conditions that enabled potentially unlawful isolation practices to become systematic still prevail.

We further note that since 2020, children and young people detained at the Centre have experienced significant periods of isolation for operational reasons, due to the impacts of the COVID-19 pandemic and staff shortages. We note that following a visit to the Centre in November 2022, the United Nations Committee against Torture (responsible for monitoring the implementation of the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment) stated that it was 'seriously concerned' about the use of isolation practices at the Centre.[2023] The committee also stated it considered that current practices contravened the Convention and the associated United Nations Standard Minimum Rules for the Treatment of Prisoners (also known as the Nelson Mandela Rules).[2024]

13 Isolation practices in 2023

In July 2023, Commissioner McLean informed us that, since August 2022, there had been a deterioration of conditions for children and young people in detention, and that isolation practices continued to be used at the Centre.[2025] She advised that over the previous six months, her office had observed (among other practices):

- Individual young people being referred to as 'unit bound' by staff during conversations, on office noticeboards, and in Weekly Review Meeting … minutes;
- The extended use of unit-specific lockdowns … and the extended isolation of individual young people, with one young person likening these practices to the 'Blue Program';
- Moving or threatening to move young people to units that experience more frequent lockdowns as a means of responding to and/or managing behaviour;
- The reintroduction of 'quiet time,' which sees young people restricted to their rooms every day between 12:30pm – 1:15pm, sometimes without staff being present in the unit …[2026]

This is extremely concerning.

In response to Commissioner McLean's comments, the Government acknowledged that restrictive practices continued to occur at Ashley Youth Detention Centre due to staff shortages (discussed in Chapter 12).[2027] Timothy Bullard, Secretary, Department for Education, Children and Young People, also stated:

> The [Commissioner for Children and Young People] has expressed concern that young people at [Ashley Youth Detention Centre], particularly those in the Franklin Unit, have been locked down in response to their behaviour. I am advised that young people in the Franklin Unit have been subject to the same restrictive practices as other young people at [the Centre]. I understand that some residents may perceive that they are being treated differently if they are in their rooms while others are out of theirs. This is not the case, as restrictive practice means that young people are out of their rooms at different times of the day, depending on the number and experience of staff present in [the Centre] and the need to accommodate any association issues between young people.[2028]

We note that the Government's response did not address Commissioner McLean's observations:

- that staff were referring to individual children as 'unit bound'
- of extended isolation of individual young people
- that daily 45-minute 'quiet time' had been reinstated.

As such, the Government's response did not address all our grave concerns about the continuing use of isolation at Ashley Youth Detention Centre. As we only became aware of these concerns in July 2023, we were unable to continue to explore these specific

matters. This evidence reinforces our concerns that the cultural and policy conditions that enabled isolation practices to occur continue to exist today.

13.1 Our observations

We remain extremely concerned that isolation practices may be continuing at the Centre at the time of writing and there may not have been the broad sweeping cultural change required to address this.

Finding—The use of isolation as a form of behaviour management, punishment or cruelty and contrary to the Youth Justice Act has been a regular and persistent practice at Ashley Youth Detention Centre since at least the early 2000s, and the conditions that enabled this practice still exist today

Whether described as isolation, unit bound, the Blue Program, segregation, individual program, separate routine, time out or some other term, practices that amount to isolation have been regularly and consistently used at Ashley Youth Detention Centre over many years, despite being contrary to the legal and policy frameworks that are intended to govern the appropriate use of isolation.

The accounts of young people in detention from the early 2000s to at least the mid-2010s consistently mention unlawful and harmful isolation practices, sometimes used as routine practice (such as on admission) and sometimes used as punishment for the conduct of the young person. While we do not comment on the veracity of each individual account, we have given weight to the consistency of their accounts across many years (and the resonances they have with terminology and events in more recent years).

From 2011, the Blue Program, which adopted a practice of unit bound, existed at the Centre as part of the Behaviour Development System, but was, in the words of one longstanding staff member, 'rescinded in December 2013 (although fondly remembered by some staff) because it had become more broadly used (for some residents who didn't really need it) and was considered in some quarters to be a punishment option'.[2029]

From 2016–17, concerns were raised that at least two children in the Centre were being unit bound as punishment for their involvement in an incident at the Centre.[2030]

In March 2019, the Blue Program was formally reintroduced with the knowledge of the Department. This involved children and young people in detention being unit bound for excessive periods (ranging from 18 to 25 days) in response to an incident

at the Centre. While the reintroduction of the Blue Program came with warnings to staff that it was not a form of punishment, it was attached to the Behaviour Development System. Given the excessive time children spent in isolation while on the Blue Program and the program's reintroduction after an incident at the Centre, the children and young people in question must have experienced it as punishment.

In December 2019, despite the shift away from the formal Blue Program, three young people were again unit bound for 11 days in response to an incident at the Centre. They were sometimes isolated in their rooms for one hour to three or four hours at a time.

In March 2020, six young people were again unit bound in response to an incident at the Centre, some for seven days.

We note that since the COVID-19 pandemic and until as recently as August 2023, children have been subject to frequent and regular lockdown practices for operational reasons. These are another form of isolation.

Given the recent evidence we received from the Commissioner for Children and Young People, and the Department's response, we are concerned that some children and young people at the Centre may still be being placed on 'unit bound', being isolated for extended periods, and being subject to daily 'quiet time'.

We are concerned the culture of using a systematic practice of isolating children as punishment or a method of behaviour management is still a risk in 2023, particularly with the lack of clarity around policies such as the segregation procedure.

As outlined in the evidence described here, isolation practices, irrespective of their label, have often involved segregating children and young people from other children and young people, denying them the right to take part in the usual educational programming offered through Ashley School and being locked in their room or unit. Such practices create an institutional culture that increases the risk of child sexual abuse and reduces the likelihood of a young person disclosing such abuse.

Finding—The Department, and sometimes the Tasmanian Government, have been on notice about potentially unlawful isolation practices at Ashley Youth Detention Centre since at least 2013, and have not taken sufficient action

We are particularly concerned the Department, and sometimes the Tasmanian Government, were put on notice several times about isolation practices that contravened both Tasmanian law and human rights principles to which Australia was a signatory, including:

- In 2013, Deputy Chief Magistrate Daly commented that a young person had been subjected to 'isolation in a manner unauthorised by the Youth Justice Act' and noted his concern that 'unauthorised isolation may [be] a normal part of the management of youths in detention or on remand'.[2031]
- During 2016–17, the then Commissioner for Children and Young People raised multiple concerns about the practice of unit bound with the Department and the Tasmanian Government, the veracity of which was acknowledged internally by the Department in the 6 May 2016 Minute.
- In 2018, the Custodial Inspector identified serious inadequacies regarding the use of formal isolation, including the failure to:
    - regularly review and monitor instances of isolation
    - meet minimum observation requirements while young people were held in isolation
    - keep proper records, including providing a reason for the isolation.
- During 2019, the current Commissioner for Children and Young People raised questions on several occasions about the practice of unit bound and the reintroduction of the Blue Program.
- On 26 March 2021, the report of the independent investigation into the response to the December 2019 roof incident at Ashley Youth Detention Centre raised concerns about the use of isolation routines at the Centre, specifically in relation to how isolation periods were extended.[2032] It provided evidence the Blue Program was still believed to be used in practice, if not in name. It also raised serious questions about whether formal isolation procedures were being followed, and that there had been retrospective amending of isolation records.

- In July 2023, Commissioner McLean told us that she had written to the Department 'persistently' in 2022 and 2023 noting the deteriorating conditions experienced by children and young people at the Centre in relation to restrictive practices, rolling lockdowns and low staffing numbers.[2033] The Department acknowledged to us in August 2023 that low staffing numbers had continued to necessitate the use of restrictive practices such as lockdowns despite recent and ongoing recruitment efforts.[2034]

These concerns expressed by multiple entities external to the Department offered the Department, and the State, multiple opportunities to address serious concerns about the safety of children and the abuse of their human rights. We consider these to ultimately be lost opportunities. We were particularly concerned the Department failed to scrutinise why the Blue Program had previously ceased before accepting its reintroduction in March 2019. These missed opportunities meant further cohorts of children detained at the Centre were subjected to likely unlawful isolation practices.

We were also concerned that the Department's response to queries often lacked a plain language description of the daily experience of children subjected to the practices of concern. This reflects the concern expressed by Deputy Chief Magistrate Daly that the response he received from the then Secretary was 'so vague that it was of no practical value' and 'wholly inadequate'.[2035] These responses were accompanied by interpretations of the legal definition of isolation, which could be seen as contrary to the best interests of children and their mental and physical wellbeing.

There were also multiple occasions when concerns about isolation practices were raised in the Department. We found the 6 May 2016 Minute to be extraordinary in its sense of urgency and concern about human rights breaches, its mention of the long retention of a significant number of staff and the culture of the Centre, and its effective call for a spill of staff.

We, too, hold serious concerns about the culture of Ashley Youth Detention Centre. We do not know whether, when the Blue Program was reintroduced in March 2019, longstanding staff identified to Centre management that the Blue Program had previously been identified as unlawful and resulted in policy change during a time when they worked at the Centre, or if they voiced concerns about its use.

We consider Digby's email comments regarding staff attitudes towards the Blue Program, including it being 'fondly remembered', and Ms Honan's assessment of 'staff that were authorising it and condoning it as a legitimate practice' as extremely disturbing. Further, we observed in the evidence made available to us (and as described here) a continued use of the Blue Program by staff, even when it was no longer formally in use. We were gravely concerned about the culture

of resistance noted by Commissioner McLean in her correspondence suggesting this remained the case as late as July 2023 after extensive airing of concerns about these practices in our public hearings. We hold concerns that a punitive culture may have been supported and applied by some staff at the Centre, who may have taken opportunities to nullify reforms and return to more punitive practices whenever they arose. Given staffing changes, we do not know if staff who may hold a more punitive youth justice orientation continue to work at the Centre.

The Department demonstrated, at best, naivety in repeatedly addressing poor and potentially unlawful isolation through training and policy change, and accepting lack of staff knowledge as an explanation, despite many staff, including operational leaders, having long employment histories at the Centre.

The Department needs to have a clear policy on the appropriateness of providing training, counselling or direction to Centre staff members who have repeatedly demonstrated resistance to change.

Finding—There was a consistent failure to include the voices of children and young people detained at Ashley Youth Detention Centre in any reviews, investigations or policy changes relating to isolation

We are concerned that too often the voices and experiences of children and young people are ignored, which can reduce their sense of safety and trust, including trust in disclosing sexual abuse. Children's voices must be heard in decisions that affect them and be taken seriously in the application of Child and Youth Safe Standards.

While we observed two Commissioners for Children and Young People raising concerns about the Blue Program and/or being unit bound, presumably a consequence of their engagement with young people detained at the Centre, we saw no evidence that young people were ever given an opportunity to provide their experience of the Blue Program or being unit bound to people or bodies undertaking reviews of isolation practices at the Centre.

The failure to identify the benefits of engaging with and hearing the voice of children and young people about the Blue Program, particularly following the clarifications requested by Commissioners for Children and Young People, was a further missed opportunity by the Department that may have helped to identify the impact of isolation practices in the Blue Program on children and young people in detention. Because of these missed opportunities, isolation practices that were potentially outside the standards set by law, policy and international conventions continued at the Centre.

Finding—Ashley Youth Detention Centre and the Department failed to support children and young people in detention who were subjected to isolation practices

Despite the many times potentially unlawful isolation practices were raised by external entities, and acknowledged internally, we saw no evidence the Department went through an open disclosure process with children and young people who were or had been in detention to acknowledge that they had been subjected to inappropriate isolation practices. Nor have we identified any records that indicate the Department sought to assess or mitigate mental health impacts of unlawful isolation practices on children and young people in detention who had experienced them.

Case study 4: Use of force in Ashley Youth Detention Centre

1 Overview

As outlined in Chapter 3 and Chapter 10, the National Royal Commission identified that some institutional contexts significantly increase the risk of child sexual abuse occurring.[2036] The National Royal Commission described 'closed' institutions as presenting the highest risk of child sexual abuse.[2037] Youth detention centres are characteristically 'closed' institutions.[2038]

The National Royal Commission described how closed institutions can become 'alternative moral universes', where the institution wholly establishes and maintains its own norms and rules.[2039] Acts of sexual abuse against children and young people are more common where the 'alternative moral universe' of an institution:

- fosters a culture of tolerance for humiliating and degrading children
- routinely uses force or violence against young people
- normalises aggression.[2040]

Research also shows that in institutions where the routine use of force or violence against young people is permitted, staff can become desensitised. This makes it easier for them to minimise the seriousness of, or tolerate, ongoing harm, including sexual harm, to children and young people.[2041] Where trust is undermined, children and young people are unlikely to disclose abuse when it occurs.[2042]

In this case study, we consider the use of force at Ashley Youth Detention Centre. First, we consider the laws and policies governing the use of force, which reinforce that the use of force against a child in detention is only permitted in exceptional situations.

Next, we consider what victim-survivors told us about their experiences of the use of force while in the Centre from the early 2000s to the early 2020s. This is a summary of the evidence we outline in Case study 1. While we do not test the veracity of these individual accounts, we draw conclusions about their consistency, including force being used as punishment and a method to sexually abuse children. Viewed as a whole, these accounts suggested a pattern of some staff using force instead of de-escalation techniques to manage young people's behaviour at the Centre.[2043]

We then discuss a series of instances where excessive force was used at the Centre during 2016–17, which echoed the direct accounts we heard in relation to failures to use de-escalation techniques in managing young people's behaviour. We discuss several

reviews into these examples of the use of force during 2016–17, which raise concerns about whether the Department and the Tasmanian Government have always responded adequately to the inappropriate use of force.

2 The law and policies

International law prohibits the use of restraint or force against young people in detention, other than in exceptional circumstances.[2044] The *Youth Justice Act 1997* ('Youth Justice Act') prohibits the use of physical force against young people in detention, unless the force is reasonable and necessary to prevent harm to the young person or anyone else, or for the security of the detention centre, or is otherwise authorised.[2045]

The *Inspection Standards for Youth Custodial Centres in Tasmania* ('Inspection Standards') provide that force must only be used 'when it is necessary to prevent an imminent and serious threat of self-harm or injury to others, and only when all other means of control have been exhausted'.[2046] The Inspection Standards also state:

- the use of force must only occur for 'the shortest time required'[2047]
- force should never be used as punishment or to obtain a young person's compliance[2048]
- force should never be used to humiliate or degrade a young person[2049]
- all instances of the use of force should be recorded, investigated and reported[2050]
- cameras should be used to record planned interventions involving the use of force[2051]
- a young person who has been subjected to a use of force should be given health care after the incident.[2052]

The Inspection Standards also require that only approved techniques and restraints should be used. The young person should be given an opportunity to speak with staff who were not involved in the incident after the use of force.[2053]

The use of force at Ashley Youth Detention Centre is also guided by the Centre's internal policy, the *Use of Physical Force Procedure*, dated 10 December 2018 ('Use of Force Procedure').[2054] Consistent with the Youth Justice Act, the Use of Force Procedure prohibits the use of force other than in specific, limited situations. It states:

> The use of physical force is a prohibited action, unless it is reasonable and necessary to prevent harm to a person or property. Where it is reasonable and necessary, the minimum amount of force must be used for the shortest time possible. The goal is to ensure the safety of all concerned and to help the young person regain control of their behaviour as quickly as possible.[2055]

The Use of Force Procedure provides that physical force may be allowed where it is reasonable and necessary to:

- conduct a search
- prevent a young person from injuring themselves or anyone else
- prevent a young person from damaging property
- ensure the security of the detention centre
- place a young person in isolation.[2056]

When there is a risk of a child or young person's behaviour requiring use of force, the Use of Force Procedure suggests a (non-exhaustive) list of strategies to reduce the chance of an incident occurring or escalating. This includes:

- using de-escalation strategies known to work with the young person
- talking to the young person in a calm and non-threatening way
- changing their routine
- changing their unit placement.[2057]

When force is required, staff must ensure that minimal force is used, as outlined in the *Minimising the Use of Physical Force and Restraint Practice Advice*.[2058] Staff must not use excessive force.[2059] 'Excessive force' is defined in the Use of Force Procedure as:

- more force than is needed or for longer than is needed
- any force or level of force continuing after the need for it has ended
- any force that might compromise the young person's breathing
- knowingly wrongfully using force.[2060]

The Use of Force Procedure explicitly states that disciplinary or criminal proceedings may follow an excessive use of force.[2061]

In this case study, we outline some accounts of the use of force at the Centre that are alleged to have taken place before the current Use of Force Procedure and Inspection Standards were adopted in 2018.

3 What we heard from victim-survivors about the use of force at Ashley Youth Detention Centre

This case study covers a series of concerning allegations regarding the use of force by some staff at Ashley Youth Detention Centre over many years. We acknowledge there have been and are staff at Ashley Youth Detention Centre who have sought to do their jobs lawfully and appropriately. References to 'staff' in this case study are not intended as a reference to all staff at the Centre, unless explicitly stated in a specific context.

As discussed in Case study 1, we heard evidence about some staff using force, violence and restraints against young people at Ashley Youth Detention Centre. While we do not comment on the veracity of each individual allegation outlined in victim-survivors' accounts, we give weight to the commonality between accounts of the use of force at the Centre, including:

- force, restraints and physical violence being used to facilitate staff members' sexual abuse of young people, or in connection with sexual abuse, including while conducting strip searches of the child. To avoid doubt, we consider strip searches that include touching of a child's anus or genitals or penetration of a child's anus or vagina to be child sexual abuse
- young people being restrained as part of isolation practices
- force, restraints and violence being used to punish young people for not following orders or for reporting abuse
- staff perpetrating violence against young people, and encouraging violence among young people, as a form of humiliation.

Ben (a pseudonym) was 11 years old when he was first detained at Ashley Youth Detention Centre in the early 2000s. He was in and out of the Centre many times throughout his childhood and teenage years.[2062] Ben recalled multiple instances where he said staff used force against him as punishment, reprisal or to manage his behaviour.[2063] He recounted that, on his first admission to the Centre, he reported abuse by older boys against him. He told us that, in response, staff restrained him, stripped him naked and verbally abused him.[2064]

Ben also recalled one occasion when, having tried to escape, he said he was 'belted', stripped naked, handcuffed behind his back, and had his feet cuffed together, before being placed in isolation.[2065] He told us he was left handcuffed and unable to move off the floor of the room where he was isolated for about five hours.[2066] He said he was then isolated for a further three weeks.[2067]

Ben told us that after multiple rapes and other instances of sexual abuse by staff during his time at the Centre, he became angrier and more aggressive.[2068] He said that as his behaviour escalated, he was often restrained by staff and targeted for further abuse.[2069] He said the amount of abuse perpetrated by staff against him was 'a blur' and led to an attempt to '[die by] suicide'.[2070] Ben recounted that following this suicide attempt, he was 'flogged' and put into isolation, where every couple of days, he would be 'belted' by staff.[2071] Ben stated that he twice suffered broken bones because of physical abuse by staff members.[2072]

Ben told us that some of the Centre staff did not have the skills to effectively manage the aggression and violence some young people displayed.[2073] He said maintenance staff at the Centre were sometimes called in to resolve incidents and to restrain young people.[2074] Ben said staff normalised violence and abuse against young people, and that on 'countless occasions' he witnessed new staff being ridiculed by long-term staff because they did not join in on restraining young people.[2075]

Simon (a pseudonym) was 10 years old when he was first admitted to Ashley Youth Detention Centre in the early 2000s.[2076] Simon recalled staff using force when carrying out strip searches. He recounted how staff told him they would need to hold him down during a strip search.[2077] When Simon refused and asked staff to perform a 'normal' search instead, three staff members wrestled him to the ground and spread his buttocks.[2078]

Simon also told us he was often physically abused by Centre staff for minor transgressions, such as refusing to go back to his room.[2079] He said that he and other young people would be 'smashed up' by staff for not going to bed on time, or 'slipping up [and] doing something simple like a kid does'.[2080] He recalled that staff regularly left him with bruises and grazes.[2081]

Simon told us he generally did not complain about poor treatment while he was at the Centre, because he was afraid that staff might physically abuse him if he did.[2082] We heard from other victim-survivors who were detained at the Centre at various times between the early 2000s and late 2010s that they were afraid of violent reprisals from staff members if they reported abuse.[2083]

Charlotte (a pseudonym) was 12 years old when she was first admitted to the Centre in the early 2000s.[2084] Like Ben, Charlotte recalled a violent episode following an instance of self-harm. She told us that when she self-harmed while in lockdown, a staff member entered her room and slammed her head against the bed base, saying she 'needed a flogging' and she was 'making more paperwork' for the staff.[2085]

Fred (a pseudonym), who was detained at the Centre in the mid-2000s, described often being restrained by staff while they were strip searching him.[2086] Fred recalled that during one strip search, three or four staff held him down and put their knees on him.[2087]

Fred said that most of the time he was at Ashley Youth Detention Centre during the mid-2000s he felt 'rough housed' by staff, never knowing when they were going to 'lash out'.[2088] Fred told us staff at the Centre would hit him on the back of his head, push him and jump on him.[2089] He recalled that when some young people from his activity group escaped from the Centre, staff handcuffed him and screamed at him to 'interrogate' him for information about the other boys' whereabouts.[2090] Fred also told us he witnessed a staff member dragging a young girl naked from the shower by her hair, before handcuffing her.[2091] Fred said staff generally treated the young people in the Centre roughly, including the youngest children.[2092]

Fred further described how staff treated violence between children and young people at the Centre 'like a sport', and often provoked young people into using violence against each other.[2093] Fred said the young people housed in the Franklin Unit called the unit the 'gladiator pit', because staff would stand back and observe violent fights, waiting until a fight was almost over before taking any action.[2094] Other victim-survivors detained at the Centre between the mid-2000s and late 2010s similarly recounted that some staff appeared to enjoy the violence that broke out between young people at the Centre.[2095]

Warren (a pseudonym), who was detained at the Centre in the mid-2000s, told us that some staff would 'bring their bad mood to work' and would be 'physical' with the children and young people whom they did not like.[2096] He recounted how staff would pin his arms behind his back, hurting his shoulders, and 'ram [his] head into the walls'.[2097] He said the staff who he alleges abused him were consistently on the same shifts, working together.[2098]

Warren also reported that he was raped by staff on numerous occasions, while other staff members restrained him to facilitate the rapes.[2099] Otis (a pseudonym), who was at the Centre after Warren, similarly reported the use of violence by staff in the context of sexual abuse.[2100] He said that when the staff were not happy with the sexual acts he was forced to perform, including oral sex and rape, they became physically violent and threatened to take away his bedding or his canteen privileges.[2101] Otis also told us he was physically abused when he tried to yell out as he was being sexually abused.[2102]

Brett Robinson, who was detained at Ashley Youth Detention Centre during the late 2000s and early 2010s, similarly reported the use of force in the context of strip searching. Brett described an incident where, after he refused to remove his boxer shorts for a strip search, a staff member forcefully removed Brett's shorts, then inserted his finger in Brett's anus, saying, 'Welcome to Ashley, boy, you do as you're told'.[2103]

Brett also told us that staff would tell him to go to his cell and if he 'didn't move straight away they would manhandle you back to your cell for no good reason'.[2104] Brett reflected that if the staff members had just told him to hurry up, he would have gone.[2105]

Erin (a pseudonym), who was detained at the Centre in the mid-2010s, also told us she regularly witnessed staff members physically abusing other children and young people at the Centre.[2106] She recalled bad physical abuse, particularly against boys at the Centre, which sometimes resulted in broken arms and legs.[2107]

Max (a pseudonym), who was detained at the Centre in the late 2010s, told us he lashed out at a staff member during a strip search on him in an area of the Centre where there were no cameras.[2108] Max said the staff member punched him and reminded him that 'there are no cameras up here'.[2109]

Max also alleged physical abuse by staff following a stand-off in the early 2020s, where he said he agreed with a staff member that he would drop his weapon if no one touched him and he was allowed to return to his room.[2110] Max recalled that when he dropped the weapon he was restrained by four staff members who 'belt[ed] the absolute shit out of [me]' before he was handcuffed and taken to his cell.[2111] Max told us his nose was bleeding, but he was left alone for an hour with no nurse sent to check on him. He had to resort to using toilet paper to stop the bleeding.[2112]

4 Reviews of use of force incidents (2016–19)

In July 2016, a series of incidents occurred at Ashley Youth Detention Centre during which young people were alleged to have damaged property at the Centre. While the incidents raised issues regarding worker safety, there were also concerns relating to how Centre staff used force and isolation to manage the incidents.[2113] We are aware of three reports prepared in response to these incidents—a Report to the Minister for Human Services (August 2016) and a Critical Incident Investigation Report (undated), both prepared by the Department, and a WorkSafe Tasmania report (February 2017).[2114]

Additional incidents involving the use of force occurred in November and December 2017, during which children and young people in detention were restrained by Centre staff. One young person was placed in isolation because of a perceived threat that he would assault other young people and staff.[2115] The Department initiated an internal review of the incidents in 2018.[2116] In 2019, the Ombudsman completed a preliminary inquiries report into one of the 2017 incidents in response to a complaint received from a young person in detention about the use of force by Centre staff.[2117]

The occurrence of these incidents in 2016 and 2017 suggested to us that, at least until recently, there was an ongoing culture of excessive, unreasonable or possibly illegal uses of force by some staff at the Centre. This reflects many of the experiences we were told of by witnesses who were detained at the Centre at various times since 2000, as described above.

Below, we briefly describe the nature of the incidents that occurred in 2016 and 2017. We then outline the major findings of each of the five reports prepared in response to the incidents by various arms of the State and oversight bodies, including the failings those reports identified and the recommendations they made.

4.1 2016 incidents of use of force and associated responses

4.1.1 Uses of force on 14 and 15 July 2016

On 14 and 15 July 2016, a series of incidents involving several young people in detention occurred at Ashley Youth Detention Centre ('the July 2016 incidents').[2118] We summarise below the aspects of the incidents that are relevant to our consideration of the uses of force. The summary is drawn from the subsequent reviews.

On the evening of 14 July, three young people detained at the Centre broke windows (including one window in the unit's common room) and armed themselves with pieces of broken glass.[2119] Tasmania Police attended the incident. Centre staff negotiated with the young people to disarm themselves.[2120] The incident eventually concluded. Centre staff (but not nurses) inspected the young people's hands for injuries, and the young people went to bed.[2121]

The following morning, 15 July 2016, two of the young people involved in the incident the previous evening entered the common room of the unit where they were housed. A maintenance worker had covered the room's broken window with cardboard.[2122] CCTV footage shows the young people appeared 'animated' or 'agitated'.[2123] An incident unfolded where a staff member appeared to attempt to block one young person gaining access or getting close to the broken window.[2124] One of the young people attempted to 'charge' at the staff member who was standing between him and the broken window.[2125] Two additional staff members stepped in, and the young person (who had 'charged' at the staff member) retreated to sit on a table tennis table in the common room.[2126] One of the three staff members (the 'third staff member') then approached the table tennis table, grabbed the young person by the shoulder, pulled him forward, swung him off the table and began pushing him by both shoulders towards his room.[2127] The third staff member and another staff member followed the young person into his room, before exiting about 15 to 30 seconds later.[2128] The next day, the young person alleged the third staff member had entered his room and punched him.[2129]

Soon after that young person was escorted to his room, another staff member put the other young person into a headlock and wrestled him to the ground.[2130] Three staff members pushed this young person down a hallway and into his room.[2131] The young person then tried to push the door open and one staff member 'kick[ed] him back in his room in … the torso region'.[2132]

Later that day, at about 12.30 pm, another young person was kicking the broken window in the common room.[2133] A staff member engaged verbally with the young person and consequently the young person left the common room and entered the dining room.[2134] Two staff members, including the third staff member from the incident earlier that morning, then walked into the dining room, grabbed this young person, and escorted him to his room.[2135] When the young person reached the door of his room, he stopped, at which point the third staff member grabbed him, put him in 'a full nelson hold' and lifted him off the ground.[2136] The third staff member then carried the young person down the hallway and threw him into another room.[2137]

Three reports were prepared in response to the July 2016 incidents. We describe the findings of each report below.

4.1.2 Report from Department to the Minister for Human Services (August 2016)

The July 2016 incidents were reported to the Minister for Human Services on 18 July 2016.[2138] On 12 August 2016, following a detailed review of CCTV footage, the Minister was given a 'full Information Brief' on the matter.[2139]

The Minister sought a further detailed report.[2140] On 19 August 2016, the Department delivered a report to the Minister about the incidents.[2141] The report examined the possible use of excessive force, focusing on the actions of one particular staff member, against young people during the incidents.[2142]

The report noted that, while the specified staff member had been trained in non-violent crisis intervention, the restraints used were not consistent with the non-violence crisis intervention manual.[2143] The report noted that the use of force appeared to be 'excessive to that which might be considered reasonable', given the young person was seen calmly sitting before the use of force.[2144] The report stated that, during the incidents, de-escalation strategies did not appear to have been followed before staff resorted to force, and that the use of a 'nelson' hold by the third staff member on a young person, where force was applied to the young person's neck and the young person was completely lifted off the ground, contradicted the type or use of authorised restraints in the Centre's training and operating procedures.[2145] There is no sign in the report that its authors spoke to the young people involved in the incidents.[2146]

The report contained an action plan that stated the following should occur:

- proceed to act immediately in relation to the staff member, including:
    - starting Employment Direction No. 4—Suspension and Employment Direction No. 5—Breach of Code of Conduct processes
    - appointing an appropriate independent investigator
    - requesting the worker to be absent from the workplace on full pay[2147]

- develop a change management process, including allocating $300,000 to appoint a senior change manager and develop a training package[2148]
- develop a WorkSafe Corrective Action Plan[2149]
- continue a review of priority practices and procedures[2150]
- develop a process to ensure the timely review of all critical incidents[2151]
- deliver risk assessment training in August 2016[2152]
- develop a proposal to strengthen the use of multidisciplinary teams to support a therapeutic-informed approach.[2153]

Secretary Pervan referred the conduct of the staff member in question to Tasmania Police, suspended the staff member on full pay as per Employment Direction No. 4, and started a formal process under Employment Direction No. 5, to run in parallel with the Tasmania Police investigation.[2154] Ultimately, the disciplinary process resulted in counselling, a reprimand and a temporary reassignment of duties.[2155] The police laid charges, however these were ultimately dismissed by the Magistrates Court, which found that the use of force was appropriate in the circumstances.[2156]

4.1.3 Critical Incident Investigation Report (undated)

Besides the report to the Minister for Human Services, the Department prepared a Critical Incident Investigation Report for WorkSafe Tasmania regarding the incidents on 14 and 15 July 2016.[2157]

The report categorised the events as five separate incidents occurring over the two-day period. It reviewed CCTV footage, policy and procedure documents, investigation reports and witness statements.[2158] The report noted difficulties due to:

- delays in receiving statements from staff
- inconsistencies between individual statements
- lack of CCTV coverage in certain areas in the Centre
- lack of audio accompanying the CCTV footage.[2159]

It appears the authors of the report did not speak to young people at the Centre.[2160]

The report made several findings, including:

- Despite statements from staff suggesting they feared for their safety and that the young people were acting in a ‘riotous manner’, no staff member activated their duress alarm or called a ‘code black’ as per the relevant Standard Operating Procedures.[2161]

- The actions of staff were 'contrary to policy' and identified an 'organisational deficiency'.[2162]
- The actions of staff highlighted deficiencies in staff training and staff capability related to emergency response, risk reduction, de-escalation of violent behaviour, and sound decision making to support proactive risk awareness and safety.[2163]
- The CCTV footage did not appear to reveal de-escalation strategies.[2164]
- The restraint the staff members used did not comply with non-violent crisis intervention training.[2165]

4.1.4 WorkSafe Tasmania Investigation Report (February 2017)

A WorkSafe Tasmania investigation, starting on 29 July 2016, was also conducted into the July 2016 incidents.[2166] The investigation report indicated that several factors led to significant deficiencies in Ashley Youth Detention Centre's current safety management system. These factors were 'training, consultation, resourcing, communication and, particularly, risk identification and effective management and control'.[2167] The investigation report noted 'the use of isolation, the use of force, and … a less institutionalised appearance within the facility' were all factors that contributed to the July 2016 incidents.[2168] There is no sign the authors of the investigation report spoke to young people at the Centre.[2169]

WorkSafe Tasmania indicated that, while it recommended that no prosecution action be undertaken against any party, the Secretary of the Department was required to provide monthly status reports regarding the implementation of a remedial corrective action plan and a comprehensive safety management plan.[2170] The remedial corrective action plan included, as a high priority, to '[r]eview, evaluate and reinforce the agenc[y] culture. Ensuring compliance with the programme, policies and procedures (change management process identified and approved)' within 12 months.[2171]

4.2 2017 incidents of use of force and associated responses

4.2.1 Use of force incidents occurring between November and December 2017

In 2017, three more incidents of possible excessive use of force occurred at Ashley Youth Detention Centre. We summarise these incidents here, drawing from the descriptions in the subsequent reviews.

In November 2017, an incident occurred where a young person assaulted an Ashley Youth Detention Centre staff member.[2172] The young person was 'placed on his stomach' on a couch and restrained, before being isolated.[2173]

In December 2017, an incident occurred involving a young person being 'taken down' by staff onto his back on a wooden bench, which he had jumped on after it appears he was informed that he was being moved to another unit.[2174] When the young person was on his back, a staff member 'grasp[ed] [the young person] around the neck or head', while four staff members restrained and handcuffed him.[2175] The young person was then dragged off the bench by the handcuffs, wrist locked and escorted to his room.[2176] CCTV footage showed the entire incident occurred within a minute of the staff members entering the TV room where the young person had been sitting.[2177] The young person was left handcuffed in his room for more than two hours. He complained that staff members used excessive force when they entered his room to remove the handcuffs.[2178]

During that December 2017 incident, another young person attempted to involve himself in the incident between the young person and four staff members.[2179] That other young person was 'flung' or 'thrown' from one staff member to another while the other young person was being restrained.[2180]

Later that month, a young person who appeared 'angry' was restrained on a wooden bench.[2181] CCTV footage showed that staff did not appear to engage non-violent crisis intervention processes before engaging in restraining the young person.[2182]

4.2.2 Department's Review of Incidents at Ashley Youth Detention Centre (2018)

The incidents described above involving the use of force between November and December 2017 were reviewed by the then Director, Strategic Youth Services and Deputy Secretary, Children and Youth Services.[2183] It was agreed to establish an Incident Review Committee to review the incidents.[2184] The specific findings of the review regarding the use of force in relation to these incidents are unclear. The report, however, includes the following comments:

- In several instances there did not appear to be appropriate de-escalation techniques adopted before the restraints.[2185]
- There was a lack of clarity about policies and procedures regarding the supervision and movement of young people and the use of handcuffs, contributing to a lack of clarity about how to manage non-complying young people and how to safely escort them without causing injury.[2186]

The review did not speak to the young people involved in the use of force incidents.[2187]

The report included recommendations relevant to the use of force and staff practices, including:

- an incident with a use of force component must be downloaded from the CCTV footage in its original form and securely stored on a separate drive[2188]

- further training and information sessions were to be provided on isolation procedures and relevant delegations[2189]
- there should be greater clarity in the Centre's Supervision and Movement of Young People Standard Operating Procedure on the required numbers of staff when moving compliant and non-compliant young people in detention[2190]
- Ashley Youth Detention Centre should be given its own training budget and:
    - a fixed-term position for a training manager should be created as a matter of urgency
    - the training manager should undertake a full audit of the training for each staff member
    - a permanent position for a training facilitator and assessor at the Centre should be created
    - the possibility of professional qualifications for all employees at the Centre should be explored[2191]
- onsite discussions should be held with management providing clear guidelines and clarifications about their roles and responsibilities regarding how employees are managed, including their ongoing professional development[2192]
- the Centre Manager must review every incident involving the use of force[2193]
- future legislative amendments should consider changes to the definition of the word isolation, noting that the term, as defined under the Youth Justice Act, was 'not considered to be appropriate terminology for a youth detention centre' and, if possible, 'this should be replaced with language more appropriate to a therapeutic environment [the Centre] is striving to achieve'[2194]
- all staff are to be trained and undertake regular review training regarding verbal judo or similar de-escalation techniques and motivational interviewing techniques by suitable qualified persons[2195]
- a Use of Force Review Committee be established, and a percentage of all incidents be reviewed by the Committee. That this Committee should have a maximum of four people and include representatives from:
    - the Centre's Training Manager or representative from Professional Services
    - Human Resources
    - Workplace Health and Safety
    - Quality Improvement and Workforce Development.[2196]

We understand the Human Resources, Workplace Health and Safety, and Quality Improvement and Workforce Development units were based in the Department and not Ashley Youth Detention Centre.

While it appears the review considered staff used inappropriate force, the Department decided that no action would be taken against the staff members involved in these incidents 'due to gaps in training and procedures' at the Centre.[2197]

4.2.3 Ombudsman's preliminary inquiries into the assessment of a use of force incident (December 2019)

In January 2018, the Ombudsman received a complaint from a young person involved in one of the use of force incidents described above (involving the young person being 'taken down' by staff onto his back on a wooden bench, in December 2017).[2198] After the Department completed its review (described above), the Ombudsman's office conducted a preliminary investigation of the specific incident relating to the complaint.[2199] This included considering the Department's 2018 internal review.[2200] In December 2019, Ombudsman Richard Connock provided a preliminary inquiries report to Secretary Pervan.[2201]

In his report to the Secretary, the Ombudsman questioned the quality and thoroughness of the Department's 2018 internal review (referred to above), describing it as 'perfunctory'.[2202] Among other criticisms of the internal review, the Ombudsman stated the Department had failed to gather basic evidence to inform its assessment of the use of force against the young person who had complained to him, including:

- speaking to that young person about his version of events
- detailing any injuries the young person may have suffered
- reviewing what training on the use of force had been provided to staff at Ashley Youth Detention Centre.[2203]

The Ombudsman also noted the internal review had not included an assessment of whether the use of force was excessive against criteria in the Youth Justice Act relevant to what constitutes 'reasonable force'.[2204]

The Ombudsman further noted in his report to the Secretary that the Department had been aware for some time there were gaps in the training of staff members at the Centre in relation to the use of force.[2205] The Ombudsman emphasised that an independent review of Ashley Youth Detention Centre, undertaken in 2015 (refer to Chapter 10), had identified that '[a] number of people who are involved in the training of Youth Workers expressed concerns at Youth Workers preferring to use physical means of dealing with young people rather than the de-escalation techniques emphasised in the training'.[2206]

The Ombudsman also emphasised that documentation relevant to a therapeutic change program that Ashley Youth Detention Centre had adopted before 2016, known as the 'Ashley+ Approach', had included significant investment in training, but that such training was not working. He quoted the Ashley+ Approach:

> In December 2016 there was a majority of Youth Workers and staff [at Ashley Youth Detention Centre] with 10+ years experience in the Centre. The majority of these staff were originally trained for operating in a corrections rather than therapeutic environment. This training and the transition over recent years from a corrections focus to a rehabilitation and treatment focus are often at odds and despite significant investment in training some staff continue to operate from a corrections philosophy.[2207]

We are particularly concerned by the observations of the Ombudsman that:

> Rather than supporting the Department's position that there are gaps in training, the reports appear to be demonstrating that there has been training provided but that there is an underlying cultural issue affecting its adoption.[2208]

The Ombudsman highlighted several similarities between the use of force incident in December 2017 and the earlier use of force incident that occurred in July 2016. According to the Ombudsman, these similarities included:

- de-escalation attempts appear to be limited
- the use of force was questionable
- there were no obvious immediate threats to the staff involved.[2209]

The Ombudsman questioned why the Department had not sought advice about whether the use of force in December 2017 amounted to an offence, considering that the use of force during the July 2016 incidents had been referred to Tasmania Police.[2210] The Ombudsman said it became apparent to him, when following up the December 2017 incident, that 'an unwritten reason for not pursuing any formal action in this case was due to concerns about already low staff morale following the prosecution in 2016'.[2211] The Ombudsman characterised this rationale as 'concerning', considering that '[t]he paramount consideration for the Department should be the safety and care of the vulnerable children in its care'.[2212]

At the end of his report to Secretary Pervan, the Ombudsman suggested the Department implement a formal process to ensure greater oversight of the use of force by Centre staff, namely that the Ombudsman's office be notified of all future use-of-force incidents at the Centre.[2213]

4.3 Systems observations

During 2016 and 2017, there appear to have been multiple instances of the inappropriate use of force at Ashley Youth Detention Centre. While one incident was raised with police, we remain unclear why others were not, despite the Department being aware of these incidents. We hold serious concerns regarding the Ombudsman's view that the Department appears to have placed undue emphasis on low staff morale as a reason to not take proportionate action, particularly in relation to the December 2017 incident. Staff morale should not be given priority over the safety of vulnerable children. We are also very concerned by the reliance in multiple reviews on additional staff training and policy clarification as the solution to addressing excessive use of force, particularly considering evidence that:

- training had been provided
- the conduct was inconsistent with existing policies on use of force
- there appeared to be cultural resistance to the adoption of the practices recommended by the training.

Finding—The excessive use of force has been a longstanding method of abusing children and young people by some staff at Ashley Youth Detention Centre, and the Department and Tasmanian Government have not always responded appropriately

We find that, during the period under examination by our Commission of Inquiry (2000 to the early 2020s), some staff at the Centre have used excessive force as a method of humiliation, control and abuse of children and young people. While we have not tested the veracity of the individual allegations provided by children and young people previously detained in the Centre, we note patterns in the descriptions of the use of force from the early 2000s to the early 2020s. There were similarities between the type and circumstances of the violence across the allegations. Witnesses described force being used as punishment, and the accounts, viewed as a whole, suggested a pattern of some staff using force instead of de-escalation techniques to manage young people's behaviour. Most, if not all, of the accounts we heard describe an excessive, unreasonable or likely illegal use of force by some staff at the Centre. We heard this force was sometimes used to facilitate child sexual abuse, including through strip searching.

The series of incidents of inappropriate use of force during 2016–17, documented by the Department and other arms of the State, echoed these accounts. The various reviews identified:

- the use of force other than as a last resort
- little or no use of de-escalation attempts
- the use of force when there were no obvious threats to staff or others
- use of force that was injurious or dangerous and outside accepted practice for when force is required.

The Department and the Tasmanian Government were aware of some of these instances of force. Except for the one referral to police and a disciplinary process, we are not convinced there was an adequate response from the Department from 2016 to 2017. We are concerned by an apparent lack of disciplinary response in some instances and little evidence of supports provided to the children and young people involved. We are also concerned that instances of excessive use of force may not have been consistently reported to authorities outside the Centre.

We are particularly concerned that 'gaps in training' were accepted as an excuse for excessive use of force by staff members at the Centre. We share the views of the Ombudsman when he said the problem is more likely an 'underlying cultural issue' affecting the adoption of training. The Department should have a clear policy on the appropriateness of providing training, counselling or direction to Centre staff members who have repeatedly demonstrated resistance to change.

Finding—The Department's responses to excessive use of force do not represent a child-centred approach in line with the United Nations Convention on the Rights of the Child

We note with concern that, while the Department and Tasmanian Government were aware of excessive use of force against children and young people in detention, there are no records that suggest:

- an open disclosure process was initiated, acknowledging that the use of force was inappropriate and offering an apology—an open disclosure approach to abuses by staff of children in detention is essential to enabling a culture of disclosure and to children believing their right to be free from violence and abuse will be upheld

- young people's views and experiences were always sought in the investigations and reviews into what happened to them, or to inform the policies and reforms designed to enhance their care—the United Nations Convention on the Rights of the Child and the Child and Youth Safe Standards are clear on the critical importance of children taking part in decisions that affect them
- physical and psychological impacts of excessive use of force were adequately assessed and responded to.

Finally, concerns regarding staff morale should not be prioritised above the best interests of children.

Case study 5: A response to staff concerns about Ashley Youth Detention Centre

1 Overview

Alysha (a pseudonym) began her role as a Clinical Practice Consultant at Ashley Youth Detention Centre in October 2019.[2214] Her duties comprised professional consultation and support to the Centre's staff, including on interventions and complex cases, and promoting the application of a therapeutic approach in youth detention.[2215]

Alysha told us about the difficulties she experienced at the Centre. She described a 'toxic, misogynistic and dangerous' internal culture that she felt affected her and the young people at the Centre.[2216] Alysha said she witnessed or learned of conduct at the Centre that harmed young people or put them at risk of harm, including sexual abuse. She also said she experienced sexual harassment, bullying and discrimination from other Centre staff.

Alysha told us how she attempted to raise her concerns about the Centre's culture with members of Centre management and Department officials who oversaw the Centre's operation.[2217] In particular, between December 2019 and January 2020, Alysha told us she reported a series of allegations regarding the treatment of young people at the Centre and agitated for an appropriate response. Those allegations included:

- an incident of historical sexual abuse against a young person at the Centre by a serving Centre staff member (who we refer to as Lester (a pseudonym))[2218]
- incidents of harmful sexual behaviours between young people at the Centre
- instances of staff misconduct, including:
    - unlawful strip search and isolation practices
    - using older children in the Centre who displayed harmful sexual behaviours 'as a means of controlling' younger children
    - placing younger children in detention with older children with what Alysha said was the 'express intention' of exposing younger children to sexual abuse.[2219]

The above allegations, and the Department's substantive responses to them, are discussed in Case studies 2, 3 and 7.

Alysha told us she also reported her experiences of sexual harassment, bullying and discrimination to Centre management and the Department. While Alysha acknowledged that some of this conduct occurred at the beginning of her tenure at the Centre, she felt the sexual harassment and bullying she experienced 'escalat[ed]' during her time there.[2220]

Alysha said she considered the treatment she received at the Centre was in response to her 'speaking up about improper practices and advocating for children who were at risk'.[2221] For example, she told us how bullying from at least one co-worker 'gradually worsen[ed]' as Alysha:

- attempted to supervise Operations staff (a practice within Alysha's job description)
- recommended that matters were reported to police
- 'advoca[ted] against a highly punitive approach towards the children'
- suggested therapeutic alternatives to proposed action by Centre staff.[2222]

Alysha took leave from her role in late April 2020 due to what she described as 'safety concerns and stress'.[2223]

In 2021, Alysha raised matters concerning alleged workplace sexual harassment and bullying at the Centre directly with the then Premier, the Honourable Peter Gutwein MP.[2224]

On 10 September 2021, Premier Gutwein appointed Melanie Bartlett to undertake a review 'of the responses to and processes conducted by the [Department] in relation to any complaint made by [Alysha] concerning workplace bullying, assault or sexual harassment'.[2225] The Department was not aware of Alysha's meeting with the Premier and the contents of that discussion until after this time and did not prepare the terms of reference for Ms Bartlett's report.

On 20 September 2021, Alysha made a formal complaint about a number of matters, including the way Michael Pervan, former Secretary of the Department, and Pamela Honan, Director, Strategic Youth Services, responded (or failed to respond) to the reports Alysha had made (and which Mr Pervan and Ms Honan either were, or should have been, aware of) regarding child sexual abuse, harmful sexual behaviours and staff misconduct at the Centre. Ultimately, Alysha's specific complaints against Secretary Pervan and Ms Honan were dismissed. We refer to this complaint as 'Alysha's September 2021 complaint'. We discuss different aspects of Alysha's complaint and the associated responses below.

We understand Alysha has now resigned from the State Service. The circumstances of Alysha's leave of absence and resignation are beyond the scope of our Commission of Inquiry. However, Alysha's September 2021 complaint raised serious questions about whether high-ranking Department officials had responded appropriately to the concerns she raised about the risks faced by young people detained at the Centre and the culture there, including risks of child sexual abuse.

As then Secretary of the Department, Secretary Pervan had the portfolio responsibility for the welfare of children detained at the Centre. That responsibility is recognised in the *Youth Justice Act 1997* ('Youth Justice Act'), under which the Secretary is designated as 'guardian' of children in detention.[2226] Specifically, the Youth Justice Act states that the Secretary is responsible for (among other things) the 'safe custody and wellbeing' of young people in detention.[2227] Similarly, Ms Honan described her role as Director as encompassing oversight of the 'safe and secure operations of' Ashley Youth Detention Centre.[2228] Such oversight roles are now embedded within the Department for Education, Children and Young People. These roles are critical parts of the departmental infrastructure that ensures the welfare of young people in detention, including protecting them from sexual abuse.

Accordingly, Alysha's September 2021 complaint raised serious concerns about whether the Department acted appropriately to ensure the safety of young people at the Centre. More broadly, her complaints invited interrogation of the effectiveness of the broader system within the Department to ensure such welfare. In this context, we consider the way the State and Department responded to the complaints against Ms Honan and Secretary Pervan provides valuable insight into the State and Department's recent attitude and approach towards complaints about how reports of child sexual abuse and associated matters are managed at the Centre.

2 Complaints Alysha made against Ms Honan and Secretary Pervan

On 20 September 2021, Alysha's lawyer wrote to Paul Turner SC, Assistant Solicitor-General (Litigation), Department of Justice, setting out complaints Alysha made against Ms Honan and Secretary Pervan ('September 2021 Letter').[2229] Alysha made six complaints against Ms Honan. Alysha alleged that Ms Honan knew, or ought to have known, of the sexual harassment, bullying and discrimination Alysha suffered during her time at the Centre. Alysha also complained that Ms Honan failed to respond appropriately to Alysha's reports of such behaviours. Alysha also alleged that Ms Honan:

- discouraged Alysha from reporting allegations of Lester's serious sexual assault and/or rape of a young person at the Centre, and/or attempted to 'shut down' or 'frustrate' investigations of those allegations ('allegations of child sexual abuse by staff') (noting Alysha reported allegations about Lester in January 2020)
- discouraged Alysha from reporting harmful sexual behaviours between young people at the Centre, and attempted to 'shut down' and/or 'frustrate' investigations of those matters ('allegations of harmful sexual behaviour')

- knew of, and failed to address, staff misconduct and staff non-compliance with policies and laws, including isolation and strip searching practices, and the intentional exposure of young people to a risk of physical and sexual assault ('allegations of staff misconduct').[2230]

In relation to Secretary Pervan, Alysha alleged that he:

- mishandled Alysha's sexual harassment complaint against a Centre staff member
- knew, or ought to have reasonably known, of misconduct at the Centre regarding isolation and strip-searching practices, and the intentional exposure of young people to a risk of physical and sexual assault, and failed to respond appropriately.[2231]

Alysha claimed the above actions and failures amounted to breaches of the State Service Code of Conduct by Ms Honan and Secretary Pervan (refer to Chapter 20 for a discussion of the State Service Code of Conduct).[2232]

We discuss allegations regarding child sexual abuse by staff, harmful sexual behaviours by detainees, isolation, strip searching, the intentional exposure of young people to a risk of physical and sexual abuse and the Department's response to those allegations, in greater detail in Case studies 2, 3, 4 and 7. Notably, in Case study 7, we accept evidence that the Department failed to fully investigate Alysha's report regarding Lester at the time of her report in January 2020.

In this case study, we focus on the State and Department's response to Alysha's September 2021 complaint. We identified elements of the State and Department's management of Alysha's complaint that are concerning. These elements explain recent systemic deficiencies in attitudes and responses to allegations of failures by departmental officials in taking steps to protect children in detention from abuse.

3 Fragmentation of complaint

As described above, in September 2021, Alysha raised matters personally with the Premier. She also directed a letter to the Office of the Solicitor-General that shared her concerns about the Centre—concerns she had previously raised within the Centre or with Ms Honan.[2233] Several reviews and investigations were initiated in response to Alysha's various complaints about how the Department managed the concerns, including:

- independent preliminary assessment and investigation into Alysha's complaints against Secretary Pervan (started in September 2021 and completed in March 2022) ('Bowen Investigation')
- internal preliminary assessment of Alysha's complaints against Ms Honan (started in September 2021 and completed in June 2022) ('Preliminary Assessment')

- independent investigation into the State's response to Alysha's allegations of the workplace bullying, assault or sexual harassment she experienced at the Centre (started in September 2021 and finalised in October 2021) ('Bartlett Review').

These reviews and investigations were conducted by different people, and different areas of the State or Government were involved.

In this section, we briefly discuss the focus of each response to identify that:

- some matters of serious concern Alysha raised appear to never have been addressed
- taking this approach was a missed opportunity for the State and the Department to identify and address systemic matters.

In the remainder of this case study, we focus on problems with the Preliminary Assessment of Alysha's complaints against Ms Honan.

3.1 Bowen Investigation

In September 2021, an independent investigator, Peter Bowen, commenced an investigation into the complaints against Secretary Pervan. We understand this Investigation was initiated by the then Premier, the Honourable Peter Gutwein MP.

Mr Bowen conducted an initial review of Alysha's complaints against Secretary Pervan to determine whether there were reasonable grounds to believe Secretary Pervan had breached the State Service Code of Conduct.[2234] That initial review concluded that there were reasonable grounds for such a belief in relation to some complaints.[2235] As a result, Mr Bowen carried out a more thorough investigation of those complaints for which reasonable grounds existed.

The Bowen Investigation report was finalised on 30 March 2022.[2236] Ultimately, Mr Bowen dismissed the complaints or otherwise declined to investigate them on the basis that there were no reasonable grounds to believe that Secretary Pervan had breached the State Service Code of Conduct.[2237]

We acknowledge that the Bowen Investigation was conducted independently and do not comment on how it was conducted or its findings, aside from commenting on the decision to respond to it as a separate complaint.

3.2 Preliminary Assessment

On 28 September 2021, the Office of the Solicitor-General forwarded Alysha's complaints regarding Ms Honan to Mandy Clarke, Deputy Secretary, Children, Youth and Families, Department of Communities.[2238]

Ms Clarke then conducted a Preliminary Assessment of Alysha's complaints to determine whether there was reason to believe that Ms Honan had breached the State Service Code of Conduct.[2239] Kathy Baker, then Deputy Secretary, Corporate Services, Department of Communities, reviewed the Preliminary Assessment.[2240] As discussed further in this case study, we are unclear about who the final decision maker was.

The Preliminary Assessment did not deal with Alysha's allegations about workplace sexual harassment, bullying and discrimination. Instead, it deferred to the work of the Bartlett Review, stating:

> The author is cognisant at the time of completing a preliminary assessment the Tasmanian Government commissioned an Independent Review which examined all matters concerning sexual harassment, workplace bullying and discrimination raised by the complainant.
>
> The author is of the understanding the appointed Independent Reviewer met with the complainant to discuss the matters. The author made a decision that it was inappropriate for this preliminary assessment to make specific commentary of the matters given the Independent Review process will provide procedural fairness to the complainant to support a resolution to the matters.[2241]

Accordingly, the Preliminary Assessment conducted no analysis and reached no conclusions about Ms Honan's actions relating to Alysha's allegations of workplace sexual harassment, bullying and discrimination.

We are unaware of any steps the Department of Premier and Cabinet took to ensure the Department knew of the scope and limitations of the Bartlett Review. The evidence available to us suggests that, at least as late as the end of November 2021, the Bartlett Review report had not been provided to the Department.[2242] The wording of the Preliminary Assessment suggests the author was unclear as to the status of the Bartlett Review (let alone its scope of findings) at the time the Preliminary Assessment was finalised (June 2022).

The Preliminary Assessment concluded that the Department 'did not identify nor source any evidence which suggests that there is a reason to believe that Ms Honan has breached the [State Service Code of Conduct]' and no further action was taken.[2243] Ms Baker communicated the outcome of the Preliminary Assessment to Alysha on 30 June 2022, by letter attaching a copy of the Preliminary Assessment.[2244] This was some nine months after Alysha made her complaint.

3.3 Bartlett Review

As outlined in Section 1, on 10 September 2021, the Premier appointed Ms Bartlett to undertake a review 'of the responses to and processes conducted by the [Department] in relation to any complaint made by [Alysha] concerning workplace bullying, assault or sexual harassment'.[2245] We understand the Bartlett Review was managed by the Department of Premier and Cabinet. The Bartlett Review was conducted in September and October 2021. The report was finalised on 22 October 2021.[2246] The scope of the Bartlett Review, as set out in its terms of reference, was narrow. It focused, as directed, on the Department's response to allegations of workplace bullying, assault and sexual harassment the Department had previously received. Consistent with its terms of reference, the Bartlett Review excluded new allegations of bullying, assault and sexual harassment, which the Department had not previously received, including those contained in the letter from Alysha's lawyer to the Office of the Solicitor-General. Matters not considered by the Bartlett Review included:

- Alysha's allegations that she was bullied by other Centre staff as a response to 'her needing to report matters that she had observed at [the Centre]', because these complaints were not formalised, and available evidence showed Alysha considered the issues 'to have been satisfactorily resolved'[2247]
- Alysha's allegation regarding a Centre staff member swerving their car towards her, because she had not previously reported the matter to any Department staff member and had made no formal complaint on the matter previously[2248]
- the Department's response to Alysha's complaints against Secretary Pervan and Ms Honan that were raised in September 2021, given the Department's response was ongoing.[2249]

We note also that discrimination was not within the scope of the Bartlett Review (despite the Department's incorrect belief, as set out above).[2250] The Bartlett Review found no deficiencies in the processes the Department used to resolve Alysha's previous complaints, but commented on:

- the delays in the investigation and the Secretary's decisions about the previous complaints
- how the outcome of the investigation was communicated to Alysha.[2251]

We do not discuss those findings here.

3.4 Our observations

The State and/or the Department separated Alysha's September 2021 complaint into three different investigations. We are concerned this fragmented approach obscured the totality of Alysha's concerns about child sexual abuse occurring at the Centre and ultimately undermined the effectiveness of the State and Department's response to the matters she raised. Overall, Alysha's September 2021 complaint about Ms Honan and Secretary Pervan stemmed from the same set of allegations, including her concerns about:

- the abuse of young people in detention
- a toxic workplace culture within the Centre that accepted bullying, harassment and discrimination of staff and tolerated (if not enabled) the abuse of young people in detention
- a departmental culture that minimised reports or complaints about such practices or actively sought to harm staff who made such reports or complaints.

The complaints against Secretary Pervan and Ms Honan were approached on an individual level as disciplinary matters and were divided between the Department of Premier and Cabinet and the then Department of Communities, respectively. Each disciplinary process focused on the activities or matters within the respective control of Secretary Pervan and Ms Honan to form a view about whether either official had engaged in misconduct, as Alysha alleged.

We acknowledge that Alysha's complaints about Secretary Pervan and Ms Honan were conveyed in individual disciplinary terms. Still, by dividing Alysha's complaints about Secretary Pervan and Ms Honan and focusing immediately on the disciplinary issues, the State lost an opportunity to see that the complaints potentially disclosed systemic problems or failings at a departmental (as opposed to an individual) level related to the care and protection of children in detention.

Our analysis of the Department's response to some of Alysha's allegations, including allegations of child sexual abuse by staff and harmful sexual behaviours in Case studies 2 and 7, highlights multiple systemic problems that could have been identified by an appropriate response to Alysha's complaints.

In addition, separating the complaint and the responses to it meant the State missed an opportunity to consider whether Alysha's alleged experiences of sexual harassment, bullying and discrimination were reprisals for her efforts to report child sexual abuse, harmful sexual behaviours and other misconduct at the Centre. The Bartlett Review's terms of reference meant that it focused on previous complaints about workplace sexual harassment, bullying and assault while the Preliminary Assessment excluded consideration of workplace matters because of the existence of the Bartlett Review and the incorrect belief that it would address all workplace bullying allegations.

Alysha's view was that the sustained and escalating sexual harassment, bullying and discrimination she experienced was a direct response to her 'speaking up'.[2252] We are not aware that any government department or official acknowledged or was tasked with considering any potential nexus between Alysha's attempts to highlight issues at the Centre and the alleged mistreatment she experienced. While we are not in a position to determine whether Alysha was targeted by staff for raising concerns about children and young people, we are concerned the fragmentation of Alysha's September 2021 complaint left a significant issue unaddressed and may dissuade those who seek to raise concerns about risks to young people in detention.

We are also concerned that a response that separates elements of a complaint means the complainant must engage with multiple investigations, which is onerous, and may, again, deter people from raising concerns.

We do not consider the failure of the State or Department to recognise the systemic issues in Alysha's September 2021 complaint is attributable to the manner or form in which Alysha expressed her concerns about Secretary Pervan and Ms Honan. It was not her role to guide the State or Department to understand or acknowledge systemic problems in the issues she raised. A complaint or concern must always be addressed for its substance, not its form. We also accept Alysha was only reacting to actions or inactions she was aware of. Her efforts highlight the difficulties associated with raising complaints of this nature.

We appreciate that Alysha's September 2021 complaint started disciplinary procedures that engaged important principles, such as privacy and procedural fairness, which may require complaints to be dealt with individually or compartmentalised. However, we do not consider that such procedures must necessarily occur at the expense of acknowledging that such complaints can provide valuable information about the appropriate operation of the Department as a whole. An alternative approach that involved the appointment of a single investigator to investigate the complaints against the two individuals and the Department as a whole would have reduced risks associated with fragmentation.

4 Preliminary Assessment

In the remainder of this case study, we consider how the State responded to the complaint about Ms Honan specifically and identify several problems regarding:

- how the Preliminary Assessment was allocated and managed
- delays in conducting the Preliminary Assessment
- the Preliminary Assessment becoming a quasi-investigation and containing many inaccuracies.

4.1 The process for allocating and managing the Preliminary Assessment

We were concerned that Ms Clarke and Ms Baker were inappropriately allocated the Preliminary Assessment as they had an actual, real or perceived conflict of interest in the substantive matters of the complaint. We were also concerned that there was no clear decision maker in this Preliminary Assessment. We set out our concerns below.

4.1.1 Conflicts of interest

As described earlier, Alysha's September 2021 complaint was directed to the Office of the Solicitor-General. Ms Clarke told us that on 28 September 2021, the Office of the Solicitor-General 'forwarded' Alysha's complaint to Ms Clarke by email.[2253] In her evidence at our hearings, Ms Clarke also referred to the complaint having been referred from the Office of the Solicitor-General to the Deputy Secretary.[2254] Ms Baker told us that the complaint was 'referr[ed]' from the Office of the Solicitor-General to Ms Clarke.[2255]

By the Office of the Solicitor-General 'providing' or forwarding' Alysha's complaint to Ms Clarke it is not clear whether:

- the Office was seeking to have Ms Clarke carry out a Preliminary Assessment
- Ms Clarke understood the referring or forwarding of the complaint as a direction to do so
- the Office was simply forwarding the relevant portion of the complaint to Ms Clarke as the manager to whom Ms Honan reported and to determine herself how to respond.

We received no evidence that the Office of the Solicitor-General played a role in managing the response.

Both Ms Clarke and Ms Baker are listed as the 'decision-makers' on the Preliminary Assessment form, with Ms Clarke identified as the 'preliminary assessor' and Ms Baker identified as the 'reviewer'.[2256] Ms Clarke explained that the reason the matter was referred to her as Deputy Secretary was because Secretary Pervan had a conflict of interest in the matter (as Alysha had also made a complaint about Secretary Pervan).[2257] Ms Baker, in responding to a query about Ms Clarke's role in conducting the Preliminary Assessment, also noted Secretary Pervan's conflict of interest.[2258]

We commend the State's early recognition of Secretary Pervan's conflict and his consequent inability to take part in the Preliminary Assessment. We were concerned that Ms Clarke and Ms Baker were involved in carrying out the Preliminary Assessment. Ms Clarke and Ms Baker had been involved in the Department's response to some of the matters Alysha had initially reported to Ms Honan, both personally and as executive managers of their respective areas in the Department.

Ms Clarke and Ms Baker's involvement in responding to some of the substantive matters in Alysha's complaints, particularly relating to the allegations about child sexual abuse by staff and harmful sexual behaviours at the Centre, included:

- Ms Baker was notified of the allegations about child sexual abuse by staff on 10 January 2020, the day after Alysha raised this concern with Ms Honan.[2259]
- Ms Baker directed People and Culture to consider the matter in January 2020.[2260]
- Ms Baker understood that People and Culture had undertaken 'extensive file searches' shortly after Alysha's report to determine whether information relating to the allegation was held on Lester's file or there had been prior Abuse in State Care Program claims against Lester.[2261]
- Ms Clarke became aware of the allegations against Lester in September 2020 and was involved in the response from that point.[2262]
- Ms Baker and Ms Clarke attended key Strengthening Safeguards Working Group meetings in the Department to discuss how the Department managed allegations against Lester and other allegations of child sexual abuse against staff, at least up to Lester's suspension from the State Service in November 2020.
- Ms Baker (and later, Ms Clarke, who was the Deputy Secretary with portfolio responsibility for child safety) knew that Lester continued to be on site at the Centre through much of 2020.
- As the Deputy Secretary, Corporate Services, Ms Baker was responsible for the People and Culture division. This division reported allegations of abuse against Lester to police in November 2020.

In Case study 7, we accept evidence that the Department initially failed to investigate Alysha's report to Ms Honan about Lester. We base this conclusion on a statement Ms Clarke made in an internal email dated 21 September 2020, where she said in relation to an issues register recording matters relating to allegations of abuse at the Centre:

> The Issues Register captures the issue that was raised by an AYDC employee [Alysha] which Pam [Honan] forwarded earlier today. This came to light during a discussion I had with Pam today and dates back to January 2020. It does not appear that any investigation has been undertaken on this matter, and I note [Lester] is also the alleged abuser.
>
> I would suggest these are serious allegations relating to [Lester] … A HR file review needs to occur, and the abuse in state care file may inform us as to whether a police report was made at the time.[2263]

We note that Ms Clarke was not aware of the allegations against Lester until around this time and the steps Ms Clarke took in September 2020 ultimately resulted in the Department assessing and responding to reports about Lester.

The Preliminary Assessment provided the following details about Ms Clarke's involvement in the Department's response to Alysha's report regarding harmful sexual behaviours at the Centre:

- On the day that Ms Honan received Alysha's report, 'Ms Honan discussed the matter with the Deputy Secretary Children, Youth & Families [Ms Clarke] which triggered the commissioning of a Serious Event Review of the incident'.[2264]
- The Serious Events Review Team terms of reference were 'developed and approved' by Ms Clarke (together with a member of the Serious Events Review Team).[2265]
- Ms Clarke received the Serious Events Review Team's report on 27 April 2020.[2266]

We were concerned by Ms Baker's proximity to the departmental response to Alysha's report about Lester, and Ms Clarke's proximity to the departmental response to Alysha's report about both Lester and incidents of harmful sexual behaviours at the Centre.

We understand the purpose of the Preliminary Assessment to have been to determine whether there was reason to believe Ms Honan had breached the State Service Code of Conduct. In doing so, Ms Clarke and Ms Baker were investigating the appropriateness of Ms Honan's conduct in responding to Alysha's reports for a disciplinary process. Their task was not, ostensibly, to inquire into the appropriateness of the Department's response to those reports more broadly, or the actions or inactions of other Department officials (including their own). However, we are concerned that, in investigating the appropriateness of Ms Honan's actions, Ms Clarke and Ms Baker were indirectly reflecting upon their own responses to some of the reports Alysha made.

We asked Secretary Pervan, Ms Baker and Ms Clarke whether they considered it was appropriate for Ms Clarke and Ms Baker to carry out the Preliminary Assessment, given their respective roles in responding to Alysha's reports.[2267]

Secretary Pervan said he considered their involvement in the Preliminary Assessment to be appropriate but provided no further comments or justification for his view.[2268]

In her written statement, Ms Clarke declined to comment on this request, deferring to the view of Secretary Pervan.[2269] When asked about the matter during our public hearings, she said:

> … over the years I've certainly assessed individual directors or managers over time. I have no issue - I mean, I have professional working relationships with directors, I had a particular interest in this, I actually did want to assure myself, as I've said, so I felt I was best placed to. I was across detail, and so, perhaps you're saying, is there a perceived conflict of interest? I guess that then goes to who else would have been in a position to do that preliminary assessment because one of the reasons it was referred from the Office of the Solicitor-General to the Deputy Secretary was, Alysha was making a complaint about the Secretary as well, so there were different arrangements in place, which is why it ended up being the Deputy Secretary.[2270]

Ms Baker also acknowledged that Secretary Pervan was likely to have a view on the potential conflict, but commented in relation to Ms Clarke:

> I note that the referral of the complaint was from the Office of the Solicitor General to Ms Clarke and given the allegations were against a Senior Executive Officer, it is my view that it was appropriate that Ms Clarke was the most suitable person to undertake the preliminary assessment. She had the requisite skills, knowledge and experience to undertake this in an objective and fair manner. I don't consider that because Ms Honan reported to Ms Clarke that it meant she could not complete the assessment.[2271]

We asked the State whether it had identified any actual, potential or perceived conflict of interest relating to the investigation, management or determination of Alysha's complaints against Ms Honan. In a response received from the Department for Education, Children and Young People, we were told that the State had not identified any such conflict of interest.[2272]

We are not convinced the process for referring the matter to Ms Clarke and Ms Baker adequately considered or reflected upon the extent to which Ms Baker and Ms Clarke may have each had a conflict of interest in this matter—that potential conflict being that in investigating the suitability of Ms Honan's actions, Ms Clarke and Ms Baker were indirectly reflecting upon their own responses to some of the reports Alysha made. Ms Baker and Ms Clarke have both expressed to us that they do not consider they had any conflict of interest. We consider it would have been preferable, subject to any overriding requirements in Ms Honan's instrument of employment, for the complaint against Ms Honan to have been outsourced to an independent assessor, as was done in relation to the complaint against Secretary Pervan.

Finding—The Department should not have conducted the Preliminary Assessment and this reflects systemic problems

We were concerned by the lack of evidence provided to our Commission of Inquiry about the appropriate allocation of the Preliminary Assessment, including the extent to which the State considered the appropriateness of Ms Clarke and Ms Baker's involvement in the Preliminary Assessment.

Ms Clarke and Ms Baker were involved in processes that were under direct consideration in the Preliminary Assessment. These processes included initiating, conducting or directing the scope of investigations relating to Alysha's complaints regarding Lester and (in Ms Clarke's case) responding to allegations of harmful sexual behaviours at the Centre. Each had a personal interest in demonstrating the suitability of Ms Honan's (and, by extension, theirs and the Department's) response to Alysha's reports. In that context, we consider there are serious

questions about whether Ms Clarke and Ms Baker had actual, potential or perceived conflicts of interest such that they should not have been allocated or conducted the Preliminary Assessment.

As described above, Ms Clarke contended that the question of her and Ms Baker's conflicts 'goes to who else would have been in a position' to conduct the Preliminary Assessment. We disagree that no other person was suitable to undertake the Preliminary Assessment. We were not convinced that an independent reviewer, such as a Secretary from another Department or the Head of the State Service, could not have been appointed to undertake this task. More objective reviewers may have been better placed to identify systemic concerns and to divert them for consideration appropriately (beyond the narrow forum of the disciplinary action against Ms Honan).

These problems reflect systemic matters we have observed elsewhere. The absence of clear direction and policy guidance relating to preliminary assessments raises the risk of conflicts of interest not being recognised and understood. We are not confident the process for initiating and conducting a preliminary assessment was well understood because:

- the complaint was forwarded to Ms Clarke by the Office of the Solicitor-General
- Ms Clarke and Ms Baker were allowed to conduct the Preliminary Assessment without apparent acknowledgment or management of their actual, potential or perceived conflicts of interest.

We do not consider the Preliminary Assessment should have been structured in this way.

We consider it is a critical systemic issue that the Employment Direction No. 5—Breach of Code of Conduct process does not provide for situations where there is or may be a conflict of interest, as there was in this instance.

Poor or unclear processes for complaints, including the Preliminary Assessment process, can undermine people's confidence in making complaints about child sexual abuse or responses to it.

4.1.2 Lack of a clear decision maker

We were unable to determine who was the decision maker regarding the Preliminary Assessment.

Ms Clarke and Ms Baker are listed as the 'decision-makers' on the Preliminary Assessment form.[2273] The Preliminary Assessment form does not state that any other person played a role in managing, conducting or determining the outcome of the assessment.

Before our public hearings, Secretary Pervan, Ms Baker and Ms Clarke were asked several questions about the Preliminary Assessment.[2274] In response to some questions, Secretary Pervan responded:

> … I was advised by Kathy Baker that a complaint had been received and due to potential conflict of interest, Kathy Baker and Mandy Clarke would manage it. As a result, I do not have any further information to give.[2275]

We understand that Secretary Pervan's evidence is that he did not 'manage' the Preliminary Assessment and that Ms Baker and Ms Clarke managed it instead.

We also asked Ms Clarke questions about the Preliminary Assessment, including whether she was satisfied that the Preliminary Assessment was conducted adequately and was an accurate and complete document.[2276] Ms Clarke did not respond to this question, stating that '[a]s the decision maker [Secretary Pervan] is best placed to answer this question'.[2277] In her procedural fairness response, Ms Clarke told us Secretary Pervan was the decision maker. She told us that this is demonstrated by Secretary Pervan approving and signing a Minute regarding Alysha's complaint on 30 June 2022.[2278]

We also received evidence that the Office of the Solicitor-General was provided the Preliminary Assessment, although we are unclear for what purpose.[2279] We outline the timing of their involvement in more detail below.

After the hearings, we asked the State to describe how it managed Alysha's complaint against Ms Honan, including by identifying each person:

- responsible for investigating, managing and determining the complaint and its outcome, the period during which they held that responsibility and the extent of their responsibility
- who provided input into the investigation, management and determination of the complaint, the nature of any such input and how the input was provided.[2280]

In response, the Department for Education, Children and Young People confirmed Ms Clarke undertook the Preliminary Assessment, which Ms Baker then reviewed.[2281] This response aligns with our understanding of Ms Baker and Ms Clarke's evidence, as well as the information presented in the Preliminary Assessment.[2282]

The Department also told us that Secretary Pervan 'manage[d]' Alysha's complaint against Ms Honan.[2283] The Department did not explain the nature of that role. For example, we are unaware whether Secretary Pervan's role involved all or any of the following:

- making a final decision on whether to start an investigation under Employment Direction No. 5 (that is, an investigation into a possible breach of the State Service Code of Conduct) based on Ms Clarke and Ms Baker's assessment
- providing advice or guidance to Ms Clarke and Ms Baker about how to conduct the Preliminary Assessment
- only providing administrative oversight of Ms Baker and Ms Clarke as their line manager but otherwise not participating in the decision making.

The Department did not identify any staff member adopting the role of decision maker or making a determination or decision, although noted the list of people it identified was not exhaustive.[2284]

We do not consider Secretary Pervan played a decision-making role regarding the Preliminary Assessment. However, we remain unclear as to the extent of his 'management' role as suggested by the Department.

The lack of a clear decision maker is concerning. In the usual course of events, the purpose of a preliminary assessment is to assist the Secretary to reach a conclusion about whether reasonable grounds exist to begin an investigation under Employment Direction No. 5—Breach of Code of Conduct (refer to Chapter 20 for a discussion of disciplinary processes).

When asked about the disciplinary process in place at the time of the Preliminary Assessment, Ms Baker explained that an investigation would begin only if the 'Secretary, Communities Tasmania form[ed] a reasonable belief that [the] code [may] have been breached'.[2285] The Acting Executive Director, People and Culture, similarly noted that the decision to begin an investigation relied on the Secretary's view that reasonable grounds existed to believe that a breach of the State Service Code of Conduct may have occurred.[2286] It was explained that:

> Essentially a preliminary assessment is the collection and organisation of relevant information that can be progressed to the Head of Agency [i.e., Secretary Pervan] to consider whether he can form a reason to believe a breach of the Code may have occurred.
>
> ...
>
> [People and Culture], in conjunction with operational managers / directors, and relevant Deputy Secretaries, review the information as part of the preliminary assessment.
>
> ...

> Usually, it is the Deputy Secretary Children Youth and Families who briefs the Head of Agency in relation to whether a [disciplinary] process should be commenced in relation to an AYDC Official.
>
> At times, this may also be the Deputy Secretary Corporate Services.[2287]

Ms Baker told us that the Secretary of the former Department of Communities could not delegate the power to decide to commence an investigation under Employment Direction No. 5—Breach of Code of Conduct.[2288] Ms Baker told us that a delegation is not required to undertake a Preliminary Assessment.[2289] It is unclear who would have made a decision to take disciplinary action against Ms Honan had it been recommended by the Preliminary Assessment.

Finding—The State does not have a clear process for initiating a preliminary assessment when the Secretary has a conflict of interest, including identifying a suitable decision maker

We were concerned by the lack of a clear decision maker for the Preliminary Assessment in the context of Secretary Pervan's recognised conflict of interest.

Had the Preliminary Assessment recommended disciplinary action against Ms Honan, it is not clear who would have made the decision to take such action. We were particularly concerned that we received inconsistent evidence about the nature of the role of decision maker in a preliminary assessment.

We also remain confused by:

- the lack of clarity about Secretary Pervan's role as manager
- the role of the Office of the Solicitor-General in forwarding Alysha's complaint about Ms Honan and in receiving the Preliminary Assessment once it was complete.

4.2 Delay in finalising the Preliminary Assessment

There was an unacceptable delay in responding to Alysha's September 2021 complaint.

Alysha's complaints regarding Ms Honan were sent to the Office of the Solicitor-General on 20 September 2021. The decision based on the Preliminary Assessment was not finalised and communicated to Alysha until 30 June 2022, some nine months later.[2290]

We have serious concerns about the substantial time taken to finalise the Preliminary Assessment, as the complaint included concerns about the handling of allegations of child sexual abuse by staff and harmful sexual behaviours. Such complaints must be addressed quickly to ensure any ongoing risk to children is addressed.

We understand the timeline for completion of the Preliminary Assessment was:

- The Office of the Solicitor-General forwarded Alysha's complaints regarding Ms Honan to Ms Clarke on 28 September 2021.[2291]
- Ms Clarke sent her initial assessment to Ms Baker on or around 20 January 2022.[2292]
- Ms Baker completed her review of Ms Clarke's initial assessment before 9 February 2022 (according to Ms Baker's statement to our Inquiry) or on 28 March 2022 (according to the date noted in the Preliminary Assessment).[2293]
- On 28 March 2022, Ms Baker forwarded the Preliminary Assessment to the Office of the Solicitor-General.[2294]
- A meeting between the Office of the Solicitor-General and Ms Baker to discuss the Preliminary Assessment was scheduled for 24 February 2022, but abandoned following the announcement that day of the decision to abolish the Department.[2295]
- Ms Baker followed up with the Office of the Solicitor-General twice in late March 2022 and once in early June 2022.[2296]
- Ms Baker communicated the final Preliminary Assessment to Alysha on 30 June 2022.[2297]

We have not received any documents confirming when the Preliminary Assessment was forwarded to the Office of the Solicitor-General. Based on the above timeline Ms Baker presented to us, we understand the Preliminary Assessment was with the Office of the Solicitor-General for approximately four months before Ms Baker communicated it to Alysha on 30 June 2022.

The Department for Education, Children and Young People told us the former Department of Communities 'did not pursue finalisation of correspondence' with Alysha in relation to the Preliminary Assessment because Alysha obtained new legal representation after March 2022.[2298] We are unclear why a change in legal representation might delay communication of the outcome of the Preliminary Assessment.

As discussed in Chapter 20, the Integrity Commission publishes guidelines on the management of misconduct in the public sector. Relevantly, it provides the following guidance on the timeframes for conducting preliminary assessments and investigations:

- The initial handling of a complaint should take between three working days and one week.[2299]
- A preliminary assessment and decision on whether to investigate should take up to two weeks.[2300]
- A simple investigation should take up to three months. A more serious or complex investigation should take between three and 12 months (and 'ideally' no longer than six months).[2301]

- A decision in response to an investigation should take no longer than two months, depending on a range of factors.[2302]

As this is guidance only, the Department is not required to comply with these timeframes.

We asked Secretary Pervan, Ms Clarke and Ms Baker to comment on whether they considered it was standard or acceptable for the Preliminary Assessment to take nine months to complete.

Secretary Pervan responded:

> It is not standard but not unusual in cases without a participating victim, no participating or direct witnesses and no documentary evidence in an investigative process limited by the powers available under the *State Service Act 2000*.[2303]

As described above, we were told Ms Clarke completed her task of conducting the initial assessment by around 20 January 2022, approximately four months after the Office of the Solicitor-General forwarded the complaint on to her.[2304] Ms Clarke ended her role as Deputy Secretary for Children, Youth and Families on 11 February 2022. She was not with the Department when the Preliminary Assessment was finalised.[2305] Of the delay in completing the Preliminary Assessment, Ms Clarke said:

> The timeframe for completing the preliminary assessment in my view and by my standards was not acceptable.
>
> I am extremely disappointed that the assessment took this length of time. I acknowledge [Alysha] had been out of the workplace for some time and did not have up to date information and the matters raised by [Alysha] were important and serious and a more timely response was warranted.
>
> There were a number of contributing factors as to why I was unable to complete the assessment sooner. The closure of [Ashley Youth Detention Centre] announcement in late September did divert my attention to preparing Youth Justice Reform planning and documents.
>
> This meant the assessment was completed out of hours which I acknowledge is not satisfactory.[2306]

Ms Baker also said that competing priorities contributed to the delay, stating:

> … the volume of work that [Ms Clarke, then] Deputy Secretary, [Children, Youth and Families] was undertaking at the time was significant. I consider the load on that role to be unsustainable. The nature of my own role often required work to be reprioritised, [one] such example which is relevant was needing to respond to the Government announcement to abolish the Department.[2307]

Ms Baker noted that while she 'pursue[d] the matter for settlement with the [Office of the Solicitor-General] on multiple occasions', she recognised that the Office had its own 'competing priorities'.[2308]

Ms Baker shared Ms Clarke's disappointment with the delay, acknowledging that the 'timeframes are not ideal' and 'could have been improved'.[2309]

Finding—The delay in the Preliminary Assessment was not acceptable and risked exposing children to ongoing harm

It concerns us that the Preliminary Assessment took significantly longer to finalise than the two-week timeframe recommended by the Integrity Commission. Indeed, the Preliminary Assessment even exceeded the recommended timeframe for a complex investigation of a breach of the State Service Code of Conduct. Delaying a response to a complaint about child sexual abuse or harmful sexual behaviours can result in a failure to address any ongoing harm to children, where the alleged abuser remains in their position. While we note that Lester had been suspended from November 2020, and so presented no immediate risk to child safety, there were still potential risks of harmful sexual behaviours being inadequately managed (which the Preliminary Assessment might have uncovered). In addition, unaddressed poor responses to allegations of abuse increase the risk of abuses going undetected.

As described above, Ms Honan's role is an important part of the Department's management structure that ensures the safety of children and young people in detention, including to protect them from sexual abuse. In our view, allegations that Ms Honan was not taking appropriate steps to respond to reports of harm to children and young people at the Centre should have attracted a swift response from the Department. Failing to do so may have placed children and young people at continued risk of harm.

This delay also had the unfortunate effect of drawing out the process and we are concerned about the degree to which this contributed to unnecessary stress on Alysha. We are unaware of attempts any person took to keep Alysha updated on the status of the Preliminary Assessment during this time.

We are also not aware that any person took steps to request the matter be allocated to another person; for example, an independent reviewer. We note the matter was with Ms Clarke for several months and she appeared to have submitted the initial assessment immediately before vacating her role.

It is concerning that, when asked whether the timeframe to complete the Preliminary Assessment was standard or acceptable, Secretary Pervan told us that it was 'not standard, but not unusual'.

We have given weight to the heavy workload under which both Ms Baker and Ms Clarke were operating and understand this likely contributed to the delay. We are concerned the role of Deputy Secretary, Children, Youth and Families was under-resourced and the scope of responsibility too broad, which may have contributed to the delay. This role had responsibility for Child Safety Services (including the Advice and Referral Line and out of home care) and Ashley Youth Detention Centre,

among other things (refer to Volume 4). This role carries significant responsibility for some of the State's most vulnerable children. The State must resource these functions adequately. For these reasons, we consider the delay to be reflective of broader systemic problems about the value placed on resourcing child safety.

4.3 Purpose and nature of the Preliminary Assessment

As discussed above and in more detail in Chapter 20, we understand the Department undertakes preliminary assessments to collate relevant information and determine whether there is reason to believe a breach of the State Service Code of Conduct may have occurred (being the threshold for the commencement of an investigation under Employment Direction No. 5).[2310] When describing to us how preliminary assessments are conducted, we were told: 'It is important to outline that preliminary work is not investigation work, it is a preliminary assessment, determining if, and how, to proceed'.[2311]

The Integrity Commission's *Guide to Managing Misconduct in the Tasmanian Public Sector* states the purpose of a preliminary assessment is to 'quickly collect information so that someone in a position of authority can decide … whether there is a reasonable suspicion of misconduct and … the most appropriate way to deal with the matter'.[2312] As noted, the Integrity Commission recommends that preliminary assessments be conducted in three working days to verify basic factual information.[2313] It is not intended to become a quasi-investigation.

Based on this evidence, we would have expected the Preliminary Assessment to quickly ascertain whether Alysha had made complaints to Ms Honan and whether, on the face of it, there could have been serious questions about Ms Honan's response to these complaints.

In our view, features of the Preliminary Assessment, particularly in relation to the allegation about child sexual abuse by staff, were more closely aligned with a fully-fledged investigation into the reports that Alysha made, straying well beyond the narrow focus of a preliminary assessment. In particular:

- The Preliminary Assessment took a long time (refer to discussion above).
- Ms Clarke consulted a large volume of material as part of her assessment.[2314]
- The Preliminary Assessment addressed multiple matters that would appear more relevant to a full investigation into a possible breach of the Code of Conduct, including:
    - comparisons with other allegations made about Lester
    - weighing up of the veracity and consistency of Alysha's allegations.

Concerningly, the Preliminary Assessment appeared to consider the likelihood of the truth of the allegations against Lester and did not restrict itself to the appropriateness of responses to alleged child sexual abuse by a staff member.

In particular, the Preliminary Assessment compared the information received by Ms Honan from Alysha in January 2020 with other reports of Lester's behaviour received by the Department in August and November 2020.[2315]

Before our public hearings, we asked Secretary Pervan, Ms Baker and Ms Clarke each to explain the relevance of the discrepancies identified by the Preliminary Assessment between Alysha's report and information later received by the Department.

Secretary Pervan declined to respond to our request, deferring to Ms Baker and Ms Clarke's knowledge.[2316]

Ms Baker and Ms Clarke differed on the relevance of the analysis. Ms Baker responded:

> The preliminary assessment sought to highlight the records that the Assessor (and in my case the Reviewer) analysed. It highlights the discrepancies between the initial report, what was reported via [Alysha's] representative at the time … and what was reported in *The Nurse* podcast. It does highlight that the Department was dealing with varied information that needed to be worked through thoroughly in an attempt to verify what [Alysha] had reported.[2317]

We consider this comment indicates Ms Baker understood the purpose of the Preliminary Assessment to be about determining the truth of Alysha's report about Lester. In that context, discrepancies between reports of abuse may be relevant.

Conversely, Ms Clarke responded:

> The preliminary assessment included information where discrepancies were identified and the witness statement [was] for [Alysha's] information only. The information had no relevance on the adequacy of Ms Honan's response. As the author I was very aware that I was not able to fully disclose a range of information to [Alysha]. The intention in sharing the discrepancies and information about the witness statement was an attempt to demonstrate to [Alysha] that the Department made every effort to identify all potential avenues of information that related to the matter she raised.
>
> On reflection the intention of including this information may have been communicated differently to make this intention clear.[2318]

We understand Ms Clarke's response to suggest that the discrepancy between reports was not relevant to the Preliminary Assessment and that this detail was included for other, external reasons. Ms Clarke appears to have considered that the purpose of the Preliminary Assessment was to assess the adequacy of Ms Honan's response.

These responses are consistent with the varied evidence we received about the scope and purpose of the Preliminary Assessment more generally. In our public

hearings, Ms Clarke described the Preliminary Assessment of Alysha's complaints in relation to Ms Honan as taking a form 'similar to other preliminary assessments'.[2319] She said it did not involve 'drilling into the actual specific detail of the actual individual complaints'.[2320] Rather, Ms Clarke said the Preliminary Assessment required 'assessing the detail that was available that would form reasonable grounds for a breach of the Code [of Conduct]'.[2321] During our public hearings, Ms Baker described the Preliminary Assessment as 'preliminarily assessing … whether Ms Honan had responded appropriately or not appropriately to Alysha's report'.[2322]

As described above, the purpose of the Preliminary Assessment was to 'quickly collect information' so the decision maker could determine whether there was reason to consider Ms Honan may have breached the State Service Code of Conduct, and to trigger a full investigation.[2323] Its purpose was not to determine the reliability or truth of the content of Alysha's report or to assess the allegation against Lester.

Finding—The Preliminary Assessment was, at least in part, a quasi-investigation into the substantive reports made by Alysha (a pseudonym) about child sexual abuse by staff, due to a lack of clarity about preliminary assessments

By engaging in this substantive assessment of the accuracy of Alysha's report in relation to Lester in particular, it appears the Preliminary Assessment strayed into an investigation of Ms Honan's response and the veracity of the allegations of child sexual abuse.

A full investigation of Alysha's reports to Ms Honan was well beyond the purpose of the Preliminary Assessment—being to determine whether there were reasonable grounds to believe that Ms Honan may have breached the State Service Code of Conduct and so should have been further investigated. While an investigation of the accuracy of the allegations against Lester was an activity the Department should have undertaken, we disagree it was an appropriate feature of a preliminary assessment.

If the Preliminary Assessment had stuck to its task, there would have been an earlier opportunity to assess the need for an independent investigation into Ms Honan's response to Alysha's reports. Had this occurred, some inaccuracies in the investigation we highlight below may have been avoided.

Across many of our case studies, we have found that preliminary assessments stray into becoming quasi-investigations but without all the protections attracted by a formal investigation, including independence and procedural fairness. This is a systemic problem across many agencies.

4.4 Flaws in the Preliminary Assessment

We consider the Preliminary Assessment was better understood as a quasi-investigation. As a quasi-investigation, we had serious concerns about its accuracy, the thresholds applied in the Preliminary Assessment, and the impression the Preliminary Assessment gave about the adequacy of the Department's response to the matters Alysha raised concerning child sexual abuse and harmful sexual behaviours at the Centre. We discuss our most critical concerns below.

4.4.1 Inappropriate threshold for responding to reports of abuse

Building upon the discrepancies it identified between Alysha's report and later information received by the Department (described above), the Preliminary Assessment concluded Alysha's report regarding Lester '[did] not provide information that would lead a reader to conclude without doubt a serious sexual assault [and/or] rape was perpetrated by [Lester]', but contained 'concerning information' that 'did warrant further assessment'.[2324]

We have had the benefit of reviewing Alysha's initial email notification to Ms Honan and the Manager, Human Resources and Workplace Relations, of the former Department of Communities, sent on 9 January 2020.[2325] In that email, Alysha referred to an earlier conversation with the manager about the same issues raised, stating that she wished to 'follow up [that] conversation' with an email 'for [her] own peace of mind'.[2326] Alysha then provided further details of the conversation she had with Ira (a pseudonym), a Centre staff member, during which he told Alysha about an event involving Lester several years earlier.[2327] Relevantly, Alysha wrote:

- … [Ira] was working alongside [Lester]
- They were working in what was known as the 'Secure unit'
- [Ira] described this in his story as a unit where only a few select staff were allowed to work, and that [it] was very secure, with a doorbell used if anyone needed to go into it
- He described walking into a room where a child … was being "punished"
- [Lester] was standing over the child laughing
- The young boy was completely naked and on all fours (hands and knees) on the floor
- [Lester] was standing over him, behind him[.][2328]

The manager acknowledged receipt of Alysha's initial email in an email later the same afternoon, copying in Ms Honan.[2329] That evening, Alysha sent a further email to Ms Honan and the manager, in which she shared the following further details:

- This was the beginning of [Lester] being involved in office work due to him not being allowed to work with children.
- [Ira] said that judging by how the centre was run at this time, he is highly doubtful it went through HR.

...

- [Ira] said that [Lester] was often abusive towards the little ones, not so much the big kids.
- [Another Centre worker] recalled that he heard the same had happened though he did not know that someone had seen [Lester] in this position. He thought it was common knowledge that something of this sort had happened, when [Lester] was removed from working with the young people.
- The child was [aged under 15] or so and small at the time.[2330]

We note the Department subsequently obtained a witness statement from Ira in November 2020, some 10 months after Alysha's report.[2331]

We hold concerns about the Preliminary Assessment's conclusion that Alysha's report regarding Lester '[did] not provide information that would lead a reader to conclude without doubt a serious sexual assault [and/or] rape was perpetrated by [Lester]'.[2332]

This statement appeared to suggest the Department was applying a test that Alysha's information about Lester was required to lead Ms Honan to conclude, without a doubt, that misconduct had occurred and that such misconduct was a serious sexual assault or rape, before Ms Honan was required to respond. While not explicitly stated in the Preliminary Assessment, we are concerned the implication of this statement is that this is a threshold to meet for a report of child sexual abuse to result in action by the Department. We have been given no other reasonable explanation as to what else this language could mean.

We asked Secretary Pervan, Ms Clarke and Ms Baker to comment on whether such a test was applied in the Preliminary Assessment and, if so, from where that test was derived.

Secretary Pervan declined to respond to our request, stating that Ms Baker advised him that Ms Clarke and Ms Baker would manage this complaint.[2333]

Ms Baker's responses to our questions on multiple matters concerning the Preliminary Assessment are difficult to interpret as we cannot easily determine which of her answers responds to which question. On our best understanding, her response to our question about the application and origin of this test was more relevant to investigating the substance of the allegations against Lester than investigating Ms Honan's conduct:

> We sought at the time [that Alysha] emailed [her complaint] … to try and validate what information the Department may hold in relation to [Lester]. [Ira's] statement was key information for the Department to put the matter to the Secretary for his consideration and to suspend [Lester] as it was through [Ira's] firsthand account we were able to verify that [Lester] was in a room and with a naked child on hands and knees. From [Ira's] statement he said [Lester] was clothed and [Lester] was standing at the head of the young person. This was different to how [Alysha] described in her email (she advised [Lester] was standing behind the young person and standing over him).[2334]

Ms Clarke, in her written statement, said that as the author of the Preliminary Assessment she 'did not apply any test'.[2335] She continued:

> In the context of [Alysha's] complaint relating to [Lester] the purpose of the preliminary assessment was to assess information to identify if there were reasonable grounds that suggested Ms Honan may have "discouraged from reporting [Lester] and/or attempted to shut down and/or frustrate investigations".[2336]

Ms Honan also told us she did not personally apply a threshold to the allegation and she immediately passed on the allegation to Ms Baker.[2337]

We received no answer as to why the Preliminary Assessment referred to, and appeared to place weight on, the view that Alysha's report did not provide information that would 'lead a reader to conclude without doubt a serious sexual assault [and/or] rape' had occurred. Neither Secretary Pervan, Ms Clarke nor Ms Baker pointed us to any standard that required Alysha's report to meet such a high threshold.

In response to the suggestion that the Department applied any threshold, Ms Baker recently told us there are examples outside the matters that Alysha raised where there is evidence the Department acted.[2338] We were unable to seek details of these examples from Ms Baker before finalising our report.

We are concerned the conclusion in the Preliminary Assessment demonstrated a lack of appreciation for the seriousness of Alysha's report. Having considered the reports Alysha made, we consider the information she supplied indicated, at the very least, that serious misconduct of a sexual nature (or sexual abuse) may have occurred. This includes the allegations that:

- the child was naked, on the floor and alone in a room with Lester
- that room was in a building that had strictly limited staff access
- the incident was of such a nature that it appeared to result in Lester being moved to a role that prevented him working directly with children
- Ira had told Alysha that Lester was often abusive towards younger children.[2339]

The suggestion that Ms Honan needed to reach such a high threshold in relation to Alysha's report before acting is concerning for several reasons. In setting that higher threshold, the Preliminary Assessment creates the impression that the Department was seeking to justify Ms Honan's (and, by extension, the Department's) response to Alysha's report on the basis that Alysha did not clearly communicate an allegation of 'serious sexual assault' or rape. This view is problematic, as it minimises reports of child sexual abuse that do not involve rape or what it describes as 'serious sexual assault'.

In addition, the suggested threshold indicates Department staff are not sufficiently trained (or expected) to identify risks to children except where they are unambiguously stated in the most serious of terms. This is concerning given that many staff, including Ms Honan, Ms Clarke and Ms Baker, are mandatory reporters under the *Children, Young Persons and Their Families Act 1997*, under which they have an obligation to report where they believe or suspect on reasonable grounds or know that a child has been, or is being, abused or neglected.[2340]

We are concerned this threshold places a significant onus on the reporter to express their report in a way that will cause the Department to take notice. This is an inappropriate burden to place on reporters of child sexual abuse. Further, reporters may have many reasons not to provide certain details about offending or may simply not know enough to identify serious offending. In our view, it is more desirable to require the Department to be actively aware of indicators of sexual abuse and to respond accordingly.

Further, suggesting that only reports of rape or 'serious sexual assault' will be taken seriously may deter prospective reporters from reporting behaviours that appear to:

- place children at risk
- possibly constitute a boundary violation
- indicate grooming.

In addition, taking such an approach would render many children and young people's reports of abuse ineffective, as we know that they often disclose abuse incrementally. Their first report may not amount to rape or a serious sexual assault.

Lastly, requiring the person who receives a report of child sexual abuse to form a conclusion 'without doubt' about the veracity of the report circumvents the disciplinary and criminal justice processes established to undertake this task. Even a full misconduct investigation need only satisfy a balance of probabilities test.

4.4.2 The Preliminary Assessment gives an inaccurate impression of the suitability of the Department's response to Alysha's reports

We were concerned by statements in the Preliminary Assessment that appeared to give an inaccurate impression of the suitability of the Department's response to the matters Alysha reported to Ms Honan.

Referrals to the police and Registrar of the Registration to Work with Vulnerable People Scheme

In relation to allegations of child sexual abuse by staff, Alysha alleged Ms Honan 'sought to instigate an internal investigation of the matter and discouraged reports being made to the "Strong Families Safe Kids" referral line and/or Tasmania Police'.[2341] Alysha also alleged Ms Honan 'took unreasonable steps in "investigating" this matter prior to referring it to the appropriate agencies and/or took steps that reasonably frustrated the investigation'.[2342]

In response, the Preliminary Assessment relevantly stated:

- 'No records were sourced during [the Preliminary Assessment] to indicate Ms Honan discouraged a report being made to Strong Families Safe Kids Referral Line and/or Tasmania Police'.[2343]
- 'All information was provided to Tasmania Police and the Registrar, Registration to Work with Vulnerable People'.[2344]

In our view, these statements suggest that appropriately timed steps were taken to inform relevant agencies of the allegation against Lester. However, the Department reported the allegation against Lester to the police and the Registrar of the Registration to Work with Vulnerable People Scheme on 6 November 2020—approximately 10 months after Alysha's initial report.[2345]

We consider the timing of these reports to external agencies to be material to the appropriateness of Ms Honan's and the Department's response. By failing to acknowledge the delay in reporting by the Department, the Preliminary Assessment failed to appropriately assess the reasons for that delay (and Ms Honan's contribution to it, if any). Rather, the Preliminary Assessment appeared to simply accept the delay. This suggests the Department did not consider the reporting of the allegations against Lester to be urgent. Nor did it appear to consider the potential risk posed by Lester to other children with whom he had contact in his role at the Centre. This is indicated by the fact that the allegations against Lester are simply categorised in the Preliminary Assessment as 'historical'.[2346]

The Department's knowledge of other allegations made against Lester

In relation to allegations of child sexual abuse by staff, the Preliminary Assessment stated:

> Following receipt of information from a third party the Department commenced a comprehensive review of the Tasmania Abuse in State Care Ex-Gratia Scheme records. The review found no application had been received in any one of the four Tasmanian Abuse in State care Ex-Gratia Scheme rounds in relation to the matter reported by the complainant or the third party.
>
> ...
>
> At the time of completing this preliminary assessment the Department of Communities Tasmania has not received a request for information under the National Redress Scheme that relates to the matter raised by the complainant and/or is aware of any civil proceeding that may have relevance to the information provided by the complainant.[2347]

These statements are narrow and only confirm no claims or reports had been made that corroborate the specific allegation reported by Alysha in relation to Lester. While we accept the Preliminary Assessment, as a quasi-investigation, was primarily investigating Ms Honan's response to Alysha's allegations, we consider that, having determined to report upon Abuse in State Care Program and other allegations in the Preliminary Assessment, additional allegations against Lester are relevant to that response.

The Preliminary Assessment neglected to acknowledge various allegations of Lester's sexual abuse of young people (unrelated to the specific allegation Alysha reported in relation to Lester) which were known to either Ms Clarke or Ms Baker (or both) when the Preliminary Assessment was finalised. These included the following claims:

- Four claims made under the Abuse in State Care Program (including at least two claims made as early as 2008). Those four claims were known to the Strengthening Safeguards Working Group, of which Ms Baker and Ms Clarke were members, by October 2020.[2348]
- One other allegation of child sexual abuse of which Ms Clarke became aware in April 2021.[2349]

We asked Secretary Pervan, Ms Baker and Ms Clarke whether they considered the above statements in the Preliminary Assessment to be misleading.

Secretary Pervan said:

> ... while the Department was aware of other claimants and allegations against [Lester], we had not received [an allegation by the victim-survivor] arising from the incident described in [Alysha's] complaint.[2350]

Ms Baker and Ms Clarke responded similarly. They acknowledged other allegations concerning Lester but noted the lack of allegations about the specific incident Alysha reported.[2351] Ms Baker did, however, concede that '[w]ith the benefit of hindsight, [the statements] could have been better worded'.[2352]

Ms Clarke and Ms Baker emphasised they were concerned not to disclose personal information about Lester (including other allegations made against him) to Alysha through the Preliminary Assessment. During our public hearings, Ms Clarke told us she did not include this information in the Preliminary Assessment because Ms Clarke 'wasn't absolutely sure what [she] could disclose' to Alysha.[2353] Ms Baker made a similar comment, stating that:

> … I don't think that [the statements that the Department had not received other reports of the allegation] was misleading. I think we could have better worded the disclosure in that report. Being mindful of what could be disclosed, but also bearing in mind that the matter that we were preliminarily assessing was whether Ms Honan had responded appropriately or not appropriately to Alysha's report. I don't think that it's misleading but I think that we could have possibly worded it better.[2354]

We consider there was good reason to reflect upon those other matters when conducting the Preliminary Assessment to assess Ms Honan's conduct. For example, the four claims made under the Abuse in State Care Program were not known to the Department until late 2020. Again, by not acknowledging these claims or the timing of their discovery, the Preliminary Assessment failed to consider their relevance to the complaint regarding Ms Honan's conduct (or others).

Reason for suspension from work

The Preliminary Assessment stated the Department did not suspend Lester from work 'in relation to an allegation of serious sexual assault or rape as alleged by [Alysha] and in the Parliament in November 2020'.[2355]

We are unaware of what evidence was relied on to substantiate that statement in the Preliminary Assessment. However, the statement is inconsistent with the evidence we received. Specifically, we note:

- A Minute recommending the commencement of an investigation of Lester under Employment Direction No. 5 referred in detail to the allegations Alysha initially reported (and that Ira later recounted in his witness statement).[2356] The Minute also attached Alysha's initial email of 9 January 2020, which is described above.[2357] The Minute was cleared by Ms Baker on 7 November 2020 and approved by Secretary Pervan on 8 November 2020.[2358]
- In a letter to Lester notifying him of the commencement of an investigation under Employment Direction No. 5, the Secretary specifically referred to the allegations Alysha initially reported (and that Ira later recounted in his witness statement).[2359]

- In his written statement, Secretary Pervan confirmed the basis for his decision is 'recorded in the documentation for the [Employment Direction No. 5 decision]'.[2360] We understand this includes the Minute he approved on 8 November 2020 inviting Secretary Pervan's approval to commence a formal investigation under Employment Direction No. 5.

We acknowledge the 8 November 2020 Minute also refers to claims made previously under the Abuse in State Care Program. However, in our view, the above documents indicate that Secretary Pervan's decision to start the investigation process under Employment Direction No. 5 was predicated on Alysha's report and Ira's confirmation of the account in that report.

We were surprised by the Preliminary Assessment's insistence that Alysha's report did not contribute to the decision to suspend Lester, despite the above evidence. That insistence appeared to downplay the relevance of Alysha's actions to the Department's ultimate response, inviting a view that her information was of little consequence or importance and (accordingly) did not warrant a thorough response from Ms Honan or the Department.

4.4.3 The Department's view regarding the accuracy of the Preliminary Assessment

We asked Secretary Pervan, Ms Clarke and Ms Baker whether they considered the Preliminary Assessment to be accurate and complete.

Secretary Pervan replied affirmatively but did not provide reasons for his view.[2361]

Ms Clarke would not express a view on the accuracy or completeness of the Preliminary Assessment in her written statement.[2362] She said that as 'the decision maker [Secretary Pervan] is best placed to answer this question'.[2363]

Ms Baker did not respond to this question. However, Ms Baker commented that, in her view as reviewer, the Preliminary Assessment 'was adequate'.[2364]

We do not agree the Preliminary Assessment into Alysha's complaint about Ms Honan was accurate or complete.

Finding—The Preliminary Assessment gave a false impression of the adequacy of the Department's response to reports made by Alysha about child sexual abuse by staff

As described above, we consider the Preliminary Assessment was conducted as a quasi-investigation into the matters Alysha reported. In that context, we are concerned by several flaws in the investigation, including that it:

- adopted an inappropriate threshold for responding to child sexual abuse allegations
- was misleading in terms of the Department's response to some of Alysha's allegations, including in relation to:
    - referrals to the police and the Registrar of the Registration to Work with Vulnerable People Scheme in relation to Lester
    - the Department's knowledge of other allegations made against Lester
    - the reasons for Lester's suspension.

It is unacceptable that the Preliminary Assessment stated that referrals regarding Alysha's report of Lester's alleged behaviours had been made to the police and the Registrar of the Registration to Work with Vulnerable People Scheme but did not acknowledge the timing of those reports was many months after Alysha's initial report to Ms Honan.

It is also unacceptable that the Preliminary Assessment narrowly stated that no Abuse in State Care Program claims or other allegations had been made in relation to the matter Alysha reported regarding Lester, while failing to acknowledge allegations relating to Lester (but not otherwise related to the specific allegations Alysha reported) known to Ms Baker and Ms Clarke by late 2020, and a further unrelated allegation known to Ms Clarke by April 2021.

We consider that without further clarification, these statements gave the false impression there were no other matters known to the Department relevant to the issues in question at the time of the Preliminary Assessment. This includes whether there was a risk that Lester posed a threat to children detained at the Centre.

It is also unacceptable that the Preliminary Assessment failed to acknowledge the view formed by Ms Clarke herself in September 2020 that, at that time, Alysha's January 2020 report of Lester's suspected abuse had not been investigated by the Department.

Together, the above statements in the Preliminary Assessment gave a misleading impression that the Department had responded in a timely and appropriate way to Alysha's reports. They had the effect of overstating the appropriateness of the Department's actions (beyond merely those of Ms Honan) and ultimately directed the Preliminary Assessment away from relevant lines of inquiry, including what steps Ms Honan or other Department staff should have taken to better respond to Alysha's concerns.

It is also unacceptable that the Preliminary Assessment minimised the relevance of Alysha's report in the decision to suspend Lester from work.

We do not accept Ms Baker and Ms Clarke's evidence that the content of the Preliminary Assessment was limited by what could be disclosed to Alysha, such that they needed to exclude relevant evidence. Disclosure to Alysha was not the purpose of the Preliminary Assessment and should not have guided the way it was undertaken, particularly if it contributed to incomplete or inaccurate findings.

5 System problems

The Preliminary Assessment was finalised in the weeks and months before our public hearings regarding Ashley Youth Detention Centre. It provides a very recent snapshot of the Department's attitudes and approaches to reports of child sexual abuse and those who make such reports.

We asked Secretary Pervan, Ms Baker and Ms Clarke to each comment on whether they considered the State's response in 2022 to Alysha's complaints about Ms Honan represented a significant current failure to respond to reports about the handling of allegations of child sexual abuse.

Secretary Pervan said:

> I would respond by pointing out that both Ms Clarke and Ms Baker are highly experienced managerial professionals. While I was not involved in this process I am aware that the approach they took was meticulous and involved discussions with the Office of the Solicitor-General. [Alysha's] complaints were made to Ms Honan during a complex period of change with respect to the State's consideration and response to allegations of child sexual abuse raised through financial redress applications.[2365]

Ms Baker responded:

> As the Reviewer of the Preliminary Assessment, I don't agree that this was a significant failure. The timeframes could have been improved, and I would also like to acknowledge [Alysha] bringing this matter to the [Department's] attention.[2366]

Ms Clarke replied:

> As the Official that undertook the preliminary assessment I do not agree the Departments' response in 2022 to the complaint raised by [Alysha] in relation to Ms Honan's response to her complaint represents a significant current failure to respond to complaints about the handling of allegations of child sexual abuse. In the context of [Alysha's] complaint against Ms Honan regarding [Lester] the purpose of the preliminary assessment was to assess the available information to identify if there were reasonable grounds that suggested Ms Honan may have "discouraged from reporting [Lester] and/or attempted to shut down and/or frustrate investigations" as alleged by [Alysha]. At the time the preliminary assessment was unable to identify any information that suggested Ms Honan "discouraged from reporting [Lester] and/or attempted to shut down and/or frustrate investigations".

We are not convinced by these responses.

In our view, the responses to Alysha's September 2021 complaint indicate the following themes and attitudes in the Department's handling of reports of child sexual abuse and related matters:

- There was a culture within the former Department of Communities that failed to understand the behaviours that amount to child sexual abuse, considering only reports of rape or serious sexual assault would attract a thorough and timely response and applying a criminal standard of proof for disciplinary processes.
- Matters of relevance to child safety did not always attract urgent responses, and lengthy delays in investigating those matters did not raise significant concerns among Department staff.
- The former Department of Communities relied heavily on reporters to provide the right information in the right order and form before considering allegations about possible child sexual abuse.[2367]
- Senior staff of the former Department of Communities did not identify actual, potential or perceived conflicts of interest in conducting a preliminary assessment.
- Matters raised in complaints were on occasion siloed at the expense of engaging with the intent of the complaint.
- There was a failure within the State to recognise that bullying, harassment or discriminatory behaviours can be inextricably linked to an official's reports of child sexual abuse and illustrate a culture that does not promote or value child safety.
- There was a failure within the State to recognise that complaints against individuals can represent systems' failures that require a broader lens and response.
- Preliminary assessments appear to be used sometimes as quasi-misconduct investigations while avoiding the requirements of those investigations.
- There is no clear process for determining a decision maker for a preliminary assessment when the Secretary has a conflict of interest.

Case study 6: A complaint by Max (a pseudonym)

1 Introduction

In Case study 1, we outlined the experiences of Max (a pseudonym), who was first detained at Ashley Youth Detention Centre in the late 2010s.[2368] In addition to Max's general experiences at the Centre, we have prepared an additional case example outlining an allegation that Max made during our Commission of Inquiry and how the Centre and senior management in the Department responded to that allegation.

Max's allegation was that a person in a managerial role ('the manager') at Ashley Youth Detention Centre offered him incentives to not meet with or complain to our Commission of Inquiry about his treatment at the Centre. This is a very serious allegation. Recognising the significance of this matter and the fact that there were differing accounts of what occurred, we have outlined the accounts of the different people involved in this allegation, which includes Max's account, as well as evidence from Ashley Youth Detention Centre's management and the Commissioner for Children and Young People.

In line with our practice of not proactively seeking out victim-survivors and other vulnerable people who had not voluntarily engaged with or provided information to our Commission of Inquiry, we did not contact another detainee who was said to have been a witness to the conversation between Max and the manager, and we did not rely on any evidence relating to this person.

We discovered the relevance of some witnesses to this matter late in our Inquiry, after our public hearings, when we received written notes from the Commissioner for Children and Young People. The timing of this discovery limited our ability to seek statements and test this evidence.

In the end, despite considering the matter carefully, we did not have enough evidence to draw a conclusion, on the balance of probabilities, and make a finding in relation to Max's allegation. Instead, our focus has been on how the Centre and the Department responded to that allegation.

We consider that the Department's approach to responding to Max's allegation was inappropriate and unacceptable given the nature and seriousness of the allegation. We consider the Centre's approach fell short of acceptable process. We consider the response to Max's allegation justifies a finding that the Centre and the Department did not appropriately respond to the allegation.

2 Max's recollection

Max spent time at Ashley Youth Detention Centre from 12 to 18 years of age.[2369] In Case study 1, we share some of Max's recollections of his experiences at the Centre.

Max told us that while detained at the Centre he engaged with the former Commissioner for Children and Young People 'to complain about what was happening at Ashley and the way the youth workers were treating me'.[2370] He said that this pattern of engagement continued when a new Commissioner, Leanne McLean, was appointed.[2371] Max told us that the way staff treated him changed once he started making complaints about his treatment:

> After I started speaking to the Children's Commissioner the staff started treating me like shit. They stopped giving me food and drinks when I asked for them and would say 'you get what you get when you get it'. Before I started calling the Children's Commissioner they would just give things to me when I asked for it.[2372]

By his own account, Max was involved in some serious incidents at the Centre, including:

- Max was involved in a 'stand-off' with other detainees. Ashley Youth Detention Centre policy documents define a 'stand-off' as 'a situation in which neither of two opposing groups or forces will make a move until the other one does something, so nothing can happen until one of them gives way'.[2373] Max told us that staff sexually assaulted him during a strip search after this incident.[2374]
- Max consumed items from a package smuggled in by a fellow detainee, which Max told us led to him being physically restrained and invasively strip searched by staff while he resisted and attempted to hit a staff member.[2375]
- Max described an incident in which he attempted to hit a staff member and described other workers 'hitting, kicking and kneeing' him as a result.[2376]

Throughout his evidence and in his statement, Max acknowledged his own (sometimes destructive) behaviours and actions.

In late 2021, while detained at Ashley Youth Detention Centre, Max heard about our Commission of Inquiry and the planned closure of the Centre.[2377] Max told us: 'Once I saw that the Commission of Inquiry was starting up and Ashley was going to be shut down, I thought that was the best thing that could ever happen'.[2378]

At this same time, Max was complaining to Commissioner McLean about his treatment at Ashley Youth Detention Centre.[2379] He said that Commissioner McLean asked him whether he would like to speak to our Commission of Inquiry.[2380] Max recalled that he agreed to speak to us as 'an opportunity to tell my story'.[2381]

Max told us that the manager found out about his planned session with a Commissioner because it was organised by the Centre and Commissioner McLean.[2382] Max recalled:

> About a week before I was due to meet the Commission of Inquiry, [the manager] came to see me and [another detainee] in [our unit]. He asked us 'why are you having a meeting with the Commission?' I said, 'to tell them about everything that happens in this shit-hole'. He said 'they don't need to hear all that bullshit. They've got enough going on with fake allegations as it is'. He told us that if we said good things and don't go telling lies he'd make it worth our while. He said that we would get to move to the step-down unit and that we would get to go off property at least twice a week. [The other detainee] and I both looked at each other and agreed to it as soon as he said it. It was a filth [good] deal ... [2383]

Max told us during our public hearings:

> [The manager], he pretty much tried to bribe me—well, not 'pretty much', he did; he said that he'd give us MA+ games ... he'd let the other person that done it as well with me go off-site ... he'd let us move to the new unit. Like, he's giving us all these things, and straightaway we're thinking, we can't get any of them; yep, we'll definitely do that.[2384]

On 10 November 2021, Max attended a session with a Commissioner held at Ashley Youth Detention Centre. Commissioner McLean also attended this session. Max later told our Commission of Inquiry that before this session he was unsure whether he should 'tell the truth or act like it was all fine'.[2385] Max recalled that: 'I went into the meeting and was asked what I wanted to speak about. I said I wanted to speak about how good the centre was. I said how great the centre was and how they help kids'.[2386] Max told us in a later statement to our Commission of Inquiry and during our public hearings that the information he gave in his session with a Commissioner was untrue. He said he 'just went in there and said that, how good Ashley was, which was a load of shit'.[2387] He stated: 'I fed them up on bullshit. I regret doing it now'.[2388]

Max told us that after his session with a Commissioner he spoke to the manager and told him that he 'had said everything [at the Centre] was good'.[2389] Max recalled asking the manager when he would be moving to a new unit and when he would be able to go off-property.[2390] Max said that the manager told him he would have access to those privileges when his 'behaviour change[d]'.[2391]

Max explained that when he heard this he felt the manager had 'backed out' of their deal.[2392] He felt that the manager 'knew that we couldn't take back what we said, so he just acted as if nothing happened, he acted like the conversation never happened'.[2393] Max told us he thought this was 'bullshit', so he 'went off' at the manager and a 'code black' was called.[2394] As discussed in Chapter 10, Ashley Youth Detention Centre staff call a code black as a request for immediate assistance.[2395]

After speaking to the manager, Max said that he phoned Commissioner McLean.[2396] He told her that the manager had 'bribed me but then backed out of the deal'.[2397] Max said that Commissioner McLean asked 'what the deal was' and Max explained it to her.[2398] Max recalled Commissioner McLean telling him that she would call the manager to 'find out what was going on'.[2399]

Max explained that after Commissioner McLean told him that the manager had denied his allegation, Max became angry and continued to act out:

> [Commissioner McLean] later told me that she had spoken to [the manager] and that he denied it which he was obviously going to do. This really pissed me off so I continued with my behaviour.
>
> At some point later I told [Commissioner McLean] that I probably wanted to talk to the Commission again.[2400]

When told by Counsel Assisting our Commission of Inquiry that the manager would give evidence that the conversation never happened, Max told us that his own account was '100 per cent truth'.[2401]

We are grateful to Max for speaking with us and recognise people who shared information with us often did so with a fear of perceived consequences or risk.

3 Commissioner McLean's recollection

During our public hearings, we asked Commissioner McLean about her recollection of her engagement with Max in relation to his allegation that the manager 'bribed' him. Following the hearings, Commissioner McLean gave us a copy of the notes she compiled in advance of her appearance and to which she referred during her appearance.[2402] We acknowledge these notes were prepared for purposes other than providing a formal response to our Commission of Inquiry.

Commissioner McLean had advocated on behalf of Max a number of times during his previous detentions at Ashley Youth Detention Centre.[2403] She told us Max approached her on 29 October 2021 to ask for help to arrange a meeting with the Prime Minister or Premier 'so that he could tell them the good things about Ashley'.[2404] She also told us that at the time Max wanted her help to access MA15+ video games while at the Centre. Commissioner McLean recalled that she suggested Max speak to us and arranged for him to attend a session with a Commissioner.[2405]

Commissioner McLean said she then began making arrangements for the session with a Commissioner.[2406]

Commissioner McLean told us that, on 4 November 2021, she also spoke to Max at length about his access to video games.

Commissioner McLean recalled receiving a phone call from Max on 9 November 2021.[2407] She said Max disclosed to her that the manager had visited him and, on Commissioner McLean's recollection, alleged that he was offered an incentive to not speak to our Inquiry.[2408]

Commissioner McLean told us that Max's comments concerned her.[2409] She told us that she spoke again to Max later the same day.[2410] Commissioner McLean also recalled speaking to the Centre's psychologist on 9 November 2021, with Max's consent.[2411] When they spoke, the psychologist confirmed to Commissioner McLean that she had spoken to Max the previous day (8 November 2021) about his complaint.[2412]

Commissioner McLean confirmed to us in hearings that she raised Max's complaint with the Centre's management after Max's session with a Commissioner and never raised Max's allegation directly with the manager.[2413]

On 10 November 2021, Commissioner McLean attended Max's session with a Commissioner at Ashley Youth Detention Centre.

Commissioner McLean told us that Max contacted her again after his session with a Commissioner, on 12 November 2021.[2414] She recalled Max telling her that the manager had visited him after his evidence. During our hearings, Commissioner McLean described her conversation with Max:

> Max contacted me to report that after the Commission of Inquiry meeting, [the manager] came to him and asked if he had mentioned the 'blackmail'—and they were very specific used words—to the Commission of Inquiry. Max reported that [the manager] made statements that, 'You know you're old enough to go to Risdon, don't you?' Max appeared unsettled during the phone call and reported he was involved in several incidents that day. He expressed a wish to go to Risdon straightaway and that he wanted to give up on his exit plan.[2415]

On 14 November 2021, Commissioner McLean phoned Pamela Honan, Director, Strategic Youth Services, to disclose Max's allegation. Commissioner McLean then wrote to Ms Honan the following day summarising Commissioner McLean's discussions with Max.[2416] Commissioner McLean's email to Ms Honan said that, on 9 November 2021, Max had told Commissioner McLean that the manager had told Max he could get Max the video games 'if you don't get involved in any political stuff/speaking with the [Commission of Inquiry or Commissioner McLean] because if you do then it gets taken out of our hands'.[2417] Commissioner McLean's email also referred to her conversation with Max on 12 November 2021.[2418]

On 22 November 2021, when she returned from leave, Ms Honan forwarded Commissioner McLean's email summary to the manager in its entirety, noting:

> Events as reported by the C4C [Commissioner for Children and Young People].
>
> Can you respond so that this is on the record and adopt the strategies we discussed moving forward re two staff present during conversations and documenting of conversations in shift notes.[2419]

On 25 November 2021, Ms Honan emailed Commissioner McLean, forwarding the manager's denial of Max's allegation and describing a meeting with the manager and Max.[2420] We describe this in more detail below. Ms Honan told Commissioner McLean that 'it was agreed by [Max] that he may have confused what [has] been told to him and taken it out of context'. [2421]

After this time, Commissioner McLean said that she continued to advocate for Max about his access to psychological support while at Ashley Youth Detention Centre.[2422]

4 The manager's recollection

In his evidence to us, the manager strongly denied Max's allegation. The manager said: 'I'm confident that I didn't bribe or incentivise Max to provide or not provide information to the Commission [of Inquiry]'.[2423] The manager also told us that 'at no time did I ever try to coerce Max into doing anything but provide his own evidence to the Commission [of Inquiry]'.[2424] The manager stated that he was 'actually pleased that [Ashley Youth Detention Centre] residents were speaking to the Commission [of Inquiry] because it's their voice that needs to be heard and in any child-centred approach that's what should happen'.[2425] The manager later noted that Max's conversation with Commissioner McLean about wishing to speak to the Prime Minister or Premier to tell them good things about the Centre occurred before Max's conversation with the manager that was the basis of Max's allegation.[2426] The manager observed that this timing tended to support his evidence that he did not attempt to bribe Max.[2427]

The manager recalled speaking to Max before Max's session with a Commissioner, which was held on 10 November 2021. At our public hearings, the manager agreed that before Max's session with a Commissioner he had discussed moving to a step-down unit, going off-property and access to MA15+ video games with Max and another detainee.[2428] The manager told us that access to MA15+ video games was something that Commissioner McLean had raised with him as well during this period.[2429] The manager said that he later told Commissioner McLean that he had considered the issue and thought it was reasonable for young people to be able to access age-appropriate video games.[2430]

The manager told us, however, that his discussion with Max was 'around [Max's] pathway forward and what he wanted to achieve' in the context of some deterioration in his behaviour.[2431] The manager said that he approached Max about his progress after an incident involving Max breaking into a prohibited area.[2432] He said that during the

conversation he and Max discussed Max's progress, his recent work experience and his plan to enrol in a TAFE course.[2433] The manager explained to us that at the time of the conversation, Max had wanted to enter a step-down unit before leaving Ashley Youth Detention Centre and to have access to MA15+ video games.[2434]

The manager recalled that before the discussion, Max had been involved in a range of incidents. The manager said:

> In the time previously before that [Max] had destroyed a $7,000 coffee machine, I think he'd broken two laptop computers, he'd broken into that building area, there had been quite a few incidents as part of his spiral sort of downwards, and we were trying to get him to come up from that.[2435]

We have had the benefit of reviewing the Department's registers of incidents at Ashley Youth Detention Centre, as well as the minutes of meetings of the Multi-Disciplinary and Centre Support Teams. The meeting minutes and incident registers provided to us do not appear to record the incidents as recalled by the manager, although they do indicate other incidents involving Max in October and November 2021.[2436] There was evidence of Max's involvement in a stand-off during the weeks leading to Max's session with a Commissioner. They do not record Max being involved in unauthorised entry to prohibited areas, or damaging property, between 1 October 2021 and 10 November 2021.[2437] The meetings of the Centre Support Team also describe Max's behaviour as 'polite', 'settled' and 'positive' before his session with a Commissioner on 10 November 2021.[2438]

The registers do, however, record incidents involving Max gaining 'unauthorised entry to a prohibited area' on 19 and 20 November 2021, after his session with a Commissioner.[2439] Similarly, the documents we have reviewed show that Max damaged a coffee machine and a computer in late November 2021, several weeks after his session with a Commissioner.[2440]

During our public hearings, the manager was asked whether his conversation with Max before Max's session with a Commissioner related to the information Max would provide at that session. The manager told us he could not recall such a conversation:

> Q [Counsel Assisting]: So, [the manager], I'm sorry to interrupt you but you haven't answered the specific question which you were asked, which is, do you recall having a specific conversation with Max about the fact that he was going to give evidence to the Commission?
>
> A [The manager]: No, I do not.
>
> Q: And, are you saying that you never had such a conversation?
>
> A: I can't recall a conversation about that.[2441]

The manager reiterated his denial that he attempted to bribe Max.[2442] The manager also told us that his conversation with Max 'was absolutely nothing to do with him meeting the Commissioner' and that 'young people need to be heard, and the young people should be meeting with the Commissioner'.[2443] The manager also observed that Max is 'very, very well spoken' and 'quite articulate'.[2444]

On 8 November 2021, two days before Max's session with a Commissioner and in response to a query from Ms Honan about whether the manager needed any support to accommodate Max's session with a Commissioner, the manager said:

> I think that [the other detainee] and [Max] want to voice their opinion of [the Centre] and the support they receive, it could actually be a good opportunity for the centre.[2445]

In his later email to Ms Honan, the manager said Commissioner McLean had told him that Max and the other detainee had positive things to say about the Centre.[2446]

The manager told us he did not recall speaking to Max after the session with the Commissioner in relation to Max going off-property and moving to the step-down unit.[2447] He also said that after the session with a Commissioner, he spoke to Commissioner McLean and Ms Honan about Max's allegation.[2448]

5 Ms Honan's recollection

Ms Honan gave evidence in our hearings before Max and the manager gave their evidence. Therefore, during her appearance we did not ask her about the allegation made by Max. After her evidence, we asked Ms Honan to provide us with her account of events, which she did in a statement on 16 November 2022.

Ms Honan told us that Commissioner McLean raised Max's allegation with her on 14 November 2021. Ms Honan told us she 'viewed the concerns as serious'.[2449] Ms Honan said she spoke to the manager when she returned to work on 22 November 2021 and that this conversation covered 'strategies' including the manager having no individual contact with Max and documenting all conversations with him 'to ensure clarity of conversations'.[2450] She said it was also agreed (although it is unclear by whom) that Ms Honan would meet with Max and the manager on 24 November 2021 'to discuss the concern'.[2451] As described earlier, Ms Honan also emailed the manager and asked him to respond to the allegation 'so that this is on the record and [to] adopt the strategies we discussed moving forward re two staff present during conversations and documenting of conversations in shift notes'.[2452] This forwarded email contained all the details of Max's complaint as captured and summarised by Commissioner McLean.

On 23 November 2021, the manager emailed Ms Honan in response to Ms Honan's email about Max's allegation. In that email the manager said that he had spoken to Max after being contacted by Commissioner McLean in relation to Max and another young person accessing MA15+ video games while they were detained at the Centre.[2453] The manager's email stated that Max was 'despondent' because 'the week before [his session with a Commissioner] he had led a stand off'.[2454] As noted above, the documents we reviewed record Max being involved in a stand-off in late October 2021.[2455] The manager wrote that he spoke to Max about him being able to go off-property, being able to access MA15+ video games and being moved to the unit being run as a 'semi-step down unit' once Max was 'on green' (a reference to Max being on the highest colour level for good behaviour on the behaviour management system—refer to Chapter 10).[2456]

In his email of 23 November 2021, the manager also told Ms Honan that Commissioner McLean had contacted him before the session with a Commissioner, who told him that Max and another detainee wanted to speak to our Commission of Inquiry about 'their lives at [the Centre] and how they felt it was their home and that they were treated well by the staff'.[2457] The manager told Ms Honan that he 'was surprised at first by this action but felt buoyed as it showed that we were doing our jobs well'.[2458]

In his email to Ms Honan, the manager denied Max's account of the conversation as described by Commissioner McLean, stating that he did not attempt to 'influence, bribe or blackmail' Max.[2459] The manager acknowledged that he 'did try to influence [Max] to improve his behaviour by suggesting that he may be able to go [f]ishing when Green and that MA15+ video games will be available in the semi step down unit', but that this was unrelated to Max's session with a Commissioner.[2460]

Ms Honan said that on 24 November 2021, following the manager's email, she met with Max and the manager together to discuss the allegation.[2461] Ms Honan told us that she spoke to Max separately before this meeting to discuss its purpose, to confirm Max was comfortable with the manager being present and to discuss the option of the meeting being ended if Max felt uncomfortable or became angry.[2462] No independent support person was present for Max at the meeting.

Ms Honan wrote to Commissioner McLean the following day, stating that she and the manager had met with Max and that Max had agreed that he 'may have confused what was … told to him and taken out of context'.[2463] Ms Honan did not explain to Commissioner McLean why or how Max had been confused. Ms Honan later told us that, during the meeting, Max said he may have been confused by the conversation with the manager occurring 'so close to the time' of Max's session with a Commissioner.[2464]

Ms Honan also said in her email to Commissioner McLean that Max was now 'in a positive frame of mind' and was 'motivated to try and reach green'.[2465] Despite Ms Honan's instruction to the manager on 22 November 2021 that any conversations

with Max be documented, Ms Honan did not provide to us any notes recording the 24 November 2021 conversation in response to our request for details of her conversations and correspondence in relation to this matter.[2466] Ms Honan told us that she used her 25 November 2021 email to Commissioner McLean as her case note of the meeting with Max and the manager.[2467]

6 Findings

We do not make a finding, on the balance of probabilities, of whether or not the manager attempted to bribe Max. We found both Max and the manager's accounts plausible. We are concerned, however, by the response of Ashley Youth Detention Centre and the Department to that allegation.

Finding—Ashley Youth Detention Centre and the Department did not respond to Max's allegation appropriately

Max's allegation against the manager was serious. We are concerned that the response to the allegation, including its investigation, did not reflect its seriousness.

Our concerns with the response to Max's complaint include the following:

- If Max's allegation were true, it would constitute, at least, serious misconduct. We received no evidence to suggest this possibility was considered or was raised with anyone in the Department other than the manager. The complaint might have been reported or referred to more senior management and human resources staff and advice sought about what steps to take, including whether the allegation should be referred to the Secretary to consider a disciplinary investigation.
- Ms Honan spoke with the manager before making any enquiries with Max and apparently provided the complaint from Commissioner McLean with all the details of Max's account to the manager. We consider it would be best practice to speak with the young person making the allegation before speaking to the person against whom the allegation is being made and then appropriately formulate and present the issues to which that person should respond.
- We received no evidence to suggest that Ashley Youth Detention Centre took steps to consider whether other detainees were relevant to the investigation of Max's allegation. While the Centre may not have been aware that Max alleged another detainee witnessed the bribe, it was known to the Centre that two detainees were seeking access to MA15+ video games and were participating in sessions with a Commissioner.

- We received no evidence to suggest that Ashley Youth Detention Centre took steps to gather information from any other Centre staff (including the Centre's psychologist) who may have been aware of the allegation and may have had information relevant to Max's complaint and what, if any, action they may have taken.
- Max was called into a meeting with two senior managers—one who he had accused of bribery (the manager) and that person's superior (Ms Honan). We received no evidence to suggest that Max had an independent support person present in the meeting or any other accommodations to acknowledge the significant power imbalance in the room. We consider that the manager should not have been present at this meeting.
- There appear to be no records of the meeting between Ms Honan, the manager and Max beyond Ms Honan's email the next day to Commissioner McLean. Given the seriousness of the allegations, a detailed record of the meeting and indeed the investigation process more generally should have been taken and recorded appropriately.

Overall, we consider there was not an appropriate response to what was a serious complaint from a detainee. We consider the response to Max's allegation suggests systemic problems in how Ashley Youth Detention Centre and the Department respond to serious allegations, including by children and young people against staff members. We observed similar problems in the Department's response to allegations of child sexual abuse against staff and in a complaint from Alysha (a pseudonym), a former Clinical Practice Consultant at Ashley Youth Detention Centre, about the safety of children (refer to Case studies 5 and 7).[2468]

It is important that any investigation appropriately addresses the power imbalance between adults and children, particularly detainees who are highly dependent on staff while in detention. It is important, too, to manage the risk that the accounts of adults are preferred over those of children and young people, even where those children and young people may sometimes display challenging behaviours. Also, information gathering should include the accounts of others who may be able to provide clarifying or corroborating information. Finally, it is imperative that serious allegations be formally responded to in line with policy and procedures, and that this be properly documented. We are concerned that the way in which Ashley Youth Detention Centre responds to serious allegations may affect whether detainees raise allegations about child sexual abuse.

We discuss in Chapter 12 changes we consider can be made to strengthen independent individual advocacy for children and young people in detention through a new Commission for Children and Young People.

Case study 7: Allegations of child sexual abuse against staff at Ashley Youth Detention Centre

A note on language

In this case study, we use the term 'Department' to mean the department responsible for youth detention at the relevant time. From 2000 to 2018, this was the Department for Health and Human Services. From 2018, it became the Department for Communities (also referred to as Communities Tasmania). In October 2022, the department responsible for youth detention changed to the newly formed Department for Education, Children and Young People. Where there is potential ambiguity, we use the full name of the relevant department.

1 Overview

In this case study, we explore responses to allegations of the sexual abuse of detainees made against some Ashley Youth Detention Centre staff. There is a long history of allegations of abuse at the Centre, but this case study establishes that appropriately responding to allegations of child sexual abuse is an ongoing challenge for the Centre and the Department to manage. It is crucial that the Department has the policies and practices in place to identify and appropriately respond to allegations of staff misconduct related to children and young people at the Centre.

It can be difficult to get timely information about potential abuse perpetrated by staff in detention. As we learned in Case study 1, detainees may be fearful about speaking out against mistreatment, particularly if they are still in detention or likely to return. We heard that reporting or cooperating with authorities is heavily stigmatised among young (and adult) offenders, which can discourage reporting. However, we also observed that where young people did try to report concerns, they often recalled that these reports were not recognised as disclosures or allegations of abuse or were otherwise minimised or downplayed. We saw that many former detainees reported their mistreatment in adulthood, perhaps as they recognised and came to terms with what happened to them, felt safer to do so, or hoped that they would be believed this time.

There has been a steady escalation of allegations against current and former staff at Ashley Youth Detention Centre over several years. Establishing redress schemes (Tasmania's Abuse in State Care Program and the later Abuse in State Care Support

Service, as well as the National Redress Scheme) became an important source of information for the Tasmanian Government to understand the nature and scale of potential abuses by current and former staff. The objective of these schemes is to recognise and acknowledge harm that occurs in institutional contexts and to provide some form of compensation for the impacts of abuse and mistreatment, but not to closely examine the conduct of alleged abusers. This can sometimes make it difficult for agencies to respond to information received, particularly where it relates to allegations from a long time ago or where there is limited detail about alleged abusers and their actions. More recently, there has been an increasing number of former detainees who have initiated civil action against the Tasmanian Government (most prominently, in a class action) alleging abuses while they were detainees.

This case study explores how the Tasmanian Government and other State entities have responded to allegations of child sexual abuse by some Ashley Youth Detention Centre staff, particularly in relation to information that it has received through redress schemes and civil action. In addition to the Department, we also discuss the role of the Department of Justice, Tasmania Police, the Registrar of the Registration to Work with Vulnerable People Scheme ('Registrar') and the Ombudsman in responding to allegations of abuse by Ashley Youth Detention Centre staff. This case study should be considered alongside Case study 1, where we found that for decades some children and young people detained at Ashley Youth Detention Centre experienced systematic harm and abuse. However, we expect that some of the challenges (for example, in acting on information in National Redress Scheme applications) would be consistent among other institutions and government departments, in Tasmania and nationally.

1.1 The structure of this case study

We begin the case study by describing the key sources of information for allegations of abuse by current and former staff—including the Abuse in State Care Program, the Abuse in State Care Support Service, the National Redress Scheme and civil claims in Section 2. We then provide, in Section 3, some background for this case study, including an outline of the various responsibilities of agencies in responding to allegations against Ashley Youth Detention Centre staff. This includes the duty of care owed to detainees and reporting obligations to authorities such as Tasmania Police and the Registrar, and powers to address risks to detainees through disciplinary action.

The rest of the case study is set within a broad chronology, focusing on the response to allegations against staff over several key periods, noting these sometimes overlap. In Section 4, we describe how the Department responded to allegations against Ashley Youth Detention Centre staff arising from the Abuse in State Care Program between 2003 and 2013. We note that several claims were also received about out of home carers and about other state care contexts, although we have not examined these in detail. The section includes an explanation of legal advice the Department obtained

in 2007 from the then Solicitor-General on whether (and how) the Department could use information received through these claims. The legal advice at that time concluded no disciplinary action or police reporting could occur without the Department seeking a sworn statement from a complainant. While this legal advice (and the practice that emerged because of it) is a significant and recurring theme throughout this case study, we do not consider it was the sole reason for not using this information to protect children from further harm.

Section 5 covers the establishment of the Abuse in State Care Support Service in 2015 to replace the Abuse in State Care Program, noting that the Department continued to receive allegations against staff through this redress program.

We then describe, in Section 6, disciplinary processes undertaken against Ashley Youth Detention Centre staff from 2007 to 2018, which show examples of serious complaints sometimes being investigated by the Centre itself. This section reflects some of the challenges we have seen across the Tasmanian Government in applying the State Service disciplinary framework to allegations of inappropriate staff conduct towards children.

In relation to this period—2007 to 2018—we chose a case example to examine responses from agencies around this time. This case example is about a former staff member called Walter (a pseudonym), who was the subject of extensive and serious complaints of alleged abuse from a variety of sources.[2469] In that case example, we discuss an arrangement within the then Office of the Ombudsman that incorrectly resulted in some serious complaints made to the Ombudsman (including a complaint about Walter) being referred back to Ashley Youth Detention Centre for response without adequate scrutiny. This arrangement has since ceased but highlights the important role of robust oversight bodies in youth detention. We also saw significant problems in the response to complaints against Walter, which allowed for serious complaints to be managed through counselling, warnings and other minor sanctions for far too long. When a formal disciplinary investigation was initiated, it failed to consider the history of complaints against Walter in their totality and recognise an alarming pattern of behaviour within the allegations.

In Section 7, we note the introduction of the National Redress Scheme in 2018 and outline the processes Tasmania has adopted in responding to claims under this scheme.

We then look to 2019 and onwards in Section 8, which is when the Tasmanian Government began to receive information about current and former Ashley Youth Detention Centre staff through National Redress Scheme applications. We illustrate the key systemic issues we observed during this period with reference to the more recent case examples of Ira, Lester and Stan (all pseudonyms).[2470] Each of these staff members had serious and significant complaint histories relating to abuse of detainees that became apparent from 2019 and arising from claims to the Abuse in State Care

Program, the Abuse in State Care Support Service, the National Redress Scheme and civil litigation. We identify failings and shortcomings in the Department's responses to allegations against staff from 2019 to 2020, while noting some challenges it was facing.

In Section 9, we describe a welcome change in the Department's approach, with a greater focus on the public interest in the safety and wellbeing of children. We also note ongoing shortcomings in the Department's response to allegations against staff.

In Sections 10 to 12, we make observations about systemic problems from 2019 to 2021 regarding responses from Tasmania Police, the Registrar and the Department of Justice to alleged abuses by Ashley Youth Detention Centre staff.

We then, in Section 13, describe continuing departmental initiatives to improve records and responses to child sexual abuse from 2021, before making brief observations about more recent responses to abuse allegations against staff from the similar period in Section 14. In that section, we identify some areas of improvement—particularly in the timeliness of the response—that we want to acknowledge. However, we describe some of our ongoing concerns about the effectiveness of the Department's response to allegations. We also identify that staff morale re-emerges as a dominant consideration and warn against allowing this focus to come at the expense of the safety of children.

Overall, the problems we identify cannot be reduced to the decisions or actions of individuals—they occur in the context of a fundamentally broken system that struggles to prioritise the safety and wellbeing of young people in detention.

1.2 Approach to case examples

As mentioned, in this case study we include several case examples to help us understand the challenges and realities associated with responding to allegations of child sexual abuse. We have chosen these case examples to inform our understanding of the problems and to guide our recommendations. We examine case examples to varying degrees. For instance, we consider only some aspects of the response to allegations of child sexual abuse by Walter in detail to illustrate problems specific to that period (the mid-2010s). In more recent case examples, we were able to include greater detail about those problems and the extensive history of complaints about Walter.

With our case examples of Ira, Lester and Stan, which focus on the period from 2019 to 2020, we adopt a different approach. We examine these three matters in detail, like the approach we adopted for our health case studies in Chapter 14. We chose these examples because they were relatively recent, and we wanted to test the view that allegations of abuse in Ashley Youth Detention Centre were a problem in the past. Through our forensic review of these recent examples, we found that this was not the case. We observed a range of concerning practices that compromised detainee safety and exposed significant weaknesses in the Department's recent policies, practices and

systems to respond to allegations of abuse against staff. These case examples form the basis of our systemic findings in this and other case studies in this volume and have greatly influenced our recommendations in Chapter 12.

Because of how recent the case examples of Ira, Lester and Stan are, we have not been able to lay out our analysis of these matters in detail. This is because there are still legal and other processes underway associated with these matters and we do not want to compromise them. We also needed to respect certain legal obligations to protect the confidentiality of claimants under the National Redress Scheme and other redress processes, which form part of our review.

We had considered publishing but then suppressing our more extensive analysis of these three staff, but ultimately decided against doing so. We thought it in the public interest for the Tasmanian community to receive this information as soon as possible, to the extent possible. This meant we had to present the information differently and in a significantly truncated form. As a result, there may be times where it may appear our findings and recommendations lack some detail compared with other forensic case studies or even our case example of Walter. However, all the information on which we base findings and recommendations has been provided to the State, relevant agencies and witnesses, and has been the subject of considered procedural fairness processes. While we may not always be able to publicly reflect the extent of our knowledge, we consider our findings and recommendations to be well grounded. We spend some time in Section 2 explaining the sources of information we have relied on to show the rigour and breadth of our analysis.

We give a relatively high-level review of departmental responses to several cases involving allegations against Ashley Youth Detention Centre staff that came to light in 2021 and 2022. Because responses to these matters were in such early stages during our Inquiry, we did not request extensive information about them and have not individually described them. However, we wanted to see whether lessons had been learned from the responses to allegations against Ira, Lester and Stan and had translated into meaningful and promised change. While we saw some improvements, particularly in the responsiveness and the timeliness of notifications, we continue to have concerns, which are summarised thematically in Section 14.

It is important for us to state that, as far as we are aware at the time of writing, none of the staff who we examine in our case examples have been charged with any child sexual abuse offences. As we make clear throughout our report, it is not our role to investigate and substantiate specific allegations of child sexual abuse, which is ultimately a matter for police and other agencies. Our interest lies in how agencies responded to allegations and managed risks to children in circumstances where staff who were the subject of allegations had access to vulnerable children in an extremely high-risk setting for abuse—namely, a youth detention centre.

2 Sources of information

We faced enormous challenges gathering the information we needed to thoroughly assess allegations of child sexual abuse by staff at Ashley Youth Detention Centre, and the responses to them. We often felt we were completing a jigsaw within a jigsaw in our attempts to understand exactly what occurred, particularly in our case examples. Some of the challenges were:

- We received lengthy and complex witness statements only days before a witness was due to give evidence.
- Following our public hearings in December 2022, we received a tranche of documents relating to the allegations made against one staff member included as a case example, which limited our ability to test and compare the evidence we received. This included a critical 3 December 2019 Minute to the Secretary regarding Ira.[2471] We acknowledge that some witnesses were no longer with the Department or the State Service at the time they prepared responses to our requests or gave evidence at our hearings and, therefore, were not able to access and provide to us all relevant documentation. This was not, however, the case for all witnesses.
- We did not have access to all Abuse in State Care Program documentation, in part due to the extensive manual review of hard copy files that was required by the State in order to provide some of that information to our Commission.[2472] We discuss issues relating to record keeping regarding Ashley Youth Detention Centre in Section 8.5.2 throughout this case study.
- We could not have access to a multi-agency State Budget submission and related documentation because they were cabinet-in-confidence. We acknowledge that the Department provided us with some summary information about these matters.[2473]
- Evidence was sometimes vague, confusing or internally inconsistent. Very generalised evidence often sat alongside highly qualified evidence, which could be difficult to reconcile. At times, we simply did not receive answers to some questions we posed in our requests for statements from some witnesses, without explanation.
- We saw a lack of alignment between the information held between different agencies. For example, sometimes the Department would tell us a notification was made to Tasmania Police or the Registrar on a particular date—yet evidence from those agencies suggested the notification was made on a different date or not received at all. It was impossible at times to determine why such significant discrepancies existed and whether they arose due to simple human error, a failure in systems of sharing information and recording, or another reason (or indeed,

a combination of these factors). The nature of the information or documentation that was provided to agencies in these circumstances was sometimes difficult to determine—for example, was it in the form of a verbal overview, high-level written summary or all the relevant source material? This made it difficult to assess how reasonable responses were—particularly from the Registrar—in the context of the information they held.

Despite these challenges, we drew information from multiple sources to understand, to the best of our ability, how the Department, Ashley Youth Detention Centre and other key agencies responded to allegations of child sexual abuse by staff.

In the following sections, we summarise the key sources of information that we relied on.

2.1 Current and former detainees

We observed a general and understandable reluctance by some current and former detainees to engage with our Commission of Inquiry. We recognise the significant stigma attached to reporting, the justified and profound loss of trust in institutions many detainees may hold and the very real scepticism many can encounter when they seek to report offending due to assumptions about their character and reliability. We also acknowledge that some people may have had real and genuine fears about engaging with us (particularly current detainees) because of concerns they may have had about retribution due to their participation.

Notwithstanding these barriers, several current and former detainees (and their families) showed enormous courage in sharing their experiences with us—many of which we describe in Case study 1. Our review of documentation (for example, redress applications) has given us insight into other detainees' recollections of abuse and the impact their time in Ashley Youth Detention Centre has had on their lives. Where these people have chosen not to engage with us, we have been mindful of how we have presented information to preserve their anonymity, without sanitising the scale and impact of the abuses alleged.

Some witnesses warned us to be wary of detainees' claims, which reflected a tendency from some to attribute reporting of abuse as being motivated by financial gain or an effort to undermine staff.[2474] False allegations of child sexual abuse, while rare (estimated to be 2–5 per cent), do sometimes occur.[2475] We accept that there may have been instances where detainees threatened to make unfounded complaints and that such threats may have affected the way management considered allegations. As we reiterate throughout our report, it is not our role to determine whether individual abuses occurred.

While we do not dispute that false claims can be made, we did not see evidence to suggest a concerted and organised attempt to concoct or falsify allegations. Our close engagement with the evidence led us to conclude in Case study 1 that some children

and young people experienced systematic abuse and harm at Ashley Youth Detention Centre. We note that descriptions of the culture at the Centre reported by current and former detainees, either directly to us or through documentation, were striking in the patterns of behaviour they described. Aspects of these complaints, including the general attitudes of staff towards detainees and of the practices deployed by staff, were often corroborated or openly admitted by some witnesses including former staff, regulators or authors of past reviews into the Centre.

We are grateful for all the information we reviewed about detainee experiences and consider this information—whether provided to our Inquiry directly or indirectly—will improve awareness of abuses at the Centre and contribute to a safer future.

2.2 Current and former staff

We received statements from some current and former staff of Ashley Youth Detention Centre. This evidence greatly assisted us in confronting the very real challenges that staff at the Centre face every day. Many detainees are highly traumatised and can display a range of complex behaviours that are difficult to manage, which can threaten the safety of staff, other detainees or themselves. We learned that staff were sometimes fearful and felt unsafe in their work—an assertion we do not doubt.[2476] Some reflected feeling ill-equipped and unsupported in responding to the practical challenges that could arise in a dynamic and unpredictable environment, particularly due to understaffing or lack of adequate training.[2477] It was clear that the sharp scrutiny brought to bear on frontline workers at Ashley Youth Detention Centre, who are often working under immense pressure, was a source of considerable and legitimate distress for some staff.[2478]

Despite these challenges, we found some former detainees spoke positively about some staff who they felt had their best interests at heart and were not complicit in harmful and abusive behaviours.[2479] Some detainees observed these staff sometimes did not last long in the Centre or that they eventually became inculcated into poor practices.[2480] Our Inquiry also showed there were staff who advocated for and acted in the best interests of children detained at the Centre (refer to Case study 2). In considering and weighing evidence that was critical of staff, we took account of the need to consider their actions within the challenging context of their workplace.

One former staff member, Alysha (a pseudonym), began working at Ashley Youth Detention Centre in late 2019 and recalls that, shortly after, she was told by Ira (the subject of one of our case examples) that he had witnessed what he considered to be the aftermath of an incident of sexual abuse of a child by Lester.[2481] Alysha reported this in January 2020 and was distressed that her concerns were apparently not acted upon.[2482]

Alysha went on to raise concerns about how her report was managed (refer to Case study 5), and other issues, providing a detailed statement to us about her experiences working at Ashley Youth Detention Centre. Alysha's statement was invaluable to us in

drawing our attention to concerns about current staff and informing our lines of enquiry, noting we have verified many of her concerns by reference to documentation or the evidence of others. We know her decision to speak out about the conditions within the Centre, including through our public hearings, came at what she considered to be an enormous personal cost to her and her family. Without Alysha's evidence, we would not have been able to expose what we have about the treatment of children and young people in the Centre. We were struck by Alysha's steadfast determination and advocacy on behalf of all children and young people, particularly those in youth detention.

We acknowledge the hardworking and dedicated staff at Ashley Youth Detention Centre who performed to the best of their ability in a complex and challenging environment to meet the needs of children detained at the Centre and act in their best interests.

2.3 Key witnesses

We sought statements and information from key departmental staff. Their roles and responsibilities, as well as their tenure, are described in the introduction to this chapter and we recommend referring to this to provide necessary context to this case study.

We also sought oral or written evidence from representatives from other agencies, including:

- Peter Graham, former Registrar within the Department of Justice, who we understand held the role from August 2019 until October 2022.[2483] We have referred to Mr Graham as 'the Registrar' throughout this case study for clarity and brevity.
- Jonathan Higgins APM, former Assistant Commissioner of Operations, Tasmania Police, with responsibilities for the Northern, Southern and Western District commands and the Crime and Intelligence Command since 2019 and a career within Tasmania Police since 1999.[2484] We understand that Mr Higgins now holds the role of Deputy Commissioner, Tasmania Police. We refer to Mr Higgins as Assistant Commissioner through this case study to reflect the role he held while engaging with our Commission of Inquiry.
- Richard Connock, Tasmania's Ombudsman and Custodial Inspector, holding those roles since January 2014 and January 2017 respectively.[2485]

2.4 Documents relating to complaints about staff and disciplinary action

The Department has received allegations of child sexual abuse by staff from multiple sources over a long period. We have been given summaries of many of these complaints, as well as documents outlining disciplinary action taken in response, relating to the period from January 2000 to February 2023. In considering the responses to allegations made against Ashley Youth Detention Centre staff members, we have drawn information from a range of sources, including:

- spreadsheets provided by the Department of Justice and the former Department of Communities listing allegations made against Ashley Youth Detention Centre staff through the Abuse in State Care Program[2486]
- various documents related to the National Redress Scheme, including applications relating to alleged abusers at Ashley Youth Detention Centre and related 'National Redress Scheme – Request for Information' forms
- a spreadsheet compiled for senior departmental managers in or around October 2020 of Ashley Youth Detention Centre staff named in the Abuse in State Care Program, National Redress Scheme or civil claims[2487]
- departmental Minutes to the Secretary (including briefings about claims made through the Abuse in State Care Program, National Redress Scheme, civil claims and other complaints made by individuals), staff file notes, emails and meeting minutes (including the meetings of the Department's Strengthening Safeguards Working Group that was convened in or around August or September 2020 to discuss the active employment matters at the Centre)
- documents provided by the Registrar about alleged abusers, including a table outlining the status of 69 people of interest relating to Ashley Youth Detention Centre (the table also included information the Registrar had received from Tasmania Police, Child Safety Services and the Department about some alleged abusers of interest to us)[2488]
- a table provided by Tasmania Police setting out the reports made to it about allegations against certain Ashley Youth Detention Centre staff members (the table also includes brief details on '[a]ny action or outcome' resulting from allegations and the dates on which police reported matters to the Registrar and Child Safety Services through its reporting systems)[2489]
- several spreadsheets compiled by the Department that set out the disciplinary action it took in response to allegations of child sexual abuse raised against Ashley Youth Detention Centre staff.[2490]

Although we gleaned valuable information from each document, many contained significant deficiencies and much of the information was difficult to reconcile. This made us concerned about the accuracy of some of the information provided to us.

The Department for Education, Children and Young People acknowledged deficiencies in records when it provided us with the most recent 'Employment Direction No. 5 tracker' on 6 February 2023 relating to staff from the former Department of Communities (which has since been subsumed into the Department for Education, Children and Young People), telling us:

> The information in the tracker has been compiled based on the records that were accessible at the time. We note that the Commission has requested information about historical conduct related matters, many that occurred prior to the creation of the Department of Communities Tasmania. We have reviewed the available records. For some matters the records available are incomplete. Therefore we have not been able to answer all questions … Some of our responses are also based on 'secondary' records such as Minutes, but we have not been able to source the primary document.[2491]

We also reviewed several historical documents provided by Jacqueline Allen, former Acting Executive Director, People and Culture, in response to our requests for information. This includes documents concerning events that occurred before she started her role at the Department and in which she was not involved, and often where we had not been provided those documents in response to other requests. We were grateful for her efforts in this regard, as well as for her detailed statement.

3 Background

3.1 Responsibilities on the State to protect children and young people in youth detention

Before we describe the responses of the Department and other agencies to allegations of child sexual abuse by staff at Ashley Youth Detention Centre, it is important to understand the responsibilities these agencies have in protecting detainees from harm. Once a young person enters detention, they fall into the care of the State, which has a range of legal obligations to uphold their rights, wellbeing and safety.

We consider that, quite aside from these specific legal obligations, the State also has a moral obligation to do everything in its power to uphold the safety and best interests of children and young people in detention, to take active steps to support them to recover from past trauma and to address the core drivers of their offending. Providing this support for children and young people reduces their vulnerability to child sexual abuse in detention because they are less likely to reoffend and end up back in detention.

We also consider that a caring and supportive model of care increases the likelihood young people will disclose child sexual abuse when it occurs, because of an established trust in the adults around them.

3.1.1 Duty of care towards detainees and staff

The Department has a duty of care to children and young people in detention. Or, put another way, a duty to take reasonable steps to protect a detainee's health, safety and wellbeing. This duty stems from several sources, including the following:

- Under the *Youth Justice Act 1997* ('Youth Justice Act'), the Secretary (and, in practice, the Department) is designated as 'guardian' of all children and young people in detention.[2492] As guardian, the Secretary has the same rights, powers, duties, obligations and liabilities over children in detention as a natural parent of the child. Under the *Children, Young Persons and Their Families Act 1997* ('Children, Young Persons and Their Families Act') the Secretary is also responsible for decisions concerning the daily care and control of a child or young person in detention.[2493] The Youth Justice Act and the Children, Young Persons and Their Families Act also impose a wide range of additional duties on the Secretary related to children and young people in detention.[2494]
- The Secretary is also responsible for the security and management of detention centres and the safe custody and wellbeing of detainees.[2495]
- The State has a common law duty to exercise reasonable care for the safety of children and young people in detention.[2496]
- From 1 May 2020, the *Civil Liability Act 2002* ('Civil Liability Act') imposes a statutory duty of care on organisations to take reasonable precautions to prevent child abuse by people associated with the organisation, which can form part of a cause of action in negligence.[2497] This duty arises for abuse perpetrated after 1 May 2020 and does not apply retrospectively.
- From 1 May 2020, the Civil Liability Act also makes organisations vicariously liable for child abuse perpetrated by employees, including those whose relationship with an institution is akin to employment (such as a volunteer or sub-contractor).[2498] This duty arises in relation to abuse perpetrated after 1 May 2020 and does not impose a retrospective duty.

The Department also has obligations under the *Work Health and Safety Act 2012* to do what is reasonably practicable to provide a safe workplace for staff.[2499]

3.1.2 Reporting obligations relating to child safety

Across the period of this case study—the early 2000s to 2022—staff in a number of State Service bodies had reporting opportunities and obligations that related to the safety of detainees, some of which were mandatory. We note that even if, on the facts, there was not a mandatory reporting obligation imposed on staff in some of these bodies, best practice would be to make a voluntary report in circumstances where information suggests a potential risk to children.

The reporting obligations relating to the type of conduct we discuss in this case study include:

- Making a report to police about potential criminal conduct, acknowledging that the offence of failing to report the abuse of a child was only introduced on 2 October 2019.[2500] This obligation does not apply where the victim-survivor is over 18 and the person making the report believes on reasonable grounds that the victim-survivor does not want the information to be reported to police.[2501]
- Making a mandatory report to Child Safety Services under sections 13 and 14 of the Children, Young Persons and Their Families Act. Mandatory reporting obligations generally apply when there is a risk of child abuse and neglect. We have observed across the Tasmanian Government that there has been confusion about whether mandatory reporting obligations arise where information suggests a potential risk to children generally, rather than risk to a specifically identified child. We acknowledge that this uncertainty may have contributed to reports not being made. We have chosen not to explore this aspect of reporting in this case study but address reporting to Child Safety Services across other parts of this volume and our report more broadly.
- Making a report of 'reportable behaviour' to the Registrar since 27 November 2015.[2502] The Registrar is responsible for determining if a person should be registered to work with children and young people.[2503] To determine this, the Registrar undertakes a 'risk assessment' to determine if the person should be registered (if they are not already) and an 'additional risk assessment' to determine if a registered person needs to be removed from the register if it receives information during the course of a person's registration.[2504] The risk assessments are based on a determination of acceptable or unacceptable risk to vulnerable people.[2505] Additional risk assessments are typically driven by reportable behaviour notified by reporting bodies.[2506] Where the Registrar determines to undertake an additional risk assessment, the Registrar has grounds for an immediate suspension while the additional risk assessment is undertaken.[2507] We discuss this reporting obligation and make an associated recommendation in Chapter 18.

We briefly discuss processes for sharing information with Tasmania Police and the Registrar as context for the case examples, including information from the National Redress Scheme.

Reporting allegations from National Redress Scheme applications

Many of the allegations of child sexual abuse made against staff at Ashley Youth Detention Centre after 2019 came to the Department through the National Redress Scheme, which was established under the *National Redress Scheme for Institutional Child Sexual Abuse Act 2018* (Cth). Although there is a general prohibition on disclosing information gained through the Scheme except for the purposes of the Scheme, it is possible for agencies and their staff to share information they receive under the National Redress Scheme for child protection purposes, including enforcing criminal law or undertaking investigations or disciplinary processes related to child safety.[2508] This includes staff working in the Department of Communities (or now the Department for Education, Children and Young People), the Department of Justice and Tasmania Police. We consider this exception enables these agencies to share the information in National Redress Scheme applications with the Registrar and Tasmania Police, as well as between agencies for the purpose of undertaking disciplinary action. We have also relied on this provision to receive, review and use information from National Redress Scheme claims for the purposes of our Inquiry and report.

Reports to the Registrar of the Registration to Work with Vulnerable People Scheme

The Registration to Work with Vulnerable People Scheme sits within the responsibilities of the Department of Justice.

Section 53A of the *Registration to Work with Vulnerable People Act 2013* ('Registration to Work with Vulnerable People Act') requires that reportable behaviours by a registered person are notified to the Registrar. 'Reportable behaviour' is defined as 'behaviour that poses a risk of harm to vulnerable persons, whether by reasons of neglect, abuse or other conduct'.[2509] The obligations apply to a 'reporting body', which includes the Department.[2510] Youth justice services have been a 'regulated activity' since 1 October 2015, requiring those working in such services to hold registration.[2511]

It is important to elaborate on the obligation to report to the Registrar because the interpretation of the obligation is important to the discussion in this case study.

A reporting body's obligation to notify the Registrar of reportable behaviour has existed since 27 November 2015.[2512] This includes an obligation to notify the Registrar of reportable behaviour that happened before 2015.[2513] However, before 1 February 2021, section 53A of the Registration to Work with Vulnerable People Act stated that the duty to report to the Registrar arose where a reporting body 'finds that a person has engaged in reportable behaviour'.[2514] The Registrar told us that his team always interpreted the term 'finds' liberally, imposing an 'expansive obligation' on reporting bodies to report risks of harm to vulnerable people.[2515] Notwithstanding this interpretation, we were told that the duty was applied by reporting bodies (including government departments) variably, with some interpreting the legislation as requiring a substantive finding of abuse, neglect or other relevant conduct before making a report.[2516]

The legislation has since been clarified to state that a reporting body must notify the Registrar if it 'becomes aware by any means, or suspects on reasonable grounds, that a registered person has engaged, or may have engaged, in reportable behaviour'.[2517] As discussed later in this case study, the Department told us that, around September 2020 (before the changes to the legislation), it began immediately referring allegations to the Registrar following discussion between People and Culture and the Registrar about best practice and the Registrar's broad interpretation of the term 'finds'.[2518]

We note that there is nothing in the Registration to Work with Vulnerable People Act preventing a body from notifying reportable behaviour to the Registrar, even if they do not have a legal duty to do so. The Registrar told us that 'the more reporting that we get, the better, and I would always encourage agencies, if in doubt, to provide [information]'.[2519] The Registration to Work with Vulnerable People Act contemplates the Registrar receiving information about reportable behaviour other than through the mandatory notification provisions, although there is less clarity about how this information is used.[2520]

In making such a report outside statutory requirements, the reporting body would need to ensure it does not breach any privacy provisions in the *Personal Information Protection Act 2004* ('Personal Information Protection Act'). We consider, however, that sharing information for the purposes of determining risk assessment for registration purposes would satisfy relevant exemptions relating to individual or public safety that have been in place since the Registration to Work with Vulnerable People Act came into force.[2521] We acknowledge other statutory privacy provisions, such as those in the Youth Justice Act, may also need to be considered and complied with depending on the circumstances and the information being shared. We accept that the specific legal context and practicalities will need to be considered in each case.

As we outline throughout our report, having effective information sharing between agencies is a critical part of keeping children safe. Describing the importance of having a system of information sharing that works, the Registrar observed:

> … the systems that we have to keep children safe rely on many actors performing their role, and that's within an agency, it's within police, it's within my office; we all have a role to play. They are distinct roles, quite deliberately, and it's important, and information sharing is really the core to that.[2522]

The Registrar told us that when a State Service agency becomes aware of child sexual abuse in a government or government-funded service, the Registrar should receive three notifications: a referral from Tasmania Police, a mandatory notification from Child Safety Services under the Children, Young Persons and Their Families Act (which should receive a report from the relevant agency), and a notification provided directly by the agency in accordance with its obligations under the Registration to Work with Vulnerable People Act.[2523] The Registrar receives nightly reports of notifications from Tasmania

Police and Child Safety Services that are matched against current registrants and applicants.[2524] The notification is typically followed by the notifier providing information one to five days later.[2525]

The Registrar told us that while there has been some improvement in the process of reporting in recent years, he still does not 'routinely' receive three notifications about each allegation.[2526] The Registrar also told us that other than one report in 2016, he did not receive any notifications of reportable behaviour relating to Ashley Youth Detention Centre until late 2020.[2527] We acknowledge that the lateness of this reporting may have stemmed from the narrow interpretation of the obligation to report under the earlier version of section 53A of the Registration to Work with Vulnerable Act, where a 'finding' was required. We note, however, there was, and still is, nothing preventing an agency from reporting reportable conduct making a notification of reportable behaviour, even if they do not have a legal duty to do so. We are concerned that the lateness of the Department's change in practice for reporting shows a lack of prioritisation of the safety of children in detention.

By August 2022, however, the Registrar had received more than 300 notifications involving Ashley Youth Detention Centre staff (including those provided by the Department).[2528] From those notifications, the Registrar has identified 69 people 'of interest' with sufficient particulars and allegations of relevant conduct.[2529] Many of those allegations related to previous staff and spanned many years, including many that stemmed from rediscovering Abuse in State Care Program claims (discussed further in Section 9.2). Of those 69 people, 33 held registration at some point, including 28 who held registration when the notification was made.[2530] As a result, the Registrar initiated 28 additional risk assessments and requested further information from reporting bodies.[2531] As at 15 August 2022, 10 of those 33 were no longer registered, although only three of these were due to some form of active exclusion by the Registrar (suspension, cancellation or interim bar).[2532] Twenty-three remained registered, including:

- Five people who had been subject to a positive risk assessment, meaning that they could maintain their registration status.
- Two people who had been subject to a proposed negative notice stating that they posed an unacceptable risk to vulnerable people, and their registration status had been suspended. These were, at the time, proposed decisions because the registered person is afforded the opportunity to request that the Registrar reconsiders a negative risk assessment.[2533] We do not know the outcome of this process regarding these two people.
- Sixteen people who continued to be subject to an additional risk assessment.[2534]

In addition to the difficulties identified by the Registrar arising from the Department's information-sharing processes, we understand that the primary source of allegations

of abuse relating to current and former staff at the Centre has been the National Redress Scheme, which made it difficult to take action to suspend or cancel registration. The Registrar told us:

> The information provided to the National Redress Scheme is collected for a different purpose and is tested against a lower legal standard for a successful outcome. As such, the reports often contain limited particulars, lack clarity with regard to allegations and might not attribute conduct to any individual. For example, it is not uncommon for allegations provided in redress to be limited to a few sentences or a paragraph. Further, due to the lower legal standard, the allegations are often not tested in any way. This is appropriate for the purposes of the National Redress Scheme but can limit its usefulness in a risk assessment. The consequence of this is that there may be allegations which suggest conduct of the most serious kind but for which limited particulars exist.
>
> Claimants to the National Redress Scheme have also typically declined to participate in or provide statements to Tasmania Police investigations relating to the alleged conduct. This, while understandable, further limits the ability for relevant information to be collected or for an appropriate criminal justice response. In the context of the alleged conduct of current and former staff, there are only two cases where Tasmania Police provided information which was in addition to any information provided by [Department of Communities] records.[2535]

Also, the Registrar described how National Redress Scheme claims 'often don't attribute specific conduct to individuals, but they may mention individuals in their statement as a whole'.[2536] We were also told that in many cases the Registrar did not receive the full National Redress Scheme application but instead received extracts or quotes, sometimes only one or two sentences in length and without the alleged abuser's name.[2537] The Department of Justice considered that 'in the majority of cases', there was unlikely to be 'sufficient information for the Registrar to "match" the alleged offender with a registration with any degree of confidence'.[2538] In our review of National Redress Scheme materials, we also observed such instances where the claimant did not include details, such as an alleged abuser's name (an application does not require an alleged abuser to be specifically identified to be accepted and redress offered).[2539] We note, however, that this was not always the case—many applications we reviewed specifically named the alleged abuser or witnesses to abuse (albeit, sometimes with understandable spelling mistakes).

While we acknowledge that National Redress Scheme claims often contain limited particulars, we are also concerned that inadequacies in the Department of Justice's processes meant that not all information received from the Scheme Operator (the Australian Government's Department of Social Services) was shared with the former Department of Communities until 2020, and that this would have affected the information the former Department of Communities gave to the Registrar. We discuss the Department of Justice's role in National Redress Scheme claims in Sections 7 and 12.

We were told that while the Registrar initiates an additional risk assessment for anyone who is named in a National Redress Scheme claim, it is 'very rare' that the claim will include substantial information about the nature of the conduct.[2540] However, we consider that the Registrar is required to consider the prospective risk to children when undertaking risk assessments rather than to substantiate information it receives. Based on our case examples, we make a finding in Section 11 that, on occasion, the Registrar appeared to adopt too high an evidentiary threshold in assessing whether staff with allegations against them posed an unacceptable risk to children. In Chapter 18, we make a recommendation to clarify what the Registrar should consider in making risk assessments.

Tasmania Police reporting to other agencies

Tasmania Police is responsible for enforcing the criminal law. Police have several reporting obligations to other agencies concerning child sexual abuse, including to Child Safety Services and the Registrar.[2541]

We were told that Tasmania Police's process for reporting to other agencies is an 'automated process'.[2542] Tasmania Police uses the following systems:

- 'Atlas', which is an intelligence system that has an option for police to select 'Presents a risk to vulnerable people' via a check box.[2543] When this box is ticked, the system generates a notification that is sent to the Department of Justice as a notification to the Registrar.[2544] Police can also select 'Child Safety Occurrences' in Atlas, in which case the information is automatically shared with Child Safety Services.[2545] Our understanding is that the 'Child Safety Occurrence' would only be selected if the victim-survivor was still a child, reflecting that Child Safety Services' focus is generally on the care and protection of a particular child at risk.[2546] This means that people whose behaviour may continue to place children at risk may not be recognised as such because the victim-survivor is now an adult.
- 'Offence Reporting System', which is a system for recording crimes and/or offences.[2547] Specific offences within the Offence Reporting System trigger a notification to the Registrar.[2548]
- 'Online Charging', which is a system used for recording those taken into custody or to generate court files.[2549] Specific offences trigger a notification to the Registrar.[2550]

Our understanding is that most police notifications to the Registrar in relation to allegations in National Redress Scheme applications would be sent through Atlas. While Assistant Commissioner Higgins described these reporting mechanisms as an 'automated process', he also agreed at our hearings that there is a manual and subjective element to the referrals made through Atlas.[2551] He explained that there are guidelines as to when a police officer should 'tick the box' that a person 'presents a risk to vulnerable people', but there is also a 'human element' that may result in human error and also introduces subjectivity into the process.[2552]

Some of the shortcomings of these notification processes became apparent to us through our case examples and were reflected in a lack of alignment in the dates reported by different agencies as to when they received certain information. We explore this further through our case study and discuss Tasmania Police responses to allegations against staff at Ashley Youth Detention Centre in Section 10.

National Redress Scheme 'Child Safe Reports' made to Tasmania Police

Assistant Commissioner Higgins told us that Tasmania Police receives certain 'Child Safe Reports' as referrals directly from the National Redress Scheme through an Australian Government Department of Social Services secure email inbox.[2553] Reports can be either identifying (meaning the complainant provided consent for their personal details to be disclosed to police) or deidentified. All applicants are asked at the time of making an application if they consent to police contacting them.[2554] The Australian Government's Department of Social Services (as the Scheme Operator) appears to have had this reporting procedure in place since August 2018 at the latest, the month after the National Redress Scheme began.[2555] We discuss this in Section 7.

The 'Child Safe Reports' are only referred to Tasmania Police where they meet a certain criterion, such as the abuse occurred in the past 10 years, children are at current risk of abuse, the alleged abuser is still working with children or where the alleged abuser may have children of their own.[2556] We understand the strict criteria for referrals were set by the Scheme Operator.[2557] We are concerned, however, that those criteria mean that relevant evidence relating to certain alleged abusers is not provided to Tasmania Police, particularly because we consider it would be difficult for the Scheme Operator to know (for example) whether a person works directly with children because this information is held by Tasmanian agencies such as the Registrar. It is for this reason we consider it important for the Department of Justice (and other departments) to apply active judgment to what should be reported to Tasmania Police rather than relying solely on an assumption that the Scheme Operator would have reported everything necessary. This active judgment may also be required to meet other reporting obligations. We discuss this in Section 12.

3.2 Disciplinary action

Where a complaint is made about the conduct of a staff member, the Department may take action to assess whether there has been a breach of the staff member's employment obligations, particularly those reflected in the *State Service Act 2000* and related State Service Code of Conduct. This can empower the Department to take a range of actions, including suspending an employee, investigating a potential breach and, in circumstances where a breach is substantiated, imposing sanctions (which may include termination).[2558]

We have summarised the key aspects of the disciplinary framework here to provide context for the case examples in this case study. For more detailed information on the disciplinary framework, refer to Chapter 20.

If an allegation of child sexual abuse is made against a member of staff, a preliminary assessment is conducted to collect and organise information to determine whether the matter should be referred to the Secretary, who would then decide if there should be an investigation for a breach of the State Service Code of Conduct. The Integrity Commission's *Guide to Managing Misconduct in the Tasmanian Public Sector* ('Integrity Commission's guide'), which is discussed in Chapter 20, states that preliminary assessments should be used to quickly (within three working days) gather relevant information to determine whether there is a reasonable suspicion of misconduct and the most appropriate way to deal with the matter.[2559] The Integrity Commission's guide is clear that a preliminary assessment should not turn into an investigation and does not require the allegations to be defined.[2560] We were told, however, that the Integrity Commission's guide was contrary to the advice that had been previously provided by the State Service Management Office, although the nature of those differences was not explained to us.[2561] We discuss the role of the State Service Management Office in providing advice and guidance in Chapter 20.

The Secretary is empowered to take disciplinary action in line with Employment Directions, which most relevantly include:

- Employment Direction No. 4—Procedure for the suspension of State Service employees with or without pay ('Employment Direction No. 4—Suspension' or 'Employment Direction No. 4')
- Employment Direction No. 5—Procedure for the investigation and determination of whether an employee has breached the Code of Conduct ('Employment Direction No. 5—Breach of Code of Conduct' or 'Employment Direction No. 5')
- Employment Direction No. 6—Procedure for the investigation and determination of whether an employee is able to efficiently and effectively perform their duties ('Employment Direction No. 6—Inability'). This direction may apply when a person no longer has capacity to perform their role or does not have the minimum requirements for employment, such as holding registration to work with vulnerable people.

An allegation of child sexual abuse reflects potential misconduct and requires steps to be taken to address any risks of harm. The Integrity Commission's guide sets out potential immediate actions that an organisation can take when an allegation of misconduct is raised. This includes reporting allegations to police and external bodies, imposing a suspension, short-term changes to the duties or the physical location of involved parties, blocking or restricting access to data or information, and securing

appropriate evidence.[2562] The Integrity Commission's guide also notes support may need to be offered to affected parties and the safety of others be considered.[2563]

These Employment Directions can be used to remove or restrict an employee and, where serious breaches are substantiated, result in termination of employment.

With respect to suspensions, the Integrity Commission's guide states, among other things, that an employee can be suspended before or during an investigation and may be required when people are at risk or the alleged conduct is very serious.[2564] It also provides that consideration should be given to reassignment before suspension.[2565] We understand reassignment in the context of a complaint raising child safety concerns may mean moving someone into a role in which they have no possibility of contact with children and young people. We saw some examples where such reassignment was not considered possible based on the nature of the role of some staff at Ashley Youth Detention Centre.

We also received evidence in the context of Ashley Youth Detention Centre that although an employee could not be suspended under Employment Direction No. 4—Suspension if an Employment Direction No. 5—Breach of Code of Conduct investigation had not begun, other action might be taken such as 'directing' the employee away from the workplace before beginning an investigation.[2566] We were told that any line manager could make such a direction.[2567] We understood this evidence to concern an employer's entitlement to issue a 'lawful and reasonable direction' to an employee, which can include, in some circumstances, a direction not to attend the workplace or perform any work while receiving full pay. Whether a direction not to attend work while receiving full pay will amount to a 'lawful and reasonable direction' or is in effect a de facto 'suspension' (such that it must comply with the terms of Employment Direction No. 4), will depend on all the circumstances of the particular case.

We prefer the view that the employer retains the capacity to immediately remove State Service employees from the workplace in circumstances of suspected misconduct (including by issuing lawful and reasonable directions that they not attend work) considering the State's duty of care to children and occupational health and safety obligations. However, the evidence presented to us suggests that this is a matter of some uncertainty and debate among those responsible for such decisions.

In Chapter 20, we describe some of the uncertainty within agencies around whether Employment Direction No. 4 enables immediate suspensions. We heard evidence that it would be useful if the scope of Employment Direction No. 4 was expanded so that suspension could occur on the grounds of child safety.[2568] We make a recommendation to achieve this in Chapter 20 (refer to Recommendation 20.6).

3.3 Department processes for responding to abuse allegations against staff

We observe in our case examples that up until late 2020, the Department did not have any documented or approved policies specific to conducting investigations and notifying other agencies of allegations of child sexual abuse by staff.[2569] This was surprising to us, given the nature of the Department's responsibilities for child safety and youth justice. Ms Allen told us that despite this, there were many informal policies and procedures that People and Culture followed.[2570] She referred, for example, to flowcharts relating to Employment Directions No. 4 and No. 5 that specifically outline the suspension and investigation process.[2571] The Department has since developed flowcharts to guide responses to allegations of child sexual abuse against staff, which we discuss in Sections 9.4 and 13.3.

Below, we outline what we understand to be the responsibilities for responding to allegations against staff based on the evidence we received from various departmental officials in our Inquiry.

On receiving a notification of an allegation of child sexual abuse by an Ashley Youth Detention Centre staff member, People and Culture makes an assessment on a case-by-case basis, which is ultimately determined by many factors. However, witnesses told us that the process since mid-2020 typically includes:

- conducting an initial assessment of the information to confirm whether the alleged abuser is a current Ashley Youth Detention Centre staff member and confirming relevant biographical information
- contacting the relevant manager/director to determine whether the employee is at work and their work schedule, having regard to the risk to detainees
- notifying authorities such as Tasmania Police and the Registrar, including a copy of the allegations and employment information, and staying in contact with those agencies 'to ensure a coordinated approach'
- informing the Deputy Secretary Corporate Services, Deputy Secretary Children, Youth and Families and the Director Strategic Youth Services 'to case conference and coordinate necessary immediate actions, so that Ashley Youth Detention Centre management can ensure the safety of residents'
- compiling and organising available and relevant departmental information and records including rosters, timesheets, closed-circuit television footage, detainee records, policies and procedures
- determining the availability of investigators and confirming that the proposed investigator has no conflicts of interest with the staff member being investigated

- preparing a Minute for the Head of Agency (in this case, the Secretary) to consider whether they have reason to believe a breach of the State Service Code of Conduct may have occurred (per Employment Direction No. 5) and whether it is in the public interest to suspend the employee (per Employment Direction No. 4), together with a draft letter to the employee, investigator appointment documentation and a briefing note to the Head of the State Service
- providing the employee with relevant paperwork, in conjunction with Ashley Youth Detention Centre management
- engaging with the appointed investigator, including providing any identified records
- providing the investigation report to the Head of Agency, Tasmania Police and/or the Registrar and liaising with the relevant staff member on their response to allegations
- undertaking activities to provide advice to the Head of Agency for their consideration and decision
- communicating decisions and outcomes to the employee, Tasmania Police and/or the Registrar.[2572]

We received conflicting evidence about the extent to which the Secretary would be briefed (including verbally) on details of allegations once senior departmental officials became aware of those allegations and before any formal documentation was prepared for initiating an Employment Direction No. 5 investigation.[2573]

It is the Secretary's role to make decisions about disciplinary action under Employment Directions, including investigating or suspending an employee, guided by the advice of the Department. We understand that there is no specific timeframe within which People and Culture must undertake a preliminary assessment, particularly given that the actions that may be required as part of that assessment are determined on a case-by-case basis.[2574] However, as discussed earlier, the Integrity Commission's guide states that preliminary assessments should be undertaken within three working days of receiving an allegation of child sexual abuse against a staff member.

Ms Allen told us that the factors taken into account when deciding whether to recommend a matter should be investigated include, but are not limited to, the risk of harm to children or young people; the severity of the matter; the potential severity of the outcome for the employee; whether the allegations are easily proven or disproven; the complexity of the matter; when the alleged conduct took place; whether the matter has already been dealt with or investigated; whether there is likely to be any evidence relating to the allegation; whether there is a pattern of similar complaints; the past conduct of the employee; and matters relating to public confidence.[2575]

4 2003–2013—Abuse in State Care Program claims

In this section, we outline the extent of allegations received through the Abuse in State Care Program from 2003 to 2013 and how the Department responded to these allegations, including any measures taken to protect children from the potential risks posed by staff. From at least 2007, the Department was on notice that current staff (of Ashley Youth Detention Centre, other parts of the Department and foster carers) were the subject of allegations of child sexual abuse when it sought legal advice on how it could use information arising from claims. As we discuss throughout this case study, based on this legal advice (and a practice that seemingly emerged because of it), the Department did not use information from Abuse in State Care Program claims to manage potential risks to children and young people from serving staff.

4.1 Allegations of abuse through the Abuse in State Care Program

People who were abused while under state care (whether in youth detention or out of home care) could make applications for compensation through Tasmania's Abuse in State Care Program between 2003 and 2013. Claims could relate to any kind of abuse (physical, emotional or sexual abuse, or neglect) by staff or carers. Claims could also be made by victim-survivors in relation to harmful sexual behaviour they experienced while in state care.

As we outlined in Case study 1, the Abuse in State Care Program received hundreds of claims related to abuse in Ashley Youth Detention Centre (or its predecessor, Ashley Home for Boys), including claims of sexual abuse.

The Department is the information custodian for Abuse in State Care Program records and had access to the claimant files.[2576] With the change in departmental structures, we assume the Department for Education, Children and Young People would now be the custodian. Despite this, as we explore in our case examples below, departmental knowledge of the existence of the Abuse in State Care Program was piecemeal and, as recently as 2020, senior members of the Department did not know that allegations had been raised through it against staff still working at Ashley Youth Detention Centre.

4.2 Departmental response to Abuse in State Care Program claims

We received limited evidence to suggest the Department took any action prior to 2020 in response to allegations made against current or former staff arising from Abuse in State Care Program claims, despite some describing serious sexual abuses.

A 4 November 2021 briefing to the Minister for Children and Youth said the Department had 'not been able to source any records that indicates any action was taken against any employees as a result of the information provided through the State Based Redress Scheme'.[2577]

We did not receive evidence of the Department taking any steps in response to information from Abuse in State Care Program claims, such as reallocating the duties of staff, making notifications to other agencies or initiating disciplinary action.[2578] While the application form for the Abuse in State Care Program included a question to the claimant about whether they would like to make a complaint to the police, there was not a similar question about a claimant's willingness to take part in any disciplinary processes if the person they alleged abuse against was still a State Service employee or a carer for children in the care system.[2579]

This inaction meant that Ashley Youth Detention Centre staff, who were the subject of allegations of child sexual abuse, continued working directly with children at the Centre over a long period.[2580] Quite apart from the potential for children to be harmed, it exposed the State to the financial risks of having to meet more compensation claims in the future.

We understand that part of the reason why the Department did not proactively act on information it received through claims was because of the purpose of the Abuse in State Care Program itself. The program was intended to be a healing and restorative act of recognition of past harm, rather than a way to test the veracity of claims or take further action. A December 2020 departmental review into the Abuse in State Care Program considered the notifications process associated with the Abuse in State Care Program as well as its scope and aims. The review noted:

> … the aim of the [Abuse in State Care Program] process was not one established to ascertain blame or fault but rather to be part of a supportive, healing reconciliation process for those who suffered abuse in the care of the State. It was only when claimants specifically requested it, that matters were referred to police.[2581]

The 2020 review described steps the Department intended to take during the life of the Abuse in State Care Program to safeguard children if it was revealed that the alleged abuser continued to provide care to children in state care, which would include those working at Ashley Youth Detention Centre. The review quoted a discussion paper from 14 November 2003 (around the time of the first round of Abuse in State Care Program) that described the respective roles of the Ombudsman, the Department and the Independent Assessor, and said:

> The Department was responsible for checking departmental records to find out if any named perpetrators were still in the State care system and if so, providing that the perpetrator had not already been referred to the Police by the Ombudsman, the claimant should be advised that the matter may be referred to Police for investigation …[2582]

However, this review also quoted a 2004 Minute to the then Minister for Health and Human Services confirming the intention of the Abuse in State Care Program was never to test the veracity of claims or otherwise engage with alleged abusers:

> Except in those cases where a matter has been referred to the Police at the request of a claimant, unless [the Independent Assessor] determines otherwise, no attempt is being made to put allegations to alleged perpetrators. Thus, while initially the Ombudsman and subsequently [the Independent Assessor] must be satisfied that the abuse occurred, it is not intended that there be specific findings made against alleged perpetrators, and ordinarily natural justice would require allegations to be put to alleged perpetrators so that they were in a position to deny, admit or otherwise comment on.[2583]

As the custodian of these records and due to its involvement in the operation of the program, the Department knew of serious allegations made about current and former staff at Ashley Youth Detention Centre.

In September 2014, former Secretary of the Department, Michael Pervan, (then in his first week as Acting Secretary) signed off on the *Review of Claims of Abuse of Children in State Care Final Report*.[2584] This report stated that during the period from 2011 to 2013, 172 claims were made against staff from Ashley Youth Detention Centre or Ashley Home for Boys, as well as hundreds of claims involving out of home care.[2585]

During our hearings in August 2022, Secretary Pervan acknowledged he was aware in 2014 that claims had been made alleging abuse at Ashley Youth Detention Centre at a high level and he did not 'recall' turning his mind to the question of whether alleged abusers named in the Abuse in State Care Program might still be working at the Centre.[2586] However, he did recall asking:

> … regardless of whether they were employees or not, what happens with this information on the grounds that it was pretty clear that we were talking about horrible criminal offences, and I just asked the general question, 'What happens with these?', and I was referred to particular advice and a general practice which was current across government until late 2020 where matters raised in redress were not to be used for investigation, prosecution, and the assumption of course that would have been made by people in the People & Culture or Human Resources area was that, if we were told that they couldn't be used for [Employment Direction No. 5 processes], then those matters weren't open anymore, that they weren't tracked across time. Of course, regardless now, in retrospect, regardless of that advice that we couldn't pursue those matters, we should have come up with some way of keeping track of that information, I can see that.[2587]

The 'particular advice' Secretary Pervan is referring to is legal advice the Department sought in 2007 about whether (and how) it could use information received through Abuse in State Care Program claims ('2007 Solicitor-General's advice').[2588] We discuss this in Section 4.2.1.

We understand that the limitations described by Secretary Pervan also applied to the out of home care context. We were not aware of all the detail about the Abuse in State Care Program, the Department becoming aware of it again, and the Solicitor-General's 2007 legal advice (or the practice that developed from it) when requesting information and conducting our public hearings into the safety of children in the out of home care system. Given we have not examined this issue closely, our findings are confined to failures to use this information regarding staff at Ashley Youth Detention Centre.

As will become apparent, the Department's awareness of the information arising from the Abuse in State Care Program seemed to diminish over time and be lost from much of the corporate memory until 2020.

4.2.1 2007—Solicitor-General's advice on using information received through the Abuse in State Care Program

Despite the intended purpose of the Abuse in State Care Program, the Department showed some concern about allegations against serving Centre staff in the early years of the program. As mentioned, in 2007 the Department requested legal advice from the then Solicitor-General on whether (and how) the Department could use information received through Abuse in State Care Program claims.[2589] Specifically, the 2007 Solicitor-General's advice was sought because the Department's review of the Abuse in State Care Program claims around 2007 had 'disclosed that a number of allegations of abuse were made against persons who are still either [out of home care] carers or are employed by the Department in some capacity'.[2590] Our Commission of Inquiry did not receive the request for advice which resulted in the 2007 Solicitor-General's advice. As such, we cannot assess whether the scope of the request affected the advice which was ultimately provided. On the face of the advice, the Department asked three questions of the Solicitor-General at that time:

1. Should prosecution be considered?
2. Should disciplinary action be considered?
3. Is some other action required to ensure proper protection for children in care either now or in future?[2591]

The then Solicitor-General advised, among other things, that to pursue any disciplinary action against current departmental employees on the basis of allegations made through the Abuse in State Care Program, the Department needed complainants to make statements under oath.[2592] The then Solicitor-General advised that the 'appropriate first step' was for the Department to contact complainants to see whether they would be willing to make a statutory declaration.[2593] The then Solicitor-General also suggested that the Department refer complaints that related to criminal conduct to police, if the complainant agreed and was willing to swear the allegations under oath.[2594]

The advice did not address the third question: 'Is some other action required to ensure proper protection for children in care either now or in future?' beyond a recommendation that the Department engage with complainants to determine their willingness to make statements under oath to facilitate disciplinary and other processes, as described above.

Importantly, the 2007 Solicitor-General's advice extended beyond allegations against Ashley Youth Detention Centre to all departmental employees (including carers). Curiously, the advice did not address the need for any differences in approach between departmental employees and carers in the out of home care system (who are not employees and are not subject to the same procedural fairness requirements for disciplinary action).

4.2.2 The effect of the 2007 Solicitor-General's advice on the Department's response to allegations of abuse

We received varying evidence about the extent to which the 2007 Solicitor-General's advice influenced the Department's response to allegations from 2007 to December 2020.

Some senior leaders in the Department told us that the Department was required to follow the 2007 Solicitor-General's advice and accordingly, the Department could not begin disciplinary action without the participation of the complainant.[2595] Secretary Pervan clarified that this was due to Department of Treasury and Finance rules.[2596] We were told that departmental leadership found this position 'frustrating'.[2597]

During our public hearings, Secretary Pervan reflected on the prevailing view at the time, telling us that 'it wasn't just the practice', adding that the inability to take disciplinary action on allegations raised through claims under the Abuse in State Care Program was a 'very uncomfortable message that none of us were happy with'.[2598]

Secretary Pervan also responded to questioning by Counsel Assisting at hearings as follows:

> Q [Counsel Assisting]: … at around the time you were publishing the report in 2014 it appears that, because of practices that had come to exist, no one invited you to and you didn't yourself reflect on the possibility of reaching out to some of those 172 claimants from Ashley Boys Home to see if any of them wanted to be part of a disciplinary process?
>
> A [Secretary Pervan]: No, the assumption was that we could not.[2599]

While the 2007 Solicitor-General's advice was specific to the Abuse in State Care Program, its principles appear to have extended into other types of claims. For example, it was cited as a barrier to responding to allegations of abuse arising from the Abuse in State Care Support Service (established in 2015), the National Redress Scheme, allegations reported by other staff and even civil claims.[2600]

We saw limited awareness of the 2007 Solicitor-General's advice from some other witnesses. For example, Ginna Webster, Secretary, Department of Justice (who held Deputy Secretary and Secretary roles in the Department of Communities and its predecessor from July 2018 to September 2019) told us in January 2023 that she only 'recently' became aware of the 2007 Solicitor-General's advice.[2601] Other departmental managers also told us they were unaware of the 2007 Solicitor-General's advice until our Inquiry brought it to their attention.[2602]

The 2007 Solicitor-General's advice was not referred to (including as a potential limitation in taking action against staff) in any of the Department's extensive documentation about responses to allegations made in the redress schemes, civil claims or other complaints (and related documentation) that we reviewed.

Despite this, it appears that from at least 2007 a practice emerged within the Department that was based on, or related to, the 2007 Solicitor-General's advice.[2603] That practice had the following features:

- Disciplinary processes were not pursued in response to allegations made through the Abuse in State Care Program based on an understanding that the Department could not do so without a sworn statement or the involvement of the complainant.[2604]
- The Department had no formal process for contacting complainants to get their statement or participation in a disciplinary process and did not do so as a matter of course (despite the Solicitor-General's advice suggesting this was the appropriate first step in any attempt to act on allegations against staff).[2605] On this issue, Secretary Pervan conceded that there was nothing preventing those with responsibility for Ashley Youth Detention Centre at various points from contacting the complainants to check whether they would participate.[2606]
- The principle of not taking disciplinary action extended to complaints or allegations 'where indirect evidence of abuse was raised', including for allegations made through the Abuse in State Care Support Service, the National Redress Scheme, civil claims and complaints from employees. [2607]

This practice appeared to exist until late 2020. Secretary Pervan said the Department had its 'hands tied' until it received further legal advice on 15 December 2020, telling us:[2608]

> … the advice from the Solicitor-General that effectively prevented us from using information provided in applications for financial compensation for disciplinary purposes, applied from 2007 until 15 December 2020. Our management of these matters changed with the change of position from the Solicitor-General.[2609]

We discuss this change in legal advice in Section 9.8.

We acknowledge that the 2007 Solicitor-General's advice constrained some actions available to the Department around the time it was provided. We are concerned, however, that the practice that emerged from the advice appears to have been in place for more than a decade without apparently being revisited and reconsidered. We are particularly concerned that the establishment of the Registration to Work with Vulnerable People Scheme in 2014, and the associated reporting obligations in 2015, did not appear to trigger a reconsideration of how the Department handled and responded to allegations of abuse—noting that much of the information received through these claims would constitute 'reportable behaviour' under that Act. The National Royal Commission, which ran between 2013 and 2017 and highlighted failures to protect children within institutions, also did not prompt the Department to revisit this advice.

As we discuss in our case example relating to Lester, providing all the Department's information holdings at the time the scheme was established would have revealed an extensive history of complaints made in Abuse in State Care Program claims that the Registrar could have considered in determining Lester's suitability for registration. We consider the failure to take more active steps to use information from Abuse in State Care Program claims to have been a significant missed opportunity to protect detainees from potential risks to their safety.

Finding—From at least 2007 the Department should have taken more active steps to use information gained through state redress programs to protect children from the risk of harm

From at least 2007 and possibly from 2003 when the Abuse in State Care Program began, the Department was on notice that some current staff at Ashley Youth Detention Centre were the subject of allegations of child sexual abuse and other abuses. From this point, it had an obligation to take active steps to protect children from harm.

It is not apparent what steps the Department took to investigate claims against staff before seeking advice from the Solicitor-General in 2007 on how it could act on the information it received. We are pleased it sought this advice.

It is regrettable that the 2007 Solicitor-General's advice and associated departmental practices did not prioritise the safety and best interests of children. While we recognise the intention behind the Abuse in State Care Program was to be restorative for claimants (rather than a basis for action in relation to alleged abusers) we do not consider it in the public interest to have a situation where the

Department holds potentially credible information alleging serious abuses against current staff and carers (whether in the out of home care system or Ashley Youth Detention Centre) and does not act on that information.

We accept that the 2007 Solicitor-General's advice constrained some actions available to the Department around the time it was provided, including for taking disciplinary action against staff. However, we consider more could have been done to use the information received from 2007 to 2020 (when new legal advice was sought), including:

- contacting complainants to gauge their willingness to make a statement under oath and/or take part in other processes (including disciplinary and/or criminal justice processes)
- where there was no possibility of initiating formal procedures, taking all non-disciplinary measures available to protect children, including advising managers and supervisors of these claims against current staff to allow for greater vigilance and care in allocating staff duties and ensuring alleged abusers remained closely supervised
- ensuring relevant information was held on a staff members' personnel file to ensure any future complaints or concerns be considered in light of prior claims through the Abuse in State Care Program
- refining the design of the Abuse in State Care Program (noting there were four rounds) to maximise the ability of the Department to act on information it received; for example, this could occur by including a question directed at gauging an applicant's interest in supporting disciplinary action against their alleged abuser—and outlining the support an individual would receive should they choose to do so, to make such a process feel safe (claimants should also have been advised they could revisit this decision at any point)
- revisiting the 2007 Solicitor-General's advice sooner than December 2020, particularly given the significant changes to the legal and policy landscape as it related to child safety; for example, the establishment of the Registration to Work with Vulnerable People Scheme in 2014 should have triggered greater reflection on information that needed to be provided to the Registrar and the National Royal Commission should have invited consideration of the appropriateness of existing processes
- if fresh advice maintained the legal position of the 2007 Solicitor-General's advice, seeking ministerial approval for amendments to the legal constraints, recognising its practical effect was not sufficiently prioritising child safety and the public interest.

It appears that it was not until the Department sought further advice in December 2020 that it took any active steps to address the unsatisfactory outcome the 2007 Solicitor-General's advice (and associated practice) had created.

The Department's approach to Abuse in State Care Program claims prior to December 2020 enabled knowledge of the claims to become lost to a large portion of the Department's corporate memory. They were only rediscovered in 2020. This placed the safety of children in Ashley Youth Detention Centre at risk for years.

5 2015—Introduction of the Abuse in State Care Support Service

The Abuse in State Care Program was wound up in 2013 and replaced by the Abuse in State Care Support Service in 2015. The Abuse in State Care Support Service still operates today.[2610] Like its predecessor, the Abuse in State Care Support Service was established to support people who experienced abuse (including sexual abuse) in state care when they were children, including former Ashley Youth Detention Centre detainees.[2611]

As we discuss in Case study 1, departmental documents indicate that as at 20 July 2021, 26 claims had been made through the Abuse in State Care Support Service about allegations of sexual abuse at Ashley Youth Detention Centre (or its predecessor, the Ashley Home for Boys).[2612] Most of these allegations related to staff conduct at the Centre.[2613] The period of abuse from these claims spans 1995 to 2012.[2614]

We did not receive evidence that the Department took any steps prior to 2020 to identify if claims through the Abuse in State Care Support Service related to current staff.

6 2007–2018—Disciplinary action taken against Centre staff

In this section, we consider the way the Department approached (or as is the case in many instances, failed to initiate) disciplinary action against employees at Ashley Youth Detention Centre who were the subject of allegations of child sexual abuse between 2007 and 2018.

Again, during this period, we continued to see missed opportunities to use information gained from the Abuse in State Care Program and the Abuse in State Care Support Service to inform disciplinary action and ensure staff who posed a risk to detainees were not working at Ashley Youth Detention Centre.

As is the case across all areas of the State Service we have examined, we saw a conservative approach to initiating disciplinary proceedings, with disproportionate focus on procedural fairness at the expense of protecting the safety of children. This is discussed in Chapter 20.

We observed some key issues in the Department's approach to taking disciplinary action against employees accused of child sexual abuse, which includes:

- a lack of clarity and consistency in processes for managing complaints and allegations
- poor record keeping and failures to ensure all complaints and allegations about staff members were appropriately stored and accessible for future review
- failures to consider the cumulative effect of complaints and concerns about a staff member, including to identify patterns of behaviour
- using internal and more informal investigations to respond to serious allegations that should have been viewed as a potential breach of the State Service Code of Conduct and escalated to the Head of Agency.

The practical effect of these problems is that complaints made against Ashley Youth Detention Centre staff were not properly investigated, if at all, enabling them to continue to work with detainees. The failures of the disciplinary process are particularly apparent in the case example of Walter, which we describe in Section 6.2.

6.1 Summary of disciplinary and internal investigations between 2007 and 2018

In this section, we summarise information we received from the Department regarding disciplinary action it took between 2007 and 2018, with an overview of the nature of complaints received about staff and the response to those complaints. We have not limited this section to child sexual abuse and related conduct, including complaints about other forms of mistreatment of children and young people.

6.1.1 Disciplinary action between 2007 and 2018

From 2007 to 2018, the Department undertook several disciplinary investigations, including the following:

- In the late 2000s, the Department investigated an Ashley Youth Detention Centre employee over allegations of inappropriate physical force and inappropriate use of language.[2615] It appears from the information provided to us that two different detainees made allegations against the employee, resulting in a disciplinary investigation, with the outcome being ongoing training, supervision and a demotion.[2616]

- In the late 2000s, the Department suspended an Ashley Youth Detention Centre employee while a disciplinary investigation began over allegations including procuring and providing sexually explicit material to a child.[2617] The Department stood the employee down about seven days after it was notified of the allegations.[2618]
- In the early 2010s, the Department began a disciplinary investigation into two Ashley Youth Detention Centre employees over allegations that they brought pornographic material into the Centre.[2619] It is unclear whether these employees were suspended while the investigation was undertaken. The employees were sanctioned with reductions in salary and reassignment of duties.[2620]
- In the early 2010s, the Department initiated disciplinary investigations over allegations of physical and verbal abuse by one staff member and allegations of physical abuse by another. It appears that one of these employees was suspended four days after the Department received the complaint.[2621]
- In the mid-2010s, the Department began a disciplinary investigation into an employee involving allegations of physical assault that were also the subject of two police charges.[2622] The Magistrates Court dismissed these charges.[2623]
- In the mid-2010s, the Department began an Employment Direction No. 5—Breach of Code of Conduct investigation into Walter including because of allegations that he touched a detainee's genital area.[2624] Walter had previously been the subject of five other investigations.[2625] The Department's handling of the allegations regarding Walter is considered in Section 6.2.

6.1.2 Internal investigations between 2007 and 2014

From 2007 to 2014, Ashley Youth Detention Centre undertook several internal or informal investigations into the conduct of staff, including the following:

- A number of internal investigations were conducted in relation to Walter during this period. We discuss responses to allegations regarding Walter in Section 6.2.
- In the late 2000s, Centre management conducted a review into a staff member who had been the subject of a complaint to the Secretary about excessive use of force. The Secretary referred the complaint back to Centre management for review. The Department provided us with a spreadsheet that said the complaint was not substantiated and was referred to the Ombudsman 'for further review if required'.[2626] In reflecting on the referral, the Ombudsman has told us that there is no mechanism under the *Ombudsman Act 1978* ('Ombudsman Act') for the Department to make such a referral.[2627] Another allegation against the employee was 'referred' to the Ombudsman in the early 2010s for alleged excessive use of force and that access to medical care was withheld.[2628] The Department told us that the Ombudsman did not make an adverse finding.[2629]

- In the late 2000s, the Department terminated a staff member's employment over allegations including that he supplied a child at Ashley Youth Detention Centre with contraband in exchange for 'sex[ual] favours'.[2630]
- Centre management conducted two reviews in the late 2000s into one staff member who had been the subject of a complaint to the Ombudsman in relation to alleged abuse and inappropriate comments, and another allegation about the use of excessive force.[2631] An Employment Direction No. 5 investigation ultimately began in the late 2010s over the allegations of excessive force.[2632]
- In the mid-2010s, Centre management conducted a review into a staff member who had been the subject of a complaint to the Ombudsman about alleged physical abuse.[2633] The Department told us that it did not have information about the final finding.[2634]
- In the mid-2010s, Centre management conducted a review into allegations that a staff member had made comments of a sexual nature and perpetrated sexual abuse during a search.[2635] The review included seeking clarification from the complainant, putting the allegations to the employee for comment and reviewing closed-circuit television footage.[2636] Management found that the allegations were not substantiated.[2637]
- On an unknown date, the Department conducted a review into allegations of verbal and physical abuse by a staff member.[2638] When more allegations of verbal abuse were later raised against the staff member, these were referred to the Area Manager with a recommendation for suspension (on an unknown date).[2639] The suspension was not actioned because the staff member was on workers compensation.[2640] The Department issued a direction that the staff member was not to interact inappropriately with children and contrary to the Child Protection Practice Framework.[2641]

6.2 Case example: Walter

In this case example, we consider responses to complaints made about a former Ashley Youth Detention Centre staff member, Walter (a pseudonym).[2642] Walter began working at Ashley Home for Boys and was an employee at Ashley Youth Detention Centre until the late 2010s.[2643] He held various roles at the Centre that involved working directly with children.[2644]

While we found many aspects of the Department's response to Walter concerning, we have not examined all elements of it exhaustively. We have chosen three elements of this matter to illustrate problems and issues. This includes consideration of:

- the failure of the Department to recognise and act on, allegations received about Walter over several years that indicated a pattern of abusive behaviours, including allegations made through Abuse in State Care Program claims

- how the Office of the Ombudsman responded to a complaint from a detainee, Erin (a pseudonym), which led to her serious complaints being referred by the Office of the Ombudsman back to Ashley Youth Detention Centre for response without adequate independent oversight and scrutiny[2645]
- the Department's approach to considering and initiating formal disciplinary action against Walter.

6.2.1 Complaints about Walter's behaviour towards detainees

We examined a variety of sources about Walter's conduct at Ashley Youth Detention Centre to understand his complaints history. This information was difficult to piece together due to the nature and complexity of the spreadsheets and documents we received from various State agencies and witnesses. In some instances, we have relied on information compiled by departmental witnesses who were not with the Department at the time of the alleged incidents and who were not involved in, or responsible for, the Department's response.

What we did observe in the information available to us, however, was a significant pattern of serious allegations of abuse by Walter spanning two decades. Walter was the subject of at least 31 allegations of abuse, including child sexual abuse, made from the late 1990s to as recently as 2022—including through complaints made directly to the Department, the Ombudsman, the Commissioner for Children and Young People, through Abuse in State Care Program claims, civil claims, and reports to Tasmania Police.

The Department was aware of at least 19 of these allegations before Walter's resignation in the late 2010s, with these 19 allegations raised with the Department from the late 1990s to the mid-2010s. The allegations of Walter's abuse the Department received were extremely serious. They included inappropriate touching of female detainees, sexual abuse while strip searching a detainee, forced oral sex and rape. We also received evidence of allegations of physical abuse or excessive use of force.

We set out below, at a high level, some of the allegations made against Walter before his resignation, and the associated responses by the Department, Tasmania Police and other agencies.

In the late 1990s, two female detainees lodged complaints with Ashley Youth Detention Centre alleging that Walter touched them inappropriately.[2646] A third detainee also complained to the Centre, alleging that Walter failed to apply proportionate restraint.[2647] The Centre carried out an internal investigation into these three complaints during which Walter was suspended on full pay.[2648] As a result, Walter was required to undergo training related to at least one of these complaints and a 'first and final warning' was issued regarding the second complaint.[2649] In relation to the third complaint, Walter was issued with a notice, which we understood to confirm a finding that Walter had conducted himself 'in an improper manner' in the performance of his duties.[2650]

No further action was otherwise recommended.[2651] We understand Tasmania Police was notified about Walter's conduct at the time, but we are unclear of the specific allegations reported at this time.[2652]

Between the late 2000s and early 2010s, six people made Abuse in State Care Program claims in relation to Walter's conduct.[2653] The claims, which related to Walter's alleged conduct in the late 1990s and early 2000s, included allegations of sexual abuse while strip searching a detainee, forced oral sex and rape.[2654] We received no evidence to suggest any contact was made with the complainants who had lodged Abuse in State Care Program claims naming Walter to determine whether they would be willing to make a sworn statement—either to support a disciplinary investigation or investigation by police—which aligns with what we were told was necessary to act based on the practice at the time (refer to Section 4.2). We were also told the Department could not find evidence to suggest that the information from the Abuse in State Care Program was ever made available to those who supervised Walter or who were subsequently involved in the disciplinary investigations of him.[2655]

In the early 2000s, a male detainee disclosed that Walter had touched his genital area during strip searches.[2656] The matter was reported to the Centre and Walter was stood down for 48 hours in response to this complaint.[2657]

In the late 2000s, a female detainee alleged that Walter sexually abused her and that a staff member witnessed the incident but did not intervene.[2658] Tasmania Police found there was no evidence to support the allegations and closed the matter.[2659]

In the late 2000s, a complaint was made to the Ombudsman about Walter's restraint of a detainee, which allegedly caused their genitals to be exposed.[2660] We did not consider this matter in detail.

In the early 2010s, Walter was alleged to have physically abused a female detainee and entered her room after viewing her through the door viewing panel.[2661] The Department became aware of this complaint via a referral from the Ombudsman.[2662] Mr Connock, who was not the Ombudsman at the time, told us that the Office of the Ombudsman carried out preliminary inquiries into the matter and found that the use of force involving Walter was unjustified and 'showed a weakness in his conflict resolution skills'.[2663] Mr Connock also told us that Centre management advised that Walter had been formally counselled and received remedial training.[2664]

In the early 2010s, a former detainee, 'Erin', made a complaint about Walter's alleged sexualised behaviour towards her.[2665] We describe the Ombudsman and Department's response to Erin's complaint in Section 6.2.2.

In the mid-2010s, a detainee complained that Walter was physically threatening and intimidating towards him.[2666] We understand this complaint was raised through an internal complaints process. Walter was given a 'lawful and reasonable direction' in response.[2667]

In the mid-2010s, it was alleged that Walter touched a detainee's genital area, as well as having engaged in inappropriate use of force and failing to report the incident in line with Ashley Youth Detention Centre procedures.[2668] The Commissioner for Children and Young People, Child Safety Services and Tasmania Police were made aware of this complaint.[2669] We understand the Department notified Tasmania Police about this allegation.[2670]

In addition to the allegations the Department was aware of, **in the mid-2010s**, the then Commissioner for Children and Young People made a notification to Child Safety Services about an allegation that Walter had tried to touch a detainee's genitals.[2671] The notification stated that the future risk was low because the young person was no longer in custody, Walter was being investigated and the Centre had taken necessary steps to ensure other children were not at risk.[2672] This complaint was not included in the Department's information to us about Walter's complaints history.[2673]

Below, we explore two specific responses to allegations raised against Walter. We note generally, however, that the information we received about allegations against Walter from the Department, the Registrar and Tasmania Police was confusing and inconsistent. Based on the information the Department provided, we could not always tell which allegations were reported to Tasmania Police or the Registrar, and the dates and allegations in each of their respective responses to us did not align.

We note with some concern that the Registrar told us that the first notification he received was about the mid-2010s allegation that Walter had touched a detainee on his genital area, which was reported approximately four weeks after the allegation was made.[2674] Based on our chronology, the Department was aware of at least 12, and potentially as many as 21, previous complaints about Walter at this time. We acknowledge the obligation to report only arose in 2015 and that there was some confusion around reporting obligations to the Registrar until the Department's practice changed in 2020. However, we consider Walter's extensive complaints history to be vital information for the Registrar. This is particularly the case because decisions about granting registration to work with vulnerable people can protect children in a broader range of settings (for example, volunteer and other activities).

We note that Walter's registration to work with vulnerable people was only cancelled in the early 2020s after the Registrar received new information about the serious history of complaints against Walter around that time.[2675]

6.2.2 Erin complains about Walter to the Ombudsman in the mid-2010s

Erin told us about her experience as a detainee at Ashley Youth Detention Centre, where she was sexually and physically abused by staff (particularly during strip searches) as well as abused by other young people in detention, which we outline in Case study 1.[2676]

Erin told us that about a month after arriving at the Centre in the mid-2010s, she was feeling unwell and was worried she had appendicitis.[2677] She recalled she told Walter and asked to see the nurse.[2678] She said Walter told her to lift her top up, felt around her lower abdomen and drew a shape near her hip, telling Erin it was a 'happy appendix'.[2679] Feeling violated and that his actions were 'creepy', Erin told us she reported the incident to a female staff member, who advised Erin to report it to the Ombudsman.[2680] Erin also described an incident where Walter entered her room to collect sheets while she was showering, despite Erin's request that Walter send a female staff member to collect the sheets, or waited until she finished showering.[2681]

The Ombudsman told us the office received a complaint that 'the staff member had touched the resident's stomach and drawn a line with his finger near her hipbone'.[2682] By the time Erin made a complaint, the Ombudsman had already received at least two other complaints against Walter, which are described earlier.[2683]

Two weeks after Erin submitted her complaint, she received a letter from the Office of the Ombudsman that stated that the Ombudsman had an 'arrangement' with the Department in which 'complaints such as yours are initially referred back to Ashley management to attempt to resolve the complaint quickly and efficiently'.[2684] The letter went on to state:

> The sort of complaints that are referred are ones that appear to relate to matters such as the application of Ashley's Behaviour Development program or where it seems likely that Ashley management can resolve the matter through discussion with staff and the young person.
>
> I expect that a senior staff member will speak to you about your complaint in the near future. I am confident that your complaint will be resolved through this process and I will not contact you about it again. I will be notified of the outcome of any discussions with you by the Manager at Ashley.[2685]

In response to the referral from the Ombudsman, Centre management initiated an internal investigation into Erin's complaint, which included a review of closed-circuit television footage and obtaining a statement from Walter and witnesses.[2686] In relation to the allegation that Walter drew on Erin's body, Walter described this as an attempt to calm Erin's nerves and emphasised that other staff and detainees were present.[2687] Regarding the allegation he entered Erin's room while she was showering, Walter said another staff member was present just outside the room and that he [Walter] could not see Erin from where he stood in the room.[2688]

Ultimately, Centre management accepted Walter's version of events.[2689] Centre management concluded that Walter did not have any inappropriate intent, but he should have realised that his conduct was likely to make Erin feel uncomfortable and potentially feel unsafe.[2690] Referring to the similarities between Erin's complaint and the other detainee complaint to the Ombudsman made around this time, Centre management reflected that there was 'insufficient sensitivity on [Walter's] part to gender

considerations'.[2691] It said Walter's actions in both instances were 'ill-advised' and made him 'susceptible to a complaint such as this'.[2692] Walter was not sanctioned but was formally counselled and asked to conduct himself with greater sensitivity and focus on gender awareness.[2693]

We have not sought evidence of the processes adopted as part of this investigation and accordingly, do not make conclusions regarding whether the Department took appropriate action in this investigation. However, we note that it is our understanding Erin was not interviewed as part of this internal investigation, which appears to have been conducted outside the State Service disciplinary framework.

Erin had been released from the Centre by the time the Office of the Ombudsman received the Department's decision about her complaint.[2694] Mr Connock, who was not the Ombudsman at the time but worked in the Office of the Ombudsman, told us 'no action was taken by the Ombudsman's office other than to note the outcome', which he considered a 'questionable decision'.[2695] Erin told us that she was never notified of any outcome, and she had to continue seeing Walter in her two subsequent admissions to Ashley Youth Detention Centre.[2696] Speaking of the consequences she faced when she returned to the Centre after her complaint, Erin said staff called her a 'dog' and a 'drama queen'.[2697] She felt it was 'pointless' speaking up and she learned that it was easier to not say anything at all.[2698]

We were surprised by the letter from the Ombudsman's office to Erin, which made mention of an 'arrangement' by which complaints were referred back to the Centre, particularly given the Ombudsman's involvement in administering two rounds of the Abuse in State Care Program. This involvement should have made the Office of the Ombudsman aware of the number of complaints of abuse and mistreatment made against Ashley Youth Detention Centre staff and raised questions about the appropriateness of referring complaints back to the Centre.

We acknowledge that under the Ombudsman Act, the Ombudsman's powers are to investigate a public authority's administrative action, not individual officer conduct.[2699] In practical terms, this means the Ombudsman is responsible for reviewing the Department's (and Centre's) systems, practices and decisions made, rather than any specific misconduct by Ashley Youth Detention Centre staff. When complaints were made about particular staff members, we were told that the Ombudsman would investigate the manner in which the Department had responded to the complaint and what legal framework, policies and procedures were in place to mitigate against the circumstances of the complaint arising again.[2700] However, Mr Connock also acknowledged that the Ombudsman should have more closely considered and monitored the Centre's responses to Erin's complaint and other serious allegations.[2701] In Chapter 12, we discuss the Ombudsman's role and associated powers when responding to complaints about the treatment of children and young people at Ashley Youth Detention Centre.

Mr Connock told us he considered the referral of Erin's complaint back to the Centre to be a 'mistake' by a less experienced staff member and said that the type of allegations that were intended to go back to Centre management under the arrangement were 'low level things' such as 'not enough jam'.[2702] Mr Connock said that the arrangement should never have been used to refer any complaint that included an element of sexual abuse or harassment.[2703] He considered that a more experienced staff member would not have reached the same conclusion as the one reached in Erin's case.[2704] In any event, Mr Connock confirmed that the 'practice has long been discontinued'.[2705]

We accept Mr Connock's view that Erin's complaint was referred back in error and that this practice would not occur today. We are concerned, however, by other evidence we received about this 'arrangement'. In addition to Erin's complaint, we have reviewed four letters dated between 2009 and 2013 from the Office of the Ombudsman in response to complaints made against various Ashley Youth Detention Centre staff members. Those letters, prepared by two different staff members of the Ombudsman's office, used similar language to the letter relating to Erin referring to this 'arrangement' where complaints were referred back to Ashley Youth Detention Centre management. These complaints did not include allegations of child sexual abuse or related conduct but related to issues such as 'the application of AYDC's Behaviour Development program' and 'staff attitude and behaviour towards residents'.[2706] They also included a complaint by a child at the Centre who had been locked in his room and a complaint that a staff member told other detainees that he would give them contraband if they 'bash[ed]' the complainant.[2707]

We do not consider complaints of this kind to be minor because they relate directly to the human rights and safety of detainees. On this basis, we do not consider the referral of Erin's complaint back to the Centre was a one-off human error. We are also concerned about the integrity of the processes that were in place in the Office of the Ombudsman at that time to ensure inappropriate referrals were not made.

We are pleased Mr Connock shared our concerns about Erin's complaint and that the arrangement where 'minor' complaints are referred back to Ashley Youth Detention Centre has since ceased. We make recommendations about oversight of Ashley Youth Detention Centre in Chapters 12 and 18.

6.2.3 Employment Direction No. 5—Breach of Code of Conduct investigation into Walter's conduct in the mid-2010s

Walter was investigated (internally or by the Ombudsman) on at least five occasions before the Department started an Employment Direction No. 5 investigation in the mid-2010s.[2708]

As mentioned earlier, in the mid-2010s Ashley Youth Detention Centre management became aware that a detainee had made a complaint against Walter, alleging that Walter

had touched him in the genital area. A preliminary investigation into the matter indicated that Walter may have touched the detainee but did not necessarily make contact with his genital area.[2709] There were concerns that the contact may have constituted an inappropriate use of force.[2710] A meeting was held with Walter in which the allegations were put to him and he was invited to provide a written response to the claims.[2711] Walter was also informed that due to the nature of the allegations, he would be assigned alternative duties with no contact with detainees while the matter was investigated.[2712] This direction appears to be a result of 'preliminary investigations'.[2713]

In a written response, Walter acknowledged that he touched the detainee but rejected the allegation that he touched the detainee in the genital area.[2714] He explained that no force was involved and provided a justification for touching the detainee.[2715]

Soon after, the detainee reported his complaint to the Commissioner for Children and Young People.[2716] The matter was also referred to the police at the detainee's request and was reported to Child Safety Services.[2717]

We understand that Walter went on leave immediately after Centre management put the allegation to him and did not return to the Centre before his resignation.[2718]

Later, but before Walter's resignation, the then Acting Deputy Secretary – Children, approved a Minute recommending an Employment Direction No. 5 investigation into Walter.[2719] The three grounds on which the Employment Direction No. 5 investigation was based (and ultimately proceeded) were in relation to allegations that Walter had touched the detainee in the genital area, failed to use non-violent crisis intervention techniques, and failed to report the alleged incident relating to inappropriate contact in line with the Department's Standard Operating Procedure.[2720]

The Minute also included a heading 'Related Prior Incidents', which referred to previous concerns and allegations that had been raised against Walter. These were included to show that on several occasions Walter may have potentially shown a lack of care and diligence in his interactions with some detainees.[2721]

The Minute provided details of 'the most recent incidents' involving Walter. This included the two complaints made to the Ombudsman in the early 2010s as well as another allegation made by a female detainee in the late 2000s, which the police found to be 'unsubstantiated'.[2722] The advice to the Acting Deputy Secretary stated: 'While past incidents cannot be used in making a determination or severity, they can be used to establish a pattern of behaviour of which to determine risk'.[2723]

Consistent with the practice of not using information received through Abuse in State Care Program claims, the Minute did not mention any of the six claims made under that scheme. Surprisingly, the Minute also did not mention a late-2000s complaint to the Ombudsman or the seven other complaints that were known to the Department about

Walter at this time. As a result, 14 separate allegations about Walter, some of which were very serious allegations of child sexual abuse, were omitted from the Minute.

An independent investigator appointed to investigate the allegations provided their final investigation report. The report concluded that there was no case to answer over the substance of the allegations under investigation because the investigator did not believe inappropriate contact had occurred.[2724] Consistent with instructions from the Department, the investigator did not have regard to any previous allegations (noting they did not receive the complete complaints history in any event).[2725]

The Acting Deputy Secretary approved a Minute about the Employment Direction No. 5 investigation report after receiving that report.[2726] The Minute recommended that there be no further action on the matter.[2727] It did not refer to any previous allegations or propose any disciplinary action.

While the first Minute to the Acting Deputy Secretary included the advice that past incidents could be used to establish a pattern of behaviour on which to determine risk, Walter's conduct was ultimately assessed based on the investigation of a single incident, without reference to a potential pattern of behaviour. We were told that other than brief periods where Walter was stood down from work, there does not appear to have been any other action taken in respect of repeated complaints about his behaviour.[2728]

Following this disciplinary process, Walter made a number of WorkCover claims.[2729] Walter ultimately left the Department in the late 2010s by mutual agreement and received a lump sum payout.[2730]

Secretary Pervan agreed that an opportunity was lost to protect children entering Ashley Youth Detention Centre from the potential harm posed by Walter over this period.[2731] Reflecting on the opportunities lost during the period in which the Abuse in State Care Program information was coming in, he said:

> I agree that there was a lost opportunity to identify [Walter] as an individual against whom multiple allegations had been made. However there was no guidance on the use of this kind of information in employment decisions provided by the [State Service Act] or [Employment Directions] insofar as matters had already been tested and resolved (it is my understanding that double jeopardy applies in disciplinary proceedings). If the full history had been presented to me we would have sought urgent advice from the Solicitor-General on how to proceed given our intent to take action. I assume the advice of the Solicitor-General on our options would be different today … than they were prior to the revision of the 2007 advice.[2732]

We agree this was a lost opportunity.

Finding—The State Service disciplinary framework, including its application and interpretation by the Department, did not facilitate an appropriate response to allegations and complaints about Walter (a pseudonym) from the late 1990s to the mid-2010s

We identified several areas of concern with the disciplinary response to Walter. These reflect systemic problems across the State Service, including the following:

- To protect the procedural fairness rights and privacy of Walter, previous complaints (including Abuse in State Care Program claims) alleging sexual abuse by him were not considered (and therefore, not considered cumulatively) in investigations, despite these suggesting increased risks to child safety.
- The accounts of adults appeared to be favoured over the accounts of children and young people.
- Fragmented and poor record keeping made it difficult to gain a complete picture of Walter's past conduct and complaints history.
- Complaints that were made directly and exclusively to Ashley Youth Detention Centre management or the Department were managed 'in-house' and relatively informally (if at all).
- While some of the internal reviews had greater formality, such as the early 2010s referral from the Ombudsman's office about Erin's complaint, they did not appear to have been conducted in line with formal disciplinary processes (despite potentially constituting a breach of the State Service Code of Conduct).

We were particularly concerned that reviews and investigations into Walter's conduct were episodic and fragmented. This significantly undermined consideration of the seriousness of Walter's cumulative conduct, which meant there was no meaningful consideration given to assessing and managing risks he may have posed to detainees.

We have seen multiple examples where past complaints or concerns about a person's conduct have not been acted on due to real or perceived limitations in the industrial framework relating to previous unsubstantiated allegations. We consider the case of Walter to be an extreme manifestation of this problem.

We consider that previous allegations and complaints, not just those that are formally substantiated, could and should be considered in disciplinary processes against a staff member. They should be given appropriate weight and consideration that recognises the extent to which they were investigated and the basis for them

not being substantiated. A previously unsubstantiated matter does not mean it did not occur but that it could not be proven on the balance of probabilities. We note the significant evolution and understanding of the dynamics of sexual misconduct and abuse of children has contributed to a much more sophisticated appreciation of complaints of this nature now compared with the past. Even the criminal justice system, which requires proof beyond reasonable doubt of the alleged offence, now allows consideration of evidence that suggests a tendency towards a 'sexual interest' in children.[2733]

The lack of record-keeping systems to ensure all information was taken together (including information from Abuse in State Care Program claims) also contributed to these shortcomings.

Secretary Pervan conceded that there was a system failure in how the Department responded to information it held about Walter.[2734]

6.2.4 Observations

Because responses to this matter occurred a number of years ago, we have been able to include more detail about some elements of the Department's response compared with much more recent examples relating to Ira, Lester and Stan in Section 8 (which concern alleged offending of similar seriousness).

While we are pleased some of the problems we saw in this case example have since been addressed, we did see a striking number of similar themes continue to arise in more recent responses. This includes failures to:

- recognise certain allegations as constituting child sexual abuse and treating them with the seriousness and urgency they deserved
- consider and give adequate weight to the cumulative effect of multiple complaints over time, which suggest a significant pattern of alarming behaviour
- act on information received in Abuse in State Care Program claims due to actual or perceived barriers
- apply the State Service disciplinary framework for conduct that may constitute a breach of the State Service Code of Conduct in favour of internal investigations that did not have the level of rigour and independence that would be expected
- make appropriate notifications to other agencies, including Tasmania Police and the Registrar, in a consistent and timely manner
- keep clear and consistent records internally, but also across agencies, relating to information received about an alleged abuser and complaints about them.

We revisit some of these themes in Section 8.5 based on our examination of responses to allegations about Ira, Lester and Stan.

7 2018—Introduction of the National Redress Scheme

The National Redress Scheme began in 2018. It is available to people who experienced sexual abuse in institutional settings before 1 July 2018.[2735] While the purpose and design of the National Redress Scheme is focused on recognising and alleviating the impact of child sexual abuse, information provided through it is valuable to assessing and understanding current risks to children. The Department started receiving National Redress Scheme claims regarding Ashley Youth Detention Centre employees from 2019.

The National Redress Scheme is administered by the Australian Government through its Department of Social Services, which is the Scheme Operator ('Scheme Operator'). Tasmania's Department of Justice (through the Child Abuse Royal Commission Response Unit) coordinates the Tasmanian Government's participation in the National Redress Scheme.[2736] Ginna Webster, Secretary, Department of Justice, told us:

> Where the National Redress Scheme identifies the Tasmanian Government as potentially responsible for the abuse alleged in an application, the Scheme Operator notifies the Tasmanian Government. The notification provides the Tasmanian Government with a copy of the relevant parts of the application. This includes details of the claims as it relates to the Tasmanian Government institution but not details of any other claims made by the applicant.
>
> The relevant Tasmanian Government institution is then required to retrieve any relevant records and prepare a summary of the retrieved records and provide those documents to the Scheme Operator.[2737]

The Department of Justice described the 'relevant parts of the application' it receives from the Scheme Operator as 'redacted and curated' parts of the full National Redress Scheme application as lodged by the claimant.[2738] We understand that this is not unique to Tasmania as the Scheme Operator does not provide a copy of the full National Redress Scheme application to any institution.[2739]

7.1 Department of Justice process for responding to the Scheme Operator

We were told that Tasmania is the only jurisdiction that has centralised the processing of National Redress Scheme applications.[2740] We understand that the purpose of this centralisation is to 'ensure that the State of Tasmania provides [the Scheme Operator] with a consistent and timely response to its requests'.[2741]

The Department of Justice will often liaise with other Tasmanian Government agencies to gather information that is relevant to assessing claims.[2742]

We were told that the process the Department of Justice adopted before October 2020 involved the following steps:

- The Department of Justice's Child Abuse Royal Commission Response Unit summarised the claim based on the redacted and curated aspects of the claimant's application it received from the Scheme Operator and identified the relevant agency (or agencies) the claims related to (such as the Department).[2743]
- The Department of Justice included its summary of the claim in a 'National Redress Scheme – Request for Information' form. The 'National Redress Scheme – Request for Information' form included questions as to whether the agency holds records that document the abuse, whether there are any records of a prior payment to the complainant (for example, ex gratia payments) and whether there are records that show the alleged abuser is still an employee of the Tasmanian Government and/or working in a child-related activity.[2744] That form was sent to relevant agencies to complete based on any records searches or other material they may have held. We understand the Department of Justice sent this form to agencies within 24 hours of the claim details being provided by the Scheme Operator.[2745] If the agency needed more information, it would need to ask the Department of Justice for the complete information it received from the Scheme Operator.[2746]
- The relevant agency then reviewed its records to answer queries and supplement any information and returned the 'National Redress Scheme – Request for Information' form to the Department of Justice.[2747] The agency was expected to include information on relevant claims received through the Abuse in State Care Program or Abuse in State Care Support Service in its response.[2748]

From around October 2020, the Department of Justice changed its practice and began to pass on all information it held to agencies, rather than summarising the already redacted and curated material from the Scheme Operator. This is discussed in Section 9.4.

If allegations in National Redress Scheme claims relate to Ashley Youth Detention Centre, it is the Department's role to determine whether the alleged abuser is a current staff member or otherwise represents a continuing risk for children and to address that risk through its own processes.[2749] This includes making relevant notifications to agencies such as the Registrar.[2750]

The Tasmanian Government does not have contact details for claimants and is not permitted to contact them directly. If the Department needs more information about a claim or claimant (including to contact them) it notifies the Department of Justice, which then approaches the Scheme Operator to organise this.[2751]

8 2019–2020—Department management of increasing abuse allegations against staff

By the end of 2018, the Department had been notified of various allegations of child sexual abuse occurring at Ashley Youth Detention Centre, including through the Abuse in State Care Program and the Abuse in State Care Support Service, through other agencies (such as the Ombudsman or Commissioner for Children and Young People) and directly from detainees.

From 2019, however, the Department saw an increasing number of allegations made against Ashley Youth Detention Centre employees. This was partly due to the start of the National Redress Scheme in 2018, with allegations first being made against Ashley Youth Detention Centre staff through this scheme from 2019. Gathering information in response to National Redress Scheme claims also contributed to the rediscovery of several Abuse in State Care Program claims relating to serving staff.

The Department received at least eight National Redress Scheme claims relating to Ashley Youth Detention Centre staff members or contractors (or those of its predecessor, the Ashley Home for Boys) in 2019.[2752] Some of these claims contained multiple allegations against several staff members, and the conduct was alleged to have occurred between 1994 and 2008.[2753] Some of those claims were made by former detainees who had also already reported their abuse in other ways, including through state redress processes.

We received evidence that the Department was not equipped to deal with the allegations that were coming in during this period, with Kathy Baker, former Deputy Secretary, Corporate Services attributing this to the Department being in:

> … unfamiliar territory regarding how to handle these matters which were historical in nature, with poor record keeping practices, new personnel within the Department and the distributed nature on which the matters came into the Department.[2754]

The challenge of responding to National Redress Scheme claims would not be limited to Tasmania, as institutions across Australia also began to receive allegations of abuse against current and former staff and volunteers.

From 2019, the Department began to grapple with how to respond to this information. It was only from October 2020, however, that we saw the Department take active steps to improve its processes and responsiveness to information received through National Redress Scheme claims. This arose in the context of a steady escalation in the number of allegations from this period, as well as increased media reporting on institutional responses to child sexual abuse in late 2020. We outline the Department's responses to these increasing allegations in the following sections, with reference to the specific case examples of Ira, Lester and Stan.

8.1 Context for our review of responses to Ira, Lester and Stan

We have examined more recent responses to allegations against three Ashley Youth Detention Centre staff members—Ira, Lester and Stan (all pseudonyms). This included making multiple requests to the State, Tasmania Police, the Registrar and departmental witnesses for details of the allegations against Ira, Lester and Stan, and the responses to those allegations.[2755]

For a range of legal and procedural reasons, we cannot outline our analysis to its full extent in this report. However, these case examples have significantly informed our recommendations. Even based on the information that we have published, we consider these relatively recent examples of responses to allegations of abuse by staff at Ashley Youth Detention Centre are significant cause for concern. Particularly, as noted in Section 6.2.4, many of the problems we identified in the case example of Walter continued to feature in these more recent examples.

By around 2020, it became clear that the Department was facing an unprecedented crisis, with several staff being the subject of allegations. There were multiple competing demands relevant to the protection of children in such circumstances, including protecting children from people who may pose a risk to child safety, ensuring enough staff presence to allow children and young people to undertake their normal routines safely, as well as avoiding reinforcement of negative attitudes about detainees.

In considering responses from the Department to allegations against Ira, Lester and Stan, we kept several factors front of mind. We took seriously what we understand to be the very real challenges of running a youth detention centre, particularly during this period. Evidence from current and former staff, our site visits, private meetings and submissions all helped inform our understanding of these challenges. This includes:

- The impact of the onset of the COVID-19 pandemic, particularly in 2020, would have been a significant and consuming issue for the Department. Much of the work of the Department involved delivering essential frontline services that needed to continue, in some form, through the pandemic. This includes consideration of how to manage a child protection system that required active monitoring of at-risk children and young people and how to ensure risks of COVID-19 infections could be mitigated and managed in closed facilities such as Ashley Youth Detention Centre. The Department also assumed responsibility for Tasmania's hotel quarantine program. Several staff were seconded and diverted during this time.
- There has been a longstanding struggle to maintain adequate staffing at Ashley Youth Detention Centre. Youth justice is a difficult environment, and this can make recruitment and retention of suitably skilled and qualified staff challenging. We recognise that understaffing creates significant operational challenges and that the

scale of allegations against staff (and media attention around aspects of this) would have had a significant impact on other staff at the Centre.

- It is often difficult to take disciplinary action against conduct that is alleged to have occurred many years ago, as is often the case for claims made under the Abuse in State Care Program and the National Redress Scheme. There may be little prospect of establishing corroborative evidence due to the passage of time or complainants not wishing to participate in disciplinary processes.

The Department was notified of serious allegations of abuse about Ira, Lester and Stan. While we do not itemise these specifically and do not always link them to particular staff members, this information included allegations of rape, forced oral sex, exposure of their genitals to detainees and watching detainees in the shower or while they masturbated. Claims sometimes also included allegations of physical violence or threats that occurred in connection to the alleged sexual abuse. Many allegations referred to multiple instances of abuse, as opposed to one-off occasions. One allegation was made about child sexual abuse occurring in the community by one of these staff members.

We provide summaries of responses to these allegations below.

8.2 Case example: Ira

Ira is one of many Centre staff who began working at what was then known as Ashley Home for Boys and held multiple operational roles, including as a youth worker, until his suspension in November 2020.[2756]

8.2.1 Allegations against Ira and the Department's response

In 2019, the Department received information outlining allegations from two former detainees of Ashley Youth Detention Centre that involved Ira. This included allegations Ira witnessed or was involved in abusive strip searches, inappropriately watched detainees in the shower and that he coerced detainees to perform sexual acts upon each other for his own sexual gratification.

- In April 2019, the Department was notified of allegations from a former detainee, Parker (a pseudonym).[2757] Parker alleged that he was subjected to abuse at Ashley Youth Detention Centre.[2758] Parker did not link Ira to any specific incident of abuse or mistreatment but listed him among other staff as being somehow involved. As we describe throughout this case example, at some time point, Parker's allegations about Ira essentially fell by the wayside and were only 'rediscovered' by the Department almost a year later in October 2020.
- In September 2019, the Department was notified of allegations against Ira by another former detainee, Baxter (a pseudonym).[2759] Baxter alleged that Ira sexually abused him on multiple occasions and engaged in other forms of mistreatment (along with other allegations not involving Ira).[2760]

Almost a decade earlier, Parker and Baxter lodged Abuse in State Care Program claims alleging abuse by Ashley Youth Detention Centre staff and had each received ex gratia payments as a result.[2761] Those Abuse in State Care Program claims made similar allegations about the kind of abuse each endured at Ashley Youth Detention Centre, but neither named Ira. Both claims described the incidents as causing psychological damage and otherwise having a negative impact on their lives.[2762]

In September 2019, Ira was placed on restricted duties for reasons unrelated to abuse claims or disciplinary matters. Senior members of the Department told us that this meant Ira did not work directly with detainees from September 2019, although he remained on site at Ashley Youth Detention Centre.[2763] We received assurances that these restricted duties suitably mitigated the risk relating to the allegations against Ira. However, Stuart Watson (who was Assistant Manager from January 2020 and Acting Centre Manager from March 2020) told us he did not become aware of the allegations against Ira until March 2020 and only did so incidentally.[2764] In that context, we find it difficult to understand how Centre management could appropriately monitor Ira's engagement with detainees if it did not know the secondary purpose for which his restricted duties were being relied on. We received some evidence that suggested Ira was able to undertake activities with detainees (including on a one-on-one basis) even while he was on restricted duties.[2765] Ultimately, we do not know if Ira did in fact engage with detainees while on restricted duties, but we are concerned there was no clear restriction or safeguards to prevent him from doing so.

On 7 October 2019, an 'ad hoc' meeting between a range of senior departmental staff was convened to consider allegations raised against current employees, including through the National Redress Scheme, and to determine any required actions.[2766] The meeting also considered the information received in 2019 relating to Parker and Baxter naming Ira, but it is unclear whether their earlier Abuse in State Care Program claims were acknowledged or discussed in this meeting.[2767] The minutes of the meeting recorded a number of action items, including a review of Ira's files and otherwise trying to gather more information with a view to providing advice to Mandy Clarke, then Deputy Secretary, Children, Youth and Families.[2768] It was agreed that the next meeting would be held 'when the information associated with the actions of the meeting is available'.[2769] We did not receive information about this further meeting, including whether it occurred.

Two months later, on 3 December 2019, information about the allegations against Ira were included in a Minute to Secretary Pervan, which was described as a 'preliminary review' of the information arising from both claims.[2770] We note that the Minute focused almost exclusively on Baxter's allegations (which specifically named Ira as an alleged abuser) and recommended that Baxter's allegations be referred to Tasmania Police.[2771] The Minute also advised that the Department was empowered to act on the allegations it had received for disciplinary and risk management purposes, including by referring matters to Tasmania Police and the Registrar.[2772] The Minute did not refer to or otherwise

acknowledge limitations imposed by the 2007 Solicitor-General's advice for acting on the information and, in fact, identified options for the Department that were inconsistent with the 2007 Solicitor-General's advice and the practice that emerged from it. The Minute recommended that Secretary Pervan defer a decision on whether to conduct an Employment Direction No. 5—Breach of Code of Conduct investigation until advice was received from Tasmania Police.[2773]

Due to human error, the Department did not refer Baxter's allegations to Tasmania Police until February 2020.[2774] Tasmania Police advised, in February or March 2020, that it would not be investigating Baxter's complaints.[2775]

We received no evidence to suggest that the Department took any steps to pursue disciplinary action against Ira until August 2020 at the earliest, despite there being no impediment in doing so from the perspective of Tasmania Police.[2776]

In September 2020 (a year after Baxter's allegations were received), Ms Clarke approved a Minute to Secretary Pervan recommending that the Department put Baxter's allegations to Ira (outside of the Employment Direction No. 5 process) to gather more information given that Ira was 'at the stage of transitioning back to resident contact' because his restricted duties were ending.[2777] It was envisaged that the information gathered from this process would be used to consider whether an Employment Direction No. 5 investigation was required, although the Minute acknowledged that Ira would likely deny the allegations.[2778] The Minute was silent on Parker's allegations, which had seemingly fallen from the Department's consideration since they were last considered in December 2019. We note that we were only provided with a version of this Minute that had not been signed by Secretary Pervan; however, minutes of the 25 September 2020 Strengthening Safeguards Working Group meeting and a later 8 November 2020 Minute (discussed below) indicate that Secretary Pervan approved this September 2020 Minute and accepted the recommendation.[2779]

On or around 25 September 2020, the Department decided to delay putting Baxter's allegations to Ira. This decision was made in the context of the Department wanting information from Ira about allegations that he had raised about Lester (we discuss these allegations as they relate to Lester in Section 8.3).[2780] A draft statement was taken based on a meeting between People and Culture staff and Ira in late September 2020 but was not finalised until November 2020.

On the evidence made available to us, it appears that in or around October 2020, the Department rediscovered Parker's allegations.[2781] These were referred by the Department to Tasmania Police on 21 October 2020.[2782] The Department told us that, on 26 October 2020, five days after the Department's referral, Tasmania Police notified the Department that it had 'closed' the matter.[2783]

On 2 November 2020, Secretary Pervan was reminded of Parker's allegation against Ira in a Minute prepared by the Department and endorsed a recommendation that the

Department wait to put the allegations against Ira to him until it had a statement from Ira about the allegations against Lester, noting at this point the draft statement had not been finalised.[2784] The Department ultimately finalised this statement on 5 November 2020.[2785] We are unclear why it took more than two months to finalise Ira's statement.

A few days later, on 8 November 2020, Secretary Pervan decided, through a Minute he approved, to suspend Ira and commence an Employment Direction No. 5 investigation into Parker and Baxter's allegations against Ira, although the Minute lacked some detail about serious allegations of abuse. The Minute recommending this course of action:

- noted that Ira's restricted duties were ceasing, which would 'see him exposed to young people', although it also noted that, given additional controls at the Centre (such as closed-circuit television footage), it was considered lower risk that the abuse outlined in the allegations could occur today[2786]
- referred to media attention and scrutiny involving child sexual abuse matters, including *The Nurse* podcast, which had foreshadowed on 3 November 2020 that the Centre would be featured in its upcoming episode (due to be aired on 10 November 2020)[2787]
- noted the seriousness of the allegations and that the public would expect that the allegations would be fully investigated and that Ira would be removed from working with children and young people[2788]
- acknowledged the change in position from advice reflected in the September 2020 Minute (to put the allegations to Ira informally and seek his response) but referred to the fact that there were now multiple allegations that 'may suggest a pattern of inappropriate behaviour', stating 'what previously wasn't considered was the public expectation and pattern of behaviour'.[2789]

We were told that the decision to suspend Ira was made because there was, at that time, 'sufficient particulars' or information relating to the allegations against Ira that could be responded to.[2790] We note that the decision in November 2020 to suspend Ira and begin an Employment Direction No. 5 investigation was based on the same information that was known to the Department in September 2019. We discuss this briefing, alongside Lester and Stan's, in Section 9.6.

Ira was ultimately suspended from his employment at the Centre in November 2020, some 15 months after the Department became aware of Baxter's allegations. It was 18 months after Parker's allegations, although we accept that these alone may not have triggered an Employment Direction No. 5 investigation.

In February or March 2021, the Department appointed an external investigator to examine the allegations against Ira.[2791] Further allegations were made against Ira in 2021 and 2022 following his suspension and the start of the Employment Direction No. 5 investigation, raising concerns that are relevant to a pattern of physical and sexual abuse of children.[2792] We understand the investigation is ongoing.[2793]

8.2.2 Responses of Tasmania Police and the Registrar

We received conflicting evidence about when the Department reported Parker and Baxter's allegations to the Registrar. While the Department told us that it notified the Registrar about Baxter's allegations in August 2020 and Parker's allegations in October 2020, the Registrar gave evidence that it was only on 9 November 2020 that he received enough information about Parker and Baxter's claims to consider them notifications.[2794] Again, we note that the Department had been aware of these allegations since September 2019.

On 10 November 2020, the Registrar notified Ira that he intended to conduct an additional risk assessment to determine whether he should maintain his registration to work with vulnerable people.[2795] The Registrar did not suspend Ira's registration while this risk assessment occurred. We were told this was because there was not enough detail in the allegations.[2796]

Although the Registrar has received more information since this time (and at its request), as of 15 August 2022, the Registrar told us that he was awaiting 'further information as to investigations by the Department of Communities including receipt of all relevant information'.[2797] As of 11 August 2023, we understand that Ira still holds his registration to work with vulnerable people.

We reflect above the Department's evidence as to when it reported to Tasmania Police. This is inconsistent with some of the information received from Tasmania Police. For example:

- The Department told us that it reported Baxter's allegations to Tasmania Police in February 2020.[2798] However, Tasmania Police did not list this report in response to our request for all reports made against Ira.[2799]
- The Department told us that it reported Parker's allegation to Tasmania Police in October 2020.[2800] However, Tasmania Police's evidence suggests that it did not receive a report from the Department directly but rather from a third party, some eight months later, in June 2021.[2801]

There was also evidence of substantial delays in Tasmania Police reporting allegations to the Registrar. Parker's allegations were referred almost two years after the Department says it reported the allegations to police.[2802] We received no evidence that Tasmania Police reported Baxter's allegations to the Registrar at all.[2803]

Ultimately, Tasmania Police told us that it received three allegations against Ira and did not investigate any of these allegations given that the complainants were either deidentified in the source of the information or did not consent to being contacted by Tasmania Police.[2804]

8.3 Case example: Lester

Lester was one of many Centre staff members who began working at Ashley Home for Boys as a youth worker and continued his employment with the Centre until he resigned in the early 2020s.[2805]

8.3.1 Allegations against Lester

Multiple allegations of child sexual abuse were made against Lester from the early 2000s:

- In the early 2000s, there was an investigation into a complaint that Lester had exposed himself to detainees, although we note that the Department never told us directly about this allegation or investigation.[2806]
- From the late 2000s to early 2010s, four claims were made against Lester through the Abuse in State Care Program. The allegations included that Lester tried to rape a complainant, forced a complainant to perform oral sex, touched a complainant's penis and bottom during a strip search, watched a complainant while the complainant was masturbating, bribed a complainant with privileges to allow instances of child sexual abuse to occur, and watched a complainant in the shower and made sexual gestures towards him.[2807] We note that in two of these cases the sexual abuse allegations included associated allegations of physical abuse.[2808]
- In the early 2010s, a community member reported child sexual abuse by Lester outside the Centre to Tasmania Police, noting their concern that Lester worked with children at the Centre.[2809] Tasmania Police took a statement from the complainant who was described as 'unsure if [they] wanted to proceed to court proceedings'.[2810] Tasmania Police did not share this allegation with the Department.[2811]
- In the mid-2010s, the Department received information about a claim relating to Lester alleging child sexual abuse.[2812] The Department reported this allegation to Tasmania Police about two weeks later.[2813] Neither Tasmania Police nor the Department investigated this matter further, with Tasmania Police stating that the victim-survivor did not want to speak with police.[2814]
- In January 2020, as recalled by former Clinical Practice Consultant at the Centre, Alysha (a pseudonym), Ira told her that in the 1990s or early 2000s he had witnessed an incident in which Lester was standing with a naked child, who was on all fours in what was known as the Ashley Youth Detention Centre secure unit.[2815] Alysha reported the allegation directly to her line manager in the Department.[2816] We were not satisfied that this report was recognised as a report of potential child sexual abuse at the time of its receipt. We discuss Departmental views of this report in Case study 5. Departmental documentation from March 2022 suggested that Alysha's report 'does not provide information that would lead the reader to conclude without doubt a serious sexual assault and/rape was perpetrated', although the allegations were acknowledged as 'concerning information' that required further review.[2817]

- In September 2020, Tasmania Police also received an anonymous report that Lester sexually abused detainees over a 15-year period.[2818] The police disclosure report noted under the heading 'Previous offences' that 'many children' had alleged physical and sexual abuse by Lester.[2819]

8.3.2 Department's response to the January 2020 report

Despite Alysha's report in January 2020, the Department appeared to take no meaningful action in early 2020 in response to the allegation. We were told 'extensive file searches' were taken to determine whether information relating to the allegations was held on Lester's file, which did not uncover any information about the allegation reported by Alysha (or prior Abuse in State Care claims against Lester).[2820] Although we were told these extensive file reviews occurred shortly after Alysha's report, an email sent much later by Ms Clarke in September 2020 said it did 'not appear that any investigation has been undertaken' into Alysha's report about Lester and that an 'HR file review needs to occur'.[2821] In addition, an extensive file review is not a sufficient investigation. The Department did not meet with Ira to verify the information received from Alysha until September 2020.

In early 2020, after Alysha's report, Lester acted in an operational role at the Centre, until he was redirected back to his substantive non-operational role based on site at the Centre in May 2020.[2822] The Department told us that, during the period from May 2020 until Lester's resignation, Lester was in a non-operational role that did not have direct contact with detainees, although he remained on site at the Centre but separate from the main building.[2823] We heard allegations that Lester conducted a strip search of a detainee after Alysha made her report in January 2020, but no records documenting that strip search were identified by the Department.[2824] Some witnesses agreed that controls on Lester's contact with detainees could have been stronger. Mr Watson told us it was his view that Lester should not have been on site in any capacity.[2825] Pamela Honan, Director, Strategic Youth Services, and Ms Baker conceded that the risk to children was not fully mitigated while Lester remained at the Centre. Ms Honan said: 'Well, I wouldn't say they [detainees] weren't protected, but there was definitely a risk with this person still in the workplace'.[2826]

Ms Baker said:

> I do note that there are other controls that would have existed, however [Lester] did remain in the workplace, albeit in a non-operational role … and therefore the risk to young people at AYDC was not fully mitigated between January 2020 and when he was suspended from duty in November 2020. This is regrettable.[2827]

In September 2020, the Department finally met with Ira, despite Alysha reporting the allegation to the Department in January 2020. We remain unclear about the reasons for this delay, given a statement from Ira seemed the most obvious way to gather

more information as Ira was reportedly a direct witness to the incident. We were told that there were many 'attempts' to obtain his statement between January and May 2020.[2828] We received some evidence that suggested the delay was a result of Ira being on restricted duties and that he did not return to Ashley Youth Detention Centre until around the time that his statement was taken.[2829] This is contrary, however, to other evidence we received that Ira was still present at the Centre while he undertook restricted duties from September 2019, as discussed earlier. In any event, we are unclear why Ira's absence from the Centre would have prevented him from making a statement to the Department about the allegations against Lester.

We were also told that, at the end of August 2020, Ms Clarke became aware of the allegations Alysha reported against Lester after a discussion with a private lawyer, who had been engaging with the Commissioner for Children and Young People about a 'high number' of allegations of sexual and physical abuse of detainees by staff.[2830] After this meeting, Ms Clarke spoke to staff and became aware of Alysha's report. Ms Clarke made enquiries in the Department about Alysha's report and requested a closer review of all information held by the Department about allegations of abuse by Centre staff (discussed in Section 9). It is not clear what information Ms Clarke obtained relating to Alysha's report at the time.

It was only when Ms Clarke became aware of Alysha's report that the Department seemingly reconsidered the report. An email from Ms Clarke (mentioned earlier) suggests that there was no investigation undertaken of Alysha's report before this time, and we accept that evidence.[2831]

8.3.3 Rediscovering the Abuse in State Care Program claims

As noted, Ms Clarke's meeting with a private lawyer prompted her to check historical records relating to allegations against staff at Ashley Youth Detention Centre.[2832] In September 2020, the Department conducted a review of the Abuse in State Care Program claims to identify whether any serving Centre staff had been the subject of allegations (we discuss this review in Section 9.2). The four Abuse in State Care Program claims containing allegations against Lester were rediscovered through this review in September and October 2020.[2833] Ms Baker told us:

> The information gathered from the Abuse in State Care Scheme would suggest prior matters which when put together with the matters that [Alysha] reported forms a more holistic picture of [Lester] and his alleged offending ...[2834]

8.3.4 Suspension and investigation

Ira's statement was finalised on 5 November 2020.[2835] This allegation was then reported to Tasmania Police and the Registrar on 6 November 2020, some 10 months after the Department first received it.[2836] The Department also reported the Abuse in State Care Program allegations to Tasmania Police and the Registrar on 9 November 2020.[2837]

On 8 November 2020, Secretary Pervan decided to suspend Lester and commence an Employment Direction No. 5—Breach of Code of Conduct investigation into the allegation reported by Alysha and supported by Ira in his statement. While the Minute to the Secretary recommending this course of action also referred to three of the Abuse in State Care Program claims, the Secretary's decision did not appear to be predicated on these allegations, with the Minute stating that the Department was trying to get more information about these claims.[2838] We are unclear why the Minute did not refer to the fourth Abuse in State Care Program claim. In any event, the decision taken at this time was based on the information provided to the Department some 10 months earlier.

We note the Minute stated that given additional controls at the Centre (including the use of cameras) there was a lower risk that the abuse could occur in the environment at the Centre today.[2839] However, the Minute also acknowledged that it may not have been possible to eliminate the risk, especially if Lester was in direct contact with detainees.[2840]

Correspondence to Lester notifying him of the Employment Direction No. 5 investigation and suspension also indicated that the Secretary could not identify alternative duties that would sufficiently mitigate the risk.[2841] This was even though some witnesses identified Lester's non-operational role acting as a means by which the potential risks he posed to detainees were managed.[2842]

At some point after March 2021, an external investigator was appointed to conduct the Employment Direction No. 5 investigation into Lester.[2843] We understand that the Abuse in State Care Program allegations were added to the investigation. It appears that at least one of the allegations against Lester listed above was never added to the investigation.[2844]

A further five allegations relating to child sexual abuses were raised against Lester after his suspension, which came from a variety of sources.[2845]

Lester resigned from his employment in mid-2021.[2846] Shortly after, Secretary Pervan ceased the investigation into Lester's conduct with no further employment action to be taken unless Lester began working with the State Service again.[2847]

8.3.5 Responses of Tasmania Police and the Registrar

While the Department reported all four Abuse in State Care Program claims to Tasmania Police in November 2020, Tasmania Police referred these allegations to the Registrar some 21 months later in August 2022.[2848] Assistant Commissioner Higgins conceded at hearings that this was an oversight by Tasmania Police.[2849]

As set out above, the Registrar received information from the Department about Lester on 6 and 9 November 2020. On 10 November 2020, the Registrar notified Lester that he intended to conduct an additional risk assessment.[2850] The Registrar immediately suspended Lester's registration at this time 'due to the volume and gravity of the alleged conduct and the existence of some corroborating evidence'.[2851]

On 4 August 2021, Lester's registration to work with vulnerable people lapsed before his additional risk assessment was finalised. Lester no longer holds registration under the Registration to Work with Vulnerable People Act.[2852]

8.4 Case example: Stan

Stan is a long-time Centre staff member who started working at what was then Ashley Home for Boys and held roles that involved engaging with detainees, until his suspension in November 2020.[2853]

8.4.1 Allegations against Stan

From the early 2010s, several former detainees alleged that Stan had abused them:

- In the early 2010s, a former detainee made a claim through the Abuse in State Care Program alleging that Stan physically abused him.[2854] It is unclear when the Department rediscovered this claim, but we infer that it did so through the review of the Abuse in State Care Program claims conducted in 2020, which we explain in Section 9.2.
- In 2017, a former detainee, Ben (a pseudonym), made a submission to the National Royal Commission into Institutional Responses to Child Sexual Abuse that alleged Stan had raped him and another detainee on three occasions.[2855] This submission was provided to Tasmania Police in 2017.[2856] It is unclear whether the Department was informed of the allegations in Ben's submission in 2017. However, later exchanges between the Department and Tasmania Police indicate that Tasmania Police had thought that the Department had been aware of these allegations since around the time they were made.[2857]
- In or around early 2019, the Department was notified of allegations of sexual abuse made by a former detainee that named Stan. Due to human error (outside the Department) this allegation was only linked to Stan in October 2020.[2858] The Department referred these allegations to Tasmania Police on 21 October 2020.[2859] On 26 October 2020, five days after the Department's referral, Tasmania Police notified the Department that it had 'closed' the matter.[2860] The Department told us that it referred those allegations against Stan to the Registrar on 21 October 2020, although the Registrar told us he first received this allegation about Stan on 26 May 2021.[2861]
- In mid-2020, the Department received a Letter of Demand from Ben which, in line with his 2017 submission to the National Royal Commission, included allegations that Stan raped him on three occasions.[2862] Despite receiving those allegations in mid-2020, the Department did not report the allegations to Tasmania Police or the Registrar until about three months later.[2863] We also saw little action taken

by the Department from the time of receiving this allegation in mid-2020 until Stan's suspension in November 2020, although we received some evidence that in September 2020 the Department cross-checked Stan's records in an attempt to corroborate the allegations.[2864] Much of the Department's evidence was that it was waiting on police advice before taking action in relation to Stan.[2865] We discuss this evidence, and our views on the extent to which the interaction with police processes influenced delays, later in this section.

- In September 2020, the Department received allegations raised by another complainant.[2866] The information alleged that Stan and several other staff members engaged in child sexual abuse but did not link any specific instance of abuse to Stan.[2867] That complainant had also raised allegations of sexual abuse while at the Centre through the Abuse in State Care Support Service in 2017, although they did not name any alleged abusers at the time.[2868] The Department reported these new allegations to Tasmania Police and the Registrar three weeks later, in October 2020.[2869]

On 3 November 2020, Tasmania Police advised the Department that certain complainants did not wish to make a statement.[2870]

8.4.2 Department's response

Stan was suspended pending an Employment Direction No. 5—Breach of Code of Conduct investigation in November 2020.

The Minute to the Secretary recommending this course of action did not include all the allegations against Stan that are outlined above; it only noted Ben's allegation (contained in his Letter of Demand) and the allegation notified to the Department in September 2020.[2871]

We note the Minute stated that Stan had direct contact with detainees through his role.[2872] The letter to Stan notifying him of his suspension and intended Employment Direction No. 5 investigation also stated that Secretary Pervan could not find alternative duties for Stan that sufficiently mitigated the risk that was present in the allegations.[2873] We note that the Department told us that the risk posed by Stan remaining in the workplace was mitigated because he was in a building not accessed by detainees, and that the Centre Manager was made aware of the allegations so he could remain vigilant.[2874] We also saw evidence that the Centre Manager was raising concerns about Stan continuing to work on site with children.[2875] The Minute leading to Stan's suspension is discussed in Section 9.6.

On 12 February 2021, Secretary Pervan appointed an external investigator to examine the allegations against Stan.[2876] The other allegations made against Stan, including the earlier Abuse in State Care Program claim, were added to the investigation at this time.[2877]

A further three claims (two of which involved allegations of child sexual abuse) were raised against Stan following his suspension and the start of the Employment Direction No. 5 investigation.[2878] We understand the investigation is ongoing.[2879]

8.4.3 Response of Tasmania Police and the Registrar

As was the case with Ira and Lester, we received evidence that there were substantial delays in Tasmania Police reporting allegations to the Registrar. For example, while allegations against Stan raised directly with the Department in 2021 were reported to Tasmania Police in 2021, the police did not report this to the Registrar for some nine months.[2880] Also, we received evidence that despite receiving Ben's National Royal Commission submission in 2017, Tasmania Police did not report the allegations to the Registrar through its automated referral process.[2881] Assistant Commissioner Higgins agreed that this is an example of how the process is subject to 'human error'.[2882]

Ultimately, Tasmania Police told us that it received four allegations against Stan.[2883] The evidence indicates that Tasmania Police had also been notified by the Department of at least one further allegation against Stan.[2884]

The Registrar began an additional risk assessment into Stan on 18 September 2020, having received Ben's allegations against Stan on that day.[2885] The Registrar did not suspend Stan's registration pending the outcome of the additional risk assessment.[2886]

After receiving more allegations from the Department, the Registrar sent Stan a letter in April 2021 with notice of his intention to suspend Stan's registration to work with vulnerable people.[2887] More allegations and updates were provided to the Registrar, after which the Registrar proposed to cancel Stan's registration in February 2022.[2888] The Registrar's written reasons stated that Stan had been named as a 'responsible person for abuse by five separate alleged child victims', and that the allegations 'are those of the most serious kind and are directly relevant to [Stan's] eligibility to maintain registration'.[2889] Also, the written reasons stated that given the number of allegations raised over a lengthy period, it was reasonable to conclude that a pattern of behaviour was present.[2890]

However, after further engagement with the Department and Stan, the Registrar ultimately decided to continue Stan's registration in July 2022.[2891] There was a stark difference between some of the reasoning provided in the Registrar's proposed and final decisions, with the Registrar concluding in the final decision that it was not possible to identify a pattern of grooming or offensive behaviours.[2892] The Registrar also considered the claimants' histories of criminal offending, calling their credibility into question.[2893] As we have noted throughout this chapter, we received no evidence to support a conclusion that detainees had made false allegations for malicious or financial gain, nor did we find evidence that former detainees had colluded in making allegations. Indeed, collusion between former detainees was unlikely given the allegations spanned more

than a decade. We did receive evidence from former detainees that they believed their criminal histories meant they were less likely to be believed. We make a recommendation on factors to be considered in the Registrar's risk assessment in Chapter 18.

As of 11 August 2023, Stan continues to hold registration to work with vulnerable people.

8.5 Enduring themes we saw in our case examples

We identified a range of problems in responses to our case examples of Ira, Lester and Stan that meant allegations of serious abuses were not acted on quickly and effectively. This had the practical effect of placing detainees at risk of harm because staff who were the subject of serious allegations remained at the Centre. We were disappointed to see that many of these problems were also apparent in our case example of Walter, discussed in Section 6.2.

8.5.1 Delays in notifications

Across the three case examples we explored, we saw significant delays by the Department in reporting allegations to Tasmania Police and the Registrar. Examples include the following:

- The Department's notifications to Tasmania Police of Baxter and Parker's allegations against Ira were made around five and 18 months, respectively, after the Department became aware of the allegations.[2894]
- The Department first raised Baxter's allegations against Ira with the Registrar on 11 August 2020.[2895] However, it was not until 9 November 2020 that the Department could provide enough information to the Registrar about Baxter's allegations for the Registrar to consider it a notification of reportable behaviour.[2896]
- In relation to Lester, the Department only passed on Alysha's report to Tasmania Police and the Registrar in November 2020, despite being received around 10 months earlier in January 2020.[2897]
- In relation to Stan, the Department only reported Ben's allegations to Tasmania Police and the Registrar in September 2020, despite being received in mid-2020.[2898]

We consider there are a range of reasons that contributed to delays in making those notifications, including:

- confusion and a lack of clarity around whether and when certain matters should be reported to the Registrar (we discuss the legislative ambiguity around this in Section 3.1.2), which the Department resolved in September 2020 (described in Section 9.3)
- failures to identify certain conduct as amounting to potential child sexual abuse—we consider this to be a contributing factor for the delay in responding to Alysha's report about Lester

- poor record keeping, which made it difficult to locate and share relevant information quickly
- perceived barriers to information sharing about child safety—seeking legal advice, adopting a narrow interpretation of reporting obligations and often only reporting where required by law.

We acknowledge that we do not discuss mandatory reporting to Child Safety Services in detail in this case study. We note, however, that Child Safety Services were not notified about any of the allegations we examined in our case examples. While we note the confusion when complainants were adults and risks related to a group rather than an individual child, we consider it would have been best practice to report, as we have made clear throughout this case study.

The safety of children in institutions depends on all parties sharing what they know with other relevant agencies quickly and accurately and applying good judgment about what should be shared, even if such sharing is not mandated. It is information that is ultimately the basis upon which decisions are made and, in the context of child safety, should be treated and shared with the care and safety of children and young people at the forefront. It is critical that agencies such as Tasmania Police, the Registrar and Child Safety Services receive information relevant to their functions at the earliest opportunity to enable swift action.

We are pleased that in much more recent cases we examined in 2022 (the themes of which are discussed in Section 14.1) the timeliness of notifications has significantly improved.

8.5.2 Deficient record keeping

Across our case examples, we observed the challenges that the Department's deficient record-keeping practices presented. We were told poor record keeping made it difficult for the Department to access relevant records and contributed to delays in responding to allegations of child sexual abuse.[2899]

These problems also affected former detainees seeking information. For example, Ben told us of the difficulties he has faced in accessing information about his time in detention:

> I have applied to get a copy of my Ashley file three times, including twice while I was still in prison. All I've ever received in response to my requests are a few pieces of paper. There should be so much more. There would be hundreds of incident reports on my file, with many of them detailing violent incidents with workers ... [2900]

Departmental officials were frank about the poor record-keeping practices at Ashley Youth Detention Centre. We were told that Centre records were paper based, stored in various locations, poorly catalogued or indexed, and not easily accessible.[2901] We heard

about ‘an entire room the size of a garage full of paper files that went back for years and years and years’ and that records were sometimes only discovered ‘incidentally’.[2902]

We were told that due to these record-keeping practices, it was difficult for the Department to establish facts, timeframes and key events relating to the allegations.[2903] Records had not been catalogued or indexed, so accessing relevant information for preliminary assessments and during the investigation was time-consuming and labour-intensive.[2904] We understand this extended to even relatively basic matters, such as confirming that a complainant was at Ashley Youth Detention Centre at a particular time, or that an employee worked at the Centre at the time of an allegation.[2905] The lack of access to reliable, well-indexed catalogued records was described as a ‘limiting factor’ in undertaking preliminary assessments more quickly.[2906] It also had a major impact on the Department being able to thoroughly investigate, and act on, allegations it received and meant that senior managers and the Secretary did not have a complete picture of all the allegations that may have been made about a particular staff member.

Ms Baker said that it became clear to her in late 2020 or early 2021 that the Department was ‘severely hampered’ in its ability to respond and produce information for the Registrar and in the context of Employment Direction No. 5 investigations.[2907]

We discuss the Department’s records remediation project in Section 13.2 and make more observations and recommendations about records in Chapter 12.

8.5.3 Lack of awareness and responsiveness to Abuse in State Care claims

Abuse in State Care Program claims contained critical information that was directly relevant to potential risks posed by staff and yet there was no meaningful process to enable the Tasmanian Government and other agencies to act on it. The practical result of this was that the program itself faded from the Department’s corporate memory and the valuable information contained in claims was essentially lost. When reporting obligations to the Registrar arose in 2015, with retrospective effect, this information was not revisited for reporting purposes, even though the Abuse in State Care Support Service (the successor to the Abuse in State Care Program) continued—and continues—to operate.

Earlier in this case study, we made a finding that from 2007 onwards, the Department should have taken more active steps to protect children from potential risks posed by staff who had allegations of abuse made against them through state redress schemes. In that finding, we highlight the introduction of the Registration to Work with Vulnerable People Scheme as a particular opportunity to address a key gap in managing risks posed by staff and volunteers in institutions. If the Department and Tasmania Police had done this on the establishment of the scheme in 2015 for Lester, for example, there would have been four Abuse in State Care Program claims, one Abuse in State Care Support Service claim (which had a related police report) and one standalone police complaint referred

to the Registrar. The allegations included those of forced oral sex, attempted rape, masturbating in front of detainees, bribery for sexual acts and watching detainees while they showered or masturbated. The Registrar could have used this to assess Lester's suitability to retain registration to work with vulnerable people many years ago. Had there been stronger record keeping for complaints arising from Lester at Ashley Youth Detention Centre before 2008, there may have been even more information available.

As acknowledged above, the Department received several allegations of abuse relating to serving Centre staff through the Abuse in State Care Program and the Abuse in State Care Support Service. Seven Abuse in State Program claims named Lester or Stan, but there were many more relating to Ashley Youth Detention Centre. Taken together, they reflect an alarming pattern of alleged behaviour among some long-serving staff members.

As we describe in Section 9.2, these complaints histories only began to be pieced together in mid-2020 when newer departmental staff became aware of the program and recognised the significance of the information in these claims. While this was an important and welcome development, it came many years too late.

We acknowledge the evidence we received about the barriers the 2007 Solicitor-General's advice (and related practice) created in acting on information received through the Abuse in State Care Program. As we describe in our earlier finding, however, we consider this practice should have been revisited and revised (as it eventually was in December 2020, described in Section 9.8) in the interests of promoting children's safety and the public interest.

8.5.4 Inadequate risk management in response to information about Centre staff

Across all case examples, including that of Walter, we found a failure to recognise allegations for what they were or had the potential to be: allegations of child sexual abuse. Unlawful strip searches (such as those that involve touching or gratuitous nudity, or are not based on reasonable grounds), the touching of children's genitals outside legitimate medical treatment by a health practitioner, invasions of privacy that constitute voyeurism (such as observing detainees masturbating)—are allegations of child sexual abuse.

We saw what appeared to be reluctance from the Department to characterise Alysha's report about Lester as potential child sexual abuse, with a tendency to downplay the allegation as inappropriate or concerning conduct. This was similar to the way Erin's complaint about Walter's invasion of her privacy while she was showering was seen—as a gender insensitivity issue rather than a potential sexual violation. We discuss the Department's reluctance to characterise Alysha's report as a report of child sexual abuse in Case study 5.

Staff need to understand what may constitute child sexual abuse and related conduct, particularly in the early stages of receiving an allegation. While sometimes allegations

can seem relatively benign on the surface, more information and context can point to something far more troubling. Failure to understand the nature of allegations compromises the quality of risk assessments.

We saw other weaknesses in how potential risks to detainees were managed, with staff the subject of serious allegations remaining on site and with the potential to interact with detainees. We consider:

- Relying on Ira's restricted duties (arising from circumstances unrelated to the allegations against him) was inadequate because it was not specifically directed at preventing his contact with detainees.
- Relying on Lester moving into a role that did not involve direct contact with detainees as a safeguard was inadequate given he remained on site, was at least occasionally called on to assist in operational matters, and held different roles in an acting capacity, during which he was alleged to have conducted a strip search.
- Not modifying Stan's role or removing him from the Centre was inappropriate given his role involved significant contact with detainees.

The 8 November 2020 Minutes recommending the suspension of Ira, Lester and Stan (described in Section 9.6) make it clear that, despite the cited safeguards, Lester and Stan continued to have contact with children.

We heard of other inadequate risk mitigations. For example:

- The Department told us its risk mitigation strategy for dealing with certain allegations against Stan was that Mr Watson was 'made aware of allegations received [in late 2020] so he could remain vigilant, whilst police [undertook] their enquiries'.[2908] This was some three months after the Department received Ben's allegations against Stan.[2909]
- In the case of Ira, Mr Watson (then Acting Centre Manager) told us he only became aware of the allegations against Ira incidentally in March 2020, four months after the Secretary was first briefed on the allegations.[2910]
- In relation to Lester, Patrick Ryan, who was the Centre Manager in January 2020 when Alysha made the report, told us at our hearings that he learned of the allegations against Lester through our Commission of Inquiry.[2911] Reflecting on his lack of knowledge of previous allegations against Lester, Mr Ryan said 'it is something I should have known, something I should have been advised of'.[2912]
- Mr Ryan told us that he was also not told of any restrictions that should be placed on Lester's access to young people and, in fact (not knowing about the allegations) encouraged Lester and others to 'get out of their offices and walk around the centre, support each other, support the young people, build relationships'.[2913]

He told us:

> … if I was aware of [the allegations] at the time I would have— I wouldn't have encouraged Lester's contact with young people, there would have needed to have been some intervention.[2914]

We consider that Centre managers were not able to put in place and enforce appropriate risk mitigations given they were not advised of allegations against staff at the earliest opportunity.

We also saw the Department adopt a position that deferred to police action and justified this as a reason not to take immediate protective action. This was particularly noticeable in the context of the response to Stan but was also seen in other case examples. The evidence we received about acting on allegations of abuse by Stan was that the Department was waiting on police advice before taking disciplinary action.[2915] Yet, the Department became aware of the allegations in mid-2020, but did not report them to Tasmania Police until approximately three months later and did not suspend Stan until 8 November 2020.[2916]

Assistant Commissioner Higgins gave evidence that the way Tasmania Police and the Department work together has improved, saying:

> I honestly think this [collaboration] is done far better now with everything that the government agencies have done to improve in reporting and working together, particularly in relation to criminal matters and [Employment Direction No. 5 investigations]; I think that hasn't always been the case … but I think it's fair to say that over the last couple of years in particular that has certainly changed, for the better for all.[2917]

We accept that consultation and cooperation with Tasmania Police is important, but this should not come at the expense of child safety and can be achieved concurrently. Appropriate risk mitigations may need to be designed to address specific risks posed by alleged abusers to remove their access to children while an investigation progresses. We discuss this in Section 10.5.

At times, relying on Tasmania Police's actions suggested confusion over the test required to progress a criminal matter with that required to progress a disciplinary matter.

8.5.5 Conservative application of the State Service disciplinary framework

Throughout our Inquiry, we identified several challenges associated with applying the State Service disciplinary framework to child sexual abuse and related conduct. These reflect systemic problems across the State Service, which we discuss in Chapter 20.

We were told about the difficulties the Department faced in responding to allegations of child sexual abuse against staff, attributing this to the employee-focused requirements of the disciplinary process. We heard evidence to suggest some within the Department

feared that employees might challenge decisions to initiate investigations in the Tasmanian Industrial Commission. Such concerns were reflected in some of the meeting minutes and advice to the Secretary that we reviewed.[2918] Ms Baker said:

> The Employment Framework in the State Service facilitates employees reviewing decisions. Section 50 of the *State Service Act 2000* provides for employees to be able to review decisions related to their employment (with the exception of termination). In my view, this has naturally led to a very considered approach for decision making being adopted and is a contributing factor for some ED5s [Employment Directions No. 5] taking some time to commence, following the receipt of initial information. In undertaking an initial assessment, you seek to gather the relevant pieces of information for two key reasons. Firstly, to enable the decision maker (the Secretary of Communities Tasmania) to form a reasonable belief (as is required by ED5) that a breach may have occurred. Secondly, to frame up the allegations that you intend to put to the employee. If the allegations aren't descriptive enough, it is not providing the employee the opportunity to be able to consider and respond. If this eventuates you may end up with a review of decision, which could compromise the continuation of ED5.[2919]

Ms Clarke told us that while the Department's paramount consideration was the safety of young people in detention, she also:

> … recognised the importance of balancing the paramount consideration with the need for an initial assessment to be undertaken that would support a plausible allegation when/if subjected to industrial scrutiny.[2920]

Secretary Pervan told us that the industrial and employment lens meant that issues of natural justice to the employee were given primacy over the issue of child safety.[2921]

We saw some issues arising in the context of responses to Ira, Lester and Stan including the following:

- Oral briefings were relied on to brief to the Secretary about allegations against staff, with written material provided in a formal briefing many months later as part of the preliminary assessment process. This informality and lack of consistency also meant oral briefings were not documented.
- There also did not appear to be a clear escalation process, with identification of which role-holders were responsible for which actions, and within a set timeframe.
- Responses did not comply with best practice guidance for preliminary assessments. The timeframes for the Department's preliminary assessments of allegations were lengthy—well beyond the three working days recommended by the Integrity Commission.[2922] In relation to Ira, Lester and Stan, we saw what would best be described as preliminary investigations drag out for months (and in Ira's case, for more than a year). It was unclear at times what exactly was occurring

in those months—sometimes, on the evidence we received, very little. But what activity was described to us (extensive attempts at validation and corroboration of specific details, the interviewing and statement preparation of witnesses) went far beyond what we consider necessary for a preliminary investigation and unnecessarily delayed appropriate action. We consider the interviewing of witnesses and the taking of statements (as occurred in relation to Lester) to be more appropriately undertaken by an independent investigator.

- The protracted and involved nature of the preliminary assessment process applied by the Department suggested a very high threshold for launching a disciplinary investigation, by essentially becoming an investigation within itself. There appeared to be significant concern about the need to bring concrete and substantial evidence to the Secretary, despite the test imposed by Employment Direction No. 5—Breach of Code of Conduct that a Head of Agency need only have reasonable grounds to believe a breach of the Code *may* have occurred. It is then a matter for an investigation to determine whether the matters can be substantiated.
- The Department adopted informal practices of 'putting allegations' to alleged abusers for a response. Secretary Pervan told us that this practice occurs primarily where there is a lack of information and that he considers the approach appropriate in those circumstances.[2923] We are concerned that this option was considered in each of the cases we reviewed given the nature and number of serious allegations.
- The Department was reluctant to consider the cumulative impact of allegations. As we describe in more detail in Section 9.6, we consider there was not enough weight placed on a potential pattern of behaviour that the fuller complaints histories revealed, particularly in relation to Lester. This was partly due to delays in piecing together all relevant information (such as Abuse in State Care Program claims) but, even when this occurred, we found the fact there were multiple complaints was not emphasised or consistently taken into account for disciplinary investigations.
- Industrial pressures created challenges in responding to allegations. We heard that, while detainee safety was the most important consideration, concern about the possibility of industrial scrutiny also weighed on the Department.

We make a range of recommendations to improve disciplinary responses in child sexual abuse matters in Chapter 20, and recommend that, in future, such matters be referred to a Child-Related Serious Incident Management Directorate for specialised response (refer to Recommendation 6.6 in Chapter 6).

Finding—The Department did not take appropriate steps to manage risk, make appropriate notifications and progress investigations against Ira, Lester and Stan (all pseudonyms), which left children and young people at Ashley Youth Detention Centre at potential risk of harm

At various points between 2019 and 2020, it became clear to the Department that there were serious allegations of child sexual abuse made against Ira, Lester and Stan. We consider these allegations were not treated with the seriousness, urgency and care that was warranted. This had the effect of delayed reporting to relevant bodies and delayed disciplinary action, including the removal of staff from the Centre while a proper disciplinary process was conducted. These delays placed detainees at potential risk of harm in one of the highest risk environments for sexual abuse.

We consider these delays were a result of:

- limited understanding of the range of behaviours that constitute child sexual abuse
- concerns about privacy and sharing information with appropriate authorities
- deficient record keeping
- a corporate loss of knowledge of the Abuse in State Care Program
- a failure to consider the cumulative effect of allegations
- inadequate risk management strategies, including retaining staff on site, inappropriately relying on staff being in non-operational roles, not informing managers about potential risks and deferring action awaiting police direction
- conservative and narrow disciplinary processes, which ultimately gave preference to employee rights at the expense of child safety considerations.

Ideally, we would like to see the following:

- Allegations made against staff must be treated with seriousness and urgency, with relevant senior managers and the Secretary notified (ideally in writing). This requires an understanding of what constitutes child sexual abuse and sexual misconduct (particularly around issues such as strip searches or observing showers).
- Immediate notifications must be made to relevant key agencies, including Tasmania Police, the Registrar and Child Safety Services. Clear information-sharing channels should be established with these bodies so any more information and developments can be shared quickly with the right people in those agencies who are empowered to act.

- There needs to be immediate risk mitigation planning, including with managers at the Centre, to address potential risks to detainees. These mitigations should be tailored and proportionate to the potential risks and clear to all relevant managers and senior managers to ensure they can be monitored and enforced.
- Prompt preliminary assessments should draw on clear, accurate and accessible records that are available to the Department. Advice to the Secretary should place significant weight on the safety of detainees and reflect the relatively preliminary nature of the process (that is, not require extensive evidence or corroboration, which is more appropriately gathered through an independent investigation). The availability of potential witnesses could be canvassed and confirmed (for example, Ira in the matter of Lester) quickly as part of this preliminary assessment, but statements should be taken by the investigator at the next stage, during the Employment Direction No. 5 investigation.
- Sensitive and timely contact and engagement should take place with potential victim-survivors (where appropriate) to gauge their willingness to participate in investigations and to ensure they have appropriate support.
- All steps taken should be thoroughly documented.

9 Mid-2020 onwards—A change in the Department's approach

By 2020, the number of National Redress Scheme claims relating to Ashley Youth Detention Centre was beginning to mount. By mid-2020, the Department had received allegations against Ira, Lester and Stan at various times (and through various means). During 2020, the Department was notified of nine National Redress Scheme claims containing allegations against Ashley Youth Detention Centre staff.[2924] Some of these claims contained several allegations against multiple staff members and the conduct was alleged to have occurred between 1995 and 2012.[2925] Also, two civil claims were issued against the Department in 2020 relating to allegations of abuse by Ashley Youth Detention Centre staff between 1998 and 2006.[2926] This escalation in allegations received against staff was a significant challenge for the Department, with many of the allegations relating to serving staff members.

On 30 January 2020, the World Health Organization declared the coronavirus (COVID-19) a Public Health Emergency of International Concern.[2927] On 17 March 2020, the then Premier of Tasmania announced that the State would take several public

health emergency response measures.[2928] As we have noted earlier, we recognise that responding to the pandemic was a significant challenge for the Department and Tasmanian Government more broadly in the months before and after March 2020.

During this period, we also saw a significant growth in the knowledge and understanding of the Abuse in State Care Program among senior departmental officials and the fact that many of these past claims related to current Ashley Youth Detention Centre staff, who were also being identified through National Redress Scheme claims. This was alluded to in some of our summaries in Section 8 because it occurred while the Department was responding to allegations against Ira, Lester and Stan.

We saw a range of efforts and measures within the Department in mid to late 2020 to improve its responses to allegations of abuse. These included the Department:

- establishing the Strengthening Safeguards Working Group in September 2020 to facilitate coordinated responses to allegations against staff
- undertaking a cross-check of Abuse in State Care Program files against a list of current employees from September 2020
- compiling a spreadsheet of Centre staff named in the Abuse in State Care Program, National Redress Scheme and common law claims in October 2020
- setting up a process and guidance for responding to 'National Redress Scheme – Request for Information' forms that contained allegations against serving employees, including involving the Deputy Secretary of Children and Youth Services in approving these forms from around September 2020
- clarifying and improving processes for reporting matters to Tasmania Police and the Registrar between August and September 2020
- obtaining updated legal advice from the Solicitor-General on how it could use information in redress and other claims to support disciplinary investigations in December 2020.

This section takes us to the time the Department was in the midst of responding to increasing allegations against staff, including Ira, Lester and Stan, under increasing pressure as awareness of the nature and scale of potential abuses began to grow. We have arranged this timeframe in a broad chronology.

9.1 September 2020—Strengthening Safeguards Working Group established and meets regularly

In September 2020, the Department convened a Strengthening Safeguarding Executive Working Group to discuss active employment matters at Ashley Youth Detention Centre.[2929] Witnesses referred to 'case conferencing', the 'AYDC Working Group' and the 'Strengthening Safeguards Working Group' interchangeably.[2930] For simplicity, we have adopted the term 'Strengthening Safeguards Working Group' throughout this report.

Members of the Strengthening Safeguards Working Group included Ms Clarke, Ms Baker, Ms Allen, Ms Honan, the Director of People and Culture and a legal adviser to the Department.[2931] Other people, such as the Centre Manager, attended particular meetings. Mr Watson was a regular attendee from late October 2020.[2932]

The Strengthening Safeguards Working Group met for the first time on 18 September 2020.[2933] Meetings were scheduled fortnightly, but we understand the frequency varied depending on the number of allegations or claims of abuse and their progress.[2934]

We were told that the purpose of the Strengthening Safeguards Working Group was to ensure coordination between departmental officers involved in civil and redress matters, including operational staff such as Ms Honan, so the People and Culture team could provide progress updates and share information on relevant departmental personnel matters and investigations.[2935] We received evidence that the meetings were used as an opportunity to:

- discuss the Department's response to allegations of child sexual abuse against employees[2936]
- assist the Secretary to make decisions about suspending employees and commencing Employment Direction No. 5 investigations[2937]
- discuss options to direct staff to not have contact with children or putting staff on alternative duties[2938]
- raise other concerns, including about the delays in progressing action to suspend employees.[2939]

Secretary Pervan did not attend Strengthening Safeguards Working Group meetings. Ms Clarke recalled that she 'would keep the Secretary abreast of … new practices being implemented to mitigate risks', which included action items identified by the Strengthening Safeguards Working Group.[2940] We understood her evidence to be that these updates would form part of fortnightly meetings with the Secretary and other more ad hoc engagement.[2941] Secretary Pervan told us he had 'no hands-on involvement in the Strengthening Safeguards Working Group' and could not recall any briefings relating to the group or any detail about actions it took.[2942]

We understand that the Strengthening Safeguards Working Group met between four and six times to the end of 2020 (noting its role continued into 2021).[2943] We have reviewed meeting minutes for the first four meetings and some associated file notes and correspondence, noting the following common themes or concerns across those meetings:

- There was a lack of clarity about the nature and number of allegations concerning Ashley Youth Detention Centre staff and the need for further information to understand the extent of allegations.[2944] Despite this lack of clarity, at least some staff were expressing concerns about the safety of children at the Centre, an apparent pattern of behaviour across allegations, and risk that potential child sexual abuse offenders were on site.[2945]
- There was no 'clear co-ordinated process' to respond to those claims made through redress or civil processes, including confusion about reporting responsibilities, such as to Tasmania Police.[2946]
- There was concern about the Department being subject to parliamentary or public scrutiny over the handling of the allegations against current staff members, should it become known that Centre staff had outstanding serious allegations against them.[2947]
- There was concern about a looming class action brought by several former Ashley Youth Detention Centre detainees alleging a range of harms and abuses.[2948]
- There were concerns about the potential 'HR issues' if staff were to be dismissed, including the need to ensure procedural fairness for employees, the risk that relevant staff may go to the Tasmanian Industrial Commission and concerns for staff morale at the Centre.[2949]
- Members deferred to police advice before engaging in disciplinary action (although there seemed to be some confusion about the extent to which suspension could begin without police clearance).[2950]

These issues mirror many of the themes we describe in Section 8.5.

From the establishment of the Strengthening Safeguards Working Group in September 2020, we began to see Department and Centre managers raise concerns about alleged abusers remaining on site at the Centre. Those concerns included comments about risks to the Department. We also began to see increasing concern from Department staff about the legal and moral implications of the Department not acting.[2951] In particular, one staff member with legal training raised questions with People and Culture about the Department's apparent inability to start disciplinary investigations in the absence of a participating complainant or sworn statement, despite that imposing a higher threshold than that which applied to a civil claim.[2952]

9.2 August and October 2020—Awareness of the Abuse in State Care Program within the Department grows and information starts to be pieced together

We observed that knowledge among senior departmental officials about the Abuse in State Care Program was piecemeal and often came about by chance, even though:

- many allegations had been raised against Ashley Youth Detention Centre staff through the Abuse in State Care Program
- Secretary Pervan personally signed off on the *Review of Claims of Abuse of Children in State Care Final Report* in September 2014, which identified 172 claims made between 2011 and 2013 against Ashley Youth Detention Centre or its predecessor, Ashley Home for Boys[2953]
- the Department was the custodian of the Abuse in State Care Program records and used these materials to respond to National Redress Scheme requests for information.[2954]

We were told that only in August or September 2020 did some senior departmental officials and their advisers become aware—or more fully aware—of the Abuse in State Care Program and that allegations had been raised through this program against staff who were still employed at Ashley Youth Detention Centre.

Ms Clarke, then Deputy Secretary for Children, Youth and Families, acknowledged she was 'aware of the concept' of the Abuse in State Care Program (and had approved some 'National Redress Scheme – Request for Information' forms referring to the program in 2019).[2955] However, as mentioned, she told us she was prompted to consider the program in more detail following a meeting with a private lawyer in August 2020 about abuse allegations against staff.[2956] We note that it would have been clear from the forms that Ms Clarke approved in 2019 that allegations had been raised against employees, including through the Abuse in State Care Program.[2957]

In mid to late-2020, a legal adviser to the Department assumed responsibility for a period for overseeing responses to the National Redress Scheme information requests.[2958] As part of this process, they realised there was a possibility that some current employees may have been the subject of past Abuse in State Care Program claims.[2959] This awareness led to others learning of the Abuse in State Care Program incidentally. For example, Ms Allen learned about this through a passing comment from the legal adviser; Ms Baker found out because her office was located close to the legal adviser's.[2960]

Ms Allen had begun working at the Department six to eight weeks before becoming aware of the Abuse in State Care Program. She told us that, up until that point, she had no knowledge of the program and had only been told of two unrelated Employment

Direction No. 5 investigations that were nearing completion.[2961] We were concerned by the lack of a formal briefing to Ms Allen on these matters when she first took up her role.

Ms Allen said 'it was one of those, "Wait, wait, wait, hold up, what are you talking about? We have got all of this information that has never been put together and no action's been taken"'.[2962] She went on to say:

> It's my understanding at that point in time that the four rounds of the abuse in state care applications were never put together to paint a picture of who may have been perpetrators of child sexual abuse, and … it remains a very big disappointment of mine that that work hadn't occurred prior, because I do believe that, putting to one side issues with advice that had been provided, there was definitely valuable intelligence a long time ago in relation to potential perpetrators of child sexual abuse; and it wasn't until, again, the support of the executive that those files were got out and put together and to create a bit of that picture, a true picture, I believe, as to what may have occurred at Ashley was able to be painted.[2963]

We agree that the failure of the Department to use the information on those records reflected a critical missed opportunity to identify and address the potential risks posed by staff.

The growing awareness of abuse allegations connected to Ashley Youth Detention Centre was followed by a series of steps to consolidate the Department's knowledge of the extent of abuse allegations and to coordinate a response. We were pleased to see these steps begin in August/September 2020, as this reflects an appropriate shift in approach by the Department. We summarise those steps below.

9.2.1 September 2020—A cross-check of Abuse in State Care Program records against current staff lists begins

In or around September 2020, at Ms Clarke's request, the Department began a 'cross check' of the names of alleged abusers in Abuse in State Care Program records against a list of current Ashley Youth Detention Centre staff who had been working at the Centre before 2010.[2964] We are unclear why this date threshold was imposed, which we note below. The review was also to identify what actions may have been taken where an employee had been named in an Abuse in State Care Program claim.[2965]

This cross-check did not cover all sources of potential information held by the Department. Specifically:

- It was limited to Abuse in State Care Program records and did not extend to allegations raised through the Abuse in State Care Support Service (the program's successor from 2015).[2966]
- It was limited to serving employees who had been working at Ashley Youth Detention Centre prior to 2010. However, the Abuse in State Care Program ran until 2013, and we are aware that the period of abuse that was raised in Abuse in State

Care Program records spanned 1995 to 2013 (although, as set out in Case study 1, the period of abuse may have spanned a much longer period).[2967] This suggests the cross-check may not have captured employees who had been employed after 2010 and who were the subject of allegations regarding conduct that was alleged to have occurred between 2010 and 2013. We accept that many staff at the Centre had been employed before 2010.

- The process only considered claims relating to current Ashley Youth Detention Centre staff and not other people who were the subject of allegations (including other State Service employees, foster carers or people who were registered to work with vulnerable people) who may have also posed a potential risk to children. We discuss our concerns about the scope of the Department's reviews of claims in Chapter 12.

We understand the cross-check work was completed around December 2020.[2968]

9.2.2 September 2020—Spreadsheet of Abuse in State Care Program claims circulated to Strengthening Safeguards Working Group members

On 21 September 2020, a spreadsheet we understand was prepared by the Child Abuse Royal Commission Response Unit was circulated to members of the Strengthening Safeguards Working Group.[2969]

The spreadsheet collated information of claims made through the Abuse in State Care Program and identified that 127 claims had been made against Ashley Youth Detention Centre staff members (some of whom were named on multiple occasions).[2970] The email circulating the spreadsheet highlighted that two then current employees had been named as alleged abusers.[2971] This included Lester, who was named in four Abuse in State Care Program claims.[2972] However, the spreadsheet was incomplete because it was missing some Abuse in State Care Program allegations of which we are aware.

9.2.3 October 2020—The Department compiles a spreadsheet of all claims against Ashley Youth Detention Centre staff

To address an action item of the 9 October 2020 Strengthening Safeguards Working Group meeting, the Department compiled a spreadsheet of all Ashley Youth Detention Centre staff who were mentioned in the Abuse in State Care Program, National Redress Scheme and/or civil claims.[2973] We were told that this new spreadsheet was prepared in response to concerns that the Child Abuse Royal Commission Response Unit spreadsheet (circulated on 21 September 2020) did not present a complete picture of all allegations against Ashley Youth Detention Centre staff (for example, those arising from civil claims) and that some information may have been omitted from the original spreadsheet.[2974] We understand that the online Government Directory Service was used to verify whether named alleged abusers were current State Service employees but that concerns were expressed that this did not constitute a 'robust' checking mechanism.[2975]

Despite attempting to reflect a fuller picture of allegations against current Ashley Youth Detention Centre staff, it appears that the review did not consider allegations raised through the Abuse in State Care Support Service, which included a claim against Lester.[2976]

We understand that this spreadsheet was later expanded and maintained.[2977] However, for reasons we discuss in Chapter 12, we are not confident that a comprehensive audit has been undertaken and we are unaware of any similar reviews relating to others named in claims who may still be working with children and young people (as carers or otherwise). In that chapter, we recommend that the Tasmanian Government conducts an audit of all relevant records it holds to identify all allegations of child sexual abuse.

9.3 August–September 2020—Processes for reporting to Tasmania Police and the Registrar of the Registration to Work with Vulnerable People Scheme are clarified and strengthened

We understand that in August or September 2020, concerns were raised internally that National Redress Scheme applications and civil litigation claims may not have been notified to Tasmania Police or the Registrar.[2978] Referring to these concerns, Ms Allen (who as we noted was relatively new to the Department) told us:

> I considered that it was not Communities Tasmania's role to decide if conduct amount[ed] to criminal misconduct, or an unacceptable risk to children (insofar as Registration to Work with Vulnerable People) and therefore we should be openly sharing information immediately once received with Tasmania Police and Registration to Work with Vulnerable People.[2979]

We agree with this observation. We observed that, in August and September 2020, the processes for reporting abuse allegations to Tasmania Police and the Registrar began to be considered and improved.

9.3.1 Reporting to the Registrar

In 2018, the Office of the Solicitor-General prepared advice for the Department of Justice on the meaning of the word 'finds' in the Registration to Work with Vulnerable People Act, taking a view that there was only an obligation to report conduct that presented a risk of harm to a child if there had been a formal finding about that conduct. We discuss that advice in Section 12.2.

We were told that several senior officials in the former Department of Communities were unaware of that legal advice to the Department of Justice.[2980] However, it appears there was some confusion within the Department of Communities about what the actual reporting threshold to the Registrar was, noting the wording of the legislation at that

time. In August 2020, People and Culture contacted the Registrar to clarify reporting obligations, seeking confirmation of exactly when a reporting obligation arises.[2981] In that correspondence, People and Culture acknowledged that while the legislation appeared to require a 'finding' of reportable conduct to enliven the obligation, this could take some time to obtain and there was a desire to reflect best practice in reporting at the earliest opportunity.[2982]

A staff member from the Registration to Work with Vulnerable People Unit replied to People and Culture's email stating:

> The timely provision of information goes a long way [to protect vulnerable people from the risk of harm]. As such, we take and encourage a broad interpretation of the word 'find' so as to mean become aware of. We believe this is in keeping with the intent and purpose of the Act.[2983]

We were told that in around September 2020 (before changes to the legislation on 1 February 2021 clarifying the requirement to report described in Section 3.1.2), the Department changed its processes so information it received that constituted 'reportable behaviour' was immediately referred to the Registrar.[2984]

9.3.2 Reporting to Tasmania Police

We understand that prior to December 2020, the reporting of allegations of sexual abuse by government agencies generally occurred through informal relationships developed between Tasmania Police and government agencies within their local area.[2985] Notifications would be made in person, or via phone or email.[2986]

On 18 September 2020, the Strengthening Safeguards Working Group discussed the idea of establishing a central liaison contact in Tasmania Police for all redress and civil claims.[2987] We were told that shortly after the 18 September 2020 Strengthening Safeguards Working Group meeting, the Department changed its processes so matters were immediately referred to an appointed contact at Tasmania Police.[2988] Tasmania Police would then send the referrals to local police stations, with whom the Department (via People and Culture) would remain in contact.[2989] We understand this notification process took immediate effect.[2990]

Evidence we received from the Department and Tasmania Police was that Tasmania Police then changed its reporting processes for receiving child sexual abuse complaints from government agencies in December 2020, so all notifications of sexual abuse were made through the Assistant Commissioner of Operations' office as a single point of contact through a specific inbox.[2991] Since February 2021, all agencies use a standard police template to report allegations of child sexual abuse committed by government employees.[2992]

In relation to the reporting of civil claims to Tasmania Police, we were told that the Office of the Solicitor-General advises the Department whether the matter has been referred to police.[2993] Where a referral is not made, the Department may nevertheless decide to refer the matter to police (having regard to the Office of the Solicitor-General's reasons for not referring already).[2994]

It appears that this process was not in place at the time the Department first started making referrals to Tasmania Police, and we note that the first referral from the Office of the Solicitor-General that Tasmania Police told us about was in November 2021.[2995] We consider that best practice requires that the Office of the Solicitor-General, as first receiver of the allegations in civil claims, refers all potentially criminal allegations derived from civil claims to Tasmania Police. If a referral has not been made, the Department should consider the Office of the Solicitor-General's reasons as to why, and the Department may decide to refer.

We note that while it appears the practice of reporting to the Registrar and Tasmania Police did improve around this time (including in relation to some allegations raised against Ira and Stan), we still saw some delays and inconsistent reporting practices until as recently as 2022 (discussed in Section 14).

9.4 October 2020—New departmental guidance developed for responding to National Redress Scheme claims

Minutes of a Strengthening Safeguards Working Group meeting on 18 September 2020 indicated there was no clear process in place for responding to information arising from National Redress Scheme claims, which began coming to the attention of the Department from 2019. The minutes record the need for a procedure 'to provide a clear process and detailed steps when current staff are identified' as a required action item.[2996]

As we have described earlier, the purpose of National Redress Scheme claims is primarily to offer acknowledgment and some form of compensation to victim-survivors of child sexual abuse in institutional settings, rather than to pursue alleged abusers. However, the National Redress Scheme does contemplate some claim information being reported, shared and acted on to the extent possible to protect the safety of children. Some of the information coming to the Department's attention through such claims related to serving Ashley Youth Detention Centre staff.

By early October 2020, a new 'process flowchart' and associated procedure was prepared to guide the Department's response to information it received in National Redress Scheme claims.[2997] It is unclear when exactly these documents came into operation (noting that the procedure we were provided with has a draft watermark and

unexplained highlighting, and has no effective date), but the minutes of the 9 October 2020 Strengthening Safeguards Working Group meeting suggest that it was around this time.[2998]

The flowchart provides for the following process:

- The Department of Justice emails the National Redress Scheme – Request for Information form ('Request for Information form') to the Department of Communities with a response due date, accompanied by information held by the Department of Justice relating to a National Redress Scheme claim.[2999] As we explained in Section 7, we saw that the Department of Justice did not always send the Department of Communities all the information it held about National Redress Scheme claims.
- A Department of Communities officer identifies relevant client records (including Abuse in State Care Program and Abuse in State Care Support Service records) and adds any necessary information to the Request for Information form.[3000]
- The Department of Communities officer emails the completed Request for Information form and a copy of the claim details provided by the Department of Justice to the Deputy Secretary Children and Youth Services (also known as the Deputy Secretary, Children, Youth and Families) and flags any alleged abusers who appear to be current government employees or departmental foster carers.[3001]
- The Deputy Secretary Children and Youth Services is to be alerted as soon as possible when an alleged abuser is identified as a current government employee or foster carer.[3002]
- The Deputy Secretary Children and Youth Services reviews the draft response and forwards this to legal services to 'verify any civil matters'.[3003]
- The Deputy Secretary Children and Youth Services refers any concerns about current government employees to People and Culture for forwarding to the relevant Director (and any concerns about a current foster carer to the Director Children, Youth and Families for further review and investigation as appropriate).[3004]
- The Deputy Secretary Children and Youth Services approves the release of the completed Request for Information form to the Department of Justice.[3005]

We understand the requirement that the Deputy Secretary Children and Youth Services approves or 'clears' all Request for Information forms dates to at least late September 2020.[3006] Ms Clarke told us this requirement was embedded so she would, on a daily basis, be fully apprised of allegations being raised against departmental employees and because she 'was starting to form the view that more [National Redress Scheme] forms alleging abuse of current [Ashley Youth Detention Centre] officials may occur'.[3007] She also said the requirement sought 'to strengthen the linkage between the relevant

operational portfolios and the People and Culture Division' because both divisions needed to work together when an allegation against a current staff member was received.[3008]

Although the flowchart requires that the Deputy Secretary Children and Youth Services is alerted as soon as possible when an alleged abuser is identified as a current government employee or foster carer, it otherwise does not include any specific timeframes for notifying People and Culture or the relevant Director about current employees.[3009] We were told that, in practice, the time between receiving a National Redress Scheme claim alleging abuse by a current staff member and the Department starting an initial assessment was 'very prompt'.[3010]

The flowchart is limited to the Department's response to a Request for Information form relating to claims under the National Redress Scheme and does not refer to any reporting obligations to Tasmania Police, the Registrar or Child Safety Services. We discuss the Department of Justice's understanding of, and approach to, reporting obligations in Section 12.

9.5 November 2020—Media and parliamentary interest grows in alleged abuses at Ashley Youth Detention Centre

The Nurse podcast, created by freelance journalist Camille Bianchi, focused initially on abuses that occurred at Launceston General Hospital by paediatric nurse James Griffin and others (described in Case study 3 in Chapter 14).

On 3 November 2020, the fourth episode of *The Nurse* podcast aired. At the end of the episode, a preview was played for the forthcoming episode. The voiceover stated:

> Next time on *The Nurse*, we go outside the hospital to another institution where Jim worked, in northern Tasmania. We go to the youth prison: you're going to want to brace yourselves—it's a horror show.[3011]

It then plays audio from a person who describes an allegation that we consider to be a reference to Lester:

> There is one guard there who was witnessed engaged in the aftermath of raping a child. He was naked and the child was naked, and another guard saw it. For whatever reason a report was made that never went anywhere.[3012]

The Nurse podcast is mentioned in some of the briefing materials to Secretary Pervan, discussed in Section 9.6.

That same month, on 20 November 2020, journalist David Killick published an article in *The Mercury* newspaper referring to claims of sexual abuse and cover ups, commenting that Tasmania had an appalling record on handling Right to Information

requests. The article said that abuse claims in education, Launceston General Hospital and Ashley Youth Detention Centre 'have been known in government circles but kept under wraps for months or years' and asked: 'How many child sex abuse scandals and cover-ups will it take for someone in this government to spot the pattern?'[3013] Three days later, on 23 November 2020, then Premier Peter Gutwein announced that a Commission of Inquiry into the Tasmanian Government's responses to child sexual abuse in institutional settings would be established in early 2021.[3014]

On 25 November 2020 (a few weeks after Ira, Lester and Stan had been suspended, which we discuss in the next section), a question was raised in Parliament as to whether any of the Ashley Youth Detention Centre staff who had been publicly reported as having been 'stood down' were involved in strip searches in the period from 1 July 2019 to 30 June 2020.[3015]

On 26 November 2020, information was tabled in the Tasmanian Parliament that suggested that 'of the three staff stood down or under investigation, none have [strip] searched young people'.[3016] The Department sought to correct this information by notifying Secretary Pervan in a Minute prepared on 9 December 2020 because Lester had in fact undertaken a strip search of a detainee in 2019.[3017]

9.6 November 2020—A change in approach to initiating disciplinary action

On Sunday 8 November 2020, a few days after the preview of *The Nurse* episode referencing what we consider to be the allegations against Lester, a meeting was held to discuss each of Ira, Lester and Stan.[3018] Secretary Pervan recalled that he had 'various conversations' with departmental staff about the matter in the week leading up to this meeting.[3019]

On the same day, Secretary Pervan considered and approved three Minutes (one each for Ira, Lester and Stan) concerning allegations raised against each and the possible disciplinary action to take place. At least two of those Minutes had been drafted on 6 or 7 November 2020.[3020] It appears it was at this point that the Department felt it necessary (and felt able) to recommend disciplinary action be taken against these three staff members.

The Minutes set out details of the relevant allegations against each of Ira, Lester and Stan. They did not include all allegations made about each employee that came to be known to our Commission of Inquiry. Only some (but not all) allegations known to the relevant departmental officials at the time the Minutes were prepared were included in the Minute. We describe some of the omissions from the Minute in Section 8.

The Minutes invited Secretary Pervan to consider four options in relation to the three staff members, being to:

- advise the staff member of the allegations against them and provide them with an opportunity to respond (essentially put the allegations to them for response)
- initiate an Employment Direction No. 5—Breach of Code of Conduct investigation
- reassign the staff member's duties to prevent direct contact with detainees
- take no further action but maintain a record of the basis of that decision.[3021]

These same options were previously put to Secretary Pervan regarding Ira on 18 September 2020, which, as described above, resulted in a decision to put the allegations to Ira and provide him with an opportunity to respond (which was delayed to obtain his statement against Lester).[3022]

Across all briefings, Secretary Pervan was invited to consider a number of factors in making his decision, including the safety of detainees at Ashley Youth Detention Centre, the nature and severity of the conduct, the staff member's potential exposure to young people, the level of information available and potential to progress an investigation (including whether the complainant wanted to take part), the public interest and the staff member's wellbeing.[3023]

These considerations appear to extend beyond those articulated in the 2007 Solicitor-General's advice, which primarily focused on the complainant's participation. We acknowledge that the Minute relating to Ira advised that:

> Previously it was considered there was insufficient information to provide reasonable grounds to believe that a breach of the Code may have occurred given [one] complainant [would not at that time] participate in an investigation.[3024]

The Minute, however, pointed to a 'pattern of inappropriate behaviour' that was now before the Department to justify overcoming the lack of a complainant's participation.[3025] While the Minutes note the challenges of success without the participation of complainants, they nonetheless recommend disciplinary action—contrary to the practice we are told emerged from the 2007 Solicitor-General's advice. No Minute expressly mentioned the 2007 Solicitor-General's advice directly, or indirectly by describing its requirements.

Like the earlier 18 September 2020 Minute about Ira, Secretary Pervan was also given the following assurance across the different 8 November 2020 Minutes:

> The allegations relate to alleged events over 20 years ago. It is considered that the environment at [the Centre] has changed significantly over the past 20 years, with additional controls now in place. There is greater staff to resident ratios, less of an opportunity for Youth Justice Workers and residents to be in 1:1 situation, more cameras and monitoring, and a greater opportunity for residents to raise complaints. Given these additional controls it is considered a lower risk that abuse such as that outlined in the allegations against [the relevant employee] could occur in the environment at [the Centre] today. However, whilst it is considered that risk is minimal it may not be possible to eliminate risk, especially if [an employee] is in direct contact with residents.[3026]

Only one Minute made any reference to media attention and scrutiny over child sexual abuse matters. It noted the significant media attention that was occurring about child sexual abuse, particularly involving James Griffin.[3027] The Minute also referenced the upcoming release of *The Nurse* podcast episode on Ashley Youth Detention Centre.[3028]

Ultimately, Secretary Pervan decided to suspend all three Ashley Youth Detention Centre staff and initiate Employment Direction No. 5 investigations because he had formed a reasonable belief that each may have breached the State Service Code of Conduct.

In an email approving all three Minutes, Secretary Pervan suggested that steps had not been taken over the allegations until that point because the Department did not want to interfere with police processes.[3029] The email noted that as police had advised they did not intend to pursue criminal investigations, 'the way is therefore clear for us to pursue our process'.[3030] The email did not acknowledge that police had notified the Department in February 2020 that they would not be pursuing Baxter's allegations against Ira, clearing the way for much earlier action.

We are pleased to see more decisive action occurred on 8 November 2020. However, we consider it took too long to give serious consideration of the public interest and a possible pattern of behaviour revealed through multiple complaints.

Finding—The Department failed to adequately consider the safety of detainees and place appropriate weight on public interest considerations in relation to Ira, Lester and Stan until 8 November 2020

Despite the Department becoming increasingly aware of the extent of allegations being made against current staff by August and September 2020, we were disappointed that it took until 8 November 2020 for disciplinary action to be commenced in relation to the allegations made against certain Ashley Youth Detention Centre staff.

For example:

- The Department had the same information about Ira in September 2019 that it had on 8 November 2020. It had provided the Secretary with three previous briefings from December 2019, none of which recommended that Ira be suspended or an Employment Direction No. 5 investigation be commenced.

- The Department received Alysha's report about Lester on 9 January 2020, which was the only allegation initially included in the Employment Direction No. 5 investigation into Lester's conduct on 8 November 2020. Also, the Department had reidentified that there were four Abuse in State Care Program claims against Lester in September 2020, yet only recommended disciplinary action to Secretary Pervan on 8 November 2020 (referring to only three of these claims).
- The Department had received Ben's allegations of rape by Stan by mid-2020. This was the only allegation initially included in the Employment Direction No. 5 investigation against Stan on 8 November 2020, noting that the Minute also referred to other allegations it had received in September 2020.

While we accept responding to allegations of this nature is complex, the Department owes a duty of care to detainees that must be at the forefront of decision making. We note that the Department became aware of the relevant allegations a number of months—and in one instance, more than a year—before making the decision to suspend those staff members.

We acknowledge there was growing concern within the Department from September 2020 onwards but were surprised by the markedly different change in approach on 8 November 2020, which showed welcome emphasis on the safety of detainees and the public interest in having staff the subject of allegations removed from the workplace and investigated.

We are unclear why this outcome could not have been achieved earlier, given, at this point, there had been no apparent change to the legal advice that we were told precluded any disciplinary action without the participation of, or a sworn statement from a complainant, or to the practice that appears to have developed from that advice.

While increasing awareness of the number and nature of complaints against past detainees from September onwards can partly be attributed to this change, we also consider it likely that the growing appreciation of risks to the Department, arising from the looming class action and increased media scrutiny, was a significant contributor to the relatively sudden recommendation to take decisive action.

9.7 December 2020—Secretary Pervan receives the Department's Review of Claims of Abuse of Children in State Care

In or around December 2020, the Department prepared a review of the reporting processes under each of the four Abuse in State Care Program rounds, which considered the notifications process and the scope and aims of the program.[3031] We discuss this review, and what it revealed about the purpose of the program in Section 4.2.

On 14 December 2020, the Department sent Secretary Pervan this review. The associated cover email included an extract from the review, which stated that the program was about compensation and acknowledgment and was not established to determine blame or fault or to make specific findings against alleged abusers. Rather, the Abuse in State Care Program was intended to be part of a supportive, healing reconciliation process.[3032]

Secretary Pervan responded on 14 December 2020 to the email as follows:

> I acknowledge the intent of the Review … in terms of compensation and healing and of the advice you have compiled for Mandy [Clarke]. In the context of claims and harm done that is entirely understandable.
>
> I do think however, that if we consider these matters in the current context of our duty of care to children in our care and include in that consideration the statutory provisions relating to reporting and responding to abuse and the associated penalties where it is proven, then a different perspective on the information and our compulsion to act emerges.[3033]

This statement would appear to reflect the position taken on 8 November 2020, when Employment Direction No. 5 investigations were commenced against Ira, Stan and Lester.

9.8 December 2020—The Department seeks and receives new legal advice from the Office of the Solicitor-General on using information alleging abuses by Centre staff

We saw some evidence that the 2007 Solicitor-General's advice, or any practice associated with it, was not viewed as an immovable barrier to disciplinary action. But this was clear by November 2020, when Ira, Lester and Stan were suspended. In each of those three matters, the Department did not have the active participation of, or a sworn statement from, the relevant complainant at the time of the suspension.

Despite our efforts to enquire into the rationale for taking that disciplinary action at that specific time, we remain unclear about any change in policy or legal position that produced this different approach, until new legal advice was received on 15 December 2020.

We were told that the 'number and detail of the allegations' relating to Ira, Lester and Stan 'distinguished them from earlier matters' such that a disciplinary response was appropriate in November 2020 despite the continued application of the 2007 Solicitor-General's advice.[3034] We found this difficult to reconcile with the lengthy period over which these allegations were known to the Department (noting in particular the allegations against Ira, which had been briefed to the Secretary as early as December 2019).

In July 2023, Secretary Pervan told us that since his previous evidence to us he had recalled being informed by People and Culture earlier than 15 December 2020 that the Office of the Solicitor-General had confirmed the 2007 Solicitor-General's advice would be superseded.[3035] Secretary Pervan could not recall whether this occurred before or after the decision to approve Employment Direction No. 5 investigations into the allegations against Ira, Lester and Stan on 8 November 2020.[3036] We did not receive evidence from other departmental witnesses suggesting this advice had been given at this time, although we did not have an opportunity to test this recollection with relevant people before publishing our report.

We received evidence that the 2007 Solicitor-General's advice was reinforced in a meeting in November or December 2020 between representatives of the Office of the Solicitor-General and the Department.[3037] As we note above, we consider that heightened media attention and scrutiny likely played some role in the Department's changes in processes and practice during this period.

We outline here the evidence that we received about the lead-up to providing the 15 December 2020 legal advice, noting it suggests that:

- there continued to be real or perceived legal barriers to taking disciplinary action, even after the initiation of Employment Direction No. 5 investigations on 8 November 2020
- concerns about taking disciplinary action based on information from redress schemes was a matter exercising many Secretaries
- the extent to which the 2007 Solicitor-General's advice affected the Department's practice in managing allegations against staff (particularly by 2020) remains unclear.

At some point, the Department must have become concerned about potential barriers to using information from redress schemes in disciplinary processes.

On 23 November 2020, departmental staff met with the then Assistant Solicitor-General (and current Solicitor-General) Sarah Kay SC to discuss the Department using information about historical allegations of abuse.[3038] We were told that Ms Kay confirmed at the meeting that the Department could not progress investigations where there was no complainant.[3039] Some departmental officials expressed feeling upset with the advice.[3040] They felt 'very frustrated with a seeming inability to do anything when there were serious allegations against current employees'.[3041]

The Office of the Solicitor-General told us, and provided documentary evidence to support, that no legal advice was provided at that 23 November 2020 meeting, including advice that investigations could not be progressed.[3042] The Office of the Solicitor-General considers that the contents of that discussion may have been misinterpreted by the staff of the Department.[3043]

On 24 November 2020, Secretary Pervan emailed the then Solicitor-General stating that he had been briefed by staff about the meeting with Ms Kay on the previous day. The email stated:

> I understand that the material provided to us from civil claims and redress statements cannot be used for disciplinary purposes but remains live and usable by the Crown for the purpose of settling claims. As you know, the victims in 2 of the matters have made it abundantly clear that they do not wish to participate in any investigation by the Police or the Crown generally. Given that one of the employees in particular is accused of a significant number of potentially criminal acts this places us in a poor position.[3044]

Secretary Pervan also requested advice on the Department's mandatory reporting obligations, in addition to the advice that was being drafted about using historical information.

We asked Secretary Pervan about this email and what the basis was for his statement that material provided from civil claims and redress statements cannot be used for disciplinary purposes.[3045] He responded:

> The verbal preliminary advice from Sarah Kay was that in the absence of a sworn statement from the victim-survivor, the claims could not be used in ED5 investigations. This maintained the position that we had understood we were bound by, set out in the 2007 written advice.[3046]

On 6 December 2020, the Department requested new advice from the Solicitor-General, asking:

- whether investigations could be initiated without the complainant's consent
- whether the Department could provide information received through the state and national redress schemes and civil claims to external investigators
- whether the Department could use that information as part of a misconduct investigation in circumstances where the complainant had not made a formal complaint to the police or a statement to the Department.

On the one hand, this request for legal advice suggests the Department was actively seeking legal advice to enable it to share and act on information about child sexual abuse by staff gleaned from redress and civil claims. On the other hand, it illustrates there continued to be real or perceived barriers to taking this action, despite the Department initiating disciplinary processes a month before.

Ms Baker explained her concerns this way, in the context of managing the disciplinary process against Lester:

> Noting that [Lester] was out of the workplace and the risk to children mitigated from 8 November 2020, there was a delay in progressing the Abuse in State Care matters to [Lester]. This was initially attributable to seeking advice from the Office of the Solicitor General to ascertain whether the information (including the complainant['s] name) from the Abuse in State Care Scheme could be put to [Lester]. This was the first case where we were relying on information from the Abuse in State Care Scheme to put matters to an employee. I recall the discussion at the time on how this was unprecedented and legal advice needed to be sought. This advice was sought at a meeting between Department staff and the Office of the Solicitor General and was held on 23 November 2020, written advice was sought on the 8 December and the written advice was received from the [Office of the Solicitor-General] on the 15 December 2020.[3047]

On or around 7 December 2020, there was a multi-agency meeting at which there was a discussion about:

> … the use and retention of information concerning claims of child sexual abuse made in the course of seeking financial compensation under the National Redress Scheme and the need to take action in respect of alleged perpetrators who were still in contact with children in their roles.[3048]

We understand the meeting attendees included Secretary Pervan, Ms Clarke, Assistant Commissioner Higgins, the then Director of the Child Abuse Royal Commission Response Unit, Secretary Webster, Secretary of the Department of Health, Kathrine Morgan-Wicks PSM, and the then Deputy Secretary of the Department of Education, Rob Williams.[3049] Secretary Pervan told us:

> Although I do not recall specific statements, my general recollection is that attendees were forthright about their dissatisfaction with [the 2007 legal] advice and its practical repercussions. I recall that this meeting was the catalyst to request that the Solicitor General provide updated advice on these matters, including with respect to how the Department could engage with employment directions using information arising from the [National Redress Scheme] claims that it had received from the Department of Justice.[3050]

As mentioned above, Secretary Webster told us that she only 'recently' became aware of the Solicitor-General's 2007 legal advice and that she understands:

> … this advice may have resulted in these [Abuse in State Care Program] allegations not being pursued, however, this understanding is based on the evidence that has come to light during the Commission's hearings.[3051]

The decision to request the 15 December 2020 legal advice was made on 23 November 2020 and there was no reference to the Solicitor-General's 2007 legal advice in that request.[3052]

On 8 December 2020, there was a meeting between Secretary Jenny Gale, Secretary Webster, Secretary Pervan, Secretary Morgan-Wicks, Secretary Timothy Bullard and former Commissioner of Police, Darren Hine AO APM.[3053] The purpose of the meeting was to determine responsibility for a paper to Cabinet about internal processes for identifying whether and where employees who may have had historical allegations against them are still employed by the State and the need to ensure there was information sharing across agencies to identify whether an employee had moved from one agency to another.[3054] We understand this meeting, or discussions that followed it, included discussion about the reliance on a statement from redress claims for the purpose of disciplinary processes and the complexity this entailed.[3055]

On 15 December 2020, the Office of the Solicitor-General advised the Department that:

- The Department could commence a misconduct investigation in the absence of a complaint to Tasmania Police or a statement to the Department.[3056]
- The Department did not need to notify a complainant it was acting on the information provided unless the Department's actions might adversely affect the complainant.[3057]
- The use or disclosure of information derived from National Redress Scheme claims is permitted in certain circumstances by the Scheme's legislation. This includes disclosure or use in relation to the safety or wellbeing of children or related disciplinary or employment processes (including an Employment Direction No. 5 investigation).[3058]
- In certain circumstances, exceptions in the Personal Information Protection Act may enable the use of information for the purposes of Employment Direction No. 5 investigations without the complainant's consent.[3059] Those exceptions have been in place since 2004.[3060]

This new legal advice did not reference the 2007 Solicitor-General's advice and did not explain the reason for the change in view. We understand that the legal advice of 15 December 2020 is still current.

We were told that these measures worked to improve reporting to other agencies, reduce delays and allow for more effective disciplinary responses.[3061] We welcome information that expressed a shift towards prioritising detainee safety, including by working to remove staff from site where required.[3062] Departmental officials placed particular emphasis on the difference in approach since receiving the Solicitor-General's legal advice on 15 December 2020.[3063]

We also heard of efforts to overcome reliance on police investigations as a reason to wait to start disciplinary action. We were told that since 2020, 'generally speaking' there were not the same concerns about delaying Employment Direction No. 5

investigations pending police processes but in some cases, a person will be suspended and the Department will wait for police to confirm that the Employment Direction No. 5 investigation can begin.[3064]

Many departmental officials told us that the Department's responses to the allegations against Lester, Ira and Stan would be different if the allegations were made today.[3065]

9.9 Reflections on the Department's responses to Ira, Lester and Stan

We have outlined responses to allegations against Ira, Lester and Stan in this case study because they illustrate some significant failings in the responses of the Department and other agencies. They also highlight the complexities of responding to such matters. We recognise that the task of investigating allegations of child sexual abuse by staff is a difficult exercise that requires careful consideration, risk assessment and clear processes and supports for all parties. It requires consideration of risk to children and young people, as well as care towards complainants and fairness towards the staff subject to the allegations. It also requires close cooperation and collaboration across multiple agencies—particularly Tasmania Police and the Registrar. This requires broader systems to be designed and applied in a way that promotes the safety and best interests of children and young people.

Overall, our examination of these case examples revealed that neither occurred; systems were poorly designed or not developed at all and this greatly affected the availability and sharing of information that could enable action to be taken to protect children from potential risks over decades.

The culture we observed within the Department was indicative of an attitude we saw across the State Service—one that focused on adherence to bureaucratic processes and procedures and was conservative about the prospects of substantiating allegations of misconduct. We do not consider such reservations to be entirely unfounded, based on what we learned about the State Service disciplinary framework.

We are also conscious that the Department was beginning to face an unprecedented crisis, with numerous allegations against a substantial number of staff. We have sympathy for the challenge the Department was, and is, facing.

Through the period 2019 to 2020, we would have liked to have seen allegations made against staff treated with urgency, with proactive effort to overcome barriers that produced outcomes that directly placed detainees at risk. We would have also liked to have seen the setting of expectations within the Department that allegations would be addressed and referred without delay. We consider that the circumstances the Department described (of not being able to take action on critical information that suggested staff may be a risk to detainees) should have been intolerable for the Department, yet it was allowed to stand

for years and years. We were not advised of any proposals for legislative change made by the Department to overcome the problems. We were pleased to see more decisive action on 8 November 2020, where there was finally serious consideration of the public interest and a possible pattern of behaviour revealed through multiple complaints. We also welcome the legal advice received in December 2020, which gives the Department greater power to act on abuse allegations it receives about staff.

10 Responses by Tasmania Police

Tasmania Police plays a critical role in keeping children and young people safe from sexual abuse and misconduct and for holding abusers accountable. In this context, we identified several areas regarding Tasmania Police's response to allegations of child sexual abuse by Ashley Youth Detention Centre staff that could be improved, including information-sharing processes, police attitudes, recognising allegations of abuse, overcoming barriers to investigations, and coordinating its response with other agencies.

10.1 Quality and clarity of information held about abuse allegations and deficiencies in reporting processes

We are concerned about the quality and clarity of information we received from Tasmania Police regarding our case examples. In response to our request for information about the reports it received and made, and the actions it took in response to allegations relating to certain Centre staff members, we received multiple iterations of a table of allegations that contained different pieces of information.[3066] While we appreciated efforts to correct information through the course of our Inquiry, we are concerned about the reliability of police mechanisms to track and record this important information.

Also, information provided by Tasmania Police often did not align to the reporting dates or allegations provided by the Department or did not exist at all. For example, while we are aware the Department sent a letter to Tasmania Police on 18 February 2020 about Baxter's allegations against Ira, the police did not provide us with any information about this notification.[3067] It was difficult for us to tell why this was the case.

We also note there have been some significant delays by Tasmania Police in making notifications to the Registrar, as well as instances where it appears no notifications were made—suggesting the automatic notification process adopted was not working as intended. Examples from the case examples we considered include:

- On 9 November 2020, the Department reported allegations raised against Lester through the Abuse in State Care Program to Tasmania Police.[3068] However, the police did not enter these notifications into their intelligence system until 18 August 2022.[3069] As a result, Tasmania Police did not notify the Registrar of these allegations until that time.[3070] We were told this was an oversight by Tasmania

Police and the allegations should have been entered into its intelligence system and reported to the Registrar in November 2020.[3071]

- Tasmania Police told us that it notified the Registrar of Parker's allegations against Ira on 11 August 2022.[3072] This was more than a year after Tasmania Police was notified of the allegations by a third party (and almost two years after the Department says it reported the allegation to the police).[3073]
- Ben's allegations against Stan were reported by the Office of the Solicitor-General to Tasmania Police in November 2021, but were not listed as 'presents a risk to vulnerable people' on Atlas until 19 August 2022.[3074]
- Despite receiving a submission to the National Royal Commission containing allegations against Ashley Youth Detention Centre staff in May 2017, Tasmania Police did not report this to the Registrar through its automated referral process.[3075] Assistant Commissioner Higgins agreed that this is an example of how the process is subject to 'human error'.[3076]

Prompt notifications to the Registrar are particularly important where conduct may not satisfy a criminal threshold but nonetheless may point to a person being a risk to children.

We are also not confident that the information that has been provided to us by police is complete. We have received evidence that the ability to search for an individual is based on the accuracy of information provided and the ability of the police to link that person to a report.[3077] In the past, the manual entry of names meant that people were not identified or linked to a report due to incorrect spelling.[3078] We were told that while this still occurs and the system is 'not always perfect', the process has been improved by requiring the person inputting the data to find the offender's name and date of birth on the system.[3079]

We are concerned about problems with the accuracy and clarity of information held by police because any single piece of information can be vital to a criminal investigation. It is important that police databases enable all relevant information about an individual to be linked, accessible and accurate to give police a complete picture of its holdings. What may seem relatively insignificant in isolation can become crucial as further information emerges and is vital to establishing and understanding patterns of behaviour.

In relation to deficiencies in information provided to our Inquiry by Tasmania Police, we were told that this was due to unintentional oversights in the compilation of the information.[3080] Assistant Commissioner Higgins told us:

> I do accept that our notifications to external agencies relating to Ashley Youth Detention Centre staff have been deficient at times. This has been a result of incomplete, minimal data, or a failure on our behalf to validate information with the Department of Communities on entities identified within reports. To expand on this, incomplete and minimal data relates primarily to Redress and civil claims, where

> information at times can be limited for example to a surname only … Without prior knowledge of the individual, these individuals may not be correctly linked with the occurrence within ATLAS which results in no automatic notification being made to either Communities or Working with Vulnerable People.[3081]

He noted that Tasmania Police had begun a review of matters relating to Ashley Youth Detention Centre to ensure the correct people are linked and accurate information can be provided to other agencies.[3082]

We received evidence that December 2020 was a 'pivotal time' and during this period changes in protocols, guidelines and training led to 94 per cent of sworn police staff members receiving online training, including about requirements for making intelligence submissions and ticking the appropriate boxes for referrals.[3083] Assistant Commissioner Higgins had observed 'a measurable change' and 'more correct reporting' as a result of this training.[3084] He also described systemic safety nets, such as further supervision and audits.[3085] He acknowledged that while there will be human errors on occasion, he generally has confidence in the system, which is now far more robust.[3086]

10.2 Police attitudes towards detainees

We observed concerning attitudes among some police members regarding detainees. We saw detainees being openly described as 'the worst of the worst'.[3087] Some police members also suggested to us that detainees only make complaints to receive compensation and that those processes make it 'too easy' for complaints to be made without being substantiated.[3088]

People with criminal histories can be reluctant to report abuse because of the stigma associated with reporting but also due to distrust of police, an issue we discuss in Chapter 16. Some former detainees told us that staff who inflicted abuse on them told them that no one would believe them because they were just criminals, or that they felt they would not be believed if they made a report due to their criminal history.[3089]

One senior departmental official told us about a conversation they had with a police officer they called to discuss an allegation against an Ashley Youth Detention Centre staff member:

> I distinctly recall the officer I was talking to laughing when I relayed the claims against [the staff member] and the disbelief of this officer that we were taking the steps to suspend the employee as this complainant was apparently from a well-known criminal family, had a long criminal past, and that [their] word should not be trusted, especially when there was money involved.[3090]

At the hearings, Counsel Assisting asked Assistant Commissioner Higgins whether he had any concerns that members of the police may be less open to believing allegations that are made by detainees as distinct from other members of the community.[3091] He told us:

> It's possible. Would it be common practice? No. I think, watching a witness this

> morning, I think you'd only have to watch a victim in that case to realise how raw it is and how compelling their experience is to be able to put your personal view on the veracity of something. So, it's difficult to say. The only thing I'd say to qualify that is that, the sad reality of the detainees at Ashley over lengthy periods is that they have had very long histories with police, so there perhaps is on occasion scepticism.[3092]

Assistant Commissioner Higgins conceded that Tasmania Police needed 'to work on [its] unconscious bias' against detainees.[3093] He also acknowledged the need to educate police officers about abusers using the fact that the children are 'criminals' as a tool to stop them from disclosing because of the perception that no one will believe them.[3094]

We discuss this issue—including the relevant recommendations of the National Royal Commission that directed police to consider the credibility of complaints rather than the credibility of the complainant alone—in Chapter 16.

10.3 Failures to recognise allegations as potential child sexual abuse

As with the Department, we observed a failure by police to recognise some of the alleged conduct as potentially criminal in nature. Our consultation with Launceston Police indicated that police officers had received reports relating to Ashley Youth Detention Centre staff rubbing cream on detainees' genitals, watching detainees in the shower and watching them masturbate.[3095] Some members of Launceston Police told us this occurred in the context of staff doing their job and that it does not constitute child sexual abuse.[3096] This is consistent with the view police have taken in response to similar allegations—for example, allegations of unlawful strip searches.[3097]

We are troubled by this assessment because we consider that, accounting for the relevant context and particulars, including departmental policies that may dictate how strip searches or other procedures in detention should be undertaken, such behaviours may indeed constitute child sexual abuse and should be treated as such. There is now a wider range of offences available to police regarding child sexual abuse following Tasmania's implementation of the National Royal Commission recommendations. This includes broader offences relating to perpetrators but also offences relating to failures by institutions (such as failures to report or act on information). Tasmania Police should always consider the full suite of offences and powers it has when considering allegations, and not make assumptions about the nature of alleged conduct (for example, that it was lawfully undertaken in the course of duties) without further investigation.

10.4 Overcoming barriers to investigations

We acknowledge challenges arise for police when complainants do not want to provide statements or otherwise participate in criminal justice processes—particularly where the alleged conduct may have occurred some time ago and other evidence (such as records or witnesses) may be difficult to secure. Complainant reluctance would be more pronounced among current and former detainees, and police receive information through National Redress Scheme claims and sometimes do not have the name and details of a complainant, often having to go through third parties (such as lawyers or victim support groups) to make contact. Often, too, the complainant has indicated they do not wish to be contacted by police, which should be respected.

We consider that, rather than passively accepting these barriers (particularly in the context of multiple, serious allegations against people working with children) police should adopt proactive policing strategies, including building trust with current and former detainees. Public calls for information or dedicated reporting channels may also demonstrate police commitment to receiving and responding to such complaints. We also note that complainants can believe they are the only victim and, if later advised of other complaints, may change their minds and be more willing to proceed.

10.5 Reducing delay and ensuring institutions do not unduly defer to police

In relation to our case examples of Ira, Lester and Stan, we identified a tendency of the Department to defer to police as a justification for inaction in responding to certain allegations. We recognise that it is appropriate for the Department to consult with Tasmania Police about its intentions to ensure it does not in any way interfere with a police investigation, although note that this should not compromise child safety. As a general observation, once Tasmania Police was notified of allegations, it was often relatively prompt in confirming its intentions (for example, to not investigate an allegation further) to clear the way for the Department to pursue disciplinary action. We consider this important.

However, we also consider it important that Tasmania Police is aware of the need to manage the active risks posed by those who are the subject of allegations and its role in reminding institutions of their responsibilities to keep children safe while investigations occur. Risk management may need to be designed on a case-by-case basis and in a collaborative way between Tasmania Police and the relevant institution. We consider the introduction of Tasmania's Reportable Conduct Scheme (discussed in Chapter 18) so that responses to allegations of abuse within organisations are overseen by an Independent Regulator, will ensure this occurs.

We note that, following acknowledged failings in police responses to information received around now deceased abuser James Griffin (discussed in Chapter 14), Tasmania Police has initiated a range of reforms to improve and clarify its responses to reports of child sexual abuse. These are described in Chapter 16. It is important that these reforms are applied equally to consideration of safety for children in the community and those in the care of the State, including in youth detention.

Finding—Tasmania Police should improve its responses to allegations of child sexual abuse made by current and former detainees at Ashley Youth Detention Centre

While we recognise several recent improvements, Tasmania Police must continue to improve its responses to allegations of child sexual abuse made by current and former detainees at Ashley Youth Detention Centre. This includes responding to allegations made against former Centre staff. The fact a child or young person has previously engaged in criminal behaviour does not, and should not, deny them the right to live free from abuse and harm and to have any allegations they make taken seriously and investigated thoroughly.

In Chapter 16, we make several suggestions and observations about how Tasmania Police can improve its responses to child sexual abuse, but note in the context of this case study that Tasmania Police should improve its responses to this cohort in the following ways:

- Adopt proactive strategies to build trust with current and former detainees.
- Implement and further embed the recommendations of the National Royal Commission as they relate to complainants who may have criminal histories—by avoiding judgments of character or assessments of credibility based solely on views about the character of the complainant rather than the nature of the complaint.
- Improve its information-sharing and referral practices to ensure other agencies (including Child Safety Services and the Registrar) receive information, where appropriate, to enable those agencies to take steps to protect the safety of detainees.
- Improve record keeping to ensure all allegations and information received is accurate, accessible and appropriately linked to relevant individuals. It is important that any piece of information relating to child sexual abuse is treated as potentially important so that police can identify patterns of behaviour over time.

- Investigate all allegations thoroughly using all available tools, powers and potential offences available. While we accept police will not always be able to pursue an investigation without the participation of a complainant, we consider there may be instances (for example, where there are several past complaints) where police may be able to form a basis for actions, such as obtaining a search warrant to try to elicit further information. Police may also be able to interview other potential witnesses to gather information (for example, other staff) or re-engage with past complainants to see whether they may wish to proceed with a formal complaint at a later time (particularly if other complaints have been made since).
- Specifically regarding allegations made by current or former detainees in youth detention, police need readily accessible guidance on Tasmanian law on personal searches, isolation and use of force so they can quickly identify when the alleged conduct falls outside of the parameters of acceptable professional conduct and may indicate a crime has occurred.

11 Responses by the Registrar of the Registration to Work with Vulnerable People Scheme

The Registrar plays one of the most important roles in the context of responding to allegations against staff in institutions.

The Registrar has a primary focus on the safety of vulnerable people, including children, in its decision making and is often not bound by the limitations of other agencies (such as the Department, which must act within a rigid industrial framework, or Tasmania Police, which requires allegations to suggest there has been a defined criminal offence and to meet higher standards of proof). A loss of registration can also protect children in a wider range of settings beyond the institution where the allegations arise. For example, state servants who are the subject of allegations may also rely on registration to volunteer with children or to be foster carers. However, we recognise that the loss of registration—particularly for those in child-facing roles—has serious impacts. It can end their career and preclude them from undertaking a wide range of activities in the community. Therefore, it is proper and appropriate that the Registrar acts carefully in making adverse decisions and has the best possible information to do so.

The Registrar told us that, as of 15 August 2022, there were 16 current or former Ashley Youth Detention Centre staff who continued to be subject to an additional risk assessment.[3098] We received evidence that, at that date, no negative Employment

Direction No. 5—Breach of Code of Conduct outcomes had been provided to the Registrar relating to Ashley Youth Detention Centre staff.[3099] Describing the impact of these delays on the Registrar's functions, the Registrar told us:

> … we don't have outcomes from investigations that started in November 2020, nor do we have any real appreciable information that's come from those investigations that would enable us to make decisions to remove people from settings where they may cause harm.[3100]

The Registrar has significant powers to suspend registration and has issued some suspension notices on the basis of the volume or similarity of allegations against a registered person before police or employee conduct investigations begin, charges are laid or findings made.[3101] However, given the challenges associated with allegations that lack specificity, are isolated in nature and in respect of which there are not timely investigatory outcomes, there are some cases where the Registrar considers it is not appropriate to suspend registration while another risk assessment is undertaken.[3102] We discuss this in Chapter 18.

We received evidence that the Registrar experienced several challenges and frustrations in executing his functions in relation to information he received regarding allegations about staff in Ashley Youth Detention Centre.

In December 2020, the Registrar was provided with a spreadsheet with more than 300 allegations of child sexual abuse and physical abuse relating to current and former Centre staff. We were told that the Registrar assumed this was a starting point for receiving further, more comprehensive information. However, it became clear in February 2021 that there was:

> … an apparent reluctance within parts of [the Department] to share records from the redress scheme under reportable behaviour obligations in the [Registration to Work with Vulnerable People] Act.[3103]

We understand that, in mid-2021, many Ashley Youth Detention Centre staff were due to renew their registration and that the Registrar felt that he could not decide that the members of staff posed an unacceptable risk (thereby removing their registration) without more information.[3104]

In light of the difficulties the Registrar faced, in March and April 2021, the Registration to Work with Vulnerable People Unit began a full review of the spreadsheet provided to it by the Department in December 2020 to log reportable behaviour and start additional risk assessments.[3105] However, this resulted in only eight registered people being identified.[3106] In an attempt to verify the identities of the remaining records included in the spreadsheet, requests for information were sent to the Department. This included clarifying names or dates of birth of persons named in the spreadsheet.[3107]

We understand that in response to one of these requests from the Registrar, the Department confirmed it was seeking advice on releasing information about redress claims and confirmed on 16 March 2021 that it could provide all relevant information about redress claims to the Registrar.[3108] We understand this approach was adopted after the Department sought legal advice about the Registrar's powers to request information.

The Department received advice from the Office of the Solicitor-General dated 12 March 2021, that indicated the Registrar could request such information and there was no barrier to sharing this information with the Registrar under the Personal Information Protection Act or the National Redress Scheme legislation.[3109] We note the 15 December 2020 legal advice (discussed in Section 9.8) had previously indicated that the legislation permitted the use and disclosure of such information in certain circumstances.[3110]

We were told that, over the period from May 2021 to August 2022, the Department provided information about reportable behaviour relating to a further 14 current and former staff concerning conduct that occurred at the Centre.[3111] However, we received evidence that the Department did not respond to requests for information in a timely way. The Registrar told us that his office had made more than 80 requests for information and that it took the Department up to a year to respond to some of these requests.[3112] Sometimes the records ultimately provided by the Department did not contain much more information than the Registrar already had.[3113] We have noted the problems the Department had with record keeping and accessing records throughout this case study.

The Registrar reported difficulties his office faced around limited particulars on allegations raised through the National Redress Scheme—sometimes due to limited information within the claim itself but also because the Department had not always provided all relevant information.[3114] We note that until at least October 2020, the Department had less information about these claims than the Department of Justice. We return to this issue in Section 12.

The Registrar told us that, even though requests were made to the Secretary in November 2020 for continuous disclosure from Employment Direction No. 5 investigations, the Department had not provided records about such investigations, which form a vital source of information for the Registrar.[3115]

The Registrar highlighted delays in appointing investigators to undertake Employment Direction No. 5 investigations, giving the example that one of the staff members who was suspended in November 2020 was yet to have allegations put to him as of July 2021.[3116] The Department told us that typically the Minute recommending the commencement of an Employment Direction No. 5 investigation includes the relevant appointment documentation for the investigator, but acknowledged there were sometimes delays associated with securing suitably skilled and trained investigators and gathering all the necessary records.[3117] Also, the Registrar noted that there were no investigations into allegations where the alleged abuser was a former staff member.[3118]

The Registrar also reported that often responsibility for managing such matters in the Department would shift multiple times between People and Culture, Legal Services and the Records and Program areas 'with a sense that no area particularly saw themselves as accountable'.[3119] Secretary Pervan acknowledged that there were some restructures within the Department, but that at the time of our hearings there was greater resourcing of the records and legal areas to support such processes.[3120]

Describing his decision to send the Department 80 requests for information in 2021, the Registrar accepted that even though his role is not investigative, his unit was forced to adopt a quasi-investigative role to progress matters:

> … these were allegations of particularly grave conduct, albeit with no real particulars, so it was very hard: you're sort of sitting with something that you need to make a decision on, potentially a suspension decision on, but you don't really have information about it, so trying to understand more about the people who were alleged to have taken it was a vital kind of step.[3121]

The Registrar told us that, in July 2021, his frustrations with the lack of information being provided led him to consider whether enforcement action was necessary to compel the Department to produce records.[3122] However, he ultimately decided to instead insist on regular meetings with senior departmental representatives who acted as a clearinghouse for the information requests and status updates.[3123] The Registrar observed it was not until the second half of 2021 that information flow improved.[3124] We discuss this in Section 14.1.

Some senior departmental officials disagree there was 'reluctance' within parts of the Department to share records, at least on their own part.[3125] Ms Clarke and Ms Baker told us that it was not until August 2021 that the Registrar raised his concerns about the timeliness of the Department's response, which was followed by a series of regular meetings initiated by the Department providing 'a regular forum to address any concerns', which they considered to be effective.[3126]

During our hearings, senior departmental officials told us that the delays in reporting to the Registrar were a function of the Department's record-keeping practices and that its records remediation project, discussed in Section 13.2, resulted in the Department being able to respond to requests for information more efficiently.[3127] Ms Baker acknowledged that the Department needed to respond to the Registrar's requests for information in a more timely manner, although noted that once this was brought to her attention, she met the Registrar within two days to address this issue.[3128] We were told, however, that the Department often experienced the same limitations with information as experienced by the Registrar, noting that it often had 'non-specific allegations of concern, but without concrete information on which to make a decision'.[3129]

We identified multiple discrepancies between when agencies told us they had reported information to the Registrar and the information held by the Registrar. We have not been able to determine whether the differences were caused by errors in reporting, the receiving of information or the recording of this information. Nevertheless, we are concerned that the Registrar may not be aware of all relevant information and is not always receiving information as quickly as possible.

While we acknowledge the difficulties the Registrar faced in obtaining prompt and clear information to inform his decision making, based on our case examples, we consider the Registrar occasionally adopted too high an evidentiary threshold in assessing risk, rather than undertaking prospective risk assessment. We consider the Registrar is uniquely placed to put children's safety at the forefront of decision making and should consistently do so.

Finding—On occasion, the Registrar of the Registration to Work with Vulnerable People Scheme appeared to adopt too high an evidentiary threshold in assessing whether staff with allegations against them posed an unacceptable risk to children

As we have emphasised throughout this case study, the Registrar plays a central role in responding to risks to children in institutional settings. Their primary focus is on protecting vulnerable people, including children, from risks of harm. While the Registrar is required to extend procedural fairness to parties subject to its decisions and should recognise the weight of decisions on the lives and livelihoods of registered individuals, the Registrar is not required to 'prove' or 'substantiate' allegations in the same way that an employer may need to so as to apply disciplinary sanctions (on the balance of probabilities) or police must so as to secure a criminal conviction (beyond reasonable doubt). Rather, the Registrar is required to undertake an assessment of future risk to vulnerable people, including children. We consider this gives the Registrar greater scope to act on concerning information that suggests risk, including considering patterns and coincidence in assessing a body of allegations, and a broad array of corroborative evidence. The Registrar must be enabled and willing to adopt this approach.

In our case examples, we observed that the Registrar sometimes imposed too high a threshold when assessing risks to children. We accept the evidence of the Registrar that his decision making was sometimes hampered by belated or incomplete information from the Department. However, we consider it important that the Registrar maintains a focus on future risk, unimpeded by industrial or union concerns.

We make a detailed recommendation regarding the statutory guidance which the Tasmanian Government should provide to the Registrar in respect of risk assessments in Chapter 18.

12 Department of Justice responses to National Redress Scheme claims

In Section 3.1.2, we described the processes the Department of Justice used to get information from agencies to respond to queries from the Scheme Operator of the National Redress Scheme. In Section 9.4, we also outlined how some Department of Communities processes for responding to sharing information requests from the Department of Justice improved from October 2020.

In this section, we discuss previous concerns raised about the Department of Justice's sharing of information received under the National Redress Scheme. We also explain that the Department of Justice does not have a process for making notifications to relevant agencies based on information it receives from the Scheme Operator related to National Redress Scheme claims.

12.1 Concerns with information sharing between the Department of Justice and the former Department of Communities

Before at least October 2020, the Department of Justice's practice was to only share a summary of the information it received from the Scheme Operator, unless and until an agency specifically requested more information.[3130] We were told that this was to reduce vicarious trauma on staff who may be responsible for reviewing the information.[3131]

In 2019, concerns were raised within the Department of Communities that the information provided to agencies by the Department of Justice in respect of at least some National Redress Scheme claims was not enough to facilitate a 'thorough investigation'.[3132] We also identified at least one example where the name of an alleged abuser was not included in the 'National Redress Scheme – Request for Information' form (despite being known to the Department of Justice), which limited the Department of Communities' ability to act on that information.[3133]

The State told us the Department of Justice changed its practice in October 2020 and now provides everything it holds in respect of each National Redress Scheme application to the relevant agency.[3134] Secretary Pervan also recalled discussions at a multi-agency meeting between the Department of Justice, the former Department of Communities and others on 7 December 2020 that he considered ultimately led to

changes to the amount of detail the Department of Justice would provide to agencies in respect of National Redress Scheme claims and how quickly the information was provided.[3135] Secretary Pervan also said that this meeting led to a new process for contacting redress applicants to gauge their willingness to participate in investigations (such as police investigations or disciplinary investigations initiated by a department).[3136] Secretary Pervan did not elaborate on the specifics of these changes.

We also received evidence about a cross-agency meeting on 8 December 2020 at which attendees discussed the need to ensure there was information sharing between agencies, including to identify whether an employee may have moved from one agency to another.[3137]

Given this evidence, we are unclear as to the timing of the change in the Department of Justice's practice but accept it occurred at some point in late 2020. We welcome this change.

We are concerned, however, that prior to at least October 2020 there was not a robust process for sharing information about National Redress Scheme claims that ensured all relevant information was provided to agencies completing a 'National Redress Scheme – Request for Information' form. As noted by Secretary Webster, the relevant agency is required to deal with allegations against current employees through its own internal policies.[3138] By not consistently providing complete information to the agency, this already challenging task became more difficult because of the fragmentation and omission of information. We would be concerned if a focus on protecting staff from trauma had a negative impact on the Department's ability to make an appropriate assessment about risks to children, noting staff trauma must and can be addressed in other ways. Adding an extra step of summarising material also created greater risks of delays.

12.2 Making reports and notifications

The Department of Justice is often the first Tasmanian agency to receive allegations through the National Redress Scheme, but we were told it does not take any steps to report these allegations to authorities, including Tasmania Police, Child Safety Services and the Registrar.[3139]

We asked Secretary Webster what action the Tasmanian Government takes regarding information acquired during the National Redress Scheme process, beyond responding to information requests from the Scheme Operator about individual applications, including whether reports are made to Child Safety Services or Tasmania Police.[3140] Secretary Webster told us in response on 20 June 2022:

> The Department [of Justice] does not use the information obtained through redress applications for any purpose outside responding to the Scheme Operator save for reporting on de-identified figures in annual reports.

> I am unable to comment on what other Tasmanian Government agencies do in respect of information acquired during the National Redress Scheme process with the exception of current employees who are alleged abusers are dealt with by internal Agency policies.[3141]

12.2.1 Reporting to Tasmania Police

We were told the Department of Justice does not report matters to Tasmania Police.[3142] The National Redress Scheme's *Operational Manual for Participating Institutions* states that the Scheme Operator will report certain information directly to law enforcement, so Tasmania Police would be notified directly of some matters ahead of the Department of Justice and could then activate its processes to share information with the Registrar and Child Safety Services, where relevant. Tasmania Police also told us that if it received a report from the Department of Justice this may result in some duplication. It also told us that if it received a report regarding a matter from the Department of Justice, without identifying particulars, it might need to contact the responsible agencies to seek similar additional identifying particulars as the Department of Justice might also request from those agencies.[3143]

Tasmania Police also told us that if it received a report from the Department of Justice this may result in some duplication. It also told us that if it received a report regarding a matter from the Department of Justice, without identifying particulars, it might need to contact the responsible agencies to seek similar additional identifying particulars as the Department of Justice might also request from those agencies.[3144]

While we accept that the Department of Justice is relying on the National Redress Scheme's *Operational Manual for Participating Institutions* as reason to not make notifications to Tasmania Police, we are not sufficiently confident in that process (and in Tasmania Police's systems to make appropriate notifications). For example:

- The Department of Communities told us it reported certain National Redress Scheme allegations to Tasmania Police in October 2020, but Tasmania Police told us it received this from the Scheme Operator in June 2021.[3145] There were delays in Tasmania Police referring these allegations to the Registrar. The Department of Justice will have had this information before the Department of Communities.
- The Abuse in State Care Program claims relating to Lester were provided to Tasmania Police in November 2020, but it took Tasmania Police 21 months (in August 2022) to forward these to the Registrar.[3146] While this information was not about a National Redress Scheme claim, it illustrates the risk of relying on police reporting to the Registrar.

In Chapter 12, we discuss this issue in more detail and recommend that the Tasmanian Government advocates for changes to the National Redress Scheme operating procedures.

12.2.2 Department of Justice reporting to the Registrar

We are also concerned about the fact that the Department of Justice does not report the information it receives from the Scheme Operator to the Registrar and consider this would, in some circumstances, be a breach of the Registration to Work with Vulnerable People Act.

We consider that the Department of Justice did not, at the introduction of the National Redress Scheme, have appropriate processes in place to maximise the information it received from the Scheme Operator to inform decision making by the Registrar. This compromised responses to allegations received about Ashley Youth Detention Centre staff, particularly in contributing to delays. While we welcome changes made in October 2020 to ensure agencies are provided with complete information received from the Scheme Operator, we consider the issue of the Department of Justice not making reports to be a continuing problem.

We were given the following reasons why the Department of Justice does not report information it receives to the Registrar:

- The Department of Justice would often not have enough information to make a meaningful report and agencies would be in a better position to make notifications, noting that National Redress Scheme claims do not consistently have clear information about the identity of an abuser.[3147]
- The Registrar may become aware via a notification from Tasmania Police before the Department of Justice receives it through the process described in Section 12.1, which makes the need for the Department of Justice to report redundant.[3148]
- Too many notifications, particularly if based on incomplete information, may overwhelm agencies (such as the Registrar) when they are not necessarily able to act on that information.[3149]

We were also told there was ambiguity around the Department of Justice's obligation to report to the Registrar prior to the legislative clarification from 1 February 2021. Noting that the Department has not changed its practice since that time, we do not consider this legal advice to be determinative but consider it does reflect an attitude within the Department of Justice that was overly cautious and conservative in its approach to making notifications. This is curious given the Registrar sits within the Department of Justice and, based on our case examples, the Registrar seemed to have adopted a broad interpretation around what could, and should, be reported.

As we describe in Sections 3.1.2 and 9.3, there was some confusion around when a reporting obligation arose before 1 February 2021, given the uncertainty about whether a 'finding' of reportable conduct had been made such that the obligation arose. We note that the Department of Justice received legal advice from the Office of the Solicitor-General in September 2018 that the making of a 'finding' following an investigation under

the *State Service Act 2000* was a prerequisite for the Department of Justice to make a report under section 53A of the Registration to Work with Vulnerable People Act (which imposes a duty to report concerns about a risk of harm to a child to the Registrar).[3150]

This obligation was clarified in the legislation in February 2021 to impose an obligation on a reporting body to notify the Registrar where it 'becomes aware by any means, or suspects on reasonable grounds that a registered person has engaged, or may have engaged, in reportable behaviour' (that being, in this instance, behaviour that poses a risk of harm to a child).[3151] As noted above, Secretary Webster's evidence on 20 June 2022 was that the Department of Justice still did not report these National Redress Scheme allegations to the Registrar.

We also note that the Department of Justice was aware of the expansive interpretation given by the Registrar to the meaning of the word 'finds' before the legislative amendments in 2021, with the Department of Justice's request for legal advice to the Office of the Solicitor-General of 15 August 2018 stating:

> The word 'finds' is not defined in the Act. However, based on the object of the Act, the functions and powers of the Registrar under the Act, the purpose behind the amendment of the Act to insert section 53A, and the successful application to date of section 53A by other reporting bodies; it is the Registrar's position that the word should be given its ordinary meaning such as: 'to come upon by chance', 'to learn, attain or obtain by search or effort', 'to discover'.[3152]

This broad interpretation is consistent with advice given by the Registrar to the Department in mid-2020, as we discuss in Section 9.3.

The Department of Justice's request for legal advice also indicates an appreciation of the 'flexible approach' provided for in the Second Reading Speech to the legislation, as well as the difficulties in requiring a finding to be made before reporting to the Registrar, stating:[3153]

> If section 53A was interpreted with the narrow interpretation (ie 'a finding' as opposed to 'finds') and the Registrar were to wait until the reporting body made their own 'finding' on a matter prior to the information being reported then … it could be a matter of months, if not years until the matter is reported to the Registrar …
>
> The duty of reportable bodies to report behaviour is relevant to whether a person remains acceptable to work with vulnerable people. It is crucial for the purposes of monitoring and compliance that the Registrar is informed in real time of *any* behaviours that by definition, pose a risk of harm to vulnerable persons … [3154]
> [Emphasis in source.]

Irrespective of whether there was a duty to report a risk of harm to a child before the legislative changes in February 2021, it would have been best practice to report information obtained through the redress scheme to the Registrar.[3155]

While we accept that the Department of Justice will not always have enough information to make a notification to the Registrar, where it does, we consider it should. This is because:

- This ensures the Registrar receives the information at the earliest opportunity and is 'on notice' to contact relevant agencies for further information, where needed.
- The Registrar has identified (described in Section 11) that there is a lack of consistency in the way different agencies and departments approach their reporting obligations; the Department of Justice reporting would go some way in standardising this. Our case examples revealed delays in the former Department of Communities making notifications to the Registrar that could have been avoided if the matter was already reported by the Department of Justice.
- The Scheme Operator's reports to Tasmania Police would not necessarily capture all the information that constitutes 'reportable behaviour', which is broader than the type of matters that constitute a criminal offence. We consider that the Scheme Operator, as an Australian Government agency, is not best placed to determine some of the criteria for reporting (for example, we consider it less likely to be aware of whether an alleged abuser is working with children compared with Tasmanian agencies).

We discuss this in greater detail, and make a recommendation in this regard, in Chapter 12.

Finding—The Department of Justice does not have an appropriate process to ensure information in National Redress Scheme applications is shared in a timely manner to protect children

We are concerned that the Department of Justice does not appear to have a process for reporting allegations provided to it through the National Redress Scheme to the Registrar. As a reporting body under the Registration to Work with Vulnerable People Act, the Department of Justice is obliged to notify the Registrar of 'reportable behaviour'.[3156] We were surprised that the Department of Justice, which administers the Registration to Work with Vulnerable People Scheme, does not refer allegations received through the National Redress Scheme as a matter of course. Although it does not receive all information associated with each National Redress Scheme application from the Scheme Operator, it is well placed to make an initial notification to the Registrar if it has enough information to do so, to reduce any delay.

We consider the Department of Justice should have set up a process to immediately refer these matters to the Registrar where it has enough information to do so and made it clear to relevant agencies from which it was seeking further information that any other information or reportable conduct held or obtained by those departments should be reported separately to the Registrar. Delaying giving information to the Registrar delays the Registrar's ability to take appropriate steps for assessing a person's suitability to be working with children. It also relies on all other departments making notifications appropriately.

The Department of Justice also has reporting obligations to Tasmania Police and Child Safety Services. It should put in place a process for making all relevant reports.

13 2021—Departmental initiatives to improve records and processes

Below we outline some other initiatives progressed by the Department from 2021 to improve its responses to allegations of child sexual abuse by Ashley Youth Detention Centre staff. It will be recalled that our Commission of Inquiry was formally established by Order of the Governor of Tasmania on 15 March 2021.[3157]

13.1 January 2021—Multi-agency budget bid to improve records relating to child sexual abuse

During our public hearings, we were informed of a State Budget bid that was made to Cabinet in 2020 to seek funding for the State's response to our Commission of Inquiry, including a proposal to improve the quality and accuracy of records held that may relate to child sexual abuse.[3158] Following our hearings, we sought copies of relevant budget documentation supporting that proposal.[3159]

In January 2023, the State advised us that a 2020 multi-agency State Budget bid was prepared by the agencies that anticipated being most affected by our Inquiry's work.[3160] Those agencies were the former Department of Communities, Department of Education, Department of Health, Department of Justice and Department of Police, Fire and Emergency Management.[3161] We were told that, as part of this budget bid, the Department of Communities made a bid to Cabinet for a large-scale records remediation and centralisation of historical records.[3162] The budget bid to Cabinet was unsuccessful.[3163]

We have not reviewed the 2020 budget bid documentation, noting that these are subject to privilege on the basis that they are cabinet-in-confidence documents.[3164]

We discuss the Department's records remediation project below, which eventually began in May 2021 following the approval of an internal budget bid.

13.2 May 2021—Departmental records remediation project

Throughout this case study, we have described significant problems with the quality and accessibility of the Department's records. We know records are extremely important in child sexual abuse matters because they often provide an evidentiary basis for initiating legal, criminal or disciplinary actions. They also help victim-survivors understand important information about their past experiences, including the circumstances surrounding their abuse. As set out in the National Royal Commission report, inadequate records and record keeping have contributed to failures in identifying and responding to risks and incidents of child sexual abuse and have exacerbated distress and trauma for many victim-survivors.[3165]

We understand there have been significant delays in releasing files and documents to people who request them, such as former detainees. We were told there were more than 300 applications for personal files outstanding in March 2021 and, at that time, nearly a two-year wait time for these to be assessed and released.[3166]

After the broader budget bid discussed in Section 13.1 was unsuccessful, in or around May 2021, internal funding was approved to enable records remediation work to progress in the Department.[3167] The Department initiated the Records Digitisation and Remediation Project to centralise historical records from 2000 onwards (partly to support its responses to our Commission of Inquiry, noting our focus begins on this date).[3168] A team of eight people in the records area began the digitisation work and the Department's legal services area was given resources to enable it to dedicate the time to process personal information and requests through the Right to Information Scheme.[3169]

Ms Baker said this was a 'significant piece of work' where the Department needed to 'identify what record holdings that we had', 'catalogue those record holdings' and 'remediate and digitise those records'.[3170] She told us that this resulted in the Department having a 'fuller set of information' that it could then make available to Employment Direction No. 5 investigators and to the Registrar.[3171]

In relation to the release of client files, we understand that during the period from March 2021 to April 2022, there had been 312 applications for information processed and released. Another 86 applications remained outstanding as of April 2022, and the Department for Education, Children and Young People agreed that the team dealing with information requests would continue until November 2022 to allow the work to progress further.[3172]

We welcome the Department's investment and improvements to record keeping and make further recommendations to strengthen the integrity of files and the thoroughness (and completeness) of attempts to locate and triangulate multiple sources of information containing allegations relating to staff in Chapter 12.

13.3 Mid-late 2021—More flowcharts are developed clarifying process for responding to allegations against staff

From 2021 onwards, some additional flowcharts were developed to guide the Department's responses to allegations received about staff more broadly, including notifications processes. We describe these flowcharts, and our reflections on them, below.

13.3.1 Department of Communities flowchart: 'Common Law Claim, State-based Redress (historical), National Redress Application or other information received by People and Culture'

In Section 9.4, we describe a flowchart the Department developed in October 2020 for responding to information received through National Redress Scheme claims. In late 2021, the Department developed a new flowchart that aims to clarify the processes the Department follows on receiving allegations against current employees (whether under a civil claim, through a redress scheme or some other source).[3173] We understand this exists and applies in addition to the flowchart prepared in October 2020.

The 2021 flowchart provides that once information about allegations against staff is received through any means, People and Culture conducts a factual check of the alleged abuser's employment details and undertakes a risk assessment. If there is an immediate risk of harm to children, the following steps are taken:

- Immediate action is taken to manage the risk (such as removal from the workplace or variation of duties).
- A verbal report is provided to the Secretary.
- The Head of the State Service is notified if the abuser is removed from the workplace and an Employment Direction No. 5—Breach of Code of Conduct investigation is likely.
- A preliminary assessment is conducted.[3174]

Where it is determined that there is no immediate risk to children and young people, People and Culture proceeds to conduct a preliminary assessment without taking the above steps.

In all cases, the Department notifies 'relevant external bodies', such as the Registrar and Tasmania Police, if required.[3175]

The flowchart indicates that the preliminary assessment includes considering the role of the employee, the nature (sexual or physical) and severity of the allegation, other prior matters, available records (such as incident reports and health records) and questioning other employees. Relevantly, the flowchart states:

- If there is information that the Secretary could use to form a reason to believe a breach of the State Service Code of Conduct may have occurred, a Minute is provided to the Secretary with a recommendation for investigation and suspension.[3176]
- If there is not enough information for the Secretary to form a reason to believe a breach of the Code of Conduct may have occurred, a Minute is provided to the Secretary with other recommended actions, including putting the allegations to the alleged abuser for response, varying their duties or taking no action.[3177]
- Where putting the allegations to the alleged abuser results in more information that the Secretary could use to form a reason to believe a breach of the Code of Conduct may have occurred, a Minute to the Secretary is provided with this recommendation. Where the alleged abuser provides no such further information, the Department keeps the allegations on file and closes the matter (which is reopened if more information is received).[3178]

13.3.2 State Service Management Office flowchart: 'State Servant Suspensions due to Allegations of Child Sex Abuse – Notification Process'

We were also provided with a flowchart titled 'State Servant Suspensions due to Allegations of Child Sex Abuse – Notification Process', which we were told was prepared by the State Service Management Office for agencies to implement.[3179] It is unclear when this flowchart was created, although the document we have been provided is dated 22 April 2021. We are unclear whether and how this relates to the flowchart discussed in Section 13.3.1.

This flowchart indicates the following:

- Where an agency is aware of an allegation, it conducts a preliminary assessment including an assessment of the 'risk of an employee remaining in the workplace including duty of care and public perception'.[3180] The employee is directed to not attend the workplace.
- The agency informs the police via the approved template.[3181]

- The Head of Agency immediately notifies the Head of the State Service verbally of the allegation and preliminary assessment.[3182]
- The 'ED5 investigation remains pending, awaiting Police advice (i.e. not commenced; or on hold if commenced)'.[3183] Once the police advise the agency that there is no further police action or charges laid, the agency proceeds with the formal Employment Direction No. 5 investigation, suspends the employee (where appropriate) and updates the 'ED5 register' (including to indicate that the police assessment is now complete).[3184]
- Where a formal investigation has begun, the Head of the State Service also notifies the Premier, and the Head of the State Service or Premier informs the Minister.[3185]

13.3.3 Our observations

While we commend efforts to clarify processes for responding to allegations of abuse, we still have some reservations about this guidance. We consider aspects of these guidance materials could be clarified and further strengthened. For example:

- It is unclear how various flowcharts (including those described in Section 13.3 and the October 2020 guidance on responding to National Redress Scheme claims) are intended to operate together, noting that they have slightly different wording, emphases and requirements. For example, the 'State Servant Suspensions due to Allegations of Child Sex Abuse – Notification Process' provides for both the Premier and the Minister to be advised, which is different from other guidance. A single source of guidance would be preferable.
- The guidance often lacks specific timeframes in respect of key activities—including the conduct of a preliminary assessment or investigation, or notifications to external agencies. Given the significant delays we observed, we consider this a significant omission.
- Enabling reliance on verbal reporting (to the Secretary, for example) risks incomplete records. Where a verbal report is made to the Secretary, we consider it should require a written report to follow as soon as possible in the interests of timely and accurate record keeping and to create greater accountability.
- It is not clear from the flowcharts exactly who is responsible for which tasks (for example, who is responsible for providing the verbal report to the Secretary). Given the confusion we observed about respective responsibilities on these matters, we consider it necessary for guidance to be explicit around the roles.
- The 'State Servant Suspensions due to Allegations of Child Sex Abuse – Notification Process' appears to give unqualified deference to Tasmania Police advice without any guidance on how to mitigate risk in the interim and to continue to actively engage with Tasmania Police to minimise delays.

- The 'Common Law Claim, State-based Redress (historical), National Redress Application or other information received by People and Culture' flowchart does not offer enough clarity on when informal practices (such as putting allegations to staff) are appropriate other than there being 'insufficient information'. We acknowledge that there may be times when an informal approach is appropriate (such as when there is a first-time minor boundary breach by a staff member). We consider that the nature and number of allegations should be a key consideration as to whether such an informal process is appropriate. We also consider that all efforts should be taken to quickly gather information (including, for example, by seeking to engage with a complainant) before this course of action is taken. In all circumstances, the allegation and outcome of the process should be recorded on the employee's personnel file.

14 2021–2022—The Department continues to respond to allegations against staff

We heard that the case examples of Ira, Lester and Stan reflected a significant learning curve for the Department and were assured things had since changed. For example, Ms Clarke told us:

> … those three matters that you're talking about from my perspective of the Deputy Secretary, the Department started to enter into really unchartered territory. I think it matured in its capacity very, very quickly, I think it was a team effort; of course, learning occurs in those circumstances, and those particular matters, I think, from that, what we actually did see is the Department mobilised. In response to, when a comparison between those and today, I actually think it's vastly different.[3186]

We note some welcome improvements and investments in responding to allegations of child sexual abuse from late 2020 onwards. However, we observed continuing difficulties in the Department's response to allegations made against other Ashley Youth Detention Centre staff in 2021 and 2022, when the Department continued to receive more allegations against staff.

We did not investigate more recent responses as closely because they arose after our Commission of Inquiry was established. Accordingly, we set out below only our high-level observations of these matters.

The Department told us that, as of 20 July 2021, it had received the following allegations in 2021:

- Sixteen National Redress Scheme claims contained allegations against Ashley Youth Detention Centre staff (or those of its predecessor, the Ashley Home for Boys), some of which contained multiple allegations against multiple staff, during the period from 1998 to 2009.[3187]
- One civil claim regarding Ashley Youth Detention Centre contained allegations against multiple staff members during the period from 2002 to 2008.[3188]
- There was an allegation made through the Department that a staff member had forcibly stripped a detainee during the period from 2015 to 2016.[3189]

At the time, the Department was aware of allegations included rape, sexual abuse while strip searching (including digital penetration of a detainee's anus), being watched in the shower, being forced to watch staff members masturbate and the placement of lotion on detainees' genitals.

We also received a spreadsheet from the Department that, based on our analysis of its content, states that in the period from 20 July 2021 to 25 May 2022, the Department received another 54 claims about child sexual abuse at Ashley Youth Detention Centre (six civil claims and 48 National Redress Scheme claims).[3190] Of the 54 claims received during this period, 51 claims named Ashley Youth Detention Centre staff members (or those of its predecessor, the Ashley Home for Boys) as alleged abusers and the allegations relate to conduct over the period from 1997 to as recently as 2019.[3191]

Further, we received evidence that suggests many more civil claims have been issued in relation to physical abuse at Ashley Youth Detention Centre, with a briefing for the Minister for Children and Youth dated 4 November 2021 stating that, as of 18 October 2021, there were 42 civil claims related to allegations of physical and/or child sexual abuse that involved the Department (or its predecessor).[3192]

Also, on 11 August 2022 a class action was commenced in the Supreme Court of Tasmania on behalf of more than 100 former Ashley Youth Detention Centre detainees, with more claimants being added at the time of writing.[3193] We discuss the allegations raised in this class action in Case study 1, but note briefly here that the lawyers acting for the plaintiffs in the class action, Angela Sdrinis Legal, told us that they act for more than 150 clients who allege abuse at Ashley Youth Detention Centre and its predecessor, and that complaints include allegations of child sexual abuse spanning 40 years.[3194] As discussed in Section 9, the Department was aware that this class action was looming in 2020 and the impending class action was discussed at the Strengthening Safeguards Working Group meetings in late 2020.[3195]

Our analysis of the information provided to us indicates that in each of 2021 and 2022, the Department began Employment Direction No. 5—Breach of Code of Conduct investigations against and suspended four Ashley Youth Detention Centre employees (a total of eight suspensions over those two years).[3196]

In April 2022, the Department had also prepared a Minute recommending suspending and initiating an Employment Direction No. 5 investigation into another Ashley Youth Detention Centre employee, although this was ceased when the employee resigned.[3197] We understand that the Department began preliminary assessments for three more Ashley Youth Detention Centre employees but that these did not proceed to an Employment Direction No. 5 investigation or suspension and no further action was taken.[3198]

In August 2022, we heard that the Department had lowered the threshold required for triggering an Employment Direction No. 5 investigation where there was an allegation of child sexual abuse, and that a child raising an allegation would be much more likely to be regarded as 'reasonable grounds' for an investigation even before other extensive evidence was sought.[3199]

As of January 2023, there were 10 investigations under Employment Direction No. 5 that were outstanding, despite those investigations beginning between November 2020 and May 2022.[3200] Two other investigations had not been progressed because the employee resigned.[3201] Secretary Pervan told us that investigations have been prioritised but that they have 'all taken an inordinate amount of time because for the most part the accused Officers have not readily participated in the process because they are on sick leave'.[3202] He said he did not have powers of compulsion and he believes that he is not able to make findings where there is not enough evidence, even if the accused does not participate.[3203]

14.1 Our observations of responses from 2021 onwards

As described above, we did not conduct a forensic analysis of departmental responses to allegations of abuse from 2021 onwards, but we did receive and consider some evidence about these responses regarding four Ashley Youth Detention Centre staff. Collectively, those cases involved three Abuse in State Care Program claims, seven National Redress Scheme claims, one civil claim, one complaint to Tasmania Police and one complaint raised by former Leader of the Tasmanian Greens, Cassy O'Connor. Allegations against these four staff members included that one or more of them had rubbed heat gel on children's genitals as punishment, enabled and encouraged harmful sexual behaviours between detainees, raped one or more detainees and inappropriately strip searched or touched one or more detainees. There were also allegations of physical abuse and excessive uses of force.

Across that evidence, we observed the following themes that mirrored some of our concerns with the responses we saw in the Ira, Lester and Stan case examples. These included the following (across one or more cases):

- We noted delays and failures to reassign employees to other areas of work that did not involve any contact with detainees while a preliminary assessment or

investigation was underway. In one matter, we saw a willingness to delay decision-making on disciplinary action on the basis that detainees were sufficiently protected if the alleged abuser was in a non-operational role (but remained on site). In that case, People and Culture became aware (some months later) that the staff member was regularly entering accommodation units for certain purposes associated with their non-operational role, which was considered 'a risk to the Agency'.[3204] The staff member was then suspended.[3205]

- The Department relied on informal processes for putting allegations to alleged abusers, instead of proceeding to an Employment Direction No. 5 investigation following a preliminary assessment. Such information processes fall outside the State Service disciplinary framework. This happened even in instances where there were numerous allegations that could have been treated as a potential pattern of behaviour that had cumulative weight and warranted further investigation and suspension while that investigation was undertaken.[3206] In one Minute to the Secretary, approved in mid-2021, we saw the process of putting allegations to the staff member described as an 'opportunity to reinforce the correct standards of behaviour, operating procedures and policies'.[3207]
- Where allegations were put to alleged abusers, we observed an unwillingness to put all allegations known to the Department to alleged abusers. In one instance, we understand that the Department only put allegations of physical abuse to an alleged abuser but did not raise allegations of sexual abuse (which were numerous and severe in nature).[3208] We do not know why this approach was taken.
- There were often lengthy periods between receiving allegations, removing alleged abusers from the Centre and starting an Employment Direction No. 5 investigation—in one instance, more than a year and in another, just under a year.[3209]
- There was a failure on one occasion to act promptly on the rediscovery of an Abuse in State Care Program claim. In that instance, the claim was rediscovered in September 2020, but an Employment Direction No. 5 investigation did not begin until early 2022.[3210]
- We saw continued delays in making notifications to Tasmania Police and the Registrar (including of up to 11 months in one case and six months in another).
- In one instance, reference to the 2007 Solicitor-General's advice was used to justify failing to pursue misconduct investigations, despite allegations having been received after December 2020 (being the month in which revised legal advice was received by the Department that permitted it to act).[3211]

We also observed, in one instance, an emphasis on concerns for employee morale and wellbeing, such that it was considered important for employees to continue to attend work even where serious allegations had been made against them.[3212] In that example, we saw references to the need to perform a 'balancing act' between detainee and staff safety.[3213] We were told that at this time there were very real risks to staff welfare, but that detainee safety was 'always considered a paramount priority'.[3214]

We acknowledge that there have been several suspensions and staffing pressures over recent years and months at Ashley Youth Detention Centre. By this point, the Department was operating in uncharted and exceptional circumstances. There were several staff with allegations against them, and there were staff shortages and lockdowns (which adversely impact children and young people).

The Department was also facing the challenge that, with some allegations, there may have been little prospect of substantiation for a variety of reasons. When this occurs, it can lead to an (incorrect) assumption that the allegation was proven to be false. A non-finding can 'vindicate' the staff member in the eyes of their colleagues, reinforce negative attitudes towards current and former detainees and contribute to fears in current detention centre staff that they may be subject to false allegations. We accept that these are all difficult dynamics for the Department to manage and that care and judgment are required in responding to each matter.

While considerations of staff wellbeing should never come at the expense of the safety of children, often staff wellbeing and child safety go hand in hand. The safety and wellbeing of staff can have a direct (and indirect) impact on the collective safety and wellbeing of children and young people in their care.

In one case in late 2021 and early 2022, the Department received an allegation through a civil claim.[3215] The Department responded as follows:

- One week after receiving the civil claim, the claim was sent to Tasmania Police.[3216]
- Six weeks after receiving the civil claim, information arising from the claim was provided to People and Culture.[3217]
- Six weeks after information was provided to People and Culture, a preliminary assessment began.[3218]
- The staff member was suspended and an Employment Direction No. 5 investigation began within two days of starting the preliminary assessment.[3219]
- The Registrar was notified of the claims approximately four months after the Department received the allegations.[3220]

In another case in around mid-2022, the Department received allegations through the National Redress Scheme against a current staff member. Following this:

- The claim was provided to People and Culture approximately three weeks later.[3221]
- The preliminary assessment began on the day the claim was provided to People and Culture.[3222]
- The claim was sent to Tasmania Police and the Registrar the day after the claim was provided to People and Culture.[3223]
- The staff member was suspended and an Employment Direction No. 5 investigation launched two days after the claim was provided to People and Culture.[3224]

The above examples show some improvements in how allegations are managed, although also continuing delays in some areas. While we are concerned by some of the initial delays in referring matters to People and Culture, we can see some improvements in timeliness compared with the cases of Ira, Lester and Stan. However, these examples also show that delays in referrals to People and Culture led to delays in referring to Tasmania Police and the Registrar. We were also concerned to see that there were additional delays in reporting to the Registrar even after the referral had been made to People and Culture, with one claim being referred to the Registrar more than two months after it was provided to People and Culture. Ms Allen acknowledged that this was a concern and told us that systems and processes have now been implemented so that the legal team reports civil claims to the Registrar.[3225]

We consider this period continued to reveal a tension or 'push–pull' between prioritising risks to child safety and risks to staff morale and wellbeing. While in late 2020, concerns about child safety appeared to be dominant, by 2021 to 2022 concerns about staff morale re-emerged.[3226] This reflected a theme we identified in previous reviews and reports into Ashley Youth Detention Centre.[3227]

While we have highlighted continuing problems across responses to individual staff, ultimately, we consider this period confirms the emerging concerns of departmental officials from the 2019 to 2020 period—that there is a pattern of behaviour across multiple staff.

We consider that there may be times where the sheer number and nature of historical allegations (as is the case with Ashley Youth Detention Centre) may overwhelm the effectiveness of an individualised disciplinary approach and reach the level of what is, essentially, a catastrophic critical incident. We heard evidence to suggest that the number of staff being suspended due to allegations was compromising the safe operations of the Centre and highly damaging for the wellbeing of staff—not only because of increased workload pressure but also the broader instability, distress and fearfulness it created. Once such a catastrophic threshold is reached—as arguably it has at the Centre—we consider it in the interests of staff and detainees to initiate a change management process that includes identifying the aptitudes, attitudes and capabilities expected of youth workers and any other relevant staff, and that requires

them to reapply for their positions. This will allow reappointed current and new staff to be confident that the community will see them as part of the solution. We make such a recommendation in Chapter 12.

15 Conclusion

Across this case study we identified numerous problems with how the Department has responded to allegations of child sexual abuse perpetrated by staff, noting some different problems during varying periods.

From 2003 to 2013, the Department received multiple allegations of abuse through the Abuse in State Care Program, identified that several current staff were the subject of allegations, and received legal advice but did not take the steps outlined in that advice that may have enabled it to act on allegations received through that (and later) iterations of redress schemes and civil claims. We were told the practical effect of this advice constrained the Department up until 2020 from acting on information it received alleging abuses by staff at Ashley Youth Detention Centre.

In the years from 2007 to 2018, we saw a reluctance to consistently take formal disciplinary action against staff, with internal reviews and investigations that were not always appropriate given the severity or number of allegations against staff. The case example of Walter also highlighted problems in the Department's failure to consider the cumulative impact of allegations, including those through the Abuse in State Care Program. It also showed a concerning historical arrangement between the Office of the Ombudsman and Ashley Youth Detention Centre of referring matters back to the Centre, which appeared to capture more than minor matters and, at least on occasion, resulted in serious matters being erroneously referred back to the Centre. We were glad to hear this referral arrangement has since ceased.[3228]

From 2019, the Department started to receive a growing number of allegations through the National Redress Scheme and civil claims, as well as reidentifying previous Abuse in State Care Program allegations that had been lost to the Department's corporate memory over time. We examined the Department's response to this growth in allegations in detail because it is so recent and presents challenges the Department is still facing. In fact, we see the systemic issues uncovered in responding to National Redress Scheme claims as having potential national relevance in informing how this information can be employed to better protect children from abuse in institutions.

We identified multiple problems primarily centred around the delays in responding to allegations about three staff members—Ira, Lester and Stan. We discovered problems in not recognising the full range of conduct that may constitute child sexual abuse, poor record keeping, a lack of awareness and responsiveness to prior Abuse in State Care Program claims and inappropriate risk management strategies to protect children,

including leaving staff who were the subject of allegations on site. We also identified a conservative application of the disciplinary process, including not giving enough weight to child safety, not undertaking proper processes in response to serious allegations, and setting too high a threshold for taking disciplinary action even where there was a pattern of alleged misconduct against a staff member. There was an apparent lack of appetite for questioning these problems, taking decisive action or seeking legal advice to question perceived barriers until late 2020.

We also found there were problems with interagency responses during this time, particularly with the coordination and information sharing between the Department of Justice, the Department of Communities, Tasmania Police and the Registrar. We received no information demonstrating significant engagement or information sharing with Child Safety Services at all.

From late 2020 to 2021, we saw several system improvements to address many of these problems, including improved records management and information sharing. Despite these improvements, we remain concerned that there continue to be several challenges for responding to allegations made through redress schemes. In particular, the disciplinary process and the Registration to Work with Vulnerable People Scheme, or their application, do not appear well equipped to respond to these types of allegations.

We see the Registrar as best placed to overcome the challenge of managing allegations arising out of the National Redress Scheme—with its ability to prioritise child safety. However, this solution relies on the Registrar being enabled and willing to consider pattern and coincidence in assessing a body of allegations, considering a broad array of corroborative evidence.

In Chapter 12, we make a range of recommendations for reform that we trust will improve the way the Department and other agencies respond to allegations of abuse in youth detention more broadly. The most significant of these is our recommendation for initiating a considered change management process. Such a process will give children and young people, staff and the community confidence in Ashley Youth Detention Centre in the future.

Notes

Case study 3: Isolation in Ashley Youth Detention Centre

1531 *Royal Commission into Institutional Responses to Child Sexual Abuse* (Final Report, 2017) vol 15, 43, 90–91.

1532 Committee on the Rights of the Child, *General Comment No 24 (2019) on Children's Rights in the Child Justice System*, UN Doc CRC/C/GC/24 (18 September 2019) 16 [95](g).

1533 Children and Youth Services, 'Procedure: Use of Isolation', 1 July 2017, produced by the Tasmanian Government in response to a Commission notice to produce.

1534 *Youth Justice Act 1997* s 133(1).

1535 *Youth Justice Act 1997* ss 124(2), 133(2); Children and Youth Services, 'Procedure: Use of Isolation', 1 July 2017, 1–2, produced by the Tasmanian Government in response to a Commission notice to produce.

1536 Children and Youth Services, 'Procedure: Use of Isolation', 1 July 2017, 1, produced by the Tasmanian Government in response to a Commission notice to produce.

1537 *Youth Justice Act 1997* s 146B; Children and Youth Services, 'Procedure: Use of Isolation', 1 July 2017, 2, produced by the Tasmanian Government in response to a Commission notice to produce.

1538 Children and Youth Services, 'Procedure: Use of Isolation', 1 July 2017, 4, produced by the Tasmanian Government in response to a Commission notice to produce.

1539 Children and Youth Services, 'Procedure: Use of Isolation', 1 July 2017, 2, produced by the Tasmanian Government in response to a Commission notice to produce.

1540 Children and Youth Services, 'Procedure: Use of Isolation', 1 July 2017, 2, produced by the Tasmanian Government in response to a Commission notice to produce.

1541 Children and Youth Services, 'Procedure: Use of Isolation', 1 July 2017, 2, produced by the Tasmanian Government in response to a Commission notice to produce.

1542 References to the detention Centre Manager regarding the use of isolation procedure should be taken as a reference to the 'detention centre manager or their delegate'. Children and Youth Services, 'Procedure: Use of Isolation', 1 July 2017, 2, produced by the Tasmanian Government in response to a Commission notice to produce.

1543 Children and Youth Services, 'Procedure: Use of Isolation', 1 July 2017, 3, produced by the Tasmanian Government in response to a Commission notice to produce.

1544 Children and Youth Services, 'Procedure: Use of Isolation', 1 July 2017, 4, produced by the Tasmanian Government in response to a Commission notice to produce.

1545 Children and Youth Services, 'Procedure: Use of Isolation', 1 July 2017, 5, produced by the Tasmanian Government in response to a Commission notice to produce.

1546 Children and Youth Services, 'Procedure: Use of Isolation', 1 July 2017, 3, produced by the Tasmanian Government in response to a Commission notice to produce.

1547 Children and Youth Services, 'Procedure: Use of Isolation', 1 July 2017, 3, produced by the Tasmanian Government in response to a Commission notice to produce.

1548 Children and Youth Services, 'Procedure: Use of Isolation', 1 July 2017, 4, produced by the Tasmanian Government in response to a Commission notice to produce.

1549 Children and Youth Services, 'Procedure: Use of Isolation', 1 July 2017, 4, produced by the Tasmanian Government in response to a Commission notice to produce.

1550 The Isolation Procedure refers to this role as 'Director, Services to Young People'. As discussed in Chapter 10, this role has been known by different names and we have elected to refer to it as 'Director, Strategic Youth Services'.

1551 Children and Youth Services, 'Procedure: Use of Isolation', 1 July 2017, 4–6, produced by the Tasmanian Government in response to a Commission notice to produce.

1552 *Youth Justice Act 1997* s 133(5); Children and Youth Services, 'Procedure: Use of Isolation', 1 July 2017, 4, produced by the Tasmanian Government in response to a Commission notice to produce.

1553 Children and Youth Services, 'Procedure: Use of Isolation', 1 July 2017, 4, produced by the Tasmanian Government in response to a Commission notice to produce.

1554 Children and Youth Services, 'Procedure: Use of Isolation', 1 July 2017, 4, produced by the Tasmanian Government in response to a Commission notice to produce.

1555 Department of Communities, 'Instrument of Revocation and Delegation – Detention Centre Manager', July 2019, 2, produced by the Tasmanian Government in response to a Commission notice to produce.

1556 Department of Communities, 'Instrument of Revocation and Delegation – Detention Centre Manager', July 2019, 3, 6, produced by the Tasmanian Government in response to a Commission notice to produce.

1557 Department of Communities, 'Youth Justice Act 1997: Instrument of Revocation and Delegation – Detention Centre Manager', 16 December 2021, 2, produced by the Tasmanian Government in response to a Commission notice to produce, 2.

1558 Children and Youth Services, 'Procedure: Use of Isolation', 1 July 2017, 5, produced by the Tasmanian Government in response to a Commission notice to produce.

1559 Children and Youth Services, 'Procedure: Use of Isolation', 1 July 2017, 4, produced by the Tasmanian Government in response to a Commission notice to produce.

1560 Children and Youth Services, 'Procedure: Use of Isolation', 1 July 2017, 4, produced by the Tasmanian Government in response to a Commission notice to produce.

1561 Children and Youth Services, 'Procedure: Use of Isolation', 1 July 2017, 6, produced by the Tasmanian Government in response to a Commission notice to produce.

1562 Children and Youth Services, 'Procedure: Use of Isolation', 1 July 2017, 6, produced by the Tasmanian Government in response to a Commission notice to produce.

1563 Children and Youth Services, 'Procedure: Use of Isolation', 1 July 2017, 6, produced by the Tasmanian Government in response to a Commission notice to produce.

1564 Children and Youth Services, 'Procedure: Use of Isolation', 1 July 2017, 6, produced by the Tasmanian Government in response to a Commission notice to produce.

1565 The names 'Ben' and 'Erin' are pseudonyms; Order of the Commission of Inquiry, restricted publication order, 18 August 2022. Statement of 'Ben', 29 March 2022, Attachment [Ben]–001 ('Ben', Handwritten Submission to the National Royal Commission, undated) 2; Transcript of 'Erin', 22 August 2022, 3020 [41–42].

1566 Statement of Brett Robinson, 2 June 2022, 5 [28]; Statement of 'Ben', 29 March 2022, Attachment [Ben]–001 ('Ben', Handwritten Submission to the National Royal Commission, undated) 7.

1567 The names 'Charlotte', 'Fred' and 'Eve' are pseudonyms; Order of the Commission of Inquiry, restricted publication order, 18 August 2022. Statement of 'Charlotte', 31 January 2022, 3; Statement of 'Ben', 29 March 2022, Attachment [Ben]–001 ('Ben', Handwritten Submission to the National Royal Commission, undated) 7; Statement of 'Fred', 24 August 2022, 2 [13]; Statement of 'Eve', 18 August 2022, 4 [20].

1568 Transcript of 'Erin', 22 August 2022, 3024 [12–15]. The name 'Max' is a pseudonym; Order of the Commission of Inquiry, restricted publication order, 18 August 2022. Statement of 'Max', 19 May 2022, 1 [3].

1569 Statement of 'Ben', 29 March 2022, Attachment [Ben]–001 ('Ben', Handwritten Submission to the National Royal Commission, undated) 2. The name 'Simon' is a pseudonym; Order of the Commission of Inquiry, restricted publication order, 18 August 2022. Statement of 'Simon', 7 July 2022, 1 [5]; Statement of Brett Robinson, 2 June 2022, 5 [30]; Statement of 'Charlotte', 31 January 2022, 3.

1570 Transcript of 'Fred', 25 August 2022, 3345 [27–31]; Statement of 'Max', 19 May 2022, 9 [40].

1571 Transcript of 'Erin', 22 August 2022, 3020 [41]–3021 [1]; Statement of 'Charlotte', 31 January 2022, 3; Statement of 'Eve', 18 August 2022, 3 [13].

1572 The name 'Ben' is a pseudonym; Order of the Commission of Inquiry, restricted publication order, 18 August 2022. Statement of 'Ben', 29 March 2022, Attachment [Ben]–001 ('Ben', Handwritten Submission to the National Royal Commission, undated) 2.

1573 The name 'Simon' is a pseudonym; Order of the Commission of Inquiry, restricted publication order, 18 August 2022. Statement of 'Simon', 7 July 2022, 1 [5].

1574 The name ‘Erin’ is a pseudonym; Order of the Commission of Inquiry, restricted publication order, 18 August 2022; Transcript of ‘Erin’, 22 August 2022, 3020 [43–46].

1575 Transcript of ‘Erin’, 22 August 2022, 3020 [46]–3021 [1].

1576 Transcript of ‘Simon’, 18 August 2022, 2760 [1–10]; Statement of ‘Simon’, 7 July 2022, 3 [13].

1577 Transcript of ‘Simon’, 18 August 2022, 2760 [1–10].

1578 Transcript of ‘Simon’, 18 August 2022, 2758 [24–31].

1579 The name ‘Fred’ is a pseudonym; Order of the Commission of Inquiry, restricted publication order, 18 August 2022. Transcript of ‘Fred’, 25 August 2022, 3343 [42–46].

1580 Transcript of ‘Fred’, 25 August 2022, 3343 [42–46]; Statement of ‘Fred’, 24 August 2022, 3 [14].

1581 Transcript of ‘Erin’, 22 August 2022, 3024 [12–15].

1582 Statement of Brett Robinson, 2 June 2022, 5 [30].

1583 Statement of ‘Erin’, 18 July 2022, 6 [31].

1584 The name ‘Oscar’ is a pseudonym; Order of the Commission of Inquiry, restricted publication order, 30 August 2023. In relation to Oscar, the Commission of Inquiry received the information on the basis that the individual would remain anonymous. Consequently, the State has not been provided with identifying information in relation to this individual and has not had the opportunity to fully consider or respond to the details of the incidents alleged. Statement of ‘Oscar’, 29 July 2022, 3 [14]; Statement of Brett Robinson, 2 June 2022, 5 [28].

1585 Statement of ‘Oscar’, 29 July 2022, 2 [10].

1586 Statement of ‘Simon’, 7 July 2022, 3 [13].

1587 Statement of ‘Max’, 19 May 2022, 9 [40].

1588 Statement of Brett Robinson, 2 June 2022, 6 [31–32].

1589 Statement of ‘Ben’, 29 March 2022, Attachment [Ben]–001 (‘Ben’, Handwritten Submission to the National Royal Commission, undated) 6.

1590 Statement of ‘Ben’, 29 March 2022, Attachment [Ben]–001 (‘Ben’, Handwritten Submission to the National Royal Commission, undated) 6.

1591 The name ‘Charlotte’ is a pseudonym; Order of the Commission of Inquiry, restricted publication order, 18 August 2022.

1592 Statement of ‘Charlotte’, 31 January 2022, 3.

1593 Statement of ‘Charlotte’, 31 January 2022, 3.

1594 The names ‘Eve’ and ‘Norman’ are pseudonyms; Order of the Commission of Inquiry, restricted publication order, 18 August 2022. Statement of ‘Eve’, 18 August 2022, 3 [13].

1595 Statement of ‘Eve’, 18 August 2022, 3 [13].

1596 Statement of ‘Eve’, 18 August 2022, 4 [20].

1597 Statement of Operations Manager, Ashley Youth Detention Centre, 1 August 2022, 3 [18(b)].

1598 The name ‘Digby’ is a pseudonym. Order of the Commission of Inquiry, restricted publication order, 30 August 2023. Statement of ‘Digby’, 8 August 2022, 5 [18(c)]; Statement of Fiona Atkins, 15 August 2022, 11 [39(d)].

1599 Statement of Madeleine Gardiner, 15 August 2022, 12 [18(b)].

1600 Statement of Fiona Atkins, 15 August 2022, 11 [39(d)].

1601 Statement of former Case Management Coordinator, Ashley Youth Detention Centre, 8 August 2022, 4 [59]; Statement of Operations Manager, Ashley Youth Detention Centre, 1 August 2022, 5 [32]; Statement of ‘Digby’, 8 August 2022, 17 [56(d)].

1602 Statement of Operations Manager, Ashley Youth Detention Centre, 1 August 2022, 6 [32].

1603 Statement of ‘Digby’, 8 August 2022, 17 [56(d)].

1604 Statement of ‘Digby’, 8 August 2022, 17 [56(d)]; Statement of former Case Management Coordinator, Ashley Youth Detention Centre, 8 August 2022, 4 [59]; Statement of Madeleine Gardiner, 15 August 2022, 12 [18(b)].

1605 Statement of Madeleine Gardiner, 15 August 2022, 12 [18(b)].

1606 Statement of Fiona Atkins, 15 August 2022, 11 [39(d)].

1607 Statement of Operations Manager, Ashley Youth Detention Centre, 1 August 2022, 5 [32]; Statement of Operations Manager, Ashley Youth Detention Centre, 1 August 2022, 5 [33]. The name 'Alysha' is a pseudonym; Order of the Commission of Inquiry, restricted publication order, 18 August 2022. Statement of 'Alysha', 16 August 2022, 19 [90]; Anonymous Statement, 16 August 2022, 9 [41].

1608 Statement of Samuel Baker, 8 August 2022, 6 [48–49]; Transcript of Samuel Baker, 19 August 2022, 2908 [35]–2909 [10]; Anonymous Statement, 16 August 2022, 9 [41–42].

1609 Transcript of Samuel Baker, 19 August 2022, 2907 [24–44].

1610 Transcript of Colleen (Sue) Ray and Sarah Spencer, 18 August 2022, 2816 [27–34].

1611 Transcript of Pamela Honan, 19 August 2022, 2959 [7–9].

1612 Transcript of Pamela Honan, 19 August 2022, 2959 [11–19].

1613 Transcript of Madeleine Gardiner, 22 August 2022, 3006 [17–28].

1614 Email from former Manager, Professional Services and Policy, Ashley Youth Detention Centre to Patrick Ryan, 7 March 2019, produced by the Tasmanian Government in response to a Commission notice to produce.

1615 Ashley Youth Detention Centre, 'Behaviour Development System, Version 2.2', May 2013, 12, produced by the Tasmanian Government in response to a Commission notice to produce.

1616 Ashley Youth Detention Centre, 'Behaviour Development System, Version 2.2', May 2013, 13, produced by the Tasmanian Government in response to a Commission notice to produce.

1617 Transcript of Sarah Spencer, 18 August 2022, 2815 [1–3].

1618 Statement of former Operations Coordinator, Ashley Youth Detention Centre, 15 June 2022, 14.

1619 Statement of Madeleine Gardiner, 15 August 2022, 30 [53(d)].

1620 The name 'Alysha' is a pseudonym; Order of the Commission of Inquiry, restricted publication order, 18 August 2022.

1621 Statement of 'Alysha', 16 August 2022, 18 [86].

1622 Transcript of Sarah Spencer, 18 August 2022, 2815 [35]–2816 [7].

1623 *Lusted v ZS* [2013] TASMC 38.

1624 *Lusted v ZS* [2013] TASMC 38, 5 [12–13].

1625 *Lusted v ZS* [2013] TASMC 38, 5 [11].

1626 *Lusted v ZS* [2013] TASMC 38, 7 [15]–9 [20].

1627 *Lusted v ZS* [2013] TASMC 38, 5 [12].

1628 *Lusted v ZS* [2013] TASMC 38, 5–6 [14].

1629 *Lusted v ZS* [2013] TASMC 38, 5–6 [14].

1630 *Lusted v ZS* [2013] TASMC 38, 7 [15].

1631 *Lusted v ZS* [2013] TASMC 38, 8 [16], 9 [18].

1632 *Lusted v ZS* [2013] TASMC 38, 10 [22].

1633 Letter from Mark Morrissey to Michael Pervan, 6 April 2016.

1634 Letter from Mark Morrissey to Michael Pervan, 6 April 2016, 2–3.

1635 Letter from Mark Morrissey to Michael Pervan, 6 April 2016, 3.

1636 Children and Youth Services, 'Minute to Secretary: AYDC – Commissioner for Children Letter and Emerging Concerns', 6 May 2016, 1, produced by the Tasmanian Government in response to a Commission notice to produce.

1637 Children and Youth Services, 'Minute to Secretary: AYDC – Commissioner for Children Letter and Emerging Concerns', 6 May 2016, 1–2, produced by the Tasmanian Government in response to a Commission notice to produce.

1638 Children and Youth Services, 'Minute to Secretary: AYDC – Commissioner for Children Letter and Emerging Concerns', 6 May 2016, 5, produced by the Tasmanian Government in response to a Commission notice to produce.

1639 Children and Youth Services, 'Minute to Secretary: AYDC – Commissioner for Children Letter and Emerging Concerns', 6 May 2016, 8, produced by the Tasmanian Government in response to a Commission notice to produce.

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1644 Children and Youth Services, 'Minute to Secretary: AYDC – Commissioner for Children Letter and Emerging Concerns', 6 May 2016, 5, produced by the Tasmanian Government in response to a Commission notice to produce.

1645 Children and Youth Services, 'Minute to Secretary: AYDC – Commissioner for Children Letter and Emerging Concerns', 6 May 2016, 7, produced by the Tasmanian Government in response to a Commission notice to produce.

1646 Children and Youth Services, 'Minute to Secretary: AYDC – Commissioner for Children Letter and Emerging Concerns', 6 May 2016, 8, produced by the Tasmanian Government in response to a Commission notice to produce.

1647 Children and Youth Services, 'Minute to Secretary: AYDC – Commissioner for Children Letter and Emerging Concerns', 6 May 2016, 9, produced by the Tasmanian Government in response to a Commission notice to produce.

1648 Children and Youth Services, 'Minute to Secretary: AYDC – Commissioner for Children Letter and Emerging Concerns', 6 May 2016, 9, produced by the Tasmanian Government in response to a Commission notice to produce.

1649 Letter from Michael Pervan to Mark Morrissey, undated.

1650 Email from Mark Morrissey to Acting Deputy Secretary for Children and Youth Services, 9 November 2016, 2–3.

1651 Email from Mark Morrissey to Acting Deputy Secretary for Children and Youth Services, 9 November 2016, 2–3.

1652 Email from Acting Deputy Secretary for Children and Youth Services to Mark Morrissey, 10 November 2016, 1.

1653 Email from Acting Deputy Secretary for Children and Youth Services to Mark Morrissey, 10 November 2016, 1.

1654 Email from Acting Deputy Secretary for Children and Youth Services to Mark Morrissey, 10 November 2016, 1.

1655 Email from Acting Deputy Secretary for Children and Youth Services to Mark Morrissey, 10 November 2016, 1.

1656 Email from Acting Deputy Secretary for Children and Youth Services to Mark Morrissey, 10 November 2016, 1–2.

1657 Letter from Mark Morrissey to Minister for Human Services, 11 November 2016, 2.

1658 Letter from Mark Morrissey to Minister for Human Services, 11 November 2016, 2.

1659 Letter from Mark Morrissey to Minister for Human Services, 11 November 2016, 2.

1660 Letter from Mark Morrissey to Minister for Human Services, 11 November 2016, 2.

1661 Letter from Mark Morrissey to Minister for Human Services, 11 November 2016, 2.

1662 Letter from Michael Pervan to Mark Morrissey, 18 November 2016, 2.

1663 Letter from Michael Pervan to Mark Morrissey, 18 November 2016, 2.

1664 Letter from Michael Pervan to Mark Morrissey, 18 November 2016, 2.

1665 Letter from Michael Pervan to Mark Morrissey, 18 November 2016, 2.

1666 Email from Mark Morrissey to Acting Deputy Secretary for Children, 4 January 2017, 2.

1667 Email from Mark Morrissey to Acting Deputy Secretary for Children, 4 January 2017, 2.

1668 Email from Acting Deputy Secretary for Children to Mark Morrissey, 4 January 2017.

1669 Email from Acting Deputy Secretary for Children to Mark Morrissey, 4 January 2017, 1–2.

1670 Email from Acting Deputy Secretary for Children to Mark Morrissey, 4 January 2017, 1.

1671 Email from Mark Morrissey to Acting Deputy Secretary for Children, 11 January 2017, 1.

1672 Email from Mark Morrissey to Acting Deputy Secretary for Children, 19 January 2017, 1.

1673 Email from Mark Morrissey to Acting Deputy Secretary for Children, 19 January 2017, 1.

1674 Email from Mark Morrissey to Acting Deputy Secretary for Children, 19 January 2017, 1.

1675 Email from Mark Morrissey to Richard Connock, 9 February 2017.

1676 Email from Mark Morrissey to Richard Connock, 9 February 2017.

1677 Email from Mark Morrissey to Ginna Webster, 2 June 2017, 1.

1678 Email from Mark Morrissey to Ginna Webster, 2 June 2017, 1.

1679 Statement of Mark Morrissey, 9 August 2022, 1 [3]; Transcript of Mark Morrissey, 18 August 2022, 2781 [40]–2783 [5].

1680 Richard Connock, *Procedural Fairness Response*, 19 July 2023, 1.

1681 Children and Youth Services, 'Procedure: Use of Isolation', 1 July 2017, produced by the Tasmanian Government in response to a Commission notice to produce; *Youth Justice Act 1997* s 124(2).

1682 Office of the Custodial Inspector, *Custody Inspection Report: Inspection of Youth Custodial Services in Tasmania, 2018* (Report, August 2019).

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1684 Office of the Custodial Inspector, *Custody Inspection Report: Inspection of Youth Custodial Services in Tasmania, 2018* (Report, August 2019) 53–55.

1685 Office of the Custodial Inspector, *Custody Inspection Report: Inspection of Youth Custodial Services in Tasmania, 2018* (Report, August 2019) 54.

1686 Email from Patrick Ryan to Ashley Youth Detention Centre Operations Management, 7 March 2019, 1, produced by the Tasmanian Government in response to a Commission notice to produce; Ashley Youth Detention Centre, 'All Young People Communication', 7 March 2019, produced by the Tasmanian Government in response to a Commission notice to produce.

1687 Email from Patrick Ryan to Ashley Professional Services staff copied to Greg Brown, 7 March 2019, produced by the Tasmanian Government in response to a Commission notice to produce; Ashley Youth Detention Centre, 'All Young People Communication', 7 March 2019, produced by the Tasmanian Government in response to a Commission notice to produce.

1688 Email from Patrick Ryan to Ashley Youth Detention Centre Operations Management, 7 March 2019, 1, produced by the Tasmanian Government in response to a Commission notice to produce.

1689 Ashley Youth Detention Centre, 'Blue Colour Category Purpose and Practices', undated, 1, produced by the Tasmanian Government in response to a Commission notice to produce (emphasis in original).

1690 Ashley Youth Detention Centre, 'Blue Colour Category Purpose and Practices', undated, 1, produced by the Tasmanian Government in response to a Commission notice to produce; Ashley Youth Detention Centre, 'Blue Colour Category Details', 7 March 2019, 1, produced by the Tasmanian Government in response to a Commission notice to produce.

1691 Ashley Youth Detention Centre, 'Blue Colour Category Purpose and Practices', undated, 1, produced by the Tasmanian Government in response to a Commission notice to produce (emphasis in original).

1692 Ashley Youth Detention Centre, 'Blue Colour Category Purpose and Practices', undated, 1, produced by the Tasmanian Government in response to a Commission notice to produce (emphasis in original).

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1694 Ashley Youth Detention Centre, 'Blue Colour Category Details', 7 March 2019, 1, produced by the Tasmanian Government in response to a Commission notice to produce; Ashley Youth Detention Centre, 'Blue Colour Category Purpose and Practices', undated, 1, produced by the Tasmanian Government in response to a Commission notice to produce.

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1697 Transcript of Patrick Ryan, 7 September 2022, 3607 [35–40].

1698 Transcript of Patrick Ryan, 7 September 2022, 3607 [26]–3608 [46].

1699 Transcript of Patrick Ryan, 7 September 2022, 3607 [26]–3608 [46].

1700 Statement of Patrick Ryan, 18 August 2022, 10 [99]; Statement of Patrick Ryan, 18 August 2022, Annexure to question 23, 128–130.

1701 Statement of Patrick Ryan, 18 August 2022, 10 [99].

1702 Statement of Patrick Ryan, 18 August 2022, 10 [102].

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1704 Ashley Youth Detention Centre, 'Centre Support Team Minutes', 18 March 2019, 3, produced by the Tasmanian Government in response to a Commission notice to produce; Ashley Youth Detention Centre, 'Centre Support Team Minutes', 25 March 2019, 2, produced by the Tasmanian Government in response to a Commission notice to produce.

1705 Ashley Youth Detention Centre, 'Centre Support Team Minutes', 18 March 2019, 4, produced by the Tasmanian Government in response to a Commission notice to produce; Ashley Youth Detention Centre, 'Centre Support Team Minutes', 25 March 2019, 3, produced by the Tasmanian Government in response to a Commission notice to produce; Ashley Youth Detention Centre, 'Centre Support Team Minutes', 1 April 2019, 3, produced by the Tasmanian Government in response to a Commission notice to produce.

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1707 Statement of Greg Brown, 28 November 2022, 19 [56].

1708 Statement of Greg Brown, 28 November 2022, 18 [54].

1709 Statement of Greg Brown, 28 November 2022, 21 [61].

1710 State of Tasmania, *Procedural Fairness Response*, 16 July 2023, 3; Michael Pervan, *Procedural Fairness Response*, 21 July 2023, 4.

1711 Email from Leanne McLean to Patrick Ryan, 4 March 2019, 2, produced by the Tasmanian Government in response to a Commission notice to produce.

1712 Email from Patrick Ryan to Leanne McLean, 4 March 2019, 2, produced by the Tasmanian Government in response to a Commission notice to produce.

1713 Email from Patrick Ryan to Ashley Youth Detention Centre Operations Management, 7 March 2019, 1, produced by the Tasmanian Government in response to a Commission notice to produce.

1714 Email from Patrick Ryan to Leanne McLean, 7 March 2019, 1, produced by the Tasmanian Government in response to a Commission notice to produce. For completeness, Mr Ryan refers to the incident occurring on 25–26 'March' but given the date of his correspondence, this is likely an error.

1715 The name 'Piers' is a pseudonym; Order of the Commission of Inquiry, restricted publication order, 30 August 2023. Email from Patrick Ryan to 'Piers', 7 March 2019, 1, produced by the Tasmanian Government in response to a Commission notice to produce.

1716 Transcript of Patrick Ryan, 7 September 2022, 3624 [31–35].

1717 Transcript of Patrick Ryan, 7 September 2022, 3624 [26–29].

1718 Transcript of Patrick Ryan, 7 September 2022, 3623 [45–47].

1719 Email from Patrick Ryan to Leanne McLean, 7 March 2019, 1, produced by the Tasmanian Government in response to a Commission notice to produce.

1720 Statement of Patrick Ryan, 18 August 2022, 10 [101]; Transcript of Patrick Ryan, 7 September 2022, 3609 [1–3].

1721 Statement of Madeleine Gardiner, 15 August 2022, 23 [38], 30 [53(d)].

1722 Statement of Madeleine Gardiner, 15 August 2022, 22 [37], 23 [38], 30 [53(d)].

1723 Transcript of Madeleine Gardiner, 22 August 2022, 3008 [46]–3009 [2]; Statement of Madeleine Gardiner, 15 August 2022, 30 [53(d)].

1724 Ashley Youth Detention Centre, 'Draft BDS Review Committee Minutes', 16 November 2018, produced by the Tasmanian Government in response to a Commission notice to produce; Ashley Youth Detention Centre, 'Draft BDS Review Committee Minutes', 22 January 2019, produced by the Tasmanian Government in response to a Commission notice to produce; Ashley Youth Detention Centre, 'Draft BDS Review Committee Minutes', 19 February 2019, produced by the Tasmanian Government in response to a Commission notice to produce.

1725 Ashley Youth Detention Centre, 'Draft BDS Review Committee Minutes', 19 February 2019, produced by the Tasmanian Government in response to a Commission notice to produce.

1726 The name 'Digby' is a pseudonym; Order of the Commission of Inquiry, restricted publication order, 30 August 2023. Statement of 'Digby', 8 August 2022, 13 [41]; Email from 'Digby' to Patrick Ryan, 7 March 2019, 1, produced by the Tasmanian Government in response to a Commission notice to produce.

1727 Email from 'Digby' to Patrick Ryan, 7 March 2019, 1, produced by the Tasmanian Government in response to a Commission notice to produce.

1728 Email from Patrick Ryan to Greg Brown, 12 April 2019, 1, produced by the Tasmanian Government in response to a Commission notice to produce.

1729 Patrick Ryan, 'Draft Issues Briefing for the Minister', 12 April 2019, 1, produced by the Tasmanian Government in response to a Commission notice to produce.

1730 Patrick Ryan, *Procedural Fairness Response*, 12 July 2023, 2.

1731 Statement of Madeleine Gardiner, 15 August 2022, Attachment 8, 1.

1732 Statement of Madeleine Gardiner, 15 August 2022, 31 [53(i)].

1733 Statement of Madeleine Gardiner, 15 August 2022, 23 [38].

1734 Statement of Madeleine Gardiner, 15 August 2022, 23 [38]; Statement of Madeleine Gardiner, 15 August 2022, Attachment 9 (Email from Madeleine Gardiner to Patrick Ryan, 16 March 2019) 1.

1735 Statement of Madeleine Gardiner, 15 August 2022, Attachment 9 (Email from Madeleine Gardiner to Patrick Ryan, 16 March 2019) 2.

1736 Transcript of Madeleine Gardiner, 22 August 2022, 3006 [39].

1737 Statement of Madeleine Gardiner, 15 August 2022, Attachment 9 (Email from Madeleine Gardiner to Patrick Ryan, 16 March 2019) 1.

1738 Statement of Madeleine Gardiner, 15 August 2022, Attachment 9 (Email from Madeleine Gardiner to Patrick Ryan, 16 March 2019) 1.

1739 Transcript of Madeleine Gardiner, 22 August 2022, 3007 [1–6]; Statement of Madeleine Gardiner, 15 August 2022, 23 [38].

1740 Transcript of Madeleine Gardiner, 22 August 2022, 3007 [1–2].

1741 Transcript of Madeleine Gardiner, 22 August 2022, 3007 [6–19].

1742 Transcript of Madeleine Gardiner, 22 August 2022, 3008 [2–8]

1743 Transcript of Madeleine Gardiner, 22 August 2022, 3008 [10–44].

1744 Transcript of Patrick Ryan, 7 September 2022, 3609 [31–37].

1745 Email from Greg Brown to Madeleine Gardiner, 21 May 2019, 1, produced by the Tasmanian Government in response to a Commission notice to produce; Statement of Ginna Webster, 29 April 2022, 1 [7]. We discuss the Department's Quality Improvement and Workforce Development team in Chapter 9.

1746 Email from Greg Brown to Madeleine Gardiner, 21 May 2019, 1, produced by the Tasmanian Government in response to a Commission notice to produce.

1747 Statement of Ginna Webster, 13 January 2023, 44 [72].

1748 Letter from Leanne McLean to Ginna Webster, 22 August 2019, produced by the Tasmanian Government in response to a Commission notice to produce.

1749 Letter from Leanne McLean to Ginna Webster, 22 August 2019, 1, produced by the Tasmanian Government in response to a Commission notice to produce.

1750 Letter from Leanne McLean to Ginna Webster, 22 August 2019, 1, produced by the Tasmanian Government in response to a Commission notice to produce.

1751 Letter from Leanne McLean to Ginna Webster, 22 August 2019, 1, produced by the Tasmanian Government in response to a Commission notice to produce.

1752 Letter from Leanne McLean to Ginna Webster, 22 August 2019, 2, produced by the Tasmanian Government in response to a Commission notice to produce.

1753 Email from Administrative Support Officer, Commissioner for Children and Young People to CTECC, Department of Communities, 23 August 2019, produced by the Tasmanian Government in response to a Commission notice to produce; Email from Executive Officer, Strategic Youth Services to Patrick Ryan and Madeleine Gardiner, 29 August 2019, produced by the Tasmanian Government in response to a Commission notice to produce.

1754 Email Patrick Ryan to former Manager, Professional Services and Policy, Ashley Youth Detention Centre, 4 September 2019, 1, produced by the Tasmanian Government in response to a Commission notice to produce.

1755 Patrick Ryan, 'Draft Issues Briefing to the Secretary: Ashley Youth Detention Centre – Unit Bound Policy', 4 September 2019, 1, produced by the Tasmanian Government in response to a Commission notice to produce.

1756 Patrick Ryan, 'Draft Issues Briefing to the Secretary: Ashley Youth Detention Centre – Unit Bound Policy', 4 September 2019, 2, produced by the Tasmanian Government in response to a Commission notice to produce.

1757 Patrick Ryan, 'Draft Issues Briefing to the Secretary: Ashley Youth Detention Centre – Unit Bound Policy', 4 September 2019, 2, produced by the Tasmanian Government in response to a Commission notice to produce.

1758 Patrick Ryan, 'Draft Issues Briefing to the Secretary: Ashley Youth Detention Centre – Unit Bound Policy', 4 September 2019, 2, produced by the Tasmanian Government in response to a Commission notice to produce.

1759 Patrick Ryan, 'Draft Issues Briefing to the Secretary: Ashley Youth Detention Centre – Unit Bound Policy', 4 September 2019, 2, produced by the Tasmanian Government in response to a Commission notice to produce.

1760 Patrick Ryan, 'Draft Issues Briefing to the Secretary: Ashley Youth Detention Centre – Unit Bound Policy', 4 September 2019, 2, produced by the Tasmanian Government in response to a Commission notice to produce.

1761 Patrick Ryan, 'Draft Issues Briefing to the Secretary: Ashley Youth Detention Centre – Unit Bound Policy', 4 September 2019, 2, produced by the Tasmanian Government in response to a Commission notice to produce.

1762 Email from Patrick Ryan to former Manager, Professional Services and Policy, Ashley Youth Detention Centre, 4 September 2019, 1, produced by the Tasmanian Government in response to a notice to produce.

1763 Patrick Ryan, 'Draft Issues Briefing for the Minister', 4 September 2019, produced by the Tasmanian Government in response to a Commission notice to produce; Patrick Ryan, 'Draft Letter from Michael Pervan to Leanne McLean', 4 September 2019, produced by the Tasmanian Government in response to a Commission notice to produce.

1764 Statement of Michael Pervan, 24 August 2022, Annexure MP.77.001 ('Ashley Youth Detention Centre – Unit Bound Policy', Issues Briefing to Secretary, Department of Communities, 11 September 2019).

1765 Letter from Michael Pervan to Leanne McLean, 11 September 2019.

1766 Letter from Michael Pervan to Leanne McLean, 11 September 2019, 1.

1767 Letter from Michael Pervan to Leanne McLean, 11 September 2019, 1.

1768 Letter from Michael Pervan to Leanne McLean, 11 September 2019, 1.

1769 Email from Leanne McLean to Patrick Ryan, 23 October 2019.

1770 The description of this incident is derived from the chronology prepared by James Cumming Investigation Services as part of its report to the Secretary. The Commission of Inquiry has relied on the factual findings made in that investigation except where otherwise stated: James Cumming Investigation Services, 'Review into the Immediate and Post Management of a 13 December 2019 Incident at Ashley Youth Detention Centre', 26 March 2021, produced by the Tasmanian Government in response to a Commission notice to produce (referred to below as 'James Cumming Investigation Report').

1771 James Cumming Investigation Report, 26, 88.

1772 James Cumming Investigation Report, 94.

1773 The names 'Arlo', 'Elijah' and 'Joseph' are pseudonyms; Order of the Commission of Inquiry, restricted publication order, 18 August 2022. James Cumming Investigation Report, 1.

1774 James Cumming Investigation Report, 1, 12–13.

1775 James Cumming Investigation Report, 6–11, and 21–23.

1776 James Cumming Investigation Report, 12–13.

1777 James Cumming Investigation Report, 13.

1778 James Cumming Investigation Report, 12–13, 25, 67.

1779 James Cumming Investigation Report, 12.

1780 James Cumming Investigation Report, 10–11.

1781 James Cumming Investigation Report, 18.

1782 Department of Communities, 'Issues Briefing for the Minister: AYDC Incident – 13 December 2019', 7 January 2020, 2, produced by the Tasmanian Government in response to a Commission notice to produce; James Cumming Investigation Report, 18.

1783 James Cumming Investigation Report, 18.

1784 James Cumming Investigation Report, 14.

1785 The name 'Chester' is a pseudonym; Order of the Commission of Inquiry, restricted publication order, 18 August 2022. James Cumming Investigation Report, 14.

1786 The name 'Maude' is a pseudonym; Order of the Commission of Inquiry, restricted publication order, 18 August 2022. James Cumming Investigation Report, 15.

1787 James Cumming Investigation Report, 15.

1788 Email from Patrick Ryan to Pamela Honan, 13 December 2019, produced by the Tasmanian Government in response to a Commission notice to produce.

1789 Email from Patrick Ryan to Pamela Honan, 13 December 2019, 1, produced by the Tasmanian Government in response to a Commission notice to produce.

1790 Email from Patrick Ryan to YJS Ashley Youth Detention Centre, 13 December 2019, 1, produced by the Tasmanian Government in response to a Commission notice to produce.

1791 Email from Patrick Ryan to YJS Ashley Youth Detention Centre, 13 December 2019, 1, produced by the Tasmanian Government in response to a Commission notice to produce.

1792 James Cumming Investigation Report, 15.

1793 James Cumming Investigation Report, 15.

1794 James Cumming Investigation Report, 15.

1795 James Cumming Investigation Report, 15.

1796 James Cumming Investigation Report, 16.

1797 James Cumming Investigation Report, 47–49.

1798 James Cumming Investigation Report, 47–49.

1799 James Cumming Investigation Report, 47–49.

1800 James Cumming Investigation Report, 37–38.

1801 James Cumming Investigation Report, 78–79.

1802 James Cumming Investigation Report, 47–49.

1803 James Cumming Investigation Report, 106.

1804 James Cumming Investigation Report, 37 [69].

1805 James Cumming Investigation Report, 16.

1806 James Cumming Investigation Report, 74.

1807 Ashley Youth Detention Centre, 'Centre Support Team Minutes', 16 December 2019, 3–4, produced by the Tasmanian Government in response to a Commission notice to produce.

1808 Children and Youth Services, 'Ashley Youth Detention Centre Daily Roll', 14 December 2019, 1, produced by the Tasmanian Government in response to a Commission notice to produce; Children and Youth Services, 'Ashley Youth Detention Centre Daily Roll', 15 December 2019; Children and Youth Services, 'Ashley Youth Detention Centre Daily Roll', 16 December 2019, 1; Children and Youth Services, 'Ashley Youth Detention Centre Daily Roll', 17 December 2019, 1, produced by the Tasmanian Government in response to a Commission notice to produce; Children and Youth Services, 'Ashley Youth Detention Centre Daily Roll', 18 December 2019, 1, produced by the Tasmanian Government in response to a Commission notice to produce; Children and Youth Services, 'Ashley Youth Detention Centre Daily Roll', 19 December 2019, 1; Children and Youth Services, 'Ashley Youth Detention Centre Daily Roll', 20 December 2019, 1; Children and Youth Services, 'Ashley Youth Detention Centre Daily Roll', 21 December 2019, 1, produced by the Tasmanian Government in response to a Commission notice to produce; Children and Youth Services, 'Ashley Youth Detention Centre Daily Roll', 22 December 2019, 1; Children and Youth Services, 'Ashley Youth Detention Centre Daily Roll', 23 December 2019, 1; Children and Youth Services, 'Ashley Youth Detention Centre Daily Roll', 24 December 2019, 1.

1809 Ashley Youth Detention Centre, 'Interim Centre Support Team Minutes', 19 December 2019.

1810 Ashley Youth Detention Centre, 'Interim Centre Support Team Minutes', 19 December 2019.

1811 Department of Communities, 'Issues Briefing for the Minister: AYDC Incident – 13 December 2019', produced by the Tasmanian Government in response to a Commission notice to produce.

1812 Department of Communities, 'Issues Briefing for the Minister: AYDC Incident – 13 December 2019', 1–2, produced by the Tasmanian Government in response to a Commission notice to produce.

1813 Department of Communities, 'Issues Briefing for the Minister: AYDC Incident – 13 December 2019', 1, produced by the Tasmanian Government in response to a Commission notice to produce.

1814 Statement of Michael Pervan, 24 August 2022, 64 [267].

1815 Statement of Michael Pervan, 24 August 2022, 65 [268–269].

1816 Statement of Michael Pervan, 24 August 2022, 65 [269].

1817 Statement of Mandy Clarke, 19 August 2022, 19 [82].

1818 Statement of Mandy Clarke, 19 August 2022, 19 [82].

1819 Pamela Honan, *Procedural Fairness Response*, 19 July 2023.

1820 Pamela Honan, *Procedural Fairness Response*, 19 July 2023.

1821 Pamela Honan, *Procedural Fairness Response*, 19 July 2023.

1822 Department of Communities, 'Minute to Secretary: Request for Approval to Appoint an Investigator to Investigate the Incident of 13 December 2019 at Ashley Youth Detention Centre; and Associated Post Incident Management', 20 February 2020, 2, produced by the Tasmanian Government in response to a Commission notice to produce.

1823 Statement of Pamela Honan, 18 August 2022, 23 [30.3]; Department of Communities, 'Minute to Secretary: Attachment 2 – Background Information for the Incident of 13 December 2019 at Ashley Youth Detention Centre', undated, produced by the Tasmanian Government in response to a Commission notice to produce.

1824 Statement of Pamela Honan, 18 August 2022, 39 [61.3]; Statement of Pamela Honan, 18 August 2022, Annexure 18 (Emails between Maude and Operations Manager, January 2020); Department of Communities, 'Minute to Secretary: Attachment 2 – Background Information for the Incident of 13 December 2019 at Ashley Youth Detention Centre', undated, produced by the Tasmanian Government in response to a Commission notice to produce.

1825 Department of Communities, 'Minute to Secretary: Attachment 2 – Background Information for the Incident of 13 December 2019 at Ashley Youth Detention Centre', undated, produced by the Tasmanian Government in response to a Commission notice to produce; Emails between Pamela Honan and former Conferencing Coordinator, 8 January 2020.

1826 James Cumming Investigation Report, 111.

1827 James Cumming Investigation Report, 112.

1828 James Cumming Investigation Report, 112.

1829 James Cumming Investigation Report, 112.

1830 James Cumming Investigation Report, 112.

1831 James Cumming Investigation Report, 113.

1832 James Cumming Investigation Report, 113.

1833 Statement of Pamela Honan, 18 August 2022, 39 [61.3]; Statement of Pamela Honan, 18 August 2022, Attachment 18 (Email from Patrick Ryan to Maude and Piers, 16 January 2020) 1.

1834 Statement of Pamela Honan, 18 August 2022, 39 [61.5].

1835 Email from former Clinical Psychologist, Ashley Youth Detention Centre, to former Head of Department for Statewide Forensic Mental Health Services, 6 January 2020, produced by the Tasmanian Government in response to a Commission notice to produce.

1836 Email from former Clinical Psychologist, Ashley Youth Detention Centre to former Head of Department for Statewide Forensic Mental Health Services, 6 January 2020, produced by the Tasmanian Government in response to a Commission notice to produce.

1837 Email from former Clinical Psychologist, Ashley Youth Detention Centre to former Head of Department for Statewide Forensic Mental Health Services, 6 January 2020, produced by the Tasmanian Government in response to a Commission notice to produce.

1838 Email from former Clinical Psychologist, Ashley Youth Detention Centre to former Head of Department for Statewide Forensic Mental Health Services, 6 January 2020, produced by the Tasmanian Government in response to a Commission notice to produce.

1839 Statement of former Head of Department for Statewide Forensic Mental Health Services, 22 August 2022, 17 [88].

1840 Statement of former Head of Department for Statewide Forensic Mental Health Services, 22 August 2022, 18 [89].

1841 Department of Communities, 'Minute to Secretary: Request for Approval to Appoint an Investigator to Investigate the Incident of 13 December 2019 at Ashley Youth Detention Centre; and Associated Post Incident Management', 20 February 2020, 4, produced by the Tasmanian Government in response to a Commission notice to produce.

1842 Department of Communities, 'Minute to Secretary: Request for Approval to Appoint an Investigator to Investigate the Incident of 13 December 2019 at Ashley Youth Detention Centre; and Associated Post Incident Management', 20 February 2020, 1, produced by the Tasmanian Government in response to a Commission notice to produce.

1843 Department of Communities, 'Minute to Secretary: Request for Approval to Appoint an Investigator to Investigate the Incident of 13 December 2019 at Ashley Youth Detention Centre; and Associated Post Incident Management', 20 February 2020, 1–2, produced by the Tasmanian Government in response to a Commission notice to produce.

1844 Department of Communities, 'Minute to Secretary: Request for Approval to Appoint an Investigator to Investigate the Incident of 13 December 2019 at Ashley Youth Detention Centre; and Associated Post Incident Management', 20 February 2020, 1, produced by the Tasmanian Government in response to a Commission notice to produce.

1845 Department of Communities, 'Minute to Secretary: Request for Approval to Appoint an Investigator to Investigate the Incident of 13 December 2019 at Ashley Youth Detention Centre; and Associated Post Incident Management', 20 February 2020, 1–2, produced by the Tasmanian Government in response to a Commission notice to produce.

1846 Department of Communities, 'Minute to Secretary: Request for Approval to Appoint an Investigator to Investigate the Incident of 13 December 2019 at Ashley Youth Detention Centre; and Associated Post Incident Management', 20 February 2020, 2, produced by the Tasmanian Government in response to a Commission notice to produce.

1847 Department of Communities, 'Minute to Secretary: Request for Approval to Appoint an Investigator to Investigate the Incident of 13 December 2019 at Ashley Youth Detention Centre; and Associated Post Incident Management', 20 February 2020, produced by the Tasmanian Government in response to a Commission notice to produce.

1848 Department of Communities, 'Minute to Secretary: Attachment 1 – Proposed Scope of Investigation', 20 February 2020, produced by the Tasmanian Government in response to a Commission notice to produce; James Cumming Investigation Report, 1–2.

1849 James Cumming Investigation Report, 3; Transcript of Pamela Honan, 19 August 2022, 2960 [46]–2961 [5].

1850 James Cumming Investigation Report, 2–3.

1851 Notice to produce served on the Department for Education, Children and Young People, 25 November 2022, 7.

1852 James Cumming Investigation Report, cover page.

1853 James Cumming Investigation Report, 14, 101.

1854 James Cumming Investigation Report, 14, 101.

1855 James Cumming Investigation Report, 15, 101.

1856 James Cumming Investigation Report, 94–95, 97.

1857 James Cumming Investigation Report, 96.

1858 James Cumming Investigation Report, 96–97.

1859 James Cumming Investigation Report, 36 [56], 43 [25].

1860 James Cumming Investigation Report, 114.

1861 James Cumming Investigation Report, 78–79.

1862 James Cumming Investigation Report, 21.

1863 James Cumming Investigation Report, 44, 55, 101–102.

1864 James Cumming Investigation Report, 96, 106–107.

1865 James Cumming Investigation Report, 46.

1866 James Cumming Investigation Report, 44.

1867 James Cumming Investigation Report, 40, 55.

1868 James Cumming Investigation Report, 79, 97.

1869 James Cumming Investigation Report, 97.

1870 James Cumming Investigation Report, 27.

1871 James Cumming Investigation Report, 78–79.

1872 James Cumming Investigation Report, 97.

1873 James Cumming Investigation Report, 79.

1874 James Cumming Investigation Report, 97–98.

1875 James Cumming Investigation Report, 111–112.

1876 James Cumming Investigation Report, 112.

1877 James Cumming Investigation Report, 117.

1878 James Cumming Investigation Report, 79.

1879 James Cumming Investigation Report, 117.

1880 Statement of Patrick Ryan, 19 August 2022, 29 [267].

1881 Statement of 'Chester', Annexure B (CV, 1 August 2022) 1.

1882 Department of Communities, 'Issues Briefing to Minister for Children and Youth: Update on AYDC Matters Referred by Cassy O'Connor's Office', undated (cleared 22 December 2021), produced by the Tasmanian Government in response to a notice to produce.

1883 Department of Communities, 'Issues Briefing to Minister for Children and Youth: Update on AYDC Matters Referred by Cassy O'Connor's Office', undated (cleared 22 December 2021), 3, produced by the Tasmanian Government in response to a notice to produce.

1884 Department of Communities, 'Issues Briefing to Minister for Children and Youth: Update on AYDC Matters Referred by Cassy O'Connor's Office', undated (cleared 22 December 2021), 4, produced by the Tasmanian Government in response to a notice to produce.

1885 Statement of Jacqueline Allen, 15 August 2022, 33–34 [188].

1886 Statement of Jacqueline Allen, 15 August 2022, Attachment B Q23–25 ('Meeting to Discuss the Incident at Ashley Youth Detention Centre on 13 December 2019, and the Associated Post Incident Management', Minute to Secretary, Department of Communities, 11 February 2022) 1.

1887 Statement of Jacqueline Allen, 15 August 2022, Attachment D Q23–25 ('Finalising Matter – Incident at Ashley Youth Detention Centre on 13 December 2019, and the Associated Post Incident Management', Minute to Secretary, Department of Communities, 4 April 2022) 2.

1888 Statement of Jacqueline Allen, 15 August 2022, Attachment D Q23–25 ('Finalising Matter – Incident at Ashley Youth Detention Centre on 13 December 2019, and the Associated Post Incident Management', Minute to Secretary, Department of Communities, 4 April 2022) 2.

1889 Statement of Jacqueline Allen, 15 August 2022, Attachment D Q23–25 ('Finalising Matter – Incident at Ashley Youth Detention Centre on 13 December 2019, and the Associated Post Incident Management', Minute to Secretary, Department of Communities, 4 April 2022) 2.

1890 Statement of Jacqueline Allen, 15 August 2022, Attachment D Q23–25 ('Finalising Matter – Incident at Ashley Youth Detention Centre on 13 December 2019, and the Associated Post Incident Management', Minute to Secretary, Department of Communities, 4 April 2022) 2.

1891 Statement of Jacqueline Allen, 15 August 2022, Attachment D Q23–25 ('Finalising Matter – Incident at Ashley Youth Detention Centre on 13 December 2019, and the Associated Post Incident Management', Minute to Secretary, Department of Communities, 4 April 2022) 1.

1892 Statement of Jacqueline Allen, 15 August 2022, Attachment D Q23–25 ('Finalising Matter – Incident at Ashley Youth Detention Centre on 13 December 2019, and the Associated Post Incident Management', Minute to Secretary, Department of Communities, 4 April 2022) 6.

1893 Statement of Jacqueline Allen, 15 August 2022, Attachment E Q23–25 (Letter from Michael Pervan to Patrick Ryan, 4 April 2022) 2–3.

1894 Statement of Jacqueline Allen, 15 August 2022, Attachment G Q23–25 (Letter from Michael Pervan to Chester, 28 September 2021) 1.

1895 Statement of Jacqueline Allen, 15 August 2022, Attachment G Q23–25 (Letter from Michael Pervan to Chester, 28 September 2021) 1.

1896 Statement of Jacqueline Allen, 15 August 2022, 34 [190].

1897 Statement of Jacqueline Allen, 15 August 2022, 34 [188].

1898 Statement of Jacqueline Allen, 15 August 2022, 34 [191].

1899 Statement of Pamela Honan, 18 August 2022, 40 [63.4].

1900 Statement of Pamela Honan, 18 August 2022, 40 [63.4].

1901 Statement of Pamela Honan, 18 August 2022, 40 [63.4(c)].

1902 Statement of Pamela Honan, 18 August 2022, 41 [64.2].

1903 Statement of Pamela Honan, 18 August 2022, 41 [64.3].

1904 Statement of Pamela Honan, 18 August 2022, 41 [64.4].

1905 Transcript of Pamela Honan, 19 August 2022, 2959 [24–25].

1906 Transcript of Pamela Honan, 19 August 2022, 2959 [31–44].

1907 Transcript of Michael Pervan, 25 August 2022, 3455 [33–37].

1908 Statement of Michael Pervan, 24 August 2022, 67 [276].

1909 Department of Communities, 'Youth Justice Act 1997: Instrument of Revocation and Delegation – Detention Centre Manager', 16 December 2021, produced by the Tasmanian Government in response to a Commission notice to produce, 2.

1910 Department of Communities, 'Youth Justice Act 1997: Instrument of Revocation and Delegation – Detention Centre Manager', 16 December 2021, produced by the Tasmanian Government in response to a Commission notice to produce, 2.

1911 Department of Communities, 'Youth Justice Act 1997: Instrument of Revocation and Delegation – Detention Centre Manager', 16 December 2021, produced by the Tasmanian Government in response to a Commission notice to produce, 2.

1912 Department of Communities, 'Youth Justice Act 1997: Instrument of Revocation and Delegation – Detention Centre Manager', 16 December 2021, produced by the Tasmanian Government in response to a Commission notice to produce, 3.

1913 Department of Communities, 'Youth Justice Act 1997: Instrument of Revocation and Delegation – Detention Centre Manager', 16 December 2021, produced by the Tasmanian Government in response to a Commission notice to produce, 6.

1914 Ashley Youth Detention Centre, 'Centre Support Team Minutes', 16 December 2019, 3–4, produced by the Tasmanian Government in response to a Commission notice to produce.

1915 James Cumming Investigation Report, 44, 55, 101–102.

1916 James Cumming Investigation Report, 96, 106–107.

1917 James Cumming Investigation Report, 46.

1918 James Cumming Investigation Report, 46.

1919 Statement of Stuart Watson, 16 August 2022, 9 [53(d)].

1920 Statement of Fiona Atkins, 15 August 2022, 6 [20(a)], 13 [43(d)].

1921 Children and Youth Services, 'Procedure: Use of Isolation', 1 July 2017, 6, produced by the Tasmanian Government in response to a Commission notice to produce.

1922 Children and Youth Services, 'Form: Authorisation for Extension of Isolation', 1 July 2017, produced by the Tasmanian Government in response to a Commission notice to produce.

1923 Department of Communities, 'Youth Justice Act 1997: Instrument of Revocation and Delegation – Detention Centre Manager', 16 December 2021, produced by the Tasmanian Government in response to a Commission notice to produce, 2.

1924 Statement of Pamela Honan, 18 August 2022, 49 [75.2].

1925 Children and Youth Services, 'Procedure: Use of Isolation', 1 July 2017, produced by the Tasmanian Government in response to a Commission notice to produce.

1926 The summary of this event is derived from an internal incident report prepared in relation to this event, except where otherwise stated: Ashley Youth Detention Centre, 'Incident Report', 7 March 2020, 3, produced by the Tasmanian Government in response to a Commission notice to produce.

1927 Ashley Youth Detention Centre, 'Incident Report', 7 March 2020, 2, produced by the Tasmanian Government in response to a Commission notice to produce ('7 March 2020 Incident Report').

1928 Ashley Youth Detention Centre, 'Incident Report', 7 March 2020, 2, produced by the Tasmanian Government in response to a Commission notice to produce ('7 March 2020 Incident Report').

1929 Ashley Youth Detention Centre, 'Incident Report', 7 March 2020, 2, produced by the Tasmanian Government in response to a Commission notice to produce ('7 March 2020 Incident Report').

1930 Ashley Youth Detention Centre, 'Incident Report', 7 March 2020, 2, produced by the Tasmanian Government in response to a Commission notice to produce ('7 March 2020 Incident Report').

1931 Ashley Youth Detention Centre, 'Incident Report', 7 March 2020, 2, produced by the Tasmanian Government in response to a Commission notice to produce ('7 March 2020 Incident Report').

1932 Ashley Youth Detention Centre, 'Incident Report', 7 March 2020, 2, produced by the Tasmanian Government in response to a Commission notice to produce ('7 March 2020 Incident Report').

1933 Ashley Youth Detention Centre, 'Incident Report', 7 March 2020, 2, produced by the Tasmanian Government in response to a Commission notice to produce ('7 March 2020 Incident Report').

1934 Ashley Youth Detention Centre, 'Incident Report', 7 March 2020, 2, produced by the Tasmanian Government in response to a Commission notice to produce ('7 March 2020 Incident Report').

1935 Ashley Youth Detention Centre, 'Incident Report', 7 March 2020, 2, produced by the Tasmanian Government in response to a Commission notice to produce ('7 March 2020 Incident Report').

1936 Ashley Youth Detention Centre, 'Incident Report', 7 March 2020, 3, produced by the Tasmanian Government in response to a Commission notice to produce ('7 March 2020 Incident Report').

1937 Ashley Youth Detention Centre, 'Incident Report', 7 March 2020, 3, produced by the Tasmanian Government in response to a Commission notice to produce ('7 March 2020 Incident Report').

1938 Ashley Youth Detention Centre, 'Incident Report', 7 March 2020, 2, produced by the Tasmanian Government in response to a Commission notice to produce ('7 March 2020 Incident Report').

1939 Ashley Youth Detention Centre, 'Incident Report', 7 March 2020, 2, produced by the Tasmanian Government in response to a Commission notice to produce ('7 March 2020 Incident Report').

1940 Ashley Youth Detention Centre, 'Incident Report', 7 March 2020, 2, produced by the Tasmanian Government in response to a Commission notice to produce ('7 March 2020 Incident Report').

1941 Ashley Youth Detention Centre, 'Incident Report', 7 March 2020, 2, produced by the Tasmanian Government in response to a Commission notice to produce ('7 March 2020 Incident Report').

1942 Ashley Youth Detention Centre, 'Incident Report', 7 March 2020, 2, produced by the Tasmanian Government in response to a Commission notice to produce ('7 March 2020 Incident Report').

1943 Ashley Youth Detention Centre, 'Incident Report', 7 March 2020, 2, produced by the Tasmanian Government in response to a Commission notice to produce ('7 March 2020 Incident Report').

1944 Ashley Youth Detention Centre, 'Incident Report', 7 March 2020, 2, produced by the Tasmanian Government in response to a Commission notice to produce ('7 March 2020 Incident Report').

1945 Ashley Youth Detention Centre, 'Incident Report', 7 March 2020, 2, produced by the Tasmanian Government in response to a Commission notice to produce ('7 March 2020 Incident Report').

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1947 Former Manager, Professional Services and Policy, Ashley Youth Detention Centre, 'Family Contact Information', 6 March 2022, produced by the Tasmanian Government in response to a Commission notice to produce.

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2156 Department of Communities, 'Magistrate's Decision', 14 July 2017, produced by the Tasmanian Government in response to a Commission notice to produce.

2157 Children and Youth Services, 'Critical Incident Investigation Report – Ashley Youth Detention Centre', undated, produced by the Tasmanian Government in response to a Commission notice to produce.

2158 Children and Youth Services, 'Critical Incident Investigation Report – Ashley Youth Detention Centre', undated, 3, produced by the Tasmanian Government in response to a Commission notice to produce.

2159 Children and Youth Services, 'Critical Incident Investigation Report – Ashley Youth Detention Centre', undated, 3, 42, produced by the Tasmanian Government in response to a Commission notice to produce

2160 Children and Youth Services, 'Critical Incident Investigation Report – Ashley Youth Detention Centre', undated, 3, produced by the Tasmanian Government in response to a Commission notice to produce.

2161 Children and Youth Services, 'Critical Incident Investigation Report – Ashley Youth Detention Centre', undated, 7, produced by the Tasmanian Government in response to a Commission notice to produce.

2162 Department of Health and Human Services, 'Critical Incident Investigation Report: Ashley Youth Detention Centre', undated, 7, produced by the Tasmanian Government in response to a Commission notice to produce.

2163 Children and Youth Services, 'Critical Incident Investigation Report – Ashley Youth Detention Centre', undated, 7, 8, 11, 22–24, produced by the Tasmanian Government in response to a Commission notice to produce.

2164 Children and Youth Services, 'Critical Incident Investigation Report – Ashley Youth Detention Centre', undated, 8, produced by the Tasmanian Government in response to a Commission notice to produce.

2165 Children and Youth Services, 'Critical Incident Investigation Report – Ashley Youth Detention Centre', undated, 30, 32, 36, produced by the Tasmanian Government in response to a Commission notice to produce.

2166 WorkSafe Tasmania, 'Notified Workplace Incident: Ashley Youth Detention Centre', 8 February 2017, produced by the Tasmanian Government in response to a Commission notice to produce.

2167 WorkSafe Tasmania, 'Notified Workplace Incident: Ashley Youth Detention Centre', 8 February 2017, 2, produced by the Tasmanian Government in response to a Commission notice to produce.

2168 WorkSafe Tasmania, 'Notified Workplace Incident: Ashley Youth Detention Centre', 8 February 2017, 2, produced by the Tasmanian Government in response to a Commission notice to produce.

2169 WorkSafe Tasmania, 'Notified Workplace Incident: Ashley Youth Detention Centre', 8 February 2017, produced by the Tasmanian Government in response to a Commission notice to produce.

2170 WorkSafe Tasmania, 'Notified Workplace Incident: Ashley Youth Detention Centre', 8 February 2017, 5, produced by the Tasmanian Government in response to a Commission notice to produce.

2171 WorkSafe Tasmania, 'Notified Workplace Incident: Ashley Youth Detention Centre', 8 February 2017, Annexure A, 3, produced by the Tasmanian Government in response to a Commission notice to produce.

2172 Department of Health and Human Services, 'Review of Incidents at Ashley Youth Detention Centre', March 2018, 3, produced by the Tasmanian Government in response to a Commission notice to produce.

2173 Department of Health and Human Services, 'Review of Incidents at Ashley Youth Detention Centre', March 2018, 12, produced by the Tasmanian Government in response to a Commission notice to produce.

2174 Ombudsman Tasmania, 'Preliminary Inquiries into the Assessment of a Use of Force Incident at the Ashley Youth Detention Centre', December 2019, 2, produced by the Tasmanian Government in response to a Commission notice to produce.

2175 Ombudsman Tasmania, 'Preliminary Inquiries into the Assessment of a Use of Force Incident at the Ashley Youth Detention Centre', December 2019, 2, produced by the Tasmanian Government in response to a Commission notice to produce.

2176 Ombudsman Tasmania, 'Preliminary Inquiries into the Assessment of a Use of Force Incident at the Ashley Youth Detention Centre', December 2019, 2, produced by the Tasmanian Government in response to a Commission notice to produce.

2177 Ombudsman Tasmania, 'Preliminary Inquiries into the Assessment of a Use of Force Incident at the Ashley Youth Detention Centre', December 2019, 2, produced by the Tasmanian Government in response to a Commission notice to produce.

2178 Ombudsman Tasmania, 'Preliminary Inquiries into the Assessment of a Use of Force Incident at the Ashley Youth Detention Centre', December 2019, 2, produced by the Tasmanian Government in response to a Commission notice to produce.

2179 Department of Health and Human Services, 'Review of Incidents at Ashley Youth Detention Centre', March 2018, 11, produced by the Tasmanian Government in response to a Commission notice to produce.

2180 Department of Health and Human Services, 'Review of Incidents at Ashley Youth Detention Centre', March 2018, 11, produced by the Tasmanian Government in response to a Commission notice to produce.

2181 Department of Health and Human Services, 'Review of Incidents at Ashley Youth Detention Centre', March 2018, 13, produced by the Tasmanian Government in response to a Commission notice to produce.

2182 Department of Health and Human Services, 'Review of Incidents at Ashley Youth Detention Centre', March 2018, 13, produced by the Tasmanian Government in response to a Commission notice to produce. Note that the review appears to identify this incident as occurring in December 2018, not December 2017. Given the date of the other incidents and the date of the review, we consider this is an error.

2183 Department of Health and Human Services, 'Review of Incidents at Ashley Youth Detention Centre', March 2018, 3, produced by the Tasmanian Government in response to a Commission notice to produce.

2184 Department of Health and Human Services, 'Review of Incidents at Ashley Youth Detention Centre', March 2018, 3, produced by the Tasmanian Government in response to a Commission notice to produce.

2185 Department of Health and Human Services, 'Review of Incidents at Ashley Youth Detention Centre', March 2018, 17, produced by the Tasmanian Government in response to a Commission notice to produce.

2186 Department of Health and Human Services, 'Review of Incidents at Ashley Youth Detention Centre', March 2018, 15, produced by the Tasmanian Government in response to a Commission notice to produce.

2187 Ombudsman Tasmania, 'Preliminary Inquiries into the Assessment of a Use of Force Incident at the Ashley Youth Detention Centre', December 2019, 1, produced by the Tasmanian Government in response to a Commission notice to produce.

2188 Department of Health and Human Services, 'Review of Incidents at Ashley Youth Detention Centre', March 2018, 4, produced by the Tasmanian Government in response to a Commission notice to produce.

2189 Department of Health and Human Services, 'Review of Incidents at Ashley Youth Detention Centre', March 2018, 4, produced by the Tasmanian Government in response to a Commission notice to produce.

2190 Department of Health and Human Services, 'Review of Incidents at Ashley Youth Detention Centre', March 2018, 5, produced by the Tasmanian Government in response to a Commission notice to produce.

2191 Department of Health and Human Services, 'Review of Incidents at Ashley Youth Detention Centre', March 2018, 6, produced by the Tasmanian Government in response to a Commission notice to produce.

2192 Department of Health and Human Services, 'Review of Incidents at Ashley Youth Detention Centre', March 2018, 7, produced by the Tasmanian Government in response to a Commission notice to produce.

2193 Department of Health and Human Services, 'Review of Incidents at Ashley Youth Detention Centre', March 2018, 4, produced by the Tasmanian Government in response to a Commission notice to produce.

2194 Department of Health and Human Services, 'Review of Incidents at Ashley Youth Detention Centre', March 2018, 4, 14 produced by the Tasmanian Government in response to a Commission notice to produce.

2195 Department of Health and Human Services, 'Review of Incidents at Ashley Youth Detention Centre', March 2018, 5, produced by the Tasmanian Government in response to a Commission notice to produce.

2196 Department of Health and Human Services, 'Review of Incidents at Ashley Youth Detention Centre', March 2018, 7, produced by the Tasmanian Government in response to a Commission notice to produce.

2197 Ombudsman Tasmania, 'Preliminary Inquiries into the Assessment of a Use of Force Incident at the Ashley Youth Detention Centre', December 2019, 1, produced by the Tasmanian Government in response to a Commission notice to produce.

2198 Ombudsman Tasmania, 'Preliminary Inquiries into the Assessment of a Use of Force Incident at the Ashley Youth Detention Centre', December 2019, 1–2, produced by the Tasmanian Government in response to a Commission notice to produce.

2199 Ombudsman Tasmania, 'Preliminary Inquiries into the Assessment of a Use of Force Incident at the Ashley Youth Detention Centre', December 2019, 1, produced by the Tasmanian Government in response to a Commission notice to produce.

2200 Ombudsman Tasmania, 'Preliminary Inquiries into the Assessment of a Use of Force Incident at the Ashley Youth Detention Centre', December 2019, 1–3, produced by the Tasmanian Government in response to a Commission notice to produce.

2201 Ombudsman Tasmania, 'Preliminary Inquiries into the Assessment of a Use of Force Incident at the Ashley Youth Detention Centre', December 2019, 1, produced by the Tasmanian Government in response to a Commission notice to produce.

2202 Ombudsman Tasmania, 'Preliminary Inquiries into the Assessment of a Use of Force Incident at the Ashley Youth Detention Centre', December 2019, 12, produced by the Tasmanian Government in response to a Commission notice to produce.

2203 Ombudsman Tasmania, 'Preliminary Inquiries into the Assessment of a Use of Force Incident at the Ashley Youth Detention Centre', December 2019, 1, produced by the Tasmanian Government in response to a Commission notice to produce.

2204 Ombudsman Tasmania, 'Preliminary Inquiries into the Assessment of a Use of Force Incident at the Ashley Youth Detention Centre', December 2019, 5, produced by the Tasmanian Government in response to a Commission notice to produce.

2205 Ombudsman Tasmania, 'Preliminary Inquiries into the Assessment of a Use of Force Incident at the Ashley Youth Detention Centre', December 2019, 7–8, produced by the Tasmanian Government in response to a Commission notice to produce.

2206 Ombudsman Tasmania, 'Preliminary Inquiries into the Assessment of a Use of Force Incident at the Ashley Youth Detention Centre', December 2019, 9, produced by the Tasmanian Government in response to a Commission notice to produce. This is a reference to Heather Harker, 'Independent Review of Ashley Youth Detention Centre, Tasmania', June 2015, 2.

2207 Ombudsman Tasmania, 'Preliminary Inquiries into the Assessment of a Use of Force Incident at the Ashley Youth Detention Centre', December 2019, 9, produced by the Tasmanian Government in response to a Commission notice to produce (emphasis omitted) quoting *The Ashley+ Approach Custodial Youth Justice Organisational Change Program*, 15.

2208 Ombudsman Tasmania, 'Preliminary Inquiries into the Assessment of a Use of Force Incident at the Ashley Youth Detention Centre', December 2019, 9, produced by the Tasmanian Government in response to a Commission notice to produce.

2209 Ombudsman Tasmania, 'Preliminary Inquiries into the Assessment of a Use of Force Incident at the Ashley Youth Detention Centre', December 2019, 10, produced by the Tasmanian Government in response to a Commission notice to produce.

2210 Ombudsman Tasmania, 'Preliminary Inquiries into the Assessment of a Use of Force Incident at the Ashley Youth Detention Centre', December 2019, 11, produced by the Tasmanian Government in response to a Commission notice to produce.

2211 Ombudsman Tasmania, 'Preliminary Inquiries into the Assessment of a Use of Force Incident at the Ashley Youth Detention Centre', December 2019, 11, produced by the Tasmanian Government in response to a Commission notice to produce.

2212 Ombudsman Tasmania, 'Preliminary Inquiries into the Assessment of a Use of Force Incident at the Ashley Youth Detention Centre', December 2019, 11, produced by the Tasmanian Government in response to a Commission notice to produce.

2213 Ombudsman Tasmania, 'Preliminary Inquiries into the Assessment of a Use of Force Incident at the Ashley Youth Detention Centre', December 2019, 13, produced by the Tasmanian Government in response to a Commission notice to produce.

Case study 5: A response to staff concerns about Ashley Youth Detention Centre

2214 The name 'Alysha' is a pseudonym; Order of the Commission of Inquiry, restricted publication order, 18 August 2022. Statement of 'Alysha', 16 August 2022, 5 [18].

2215 Statement of 'Alysha', 16 August 2022, Attachment A–1 ('Statement of Duties: Clinical Practice Consultant and Support Office', Department of Communities, August 2018).

2216 Statement of 'Alysha', 16 August 2022, 79 [402].

2217 Now the Department for Education, Children and Young People.

2218 The name 'Lester' is a pseudonym; Order of the Commission of Inquiry, restricted publication order, 18 August 2022.

2219 Letter from lawyer at Odin Lawyers to Paul Turner, 20 September 2021, 3, 5.

2220 Statement of 'Alysha', 16 August 2022, 81 [414].

2221 Statement of 'Alysha', 16 August 2022, 85 [430].

2222 Statement of 'Alysha', 16 August 2022, 83 [422].

2223 Statement of 'Alysha', 16 August 2022, 5 [19].

2224 Peter Gutwein, 'Independent Review Confirmed' (Media Release, 8 September 2021) <https://www.premier.tas.gov.au/site_resources_2015/additional_releases/independent_review_confirmed>.

2225 Melanie Bartlett, 'Independent Review into Processes Conducted by the Department of Communities Tasmania in Response to the Complaints Made by the Employee Known as "Alysha"', 22 October 2021, produced by the Tasmanian Government in response to a Commission notice to produce.

2226 *Youth Justice Act 1997* ss 3 (definition of 'guardian'), 83(3).

2227 *Youth Justice Act 1997* s 124(1).

2228 Statement of Pamela Honan, 18 August 2022, 1 [1.2.3].

2229 Letter from lawyer at Odin Lawyers to Paul Turner, 20 September 2021.

2230 Letter from lawyer at Odin Lawyers to Paul Turner, 20 September 2021, 1–5.

2231 Letter from lawyer at Odin Lawyers to Paul Turner, 20 September 2021, 7–9.

2232 Letter from lawyer at Odin Lawyers to Paul Turner, 20 September 2021, 5–9.

2233 Letter from lawyer at Odin Lawyers to Paul Turner, 20 September 2021; Statement of Department for Education, Children and Young People, 6 February 2023, 22.

2234 Statement of Michael Pervan, 24 August 2022, Annexure MP.108.002 (Report of the Bowen Investigation, Peter Bowen, 30 March 2022).

2235 Statement of Michael Pervan, 24 August 2022, Annexure MP.108.002 (Report of the Bowen Investigation, Peter Bowen, 30 March 2022) 2 [5–6].

2236 Statement of Michael Pervan, 24 August 2022, Annexure MP.108.002 (Report of the Bowen Investigation, Peter Bowen, 30 March 2022) 16.

2237 Statement of Michael Pervan, 24 August 2022, Annexure MP.108.002 (Report of the Bowen Investigation, Peter Bowen, 30 March 2022) 16 [58–60].

2238 Statement of Kathy Baker, 18 August 2022, 31 [180(a)].

2239 Department of Communities, 'Preliminary Assessment of Complaint Made by [Alysha] Regarding Pamela Honan', 28 March 2022, 1, produced by the Tasmanian Government in response to a Commission notice to produce.

2240 Department of Communities, 'Preliminary Assessment of Complaint Made by [Alysha] Regarding Pamela Honan', 28 March 2022, 1, produced by the Tasmanian Government in response to a Commission notice to produce.

2241 Department of Communities, 'Preliminary Assessment of Complaint Made by [Alysha] Regarding Pamela Honan', 28 March 2022, 2, produced by the Tasmanian Government in response to a Commission notice to produce.

2242 Department of Communities, 'Draft Issues Briefing to Minister: Update on AYDC Matters Referred by Cassy O'Connor's Office', 1, produced by the Tasmanian Government in response to a Commission notice to produce.

2243 Department of Communities, 'Preliminary Assessment of Complaint Made by ['Alysha'] Regarding Pamela Honan', 28 March 2022, 1 [1–2], produced by the Tasmanian Government in response to a Commission notice to produce.

2244 Letter from Kathy Baker to 'Alysha', 30 June 2022, produced by the Tasmanian Government in response to a Commission notice to produce.

2245 Melanie Bartlett, 'Independent Review into Processes Conducted by the Department of Communities Tasmania in Response to the Complaints Made by the Employee Known as "Alysha"', 22 October 2021, 5, produced by the Tasmanian Government in response to a Commission notice to produce.

2246 Melanie Bartlett, 'Independent Review into Processes Conducted by the Department of Communities Tasmania in Response to the Complaints Made by the Employee Known as "Alysha"', 22 October 2021, produced by the Tasmanian Government in response to a Commission notice to produce.

2247 Melanie Bartlett, 'Independent Review into Processes Conducted by the Department of Communities Tasmania in Response to the Complaints Made by the Employee Known as "Alysha"', 22 October 2021, 16, produced by the Tasmanian Government in response to a Commission notice to produce.

2248 Melanie Bartlett, 'Independent Review into Processes Conducted by the Department of Communities Tasmania in Response to the Complaints Made by the Employee Known as "Alysha"', 22 October 2021, 17, produced by the Tasmanian Government in response to a Commission notice to produce.

2249 Melanie Bartlett, 'Independent Review into Processes Conducted by the Department of Communities Tasmania in Response to the Complaints Made by the Employee Known as "Alysha"', 22 October 2021, 17–18, produced by the Tasmanian Government in response to a Commission notice to produce.

2250 Melanie Bartlett, 'Independent Review into Processes Conducted by the Department of Communities Tasmania in Response to the Complaints Made by the Employee Known as "Alysha"', 22 October 2021, 5, produced by the Tasmanian Government in response to a Commission notice to produce.

2251 Melanie Bartlett, 'Independent Review into Processes Conducted by the Department of Communities Tasmania in Response to the Complaints Made by the Employee Known as "Alysha"', 22 October 2021, 35–36, 60, 63, produced by the Tasmanian Government in response to a Commission notice to produce.

2252 Statement of 'Alysha', 16 August 2022, 85 [430].

2253 Statement of Mandy Clarke, 19 August 2022, 14 [46.1].

2254 Transcript of Mandy Clarke, 25 August 2022, 3435 [22–23].

2255 Statement of Kathy Baker, 18 August 2022, 31 [176].

2256 Department of Communities, 'Preliminary Assessment of Complaint Made by [Alysha] Regarding Pamela Honan', 28 March 2022, 1, produced by the Tasmanian Government in response to a Commission notice to produce.

2257 Transcript of Mandy Clarke, 25 August 2022, 3435 [13–26].

2258 Statement of Kathy Baker, 18 August 2022, 30–1 [176].

2259 Department of Communities, 'Preliminary Assessment of Complaint Made by [Alysha] Regarding Pamela Honan', 28 March 2022, 2, produced by the Tasmanian Government in response to a Commission notice to produce.

2260 Statement of Kathy Baker, 18 August 2022, 23 [128].

2261 Statement of Kathy Baker, 18 August 2022, 23–24 [131]; Kathy Baker, *Procedural Fairness Response*, 13 July 2023, 9.

2262 Email from Mandy Clarke to Kathy Baker et al, 21 September 2020, 1, produced by the Tasmanian Government in response to a Commission notice to produce.

2263 Email from Mandy Clarke to Kathy Baker et al, 21 September 2020, 1, produced by the Tasmanian Government in response to a Commission notice to produce.

2264 Department of Communities, 'Preliminary Assessment of Complaint Made by [Alysha] Regarding Pamela Honan', 28 March 2022, 5, produced by the Tasmanian Government in response to a Commission notice to produce.

2265 Department of Communities, 'Preliminary Assessment of Complaint Made by [Alysha] Regarding Pamela Honan', 28 March 2022, 5, produced by the Tasmanian Government in response to a Commission notice to produce.

2266 Department of Communities, 'Preliminary Assessment of Complaint Made by [Alysha] Regarding Pamela Honan', 28 March 2022, 6, produced by the Tasmanian Government in response to a Commission notice to produce.

2267 Request for statement served on Michael Pervan, 2 August 2022, 18 [46(o)]; Request for statement served on Mandy Clarke, 2 August 2022, 18 [46(o)]; Request for statement served on Kathy Baker, 2 August 2022, 18 [46(o)].

2268 Statement of Michael Pervan, 24 August 2022, [164].

2269 Statement of Mandy Clarke, 19 August 2022, 15 [47].

2270 Transcript of Mandy Clarke, 25 August 2022, 3435 [13–26].

2271 Statement of Kathy Baker, 18 August 2022, 30 [176].

2272 Statement of Department for Education, Children and Young People, 6 February 2023, 41 [6.1].

2273 Department of Communities, 'Preliminary Assessment of Complaint Made by [Alysha] Regarding Pamela Honan', 28 March 2022, 1, produced by the Tasmanian Government in response to a Commission notice to produce.

2274 Request for statement served on Michael Pervan, 2 August 2022, 16–18 [46]; Request for statement served on Mandy Clarke, 2 August 2022, 16–18 [46]; Request for statement served on Kathy Baker, 2 August 2022, 16–18 [46].

2275 Statement of Michael Pervan, 24 August 2022, [158].

2276 Request for statement served on Mandy Clarke, 2 August 2022, 16–18 [46].

2277 Statement of Mandy Clarke, 19 August 2022, 13 [45].

2278 Mandy Clarke, *Procedural Fairness Response*, 13 July 2023.

2279 Statement of Kathy Baker, 18 August 2022, 31 [180(c)].

2280 Request for statement served on State of Tasmania, 19 October 2022, 5–6 [3].

2281 Statement of the Department for Education, Children and Young People, 6 February 2023, 32–33.

2282 Statement of Kathy Baker, 18 August 2022, 31 [180]; Statement of Mandy Clarke, 19 August 2022, 15 [48].

2283 Statement of Department for Education, Children and Young People, 6 February 2023, 32–33 [18].

2284 Statement of Department for Education, Children and Young People, 6 February 2023, 32–33.

2285 Statement of Kathy Baker, 18 August 2022, 15 [82(a)].

2286 Statement of Jacqueline Allen, 15 August 2022, 42 [233].

2287 Statement of Jacqueline Allen, 15 August 2022, 43 [236], 47 [274–279].

2288 Transcript of Kathy Baker and Mandy Clarke, 25 August 2022, 3442 [18–21].

2289 Kathy Baker, *Procedural Fairness Response*, 13 July 2023, 6–7.

2290 Letter from Kathy Baker to 'Alysha', 30 June 2022, produced by the Tasmanian Government in response to a Commission notice to produce.

2291 Statement of Kathy Baker, 18 August 2022, 31 [180(a)].

2292 Statement of Kathy Baker, 18 August 2022, 31 [180(b)].

2293 Department of Communities, 'Preliminary Assessment of Complaint Made by [Alysha] Regarding Pamela Honan', 28 March 2022, 1, produced by the Tasmanian Government in response to a Commission notice to produce; Statement of Kathy Baker, 18 August 2022, 31–32 [180].

2294 Statement of Kathy Baker, 18 August 2022, 31 [180(c)]; Kathy Baker, *Procedural Fairness Response*, 13 July 2023, 12.

2295 Statement of Kathy Baker, 18 August 2022, 31 [180(d)].

2296 Statement of Kathy Baker, 18 August 2022, 32 [180(f)–180(g)].

2297 Letter from Kathy Baker to 'Alysha', 30 June 2022, produced by the Tasmanian Government in response to a Commission notice to produce.

2298 Statement of Department for Education, Children and Young People, 6 February 2023, 22 [2].

2299 Integrity Commission, *Guide to Managing Misconduct in the Tasmanian Public Sector* (March 2021) 27.

2300 Integrity Commission, *Guide to Managing Misconduct in the Tasmanian Public Sector* (March 2021) 27.

2301 Integrity Commission, *Guide to Managing Misconduct in the Tasmanian Public Sector* (March 2021) 27.

2302 Integrity Commission, *Guide to Managing Misconduct in the Tasmanian Public Sector* (March 2021) 27.

2303 Statement of Michael Pervan, 24 August 2022, [166(i)].

2304 Statement of Kathy Baker, 18 August 2022, 31 [180].

2305 Statement of Mandy Clarke, 17 August 2022, 1.

2306 Statement of Mandy Clarke, 19 August 2022, 15 [46.11].

2307 Statement of Kathy Baker, 18 August 2022, 32 [181].

2308 Statement of Kathy Baker, 18 August 2022, 32 [182].

2309 Statement of Kathy Baker, 18 August 2022, 32 [181], 33 [187].

2310 Minister administering the *State Service Act 2000*, *Employment Direction No. 5: Procedures for the Investigation and Determination of Whether an Employee Has Breached the Code of Conduct* (13/3512, 4 February 2013) cl 7.1; Integrity Commission, *Guide to Managing Misconduct in the Tasmanian Public Sector* (March 2021) 9; Statement of Jacqueline Allen, 15 August 2022, 47 [274].

2311 Statement of Jacqueline Allen, 15 August 2022, 46 [273].

2312 Integrity Commission, *Guide to Managing Misconduct in the Tasmanian Public Sector* (March 2021) 9.

2313 Integrity Commission, *Guide to Managing Misconduct in the Tasmanian Public Sector* (March 2021) 10.

2314 Statement of Mandy Clarke, 19 August 2022, 14 [46.2].

2315 Department of Communities, 'Preliminary Assessment of Complaint made by [Alysha] regarding Pamela Honan', 28 March 2022, 3, produced by the Tasmanian Government in response to a Commission notice to produce.

2316 Statement of Michael Pervan, 24 August 2022, [158].

2317 Statement of Kathy Baker, 18 August 2022, 29 [168].

2318 Statement of Mandy Clarke, 19 August 2022, 14 [46.5].

2319 Transcript of Kathy Baker and Mandy Clarke, 25 August 2022, 3432 [43–44].

2320 Transcript of Kathy Baker and Mandy Clarke, 25 August 2022, 3432 [44–45].

2321 Transcript of Kathy Baker and Mandy Clarke, 25 August 2022, 3432 [46–47].

2322 Transcript of Kathy Baker and Mandy Clarke, 25 August 2022, 3441 [19–21].

2323 Integrity Commission, *Guide to Managing Misconduct in the Tasmanian Public Sector* (March 2021) 9.

2324 Department of Communities, 'Preliminary Assessment of Complaint made by [Alysha] regarding Pamela Honan', 28 March 2022, 3, produced by the Tasmanian Government in response to a Commission notice to produce.

2325 Statement of Manager, Ashley Youth Detention Centre, 14 November 2022, Attachment (Email from 'Alysha' to Pamela Honan, 9 January 2020).

2326 Statement of Manager, Ashley Youth Detention Centre, 14 November 2022, Attachment (Email from 'Alysha' to Pamela Honan, 9 January 2020).

2327 The name 'Ira' is a pseudonym; Order of the Commission of Inquiry, restricted publication order, 18 August 2022. Statement of Manager, Ashley Youth Detention Centre, 14 November 2022, Attachment (Email from 'Alysha' to Pamela Honan, 9 January 2020).

2328 Statement of Manager, Ashley Youth Detention Centre, 14 November 2022, Attachment (Email from 'Alysha' to Pamela Honan, 9 January 2020).

2329 Email from Manager, Human Resources and Workplace Relations, Department of Communities to 'Alysha', 9 January 2020.

2330 Email from 'Alysha' to Manager, Human Resources and Workplace Relations, Department of Communities and Pamela Honan, 9 January 2020.

2331 Statement of Kathy Baker, 18 August 2022, 24 [135].

2332 Department of Communities, 'Preliminary Assessment of Complaint Made by [Alysha] Regarding Pamela Honan', 28 March 2022, 3, produced by the Tasmanian Government in response to a Commission notice to produce.

2333 Statement of Michael Pervan, 24 August 2022, [158].

2334 Statement of Kathy Baker, 18 August 2022, 29 [167].

2335 Statement of Mandy Clarke, 19 August 2022, 14, [46.4].

2336 Statement of Mandy Clarke, 19 August 2022, 14, [46.4].

2337 Pamela Honan, *Procedural Fairness Response*, 19 July 2023.

2338 Kathy Baker, *Procedural Fairness Response*, 13 July 2023, 11.

2339 Email from 'Alysha' to Manager, Human Resources and Workplace Relations, Department of Communities and Pamela Honan, 9 January 2020.

2340 *Children, Young Persons and Their Families Act 1997* s 14(2).

2341 Letter from lawyer at Odin Lawyers to Paul Turner, 20 September 2021, 2.

2342 Letter from lawyer at Odin Lawyers to Paul Turner, 20 September 2021, 3.

2343 Department of Communities, 'Preliminary Assessment of Complaint Made by [Alysha] Regarding Pamela Honan', 28 March 2022, 3, produced by the Tasmanian Government in response to a Commission notice to produce.

2344 Department of Communities, 'Preliminary Assessment of Complaint Made by [Alysha] Regarding Pamela Honan', 28 March 2022, 4, produced by the Tasmanian Government in response to a Commission notice to produce.

2345 Statement of Kathy Baker, 18 August 2022, 30 [173].

2346 Department of Communities, 'Preliminary Assessment of Complaint Made by [Alysha] Regarding Pamela Honan', 28 March 2022, 3, produced by the Tasmanian Government in response to a Commission notice to produce.

2347 Department of Communities, 'Preliminary Assessment of Complaint Made by [Alysha] Regarding Pamela Honan', 28 March 2022, 4, produced by the Tasmanian Government in response to a Commission notice to produce.

2348 Statement of Pamela Honan, 16 November 2022, Annexure 1.14 (Minutes and actions from meeting re AYDC HR concerns, 26 October 2020) 2–3.

2349 Statement of Jacqueline Allen, 21 December 2022, Annexure 13 (Email from Policy & Project Officer, Child Abuse Royal Commission Response Unit to Mandy Clarke, 1 April 2021).

2350 Statement of Michael Pervan, 24 August 2022, [167].

2351 Statement of Kathy Baker, 18 August 2022, 32 [184–185]; Statement of Mandy Clarke, 19 August 2022, 14 [46.6], 15 [46.12].

2352 Statement of Kathy Baker, 18 August 2022, 32 [184–185].

2353 Transcript of Mandy Clarke, 25 August 2022, 3435 [5].

2354 Transcript of Kathy Baker and Mandy Clarke, 25 August 2022, 3441 [16–23].

2355 Department of Communities, 'Preliminary Assessment of Complaint Made by [Alysha] Regarding Pamela Honan', 28 March 2022, 4, produced by the Tasmanian Government in response to a Commission notice to produce.

2356 Department of Communities, 'Minute to the Secretary: [Lester] (the Employee) Referral for Consideration of Investigation into Alleged Breaches of the *State Service Act 2000* Code of Conduct and Suspension with Pay', 8 November 2020, produced by the Tasmanian Government in response to a Commission notice to produce.

2357 Department of Communities, 'Minute to the Secretary: [Lester] (the Employee) Referral for Consideration of Investigation into Alleged Breaches of the *State Service Act 2000* Code of Conduct and Suspension with Pay', 8 November 2020, produced by the Tasmanian Government in response to a Commission notice to produce.

2358 Department of Communities, 'Minute to the Secretary: [Lester] (the Employee) Referral for Consideration of Investigation into Alleged Breaches of the *State Service Act 2000* Code of Conduct and Suspension with Pay', 8 November 2020, produced by the Tasmanian Government in response to a Commission notice to produce.

2359 Letter from Michael Pervan to 'Lester', 9 November 2020, 1–2, produced by the Tasmanian Government in response to a Commission notice to produce.

2360 Statement of Michael Pervan, 24 August 2022, [163].

2361 Statement of Michael Pervan, 24 August 2022, [157].

2362 Statement of Mandy Clarke, 19 August 2022, 13 [45].

2363 Statement of Mandy Clarke, 19 August 2022, 13 [45].

2364 Statement of Kathy Baker, 18 August 2022, 28 [163].

2365 Statement of Michael Pervan, 24 August 2022, [169–170].

2366 Statement of Kathy Baker, 18 August 2022, 33 [187].

2367 In a letter to the Commission, Ms Baker stated she disputes this observation; Kathy Baker, *Procedural Fairness Response*, 13 July 2023, 12.

Case study 6: A complaint by Max (a pseudonym)

2368 The name 'Max' is a pseudonym; Order of the Commission of Inquiry, restricted publication order, 18 August 2022.

2369 Statement of 'Max', 19 May 2022, 1 [3].

2370 Statement of 'Max', 19 May 2022, 5 [23].

2371 Statement of 'Max', 19 May 2022, 5 [23].

2372 Statement of 'Max', 19 May 2022, 5 [24].

2373 Refer to Children, Youth and Families, 'Procedure: AYDC Significant Incident Response', undated, 2, produced by the Tasmanian Government in response to a Commission notice to produce.

2374 Statement of 'Max', 19 May 2022, 6 [26].

2375 Statement of 'Max', 19 May 2022, 7 [30–31].

2376 Statement of 'Max', 19 May 2022, 8 [36].

2377 Statement of 'Max', 19 May 2022, 10 [44–45].

2378 Statement of 'Max', 19 May 2022, 10 [44].

2379 Statement of 'Max', 19 May 2022, 10 [45].

2380 Statement of 'Max', 19 May 2022, 10 [45].

2381 Statement of 'Max', 19 May 2022, 10 [45]; Transcript of 'Max', 23 August 2022, 3124 [8–12].

2382 Statement of 'Max', 19 May 2022, 10 [46]; Transcript of 'Max', 23 August 2022, 3124 [15–17].

2383 Statement of 'Max', 19 May 2022, 10–11 [46].

2384 Transcript of 'Max', 23 August 2022, 3124 [20–27].

2385 Statement of 'Max', 19 May 2022, 11 [47].

2386 Statement of 'Max', 19 May 2022, 11 [47].

2387 Transcript of 'Max', 23 August 2022, 3125 [14–16].

2388 Statement of 'Max', 19 May 2022, 11 [47].

2389 Statement of 'Max', 19 May 2022, 11 [48].

2390 Statement of 'Max', 19 May 2022, 11 [48].

2391 Statement of 'Max', 19 May 2022, 11 [48].

2392 Statement of 'Max', 19 May 2022, 11 [49].

2393 Transcript of 'Max', 23 August 2022, 3125 [24–26].

2394 Statement of 'Max', 19 May 2022, 11 [48].

2395 Custodial Youth Justice Services, 'Procedure: Calling a Code', 6 February 2018, 3, produced by the Tasmanian Government in response to a Commission notice to produce.

2396 Statement of 'Max', 19 May 2022, 11 [49].

2397 Statement of 'Max', 19 May 2022, 11 [49].

2398 Statement of 'Max', 19 May 2022, 11 [49].

2399 Statement of 'Max', 19 May 2022, 11 [49].

2400 Statement of 'Max', 19 May 2022, 11 [49–50].

2401 Transcript of 'Max', 23 August 2022, 3125 [34], 3126 [43].

2402 Letter from Leanne McLean to the Commission of Inquiry (Attachment – 'Timeline'), 23 September 2022.

2403 Transcript of Leanne McLean, 24 August 2022, 3321 [1–5].

2404 Transcript of Leanne McLean, 24 August 2022, 3322 [40–41], 3326 [36–40].

2405 Transcript of Leanne McLean, 24 August 2022, 3322 [34–40], 3326 [14–25]

2406 Transcript of Leanne McLean, 24 August 2022, 3326 [42–47], 3327 [1–3].

2407 Transcript of Leanne McLean, 24 August 2022, 3323 [13–26].

2408 Transcript of Leanne McLean, 24 August 2022, 3323 [13–26].

2409 Transcript of Leanne McLean, 24 August 2022, 3323 [28–30].

2410 Transcript of Leanne McLean, 24 August 2022, 3323 [42–47], 3324 [1–16].

2411 Transcript of Leanne McLean, 24 August 2022, 3328 [43–47], 3329 [1–3].

2412 Transcript of Leanne McLean, 24 August 2022, 3328 [45–47], 3329 [1–13].

2413 Transcript of Leanne McLean, 24 August 2022, 3335 [44–46].

2414 Transcript of Leanne McLean, 24 August 2022, 3329 [43–45].

2415 Transcript of Leanne McLean, 24 August 2022, 3329 [44]–3330 [6].

2416 Email from Leanne McLean to Pamela Honan, 15 November 2021, 2.

2417 Email from Leanne McLean to Pamela Honan, 15 November 2021, 1.

2418 Email from Leanne McLean to Pamela Honan, 15 November 2021, 1–2.

2419 Email from Pamela Honan to Manager, Ashley Youth Detention Centre (including forward of Leanne McLean email to Pamela Honan), 22 November 2021.

2420 Email from Pamela Honan to Leanne McLean, 25 November 2021.

2421 Email from Manager, Ashley Youth Detention Centre to Pamela Honan, 23 November 2021, 1–3.

2422 Transcript of Leanne McLean, 24 August 2022, 3330 [34–38].

2423 Transcript of Manager, Ashley Youth Detention Centre [date omitted].

2424 Transcript of Manager, Ashley Youth Detention Centre [date omitted].

2425 Transcript of Manager, Ashley Youth Detention Centre [date omitted].

2426 Manager, Ashley Youth Detention Centre, *Procedural Fairness Response*, 27 June 2023, 11.

2427 Manager, Ashley Youth Detention Centre, *Procedural Fairness Response*, 27 June 2023, 11.

2428 Transcript of Manager, Ashley Youth Detention Centre [date omitted].

2429 Transcript of Manager, Ashley Youth Detention Centre [date omitted].

2430 Transcript of Manager, Ashley Youth Detention Centre [date omitted].

2431 Transcript of Manager, Ashley Youth Detention Centre [date omitted].

2432 Transcript of Manager, Ashley Youth Detention Centre [date omitted].

2433 Transcript of Manager, Ashley Youth Detention Centre [date omitted].

2434 Transcript of Manager, Ashley Youth Detention Centre [date omitted].

2435 Transcript of Manager, Ashley Youth Detention Centre [date omitted].

2436 Ashley Youth Detention Centre, 'List of Incidents from 1 October 2021 to 31 October 2021', 9 November 2021; Ashley Youth Detention Centre, 'List of Incidents from 1 November 2021 to 30 November 2021', 13 December 2021.

2437 Ashley Youth Detention Centre, 'List of Incidents from 1 October 2021 to 31 October 2021', 9 November 2021; Ashley Youth Detention Centre, 'List of Incidents from 1 November 2021 to 30 November 2021', 13 December 2021.

2438 Ashley Youth Detention Centre, 'Centre Support Team Minutes', 4 October 2021, 6, produced by the Tasmanian Government in response to a Commission notice to produce; Ashley Youth Detention Centre, 'Multi-Disciplinary Team Minutes: Signs of Safety Assessment Map [Max]', 6 October 2021, 2, produced by the Tasmanian Government in response to a Commission notice to produce; Ashley Youth Detention Centre, 'Centre Support Team Minutes', 2 November 2021, 2; Ashley Youth Detention Centre, 'Centre Support Team Minutes', 8 November 2021, 2, produced by the Tasmanian Government in response to a Commission notice to produce.

2439 Ashley Youth Detention Centre, 'List of Incidents from 1 November 2021 to 30 November 2021', 13 December 2021, compared to Ashley Youth Detention Centre, 'List of Incidents from 1 October 2021 to 31 October 2021', 9 November 2021.

2440 Ashley Youth Detention Centre, 'Multi-Disciplinary Team Minutes: Signs of Safety Assessment Map [Max]', 1 December 2021, 1, produced by the Tasmanian Government in response to a Commission notice to produce; Ashley Youth Detention Centre, 'Custodial Risk Summary and Management Plan [Max]', 1 December 2021, 1, produced by the Tasmanian Government in response to a Commission notice to produce; Ashley Youth Detention Centre, 'Custodial Risk Summary and Management Plan [Max]', 3 December 2021, 1, produced by the Tasmanian Government in response to a Commission notice to produce. Refer also to Ashley Youth Detention Centre, 'List of Incidents from 1 November 2021 to 30 November 2021', 13 December 2021.

2441 Transcript of Manager, Ashley Youth Detention Centre [date omitted].

2442 Transcript of Manager, Ashley Youth Detention Centre [date omitted].

2443 Transcript of Manager, Ashley Youth Detention Centre [date omitted].

2444 Transcript of Manager, Ashley Youth Detention Centre [date omitted].

2445 Email from Manager, Ashley Youth Detention Centre to Pamela Honan, 8 November 2021.

2446 Email from Manager, Ashley Youth Detention Centre to Pamela Honan, 23 November 2021, 2.

2447 Transcript of Manager, Ashley Youth Detention Centre [date omitted].

2448 Transcript of Manager, Ashley Youth Detention Centre [date omitted].

2449 Statement of Pamela Honan, 16 November 2022, 8 [15(a)]; Email from Leanne McLean to Pamela Honan, 15 November 2021, 1.

2450 Statement of Pamela Honan, 16 November 2022, 8 [15(b)].

2451 Statement of Pamela Honan, 16 November 2022, 8 [15(b)].

2452 Email from Pamela Honan to Manager, Ashley Youth Detention Centre, 22 November 2021, 1.

2453 Email from Manager, Ashley Youth Detention Centre to Pamela Honan, 23 November 2021, 2.

2454 Email from Manager, Ashley Youth Detention Centre to Pamela Honan, 23 November 2021, 2.

2455 Ashley Youth Detention Centre, 'Interim Centre Support Team Minutes', 27 October 2021, 1; Ashley Youth Detention Centre, 'Custodial Risk Summary and Management Plan [Max]', 27 October 2021, 1, produced by the Tasmanian Government in response to a Commission notice to produce; Ashley Youth Detention Centre, 'List of Incidents from 1 October 2021 to 31 October 2021', 9 November 2021.

2456 Email from Manager, Ashley Youth Detention Centre to Pamela Honan, 23 November 2021, 2.

2457 Email from Manager, Ashley Youth Detention Centre to Pamela Honan, 23 November 2021, 2.

2458 Email from Manager, Ashley Youth Detention Centre to Pamela Honan, 23 November 2021, 2.

2459 Email from Manager, Ashley Youth Detention Centre to Pamela Honan, 23 November 2021, 3.

2460 Email from Manager, Ashley Youth Detention Centre to Pamela Honan, 23 November 2021, 3.

2461 Email from Pamela Honan to Leanne McLean, 25 November 2021, 1.

2462 Pamela Honan, *Procedural Fairness Response*, 29 June 2023, 1.

2463 Email from Pamela Honan to Leanne McLean, 25 November 2021, 1.

2464 Pamela Honan, *Procedural Fairness Response*, 29 June 2023, 1.

2465 Email from Pamela Honan to Leanne McLean, 25 November 2021, 1. Refer to Chapter 10 for a description of the behaviour management system.

2466 Request for statement served on Pamela Honan, 21 October 2022, 9 [15(b)].

2467 Pamela Honan, *Procedural Fairness Response*, 29 June 2023, 1.

2468 The name 'Alysha' is a pseudonym; Order of the Commission of Inquiry, restricted publication order, 18 August 2022.

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2469 The name 'Walter' is a pseudonym; Order of the Commission of Inquiry, restricted publication order, 18 August 2022.

2470 The names 'Ira', 'Lester' and 'Stan' are pseudonyms; Order of the Commission of Inquiry, restricted publication order, 18 August 2022.

2471 Notice to produce served on the Tasmanian Government, 9 March 2022, 9 [22]–10 [23]; Request for statement served on Michael Pervan, 2 August 2022, 20 [60].

2472 Notice to produce served on the Tasmanian Government, 9 March 2022, 6 [13]; Department of Justice, 'Response to NTP-TAS-004, Item 13', 5 April 2022, 1, produced by the Tasmanian Government in response to a Commission notice to produce.

2473 Department for Education, Children and Young People, 'Response to NTP-TAS-008', 20 January 2023, 21 [92]–22 [95], produced by the Tasmanian Government in response to a Commission notice to produce; Letter from Craig Limkin, Acting Secretary, Department of Premier and Cabinet to the Commission of Inquiry, 20 July 2023.

2474 Statement of Youth Worker, Ashley Youth Detention Centre, 2 June 2022, 6 [25]; Statement of Youth Worker, Ashley Youth Detention Centre, 2 June 2022, 5 [25]; Statement of Youth Worker, Ashley Youth Detention Centre, 1 June 2022, 7 [38]; Statement of former Manager, Professional Services and Policy, Ashley Youth Detention Centre, 8 August 2022, 27–28 [103]; Statement of former Youth Worker, Ashley Youth Detention Centre, 8 August 2022, 8 [121]; Statement of former Project Officer, Ashley Youth Detention Centre, 15 August 2022, 39 [120].

2475 *Royal Commission into Institutional Responses to Child Sexual Abuse*: *Criminal Justice Report – Executive Summary and Parts I and II* (Report, August 2017) 11; William O'Donohue, Caroline Cummings and Brendan Willis, 'The Frequency of False Allegations of Child Sexual Abuse: A Critical Review' (2018) *Journal of Child Sexual Abuse* 27(5), 459–475; Claire Ferguson and John Malouff, 'Assessing Police Classifications of Sexual Assault Reports: A Meta-Analysis of False Reporting Rates' (2016) *Archives of Sexual Behaviour* 45, 1185–1193.

2476 Statement of former Manager, Professional Services and Policy, Ashley Youth Detention Centre, 8 August 2022, 19 [62]; Statement of Youth Worker, Ashley Youth Detention Centre, 2 June 2022, 4 [21]; Statement of Youth Worker, Ashley Youth Detention Centre, 29 May 2022, 9 [21].

2477 Transcript of Sarah Spencer, 18 August 2022, 2820 [2–26]; Ivan Dean, Submission No. 23 to Legislative Council Sessional Committee Government Administration B, *Inquiry into Tasmanian Adult Imprisonment and Youth Detention Matters* (March 2023) 4.

2478 Statement of Youth Worker, Ashley Youth Detention Centre, 29 May 2022, 14 [45]; Statement of Operations Manager, Ashley Youth Detention Centre, 1 August 2022, 11 [84]; Statement of Fiona Atkins, 15 August 2022, 15 [48].

2479 Statement of 'Ben', 29 March 2022, 4[19]; Statement of 'Warren', 19 May 2022, 2 [8], [11]. The names 'Ben' and 'Warren' are pseudonyms; Order of the Commission of Inquiry, restricted publication order, 18 August 2022.

2480 Transcript of 'Max', 23 August 2022, 3123 [24–43]. The name 'Max' is a pseudonym; Order of the Commission of Inquiry, restricted publication order, 18 August 2022. Statement of 'Ben', 29 March 2022, 4 [19]; Call with anonymous, 24 August 2022.

2481 The name 'Alysha' is a pseudonym; Order of the Commission of Inquiry, restricted publication order, 18 August 2022. Statement of 'Alysha', 16 August 2022, 64 [325–326].

2482 Statement of 'Alysha', 16 August 2022, 66 [335–337], [340], 68 [348–349].

2483 Tasmania, Tasmanian Government Gazette, No 21 907, 28 August 2019, 498; State of Tasmania, *Procedural Fairness Response*, 23 August 2023, 4.

2484 Statement of Jonathan Higgins, 7 June 2022, 2 [3].

2485 Ombudsman Tasmania, 'About us' (Web Page) <https://www.ombudsman.tas.gov.au/about-us>; Office of the Custodial Inspector, 'About us' (Web Page) <https://www.custodialinspector.tas.gov.au/about_us>.

2486 Department of Communities, 'NTP-TAS-02 – Item 15 Cover sheet', 20 September 2021, 2, produced by the Tasmanian Government in response to a Commission notice to produce; Department of Communities, 'AYDC Child Sexual Abuse Allegations', 29 October 2021 (Excel spreadsheet), produced by the Tasmanian Government in response to a Commission notice to produce; Department of Justice, 'Claims of Abuse in AYDC' (Spreadsheet), 19 September 2020, produced by the Tasmanian Government in response to a Commission notice to produce; Department of Justice, 'Response to NTP-TAS-004, Item 13', 5 April 2022, 1, produced by the Tasmanian Government in response to a Commission notice to produce; Department of Justice, 'Item 13 – Abuse in State Care Scheme', 5 April 2022, 1, produced by the Tasmanian Government in response to a Commission notice to produce.

2487 Department for Education, Children and Young People, 'Response to NTP-TAS-008', 20 January 2023, 9–10 [34], 23 [97], produced by the Tasmanian Government in response to a Commission notice to produce.

2488 Statement of Peter Graham, 15 August 2022, 5, 12–13.

2489 Statement of Jonathan Higgins, 8 August 2022, Annexure JCH-001 (Updated list of victim-survivors, allegations and actions, Spreadsheet, 24 August 2022).

2490 Department of Communities, 'NTP-TAS-02 – Item 15 Cover sheet', 20 September 2021, 2, produced by the Tasmanian Government in response to a Commission notice to produce; Department of Communities, 'AYDC Child Sexual Abuse Allegations', 29 October 2021 (Excel spreadsheet), produced by the Tasmanian Government in response to a Commission notice to produce; Department of Justice, 'Claims of Abuse in AYDC' (Spreadsheet), 19 September 2020, produced by the Tasmanian Government in response to a Commission notice to produce; Department of Justice, 'Response to NTP-TAS-004, Item 13', 5 April 2022, 1, produced by the Tasmanian Government in response to a Commission notice to produce; Department of Justice, 'Item 13 – Abuse in State Care Scheme', 5 April 2022, 1, produced by the Tasmanian Government in response to a Commission notice to produce; Department for Education, Children and Young People, 'Response to NTP-TAS-008', 20 January 2023, 9–10 [34], produced by the Tasmanian Government in response to a Commission notice to produce.

2491 Department of Communities, 'ED tracker' (Excel spreadsheet), 6 February 2023, produced by the Tasmanian Government in response to a Commission notice to produce.

2492 *Youth Justice Act 1997* ss 3 (definition of 'guardian' para (c)), 83(3).

2493 *Children, Young Persons and Their Families Act 1997* s 6.

2494 Refer generally to *Children, Young Persons and Their Families Act 1997*, in particular Part 7, and *Youth Justice Act 1997*, in particular Part 6, Division 3.

2495 *Youth Justice Act 1997* s 124(1).

2496 Refer to *Howard v Jarvis* (1958) 98 CLR 177, 183; *Campbell v Northern Territory of Australia* [2018] FCA 85, [64] cited in Neil Morrissey, 'The Duty of Care Owed to Prisoners by Prison Authorities' (2018) 147 *Precedent* 39, 40. Refer also to *Royal Commission into Institutional Responses to Child Sexual Abuse* (Final Report, December 2017) vol 15, 10, 62.

2497 *Civil Liability Act 2002* pt 10C div 2, as inserted by the *Justice Legislation Amendment (Organisational Liability for Child Abuse) Act 2019* s 6.

2498 *Civil Liability Act 2002* pt 10C div 3, as inserted by the *Justice Legislation Amendment (Organisational Liability for Child Abuse) Act 2019* s 6.

2499 *Work Health and Safety Act 2012* s 19.

2500 *Criminal Code Act 1924* s 105A, as inserted by the *Criminal Code and Related Legislation Amendment (Child Abuse) Act 2019* s 7.

2501 *Criminal Code Act 1924* s 105A(3).

2502 *Registration to Work with Vulnerable People Act 2013* s 53A, as inserted by the *Registration to Work with Vulnerable People Amendment Act 2015* s 33, later repealed and substituted by the *Registration to Work with Vulnerable People Amendment Act 2019* s 38.

2503 *Registration to Work with Vulnerable People Act 2013* s 11A(1)(b).

2504 *Registration to Work with Vulnerable People Act 2013* ss 28, 33, 46(2), 46(5).

2505 Statement of Peter Graham, 15 August 2022, 3.

2506 Statement of Peter Graham, 15 August 2022, 3.

2507 Statement of Peter Graham, 15 August 2022, 2; *Registration to Work with Vulnerable People Act 2013* s 49(2).

2508 *National Redress Scheme for Institutional Child Sexual Abuse Act 2018* (Cth) ss 6, 92, 97, 111.

2509 *Registration to Work with Vulnerable People Regulations 2014* reg 5A.

2510 *Registration to Work with Vulnerable People Act 2013* s 3 (definition of 'reporting body').

2511 Statement of Peter Graham, 15 August 2022, 2. Refer also to *Registration to Work with Vulnerable People Regulations 2014* reg 4H.

2512 *Registration to Work with Vulnerable People Act 2013* s 53A, as inserted by the *Registration to Work with Vulnerable People Amendment Act 2015* s 33, later repealed and substituted by the *Registration to Work with Vulnerable People Amendment Act 2019* s 38.

2513 *Registration to Work with Vulnerable People Act 2013* s 53A(2).

2514 *Registration to Work with Vulnerable People Act 2013* s 53A, as enacted.

2515 Transcript of Peter Graham, 24 August 2022, 3213 [6–13].

2516 Transcript of Peter Graham, 24 August 2022, 3213 [32]–3214 [1].

2517 *Registration to Work with Vulnerable People Act 2013* s 53A, as inserted by the *Registration to Work with Vulnerable People Amendment Act 2015* s 33, later repealed and substituted by the *Registration to Work with Vulnerable People Amendment Act 2019* s 38.

2518 Statement of Jacqueline Allen, 21 December 2022, 13 [78–84]; Statement of Jacqueline Allen, 21 December 2022, Attachment 84 (Emails between Jacqueline Allen and Risk Assessment Officer, Registration to Work with Vulnerable People, 11 August 2020).

2519 Transcript of Peter Graham, 24 August 2022, 3216 [24–25].

2520 *Registration to Work with Vulnerable People Act 2013* ss 28(1A)(d), 53B(1) and *Registration to Work with Vulnerable People (Risk Assessment for Child-related Activities) Order 2014* ord 5, which refers to the information the Registrar can take into account when determining an application for registration or conducting an additional risk assessment for a person who is already registered under the Act, some of which would only be available to the Registrar if an agency had notified them of this information (prior to any duty to report, which only applies when a person is already registered): ords 2(m), 5(1)(l).

2521 *Personal Information Protection Act 2004* sch 1, item 2(1)(d).

2522 Transcript of Peter Graham, 24 August 2022, 3218 [34–39].

2523 Statement of Peter Graham, 15 August 2022, 9. Refer also to *Children, Young Persons and Their Families Act 1997* s 14.

2524 Transcript of Peter Graham, 24 August 2022, 3214 [37]–3215 [11].

2525 Transcript of Peter Graham, 24 August 2022, 3215 [11–16].

2526 Statement of Peter Graham, 15 August 2022, 9.

2527 Statement of Peter Graham, 15 August 2022, 5.

2528 Statement of Peter Graham, 15 August 2022, 4.

2529 Statement of Peter Graham, 15 August 2022, 4.

2530 Statement of Peter Graham, 15 August 2022, 4.

2531 Statement of Peter Graham, 15 August 2022, 4.

2532 Statement of Peter Graham, 15 August 2022, 4.

2533 *Registration to Work with Vulnerable People Act 2013* s 30(2)(b).

2534 Statement of Peter Graham, 15 August 2022, 4.

2535 Statement of Peter Graham, 15 August 2022, 6–7 (citations omitted).

2536 Transcript of Peter Graham, 24 August 2022, 3222 [6–8].

2537 Transcript of Peter Graham, 24 August 2022, 3222 [46]–3223 [7].

2538 State of Tasmania, *Procedural Fairness Response*, 27 July 2023, 5 [7].

2539 State of Tasmania, *Procedural Fairness Response*, 27 July 2023, 5 [7].

2540 Transcript of Peter Graham, 24 August 2022, 3222 [14–25].

2541 Tasmania Police, 'Tasmanian Government's Current Service System', 23 August 2021, 6–7, produced by Tasmania Police in response to a Commission notice to produce; *Children, Young Persons and Their Families Act 1997* s 14; *Registration to Work with Vulnerable People Act 2013* ss 3, 53A; *Criminal Code Act 1924* s 105A.

2542 Statement of Jonathan Higgins, 8 August 2022, 3 [3].

2543 Statement of Jonathan Higgins, 8 August 2022, 3 [3], [5].

2544 Statement of Jonathan Higgins, 8 August 2022, 3 [3–5].

2545 Statement of Jonathan Higgins, 8 August 2022, 3 [6].

2546 Transcript of Jonathan Higgins, 24 August 2022, 3237 [25–28].

2547 Statement of Jonathan Higgins, 8 August 2022, 3 [3].

2548 Statement of Jonathan Higgins, 8 August 2022, 3 [4].

2549 Statement of Jonathan Higgins, 8 August 2022, 3 [3].

2550 Statement of Jonathan Higgins, 8 August 2022, 3 [4].

2551 Transcript of Jonathan Higgins, 24 August 2022, 3234 [30]–3235 [13].

2552 Transcript of Jonathan Higgins, 24 August 2022, 3234 [35]–3235 [18], 3237 [9–28].

2553 Statement of Jonathan Higgins, 8 August 2022, 5 [10].

2554 Statement of Jonathan Higgins, 8 August 2022, 5 [11]; Statement of Jonathan Higgins, 8 August 2022, Annexure JCH-021, 2.

2555 State of Tasmania, *Procedural Fairness Response*, 27 July 2023, Attachment 3 ('National Redress Scheme Operational Manual for Participating Institutions', August 2018) 42.

2556 Statement of Jonathan Higgins, 8 August 2022, 5 [10]; Statement of Jonathan Higgins, 8 August 2022, Annexure JCH-021 (Letter from Jonathan Higgins to Commanders, Tasmania Police, 18 January 2021) 2.

2557 State of Tasmania, *Procedural Fairness Response*, 27 July 2023, 16.

2558 The Code of Conduct is in the *State Service Act 2000* s 9 ('State Service Act'). Relevant employment directions are: Tasmanian Government, *Employment Direction No. 4—Procedure for the suspension of State Service employees with or without pay* (4 February 2013); Tasmanian Government, *Employment Direction No. 5—Procedures for the investigation and determination of whether an employee has breached the Code of Conduct* (4 February 2013). Employment Direction No. 5 was updated in April 2023. Tasmanian Government, *Employment Direction No. 6 – Procedures for the investigation and determination of whether an employee is able to efficiently and effectively perform their duties* (4 February 2013). Also relevant are the State Service Principles, which are in section 7 of the *State Service Act 2000* ('State Service Principles'). The State Service Principles are a statement about the way employment in the State Service is to be managed, and the standards expected of State Service employees.

2559 Integrity Commission Tasmania, *Guide to Managing Misconduct in the Tasmanian Public Sector* (March 2021) 9–10. We note that the Integrity Commission's guide was first published in 2017 and was updated in 2021. There are some slight textual differences between these versions, but they are otherwise substantially the same and the differences are not material for the purposes of this case study.

2560 Integrity Commission Tasmania, *Guide to Managing Misconduct in the Tasmanian Public Sector* (March 2021) 9.

2561 Jacqueline Allen, *Procedural Fairness Response*, 24 July 2023, 2.

2562 Integrity Commission Tasmania, *Guide to Managing Misconduct in the Tasmanian Public Sector* (March 2021), 15.

2563 Integrity Commission Tasmania, *Guide to Managing Misconduct in the Tasmanian Public Sector* (March 2021), 15.

2564 Integrity Commission Tasmania, *Guide to Managing Misconduct in the Tasmanian Public Sector* (March 2021), 15–16.

2565 Integrity Commission Tasmania, *Guide to Managing Misconduct in the Tasmanian Public Sector* (March 2021), 16.

2566 Statement of Michael Pervan, 14 June 2022, 43 [226]; Transcript of Jacqueline Allen, 25 August 2022, 3370 [40]–3371 [11].

2567 Transcript of Jacqueline Allen, 25 August 2022, 3371 [8–11].

2568 Transcript of Jacqueline Allen, 25 August 2022, 3372 [16–20].

2569 Statement of Jacqueline Allen, 15 August 2022, 43 [247].

2570 Jacqueline Allen, *Procedural Fairness Response*, 24 July 2023, 3 [6].

2571 Jacqueline Allen, *Procedural Fairness Response*, 24 July 2023, 3 [6].

2572 Statement of Jacqueline Allen, 15 August 2022, 36 [200]; Statement of Kathy Baker, 18 August 2022, 33 [193]; Transcript of Kathy Baker, 25 August 2022, 3420 [14]–3421 [15].

2573 Statement of Kathy Baker, 18 August 2022, 15 [79]; Statement of Kathy Baker, 16 November 2022, 5 [8]; Statement of Mandy Clarke, 16 November 2022, 5 [8(a)]; Statement of Michael Pervan, 20 December 2022, 11 [39]; Transcript of Jacqueline Allen, 25 August 2022, 3370 [33–38].

2574 Statement of Jacqueline Allen, 15 August 2022, 47 [283].

2575 Statement of Jacqueline Allen, 15 August 2022, 32–33 [182].

2576 Statement of Mandy Clarke, 19 August 2022, 11 [39]; Statement of Michael Pervan, 7 June 2022, Annexure 21 ('Responding to Requests for Information relating to Claims under the National Redress Scheme', Draft Procedure, Children and Youth Services, undated), 2 [2.2]–3 [2.6].

2577 Department of Communities, 'Briefing for the Minister: Employment Matters at Ashley Youth Detention Centre (AYDC)', 4 November 2021, 3, produced by the Tasmanian Government in response to a Commission notice to produce.

2578 Request for statement served on Michael Pervan, 2 August 2022, 7 [7], 10 [26], 14–15 [39]; Request for statement served on Mandy Clarke, 2 August 2022, 7 [7], 10 [26], 14 [39]; Request for statement served on Kathy Baker, 2 August 2022, 7 [7], 10 [26], 14–15 [39]; Request for statement served on Jacqueline Allen, 28 July 2022, 10 [26], 13–14 [47].

2579 Transcript of Michael Pervan, 26 August 2022, 3505 [38–47].

2580 Transcript of Michael Pervan, 26 August 2022, 3507 [1–10].

2581 Statement of Michael Pervan, 23 August 2022, Annexure 26.1 ('Review of Claims of Abuse of Children in State Care: Notification Process', Department of Communities, 14 December 2020) 2.

2582 Statement of Michael Pervan, 23 August 2022, Annexure 26.1 ('Review of Claims of Abuse of Children in State Care: Notification Process', Department of Communities, 14 December 2020) 1.

2583 Statement of Michael Pervan, 23 August 2022, Annexure 26.1 ('Review of Claims of Abuse of Children in State Care: Notification Process', Department of Communities, 14 December 2020) 5.

2584 Department of Health and Human Services, *Review of Claims of Abuse of Children in State Care Final Report – Round 4* (Report, November 2014) 1; Michael Pervan, *Procedural Fairness Response*, 31 July 2023, 5 [14(c)].

2585 Department of Health and Human Services, *Review of Claims of Abuse of Children in State Care: Final Report—Round 4* (Report, November 2014) 10, 14.

2586 Transcript of Michael Pervan, 26 August 2022, 3502 [7–17].

2587 Transcript of Michael Pervan, 26 August 2022, 3502 [18–33].

2588 Statement of Michael Pervan, 23 August 2022, Annexure MP.5.001 (Letter from Solicitor-General to Secretary, Department of Health and Human Services, 1 May 2007).

2589 Statement of Michael Pervan, 23 August 2022, Annexure MP.5.001 (Letter from Solicitor-General to Secretary, Department of Health and Human Services, 1 May 2007) 1.

2590 Statement of Michael Pervan, 23 August 2022, Annexure MP.5.001 (Letter from Solicitor-General to Secretary, Department of Health and Human Services, 1 May 2007) 1.

2591 Statement of Michael Pervan, 23 August 2022, Annexure MP.5.001 (Letter from Solicitor-General to Secretary, Department of Health and Human Services, 1 May 2007) 1.

2592 Statement of Michael Pervan, 23 August 2022, Annexure MP.5.001 (Letter from Solicitor-General to Secretary, Department of Health and Human Services, 1 May 2007) 2.

2593 Statement of Michael Pervan, 23 August 2022, Annexure MP.5.001 (Letter from Solicitor-General to Secretary, Department of Health and Human Services, 1 May 2007) 2.

2594 Statement of Michael Pervan, 23 August 2022, Annexure MP.5.001 (Letter from Solicitor-General to Secretary, Department of Health and Human Services, 1 May 2007) 2.

2595 Statement of Michael Pervan, 23 August 2022, 10 [32]; Statement of Jacqueline Allen, 21 December 2022, 15–16 [99], 17–18 [116]; Transcript of Kathy Baker, 25 August 2022, 3410 [27–35].

2596 Statement of Michael Pervan, 23 August 2022, 10 [32].

2597 Statement of Michael Pervan, 23 August 2022, 10 [32]. In relation to senior leadership generally, refer to Statement of Michael Pervan, 20 December 2022, 5 [17]; Statement of Jacqueline Allen, 21 December 2022, 7 [53].

2598 Transcript of Michael Pervan, 26 August 2022, 3502 [42], 3503 [8–9].

2599 Transcript of Michael Pervan, 26 August 2022, 3506 [34–40].

2600 Statement of Michael Pervan, 23 August 2022, 11 [34], 35 [130]–36 [133], 38 [142], 39 [149–151], 40 [155], 44 [170], 45 [173], 81 [340].

2601 Statement of Ginna Webster, 29 April 2022, 1 [6–8]; Statement of Ginna Webster, 13 January 2023, 15 [28(e)(i)].

2602 Statement of Pamela Honan, 16 November 2022, 2 [6]; Statement of former Director, Strategic Youth Services, Department of Communities, 28 November 2022, 35 [103].

2603 Statement of Jacqueline Allen, 21 December 2022, 7 [51]; Transcript of Michael Pervan, 26 August 2022, 3503 [11–21].

2604 Transcript of Michael Pervan, 26 August 2022, 3504 [2–18]; Statement of Jacqueline Allen, 21 December 2022, 7 [51–52]; Transcript of Kathy Baker, 25 August 2022, 3410 [28–35].

2605 Transcript of Kathy Baker and Mandy Clarke, 25 August 2022, 3410 [37]–3411 [33]; Transcript of Michael Pervan, 26 August 2022, 3505 [38]–3506 [46].

2606 Transcript of Michael Pervan, 26 August 2022, 3505 [43]–3506 [30].

2607 Statement of Michael Pervan, 23 August 2022, 10 [29], 11 [34], 35 [130]–36 [133], 39 [149–151], 40 [155], 43 [168], 44 [170], [172], 45 [173], [178], 46 [180], 47 [184], 81 [340]; Statement of Michael Pervan, 20 December 2022, 20 [77].

2608 Statement of Michael Pervan, 23 August 2022, 10 [29].

2609 Statement of Michael Pervan, 23 August 2022, 35 [132].

2610 Department for Education, Children and Young People, 'Abuse in State Care Support Service' (Web Page) <https://www.decyp.tas.gov.au/children/adoptions-and-permanency-services/abuse-in-state-care-support-service/>.

2611 Statement of Michael Pervan, 7 June 2022, 19 [118].

2612 Department of Communities, 'NTP-TAS-02 – Item 15 Cover sheet', 20 September 2021, 1–2, produced by the Tasmanian Government in response to a Commission notice to produce; Department of Communities, 'AYDC Child Sexual Abuse Allegations', 29 October 2021 (Excel spreadsheet), produced by the Tasmanian Government in response to a Commission notice to produce.

2613 Department of Communities, 'AYDC Child Sexual Abuse Allegations' (Excel spreadsheet), 29 October 2021, produced by the Tasmanian Government in response to a Commission notice to produce; Department of Communities, 'Response – Item 19', 11 April 2022, produced by the Tasmanian Government in response to a Commission notice to produce.

2614 Department of Communities, 'AYDC Child Sexual Abuse Allegations', 29 October 2021 (Excel spreadsheet), produced by the Tasmanian Government in response to a Commission notice to produce.

2615 Department of Communities, 'Allegations and incidents – Stand downs' (Excel spreadsheet), 20 September 2021, produced by the Tasmanian Government in response to a Commission notice to produce.

2616 Department of Communities, 'ED tracker' (Excel spreadsheet), 6 February 2023, produced by the Tasmanian Government in response to a Commission notice to produce; Department of Communities, 'Allegations and incidents – Stand downs' (Excel spreadsheet), 20 September 2021, produced by the Tasmanian Government in response to a Commission notice to produce.

2617 Department of Communities, 'Allegations and incidents – Stand downs' (Excel spreadsheet), 20 September 2021, produced by the Tasmanian Government in response to a Commission notice to produce.

2618 Department of Communities, 'ED tracker' (Excel spreadsheet), 6 February 2023, produced by the Tasmanian Government in response to a Commission notice to produce.

2619 Department of Communities, 'ED tracker' (Excel spreadsheet), 6 February 2023, produced by the Tasmanian Government in response to a Commission notice to produce.

2620 Department of Communities, 'Allegations and incidents – Stand downs' (Excel spreadsheet), 20 September 2021, produced by the Tasmanian Government in response to a Commission notice to produce.

2621 Department of Communities, 'Allegations and incidents – Stand downs' (Excel spreadsheet), 20 September 2021, produced by the Tasmanian Government in response to a Commission notice to produce; Department of Communities, 'ED tracker' (Excel spreadsheet), 6 February 2023, produced by the Tasmanian Government in response to a Commission notice to produce.

2622 Department of Communities, 'Allegations and incidents – Stand downs' (Excel spreadsheet), 20 September 2021, produced by the Tasmanian Government in response to a Commission notice to produce.

2623 Department of Communities, 'Magistrate's Decision', 14 July 2017, produced by the Tasmanian Government in response to a Commission notice to produce.

2624 Department of Communities, 'ED tracker' (Excel spreadsheet), 6 February 2023, produced by the Tasmanian Government in response to a Commission notice to produce.

2625 Department of Communities, 'Allegations and incidents – Stand downs' (Excel spreadsheet), 20 September 2021, produced by the Tasmanian Government in response to a Commission notice to produce.

2626 Department of Communities, 'Allegations and incidents – Stand downs' (Excel spreadsheet), 20 September 2021, produced by the Tasmanian Government in response to a Commission notice to produce.

2627 Richard Connock, *Procedural Fairness Response*, 19 July 2023, 2.

2628 Department of Communities, 'Allegations and incidents – Stand downs' (Excel spreadsheet), 20 September 2021, produced by the Tasmanian Government in response to a Commission notice to produce.

2629 Department of Communities, 'Allegations and incidents – Stand downs' (Excel spreadsheet), 20 September 2021, produced by the Tasmanian Government in response to a Commission notice to produce.

2630 Department of Communities, 'Allegations and incidents – Stand downs' (Excel spreadsheet), 20 September 2021, produced by the Tasmanian Government in response to a Commission notice to produce; Department of Communities, 'ED tracker' (Excel spreadsheet), 6 February 2023, produced by the Tasmanian Government in response to a Commission notice to produce.

2631 Department of Communities, 'Allegations and incidents – Stand downs' (Excel spreadsheet), 20 September 2021, produced by the Tasmanian Government in response to a Commission notice to produce.

2632 Department of Communities, 'ED tracker' (Excel spreadsheet), 6 February 2023, produced by the Tasmanian Government in response to a Commission notice to produce.

2633 Department of Communities, 'ED tracker' (Excel spreadsheet), 6 February 2023, produced by the Tasmanian Government in response to a Commission notice to produce.

2634 Department of Communities, 'Allegations and incidents – Stand downs' (Excel spreadsheet), 20 September 2021, produced by the Tasmanian Government in response to a Commission notice to produce; Department of Communities, 'ED tracker' (Excel spreadsheet), 6 February 2023, produced by the Tasmanian Government in response to a Commission notice to produce.

2635 Department of Communities, 'Allegations and incidents – Stand downs' (Excel spreadsheet), 20 September 2021, produced by the Tasmanian Government in response to a Commission notice to produce; Department of Communities, 'ED tracker' (Excel spreadsheet), 6 February 2023, produced by the Tasmanian Government in response to a Commission notice to produce.

2636 Department of Communities, 'ED tracker' (Excel spreadsheet), 6 February 2023, produced by the Tasmanian Government in response to a Commission notice to produce.

2637 Department of Communities, 'Allegations and incidents – Stand downs' (Excel spreadsheet), 20 September 2021, produced by the Tasmanian Government in response to a Commission notice to produce.

2638 Department of Communities, 'Allegations and incidents – Stand downs' (Excel spreadsheet), 20 September 2021, produced by the Tasmanian Government in response to a Commission notice to produce.

2639 Department of Communities, 'Allegations and incidents – Stand downs' (Excel spreadsheet), 20 September 2021, produced by the Tasmanian Government in response to a Commission notice to produce.

2640 Department of Communities, 'Allegations and incidents – Stand downs' (Excel spreadsheet), 20 September 2021, produced by the Tasmanian Government in response to a Commission notice to produce.

2641 Department of Communities, 'Allegations and incidents – Stand downs' (Excel spreadsheet), 20 September 2021, produced by the Tasmanian Government in response to a Commission notice to produce.

2642 The name 'Walter' is a pseudonym; Order of the Commission of Inquiry, restricted publication order 18 August 2022.

2643 Department of Communities, 'Employment Histories – AYDC', 29 March 2022, 5, produced by the Tasmanian Government in response to a Commission notice to produce.

2644 Department of Communities, 'Employment Histories – AYDC', 29 March 2022, 5, produced by the Tasmanian Government in response to a Commission notice to produce.

2645 The name 'Erin' is a pseudonym; Order of the Commission of Inquiry, restricted publication order, 18 August 2022.

2646 Statement of Jacqueline Allen, 20 August 2022, 2–3.

2647 Statement of Jacqueline Allen, 20 August 2022, 2–3.

2648 Statement of Jacqueline Allen, 20 August 2022, 5.

2649 Statement of Jacqueline Allen, 20 August 2022, 5.

2650 Statement of Jacqueline Allen, 20 August 2022, 5; *Tasmanian State Service Act 1984* s 54(1)(e) (repealed).

2651 Statement of Jacqueline Allen, 20 August 2022, 5.

2652 Statement of Jacqueline Allen, 20 August 2022, 4.

2653 Department of Justice, 'Claims of Abuse in AYDC' (Spreadsheet), 19 September 2020, 5, produced by the Tasmanian Government in response to a Commission notice to produce; Department of Justice, 'Item 13 – Abuse in State Care Scheme', 5 April 2022, produced by the Tasmanian Government in response to a Commission notice to produce.

2654 Department of Justice, 'Claims of Abuse in AYDC' (Spreadsheet), 19 September 2020, 5, produced by the Tasmanian Government in response to a Commission notice to produce.

2655 Statement of Michael Pervan, 23 August 2022, 31 [112]; Transcript of Michael Pervan, 26 August 2022, 3507 [42]–3508 [13].

2656 Statement of Jacqueline Allen, 20 August 2022, 2.

2657 Statement of Jacqueline Allen, 20 August 2022, 3–4.

2658 Statement of Jacqueline Allen, 20 August 2022, 2; Department of Health and Human Services, 'Draft Issues Briefing for the Minister: Allegations of Sexual Assault by a Resident at Ashley Youth Detention Centre (Ashley) Against a Staff Member There', [date omitted], 1, produced by the Tasmanian Government in response to a Commission notice to produce.

2659 Statement of Jacqueline Allen, 20 August 2022, 5; Ashley Youth Detention Centre, 'Memo from former Manager, Custodial Youth Justice to [Walter]: Allegations Made by Resident [redacted]', [date omitted], produced by the Tasmanian Government in response to a Commission notice to produce.

2660 Department of Communities, 'Allegations and incidents – Stand downs' (Excel spreadsheet), 20 September 2021, produced by the Tasmanian Government in response to a Commission notice to produce.

2661 Statement of Jacqueline Allen, 20 August 2022, 2.

2662 Statement of Jacqueline Allen, 20 August 2022, 3.

2663 Richard Connock, *Procedural Fairness Response*, 19 July 2023, 2.

2664 Richard Connock, *Procedural Fairness Response*, 19 July 2023, 2.

2665 Department of Communities, 'Allegations and incidents – Stand downs' (Excel spreadsheet), 20 September 2021, produced by the Tasmanian Government in response to a Commission notice to produce; Statement of Jacqueline Allen, 20 August 2022, 2.

2666 Statement of Jacqueline Allen, 20 August 2022, 3.

2667 Statement of Jacqueline Allen, 20 August 2022, 4–5.

2668 Statement of Jacqueline Allen, 20 August 2022, 3.

2669 Department of Health and Human Services, 'Minute to Acting Deputy Secretary Children: Investigations in accordance with Employment Direction No. 5 – [Walter]', [date omitted], 3, produced by the Tasmanian Government in response to a Commission notice to produce; Statement of Jonathan Higgins, 8 August 2022, Annexure JCH-001 (Updated list of victim-survivors, allegations and actions, Spreadsheet, 24 August 2022).

2670 Statement of Jacqueline Allen, 20 August 2022, 4.

2671 Child Safety Service, 'Notification Report', [date omitted], 4–5, 8, produced by the Tasmanian Government in response to a Commission notice to produce.

2672 Child Safety Service, 'Notification Report', [date omitted], 8, produced by the Tasmanian Government in response to a Commission notice to produce.

2673 Notice to produce served on the Tasmanian Government, 9 March 2022, 11–12 [19]; Request for statement served on Jacqueline Allen, 28 July 2022, 13–14 [47]; Statement of Jacqueline Allen, 20 August 2022.

2674 Statement of Peter Graham, 15 August 2022, Attachment 1 (Registration to Work with Vulnerable People Records Concerning Ashley Youth Detention Centre Staff, 15 August 2022) 22.

2675 Statement of Peter Graham, 15 August 2022, Attachment H (Letter from Peter Graham to 'Walter', 27 July 2021) 6.

2676 Statement of 'Erin', 18 July 2022, 2 [13], 4 [20], 7[36]; File note of telephone conversation from the Commission of Inquiry to 'Erin', 18 July 2023.

2677 Transcript of 'Erin', 22 August 2022, 3021 [3–6].

2678 Transcript of 'Erin', 22 August 2022, 3021 [6–10]; Memo from Manager Custodial Youth Justice to 'Walter', 'Complaint to Ombudsman from [Erin]', [date omitted], produced by the Tasmanian Government in response to a Commission notice to produce.

2679 Transcript of 'Erin', 22 August 2022, 3021 [10–16]; Memo from Manager Custodial Youth Justice to 'Walter', 'Complaint to Ombudsman from [Erin]', [date omitted], 2, produced by the Tasmanian Government in response to a Commission notice to produce.

2680 Transcript of 'Erin', 22 August 2022, 3021 [18–24].

2681 Transcript of 'Erin', 22 August 2022, 3029; Memo from Manager Custodial Youth Justice to 'Walter', 'Complaint to Ombudsman from [Erin]', [dated omitted], 1, produced by the Tasmanian Government in response to a Commission notice to produce.

2682 Richard Connock, *Procedural Fairness Response*, 19 July 2023, 2.

2683 Memo from Manager Custodial Youth Justice to 'Walter', 'Complaint to Ombudsman from [Erin]', [date omitted], produced by the Tasmanian Government in response to a Commission notice to produce; Department of Communities, 'Allegations and incidents – Stand downs' (Excel spreadsheet), 20 September 2021, produced by the Tasmanian Government in response to a Commission notice to produce.

2684 Statement of 'Erin', 18 July 2022, Attachment [Erin]–001 ('Letter from Investigation Officer, Ombudsman Tasmania, to 'Erin', [date omitted]).

2685 Statement of 'Erin', 18 July 2022, Attachment [Erin]–001 ('Letter from Investigation Officer, Ombudsman Tasmania, to 'Erin', [date omitted]).

2686 Memo from Manager Custodial Youth Justice to 'Walter', 'Complaint to Ombudsman from [Erin]', [date omitted], 2, produced by the Tasmanian Government in response to a Commission notice to produce.

2687 Memo from Manager Custodial Youth Justice to 'Walter', 'Complaint to Ombudsman from [Erin]', [date omitted], 2, produced by the Tasmanian Government in response to a Commission notice to produce.

2688 Memo from Manager Custodial Youth Justice to 'Walter', 'Complaint to Ombudsman from [Erin]', [date omitted], 2, produced by the Tasmanian Government in response to a Commission notice to produce.

2689 Memo from Manager Custodial Youth Justice to 'Walter', 'Complaint to Ombudsman from [Erin]', [date omitted], 2, produced by the Tasmanian Government in response to a Commission notice to produce.

2690 Memo from Manager Custodial Youth Justice to 'Walter', 'Complaint to Ombudsman from [Erin]', [date omitted], 3, produced by the Tasmanian Government in response to a Commission notice to produce.

2691 Memo from Manager Custodial Youth Justice to 'Walter', 'Complaint to Ombudsman from [Erin]', [date omitted], 3, produced by the Tasmanian Government in response to a Commission notice to produce.

2692 Memo from Manager Custodial Youth Justice to 'Walter', 'Complaint to Ombudsman from [Erin]', [date omitted], 3, produced by the Tasmanian Government in response to a Commission notice to produce.

2693 Memo from Manager Custodial Youth Justice to 'Walter', 'Complaint to Ombudsman from [Erin]', [date omitted], 3, produced by the Tasmanian Government in response to a Commission notice to produce. Refer also to Richard Connock, *Procedural Fairness Response*, 19 July 2023, 2.

2694 Submission 159 Ombudsman Tasmania, 2.

2695 Submission 159 Ombudsman Tasmania, 2.

2696 Statement of 'Erin', 18 July 2022, 3 [17].

2697 Statement of 'Erin', 18 July 2022, 3 [18].

2698 Statement of 'Erin', 18 July 2022, 3 [18].

2699 Richard Connock, *Procedural Fairness Response*, 19 July 2023, 1.

2700 Richard Connock, *Procedural Fairness Response*, 19 July 2023, 1.

2701 Richard Connock, *Procedural Fairness Response*, 19 July 2023, 2.

2702 Transcript of Richard Connock, 24 August 2022, 3314 [22–25], 3315 [1–3].

2703 Submission 159 Ombudsman Tasmania, 1.

2704 Submission 159 Ombudsman Tasmania, 1–2.

2705 Richard Connock, *Procedural Fairness Response,* 31 May 2023, 2.

2706 Department of Communities, 'File 58: Documents relating to complaints made by young people detained in Ashley Youth Detention Centre', [date omitted] 2009, 1, produced by the Tasmanian Government in response to a Commission notice to produce; Department of Communities, 'File 99: Documents relating to complaints made by a young person detained in Ashley Youth Detention Centre', [date omitted] 2010, 1, produced by the Tasmanian Government in response to a Commission notice to produce; Department of Communities, 'File 164: Documents relating to complaints made by young people detained in Ashley Youth Detention Centre', [date omitted] 2013, 1, 4, produced by the Tasmanian Government in response to a Commission notice to produce.

2707 Department of Communities, 'File 99: Documents relating to complaints made by a young person detained in Ashley Youth Detention Centre', [date omitted] 2010, 3, produced by the Tasmanian Government in response to a Commission notice to produce; Department of Communities, 'File 58: Documents relating to complaints made by young people detained in Ashley Youth Detention Centre', [date omitted] 2009, 2, produced by the Tasmanian Government in response to a Commission notice to produce.

2708 Department of Communities, 'Allegations and incidents – Stand downs' (Excel spreadsheet), 20 September 2021, produced by the Tasmanian Government in response to a Commission notice to produce.

2709 Department of Health and Human Services, 'Minute to Acting Deputy Secretary Children: Investigations in accordance with Employment Direction No. 5 – [Walter]', [date omitted], 7, produced by the Tasmanian Government in response to a Commission notice to produce.

2710 Department of Health and Human Services, 'Minute to Acting Deputy Secretary Children: Investigations in accordance with Employment Direction No. 5 – [Walter]', [date omitted], 8, produced by the Tasmanian Government in response to a Commission notice to produce.

2711 Department of Health and Human Services, 'Minute to Acting Deputy Secretary Children: Investigations in accordance with Employment Direction No. 5 – [Walter]', [date omitted], 1, 2, 4, produced by the Tasmanian Government in response to a Commission notice to produce; James Cumming Investigation Services, 'Employment Direction No. 5 Investigation', [date omitted], 60–61, produced by the Tasmanian Government in response to a Commission notice to produce.

2712 Department of Health and Human Services, 'Minute to Acting Deputy Secretary Children: Investigations in accordance with Employment Direction No. 5 – [Walter]', [date omitted], 3, produced by the Tasmanian Government in response to a Commission notice to produce.

2713 Department of Health and Human Services, 'Minute to Acting Deputy Secretary Children: Investigations in accordance with Employment Direction No. 5 – [Walter]', [date omitted], 1, produced by the Tasmanian Government in response to a Commission notice to produce.

2714 Department of Health and Human Services, 'Minute to Acting Deputy Secretary Children: Investigations in accordance with Employment Direction No. 5 – [Walter]', [date omitted], 2, produced by the Tasmanian Government in response to a Commission notice to produce.

2715 Department of Health and Human Services, 'Minute to Acting Deputy Secretary Children: Investigations in accordance with Employment Direction No. 5 – [Walter]', [date omitted], 2, produced by the Tasmanian Government in response to a Commission notice to produce.

2716 Department of Health and Human Services, 'Minute to Acting Deputy Secretary Children: Investigations in accordance with Employment Direction No. 5 – [Walter]', [date omitted], 3, 10, produced by the Tasmanian Government in response to a Commission notice to produce.

2717 Department of Communities, 'Allegations and incidents – Stand downs' (Excel spreadsheet), 20 September 2021, produced by the Tasmanian Government in response to a Commission notice to produce; Statement of Jonathan Higgins, 8 August 2022, Annexure JCH-001 (Updated list of victim-survivors, allegations and actions, Spreadsheet, 24 August 2022).

2718 Email from Assistant Consultant, Safety and Injury Management to Fiona Atkins, 27 April 2021, produced by the Tasmanian Government in response to a Commission notice to produce; Statement of Peter Graham, 15 August 2022, Attachment 1 (Registration to Work with Vulnerable People Records Concerning Ashley Youth Detention Centre Staff, 15 August 2022) 22–23; Department of Health and Human Services, 'Minute to Acting Deputy Secretary Children: Investigations in accordance with Employment Direction No. 5 – [Walter]', [date omitted], 2.

2719 Department of Health and Human Services, 'Minute to Acting Deputy Secretary Children: Investigations in accordance with Employment Direction No. 5 – [Walter]', [date omitted], 1, produced by the Tasmanian Government in response to a Commission notice to produce.

2720 Department of Health and Human Services, 'Minute to Acting Deputy Secretary Children: Investigations in accordance with Employment Direction No. 5 – [Walter]', [date omitted], 6–7, produced by the Tasmanian Government in response to a Commission notice to produce.

2721 Department of Health and Human Services, 'Minute to Acting Deputy Secretary Children: Investigations in accordance with Employment Direction No. 5 – [Walter]', [date omitted], 6–7, produced by the Tasmanian Government in response to a Commission notice to produce.

2722 Department of Health and Human Services, 'Minute to Acting Deputy Secretary Children: Investigations in accordance with Employment Direction No. 5 – [Walter]', [date omitted], 6–7, produced by the Tasmanian Government in response to a Commission notice to produce.

2723 Department of Health and Human Services, 'Minute to Acting Deputy Secretary Children: Investigations in accordance with Employment Direction No. 5 – [Walter]', [date omitted], 7, produced by the Tasmanian Government in response to a Commission notice to produce.

2724 James Cumming Investigation Services, 'Employment Direction No. 5 Investigation Report regarding [Walter]', [date omitted], 52–53, produced by the Tasmanian Government in response to a Commission notice to produce.

2725 James Cumming Investigation Services, 'Employment Direction No. 5 Investigation Report regarding [Walter]', [date omitted], 53, produced by the Tasmanian Government in response to a Commission notice to produce.

2726 Department of Health and Human Services, 'Minute to Acting Deputy Secretary Children: Employment Direction No. 5 Investigation Report – [Walter]', [date omitted], produced by the Tasmanian Government in response to a Commission notice to produce.

2727 Department of Health and Human Services, 'Minute to Acting Deputy Secretary Children: Employment Direction No. 5 Investigation Report – [Walter]', [redacted], 4, produced by the Tasmanian Government in response to a Commission notice to produce.

2728 Statement of Michael Pervan, 23 August 2022, 32 [117].

2729 Deed of Release between 'Walter' and the State of Tasmania, [date omitted], 2–3, produced by the Tasmanian Government in response to a Commission notice to produce.

2730 Deed of Release between 'Walter' and the State of Tasmania, [date omitted], 2–3, produced by the Tasmanian Government in response to a Commission notice to produce.

2731 Transcript of Michael Pervan, 26 August 2022, 3510 [32]–3511 [18].

2732 Statement of Michael Pervan, 23 August 2022, 31 [113].

2733 *Evidence Act 2001* s 97A.

2734 Transcript of Michael Pervan, 26 August 2022, 3510 [32–38].

2735 *National Redress Scheme for Institutional Child Sexual Abuse Act 2018* (Cth) s 14.

2736 Statement of Ginna Webster, 10 June 2022, 51 [325].

2737 Statement of Ginna Webster, 10 June 2022, 50 [321(b)–(c)].

2738 State of Tasmania, *Procedural Fairness Response*, 27 July 2023, 3.

2739 State of Tasmania, *Procedural Fairness Response*, 27 July 2023, 2.

2740 State of Tasmania, *Procedural Fairness Response*, 27 July 2023, 2.

2741 State of Tasmania, *Procedural Fairness Response*, 27 July 2023, 2.

2742 Statement of Ginna Webster, 10 June 2022, 3 [17], 5 [27].

2743 State of Tasmania, *Procedural Fairness Response*, 27 July 2023, 3.

2744 Refer, for example, to Department of Communities, 'National Redress Scheme (Tasmania) – Request for Additional Information from Records Custodians: Response regarding [redacted]', 6 May 2019, 1, produced by the Tasmanian Government in response to a Commission notice to produce; Department of Communities, 'National Redress Scheme (Tasmania) – Request for Additional Information from Records Custodians: Response regarding [redacted]', 26 September 2019, 1, produced by the Tasmanian Government in response to a Commission notice to produce; Department of Communities, 'National Redress Scheme (Tasmania) – Request for Additional Information from Records Custodians: Response regarding [redacted]', 5 October 2020, 1.

2745 State of Tasmania, *Procedural Fairness Response*, 27 July 2023, 2.

2746 State of Tasmania, *Procedural Fairness Response*, 27 July 2023, 9-10; Statement of Jacqueline Allen, 21 December 2022, Attachment 113 ('Child abuse national redress – Ad hoc meeting minutes', Strategy and Engagement Division, 7 October 2019) 1.

2747 State of Tasmania, *Procedural Fairness Response*, 27 July 2023, 2.

2748 Statement of Michael Pervan, 7 June 2022, 18–19 [116].

2749 Statement of Michael Pervan, 7 June 2022, 18 [114]; Statement of Ginna Webster, 10 June 2022, 51 [326].

2750 Statement of Michael Pervan, 7 June 2022, 18 [114].

2751 Statement of Ginna Webster, 10 June 2022, 51 [327].

2752 Department of Communities, 'AYDC Child Sexual Abuse Allegations' (Excel spreadsheet), 29 October 2021, produced by the Tasmanian Government in response to a Commission notice to produce.

2753 The numbers are slightly different to those in Case study 1 as we are referring here to allegations against staff only.

2754 Statement of Kathy Baker, 18 August 2022, 11 [36].

2755 Notice to produce served on the State of Tasmania, 9 March 2022, 10 [18]; Request for statement served on Darren Hine, 29 July 2022, 5 [1]; Request for statement served on Peter Graham, 1 August 2022, 4 [1]–6 [5]; Request for statement served on Michael Pervan, 2 August 2022, 13 [35]; Request for statement served on Kathy Baker, 2 August 2022, 13 [35]; Request for statement served on Mandy Clarke, 2 August 2022, 13 [35]. We also made requests to Centre management and other departmental witnesses on this point and made further requests for this information following our hearings.

2756 Department of Communities, 'Employment Histories – AYDC', 29 March 2022, 7, produced by the Tasmanian Government in response to a Commission notice to produce; Department of Communities, 'ED tracker' (Excel spreadsheet), 6 February 2023, produced by the Tasmanian Government in response to a Commission notice to produce.

2757 The name 'Parker' is a pseudonym; Order of the Commission of Inquiry, restricted publication order, 30 August 2023.

2758 Department of Communities, 'Notification regarding [Parker]', 9 April 2019, 1, produced by the Tasmanian Government in response to a Commission notice to produce.

2759 The name 'Baxter' is a pseudonym; Order of the Commission of Inquiry, restricted publication order, 30 August 2023. Department of Communities, 'Notification regarding [Baxter]', 18 September 2019, 1, produced by the Tasmanian Government in response to a Commission notice to produce.

2760 Department of Communities, 'Notification regarding [Baxter]', 18 September 2019, 1, produced by the Tasmanian Government in response to a Commission notice to produce; Statement of Jacqueline Allen, 21 December 2022, Attachment 116 ('Allegations of Sexual Abuse – [Ira]', Minute to the Secretary, 3 December 2019) 4–5, Attachment 1.

2761 Statement of Jacqueline Allen, 21 December 2022, Attachment 6.1 (Child Abuse Review Team file: [Parker], March 2010) 24, 29; Statement of Jacqueline Allen, 21 December 2022, Attachment 116 ('Allegations of Sexual Abuse – [Ira]', Minute to the Secretary, 3 December 2019) 4, Attachment 1.

2762 Statement of Jacqueline Allen, 21 December 2022, Attachment 6.1 (Child Abuse Review Team file: [Parker], March 2010) 25; Statement of Jacqueline Allen, 21 December 2022, Attachment 116 ('Allegations of Sexual Abuse – [Ira]', Minute to the Secretary, 3 December 2019) 4.

2763 Statement of Pamela Honan, 16 November 2022, 4 [9(a)]; Statement of Kathy Baker, 18 August 2022, 34 [198]; Statement of Jacqueline Allen, 21 December 2022, 6 [45]; Department of Communities, 'ED tracker' (Excel spreadsheet), 29 July 2022, produced by the Tasmanian Government in response to a Commission notice to produce.

2764 Statement of Stuart Watson, 16 August 2022 (revised 23 August 2022), 4–5 [21].

2765 Department of Communities, 'Details relating to [Ira's] restricted duties', 27 May 2020, 2, produced by the Tasmanian Government in response to a Commission notice to produce.

2766 Statement of Jacqueline Allen, 21 December 2022, Attachment 113 ('Child abuse national redress – Ad hoc meeting minutes', 7 October 2019) 1.

2767 Statement of Jacqueline Allen, 21 December 2022, Attachment 113 ('Child abuse national redress – Ad hoc meeting minutes', 7 October 2019) 1.

2768 Statement of Jacqueline Allen, 21 December 2022, Attachment 113 ('Child abuse national redress – Ad hoc meeting minutes', 7 October 2019) 1–2.

2769 Statement of Jacqueline Allen, 21 December 2022, Attachment 113 ('Child abuse national redress – Ad hoc meeting minutes', 7 October 2019) 2.

2770 Statement of Jacqueline Allen, 21 December 2022, Attachment 116 ('Allegations of Sexual Abuse – [Ira]', Minute to the Secretary, 3 December 2019) 2.

2771 Statement of Jacqueline Allen, 21 December 2022, Attachment 116 ('Allegations of Sexual Abuse – [Ira]', Minute to the Secretary, 3 December 2019).

2772 Statement of Jacqueline Allen, 21 December 2022, Attachment 116 ('Allegations of Sexual Abuse – [Ira]', Minute to the Secretary, 3 December 2019) 5–6.

2773 Statement of Jacqueline Allen, 21 December 2022, Attachment 116 ('Allegations of Sexual Abuse – [Ira]', Minute to the Secretary, 3 December 2019) 1, 6.

2774 Email from Assistant Director, Safety, Wellbeing and Industrial Relations to Director, Office of the Secretary, 18 February 2020, 1, produced by the Tasmanian Government in response to a Commission notice to produce.

2775 Department of Communities, 'ED tracker' (Excel spreadsheet), 29 July 2022, produced by the Tasmanian Government in response to a Commission notice to produce. Statement of Jacqueline Allen, 15 August 2022, 64 [339(d)].

2776 Statement of Michael Pervan, 23 August 2022, 48 [188]; Department of Communities, 'ED tracker' (Excel spreadsheet), 6 February 2023, produced by the Tasmanian Government in response to a Commission notice to produce.

2777 Department of Communities, 'Minute to the Secretary: Allegations Raised Against Employee [Ira] through the Redress Scheme', 18 September 2020, 2, produced by the Tasmanian Government in response to a Commission notice to produce.

2778 Department of Communities, 'Minute to the Secretary: Allegations Raised Against Employee [Ira] through the Redress Scheme', 18 September 2020, 3–4, produced by the Tasmanian Government in response to a Commission notice to produce.

2779 Statement of Pamela Honan, 16 November 2022, Attachment 1.3 ('Meeting re AYDC HR concerns', Minutes, Strengthening Safeguards Working Group, 25 September 2020) 3; Department of Communities, 'Minute to the Secretary: [Ira] (the Employee) Referral for Consideration of Investigation into Alleged Breaches of the *State Service Act 2000* Code of Conduct and Suspension with Pay', 8 November 2020, produced by the Tasmanian Government in response to a Commission notice to produce.

2780 Statement of Pamela Honan, 16 November 2022, Attachment 1.3 ('Meeting re AYDC HR concerns', Minutes, Strengthening Safeguards Working Group, 25 September 2020) 3; Statement of Pamela Honan, 16 November 2022, Attachment 1.1 ('Meeting re AYDC HR concerns', Minutes, Strengthening Safeguards Working Group, 9 October 2020) 2.

2781 Statement of Jacqueline Allen, 21 December 2022, 3 [20–21].

2782 Statement of Jacqueline Allen, 15 August 2022, 64 [339(d)]; Department of Communities, 'ED tracker' (Excel spreadsheet), 29 July 2022, produced by the Tasmanian Government in response to a Commission notice to produce; Statement of Jacqueline Allen, 21 December 2022, Attachment 90.19 (Email from Jacqueline Allen to Jonathan Higgins, 21 October 2020).

2783 Department of Communities, 'ED tracker' (Excel spreadsheet), 29 July 2022, produced by the Tasmanian Government in response to a Commission notice to produce; Department of Communities, 'Minute to the Secretary: Allegations Raised Against Employee [Ira] through the Redress Scheme', 2 November 2020, produced by the Tasmanian Government in response to a Commission notice to produce.

2784 Department of Communities, 'Minute to the Secretary: Allegations Raised Against Employee [Ira] through the Redress Scheme', 2 November 2020, produced by the Tasmanian Government in response to a Commission notice to produce.

2785 Statement of Kathy Baker, 18 August 2022, 24 [135].

2786 Department of Communities, 'Minute to the Secretary: [Ira] (the Employee) Referral for Consideration of Investigation into Alleged Breaches of the *State Service Act 2000* Code of Conduct and Suspension with Pay', 8 November 2020, produced by the Tasmanian Government in response to a Commission notice to produce; Department of Communities, 'Minute to the Secretary: Allegations Raised Against Employee [Ira] through the Redress Scheme', 18 September 2020, produced by the Tasmanian Government in response to a Commission notice to produce.

2787 Department of Communities, 'Minute to the Secretary: [Ira] (the Employee) Referral for Consideration of Investigation into Alleged Breaches of the *State Service Act 2000* Code of Conduct and Suspension with Pay', 8 November 2020, produced by the Tasmanian Government in response to a Commission notice to produce; Transcript of *The Nurse* podcast, 2 November 2020, 56.

2788 Department of Communities, 'Minute to the Secretary: [Ira] (the Employee) Referral for Consideration of Investigation into Alleged Breaches of the *State Service Act 2000* Code of Conduct and Suspension with Pay', 8 November 2020, produced by the Tasmanian Government in response to a Commission notice to produce.

2789 Department of Communities, 'Minute to the Secretary: [Ira] (the Employee) Referral for Consideration of Investigation into Alleged Breaches of the *State Service Act 2000* Code of Conduct and Suspension with Pay', 8 November 2020, produced by the Tasmanian Government in response to a Commission notice to produce.

2790 Kathy Baker and Mandy Clarke, *Procedural Fairness Response*, 26 July 2023, 3; Michael Pervan, *Procedural Fairness Response*, 31 July 2023, 3 [9(b)].

2791 Statement of Jacqueline Allen, 21 December 2022, Attachment 57 (AYDC Working Group, Minutes, 12 February 2021) 1–2; Statement of Jacqueline Allen, 21 December 2022, Attachment 59 (Strengthening Safeguards Executive Working Group, Minutes, 19 March 2021) 2.

2792 Statement of Jonathan Higgins, 8 August 2022, Annexure JCH-001 (Updated list of victim-survivors, allegations and actions, Spreadsheet, 24 August 2022).

2793 Department of Communities, 'ED tracker' (Excel spreadsheet), 6 February 2023, produced by the Tasmanian Government in response to a Commission notice to produce.

2794 Statement of Jacqueline Allen, 15 August 2022, 64 [339(d)]; Statement of Peter Graham, 15 August 2022, Attachment 1 (Registration to Work with Vulnerable People Records Concerning Ashley Youth Detention Centre Staff, 15 August 2022) 34–35.

2795 Statement of Peter Graham, 15 August 2022, Attachment 1 (Registration to Work with Vulnerable People Records Concerning Ashley Youth Detention Centre Staff, 15 August 2022) 35.

2796 Statement of Peter Graham, 15 August 2022, 5.

2797 Statement of Peter Graham, 15 August 2022, Attachment 1 (Registration to Work with Vulnerable People Records Concerning Ashley Youth Detention Centre Staff, 15 August 2022) 37.

2798 Email from Assistant Director, Safety, Wellbeing and Industrial Relations to Director, Office of the Secretary, 18 February 2020, 1, produced by the Tasmanian Government in response to a Commission notice to produce; Letter from Secretary Michael Pervan to Deputy Commissioner, Tasmania Police, 18 February 2020, produced by the Tasmanian Government in response to a Commission notice to produce.

2799 Request for statement served on Tasmania Police, 29 July 2022, 5 [1]; Statement of Jonathan Higgins, 8 August 2022, Annexure JCH-001 (Updated list of victim-survivors, allegations and actions, Spreadsheet, 24 August 2022).

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2801 Statement of Jonathan Higgins, 8 August 2022, Annexure JCH-001 (Updated list of victim-survivors, allegations and actions, Spreadsheet, 24 August 2022); Statement of Jonathan Higgins, 8 August 2022, Annexure JCH-002 ('Reference material – additional information – [Stan]') 3–17.

2802 Statement of Jonathan Higgins, 8 August 2022, Annexure JCH-001 (Updated list of victim-survivors, allegations and actions, Spreadsheet, 24 August 2022); Statement of Peter Graham, 15 August 2022, Attachment 1 (Registration to Work with Vulnerable People Records Concerning Ashley Youth Detention Centre Staff, 15 August 2022) 33–37; Department of Communities, 'ED tracker' (Excel spreadsheet), 29 July 2022, produced by the Tasmanian Government in response to a Commission notice to produce.

2803 Request for statement served on Tasmania Police, 29 July 2022, 5 [1]; Statement of Jonathan Higgins, 8 August 2022, Annexure JCH-001 (Updated list of victim-survivors, allegations and actions, Spreadsheet, 24 August 2022); Statement of Peter Graham, 15 August 2022, Attachment 1 (Registration to Work with Vulnerable People Records Concerning Ashley Youth Detention Centre Staff, 15 August 2022) 33–37; Statement of Jacqueline Allen, 15 August 2022, 64 [339(d)]; Department of Communities, 'ED tracker' (Excel spreadsheet), 29 July 2022, produced by the Tasmanian Government in response to a Commission notice to produce.

2804 Statement of Jonathan Higgins, 8 August 2022, Annexure JCH-001 (Updated list of victim-survivors, allegations and actions, Spreadsheet, 24 August 2022).

2805 Department of Communities, 'Employment Histories – AYDC', 29 March 2022, 10, produced by the Tasmanian Government in response to a Commission notice to produce; Department of Communities, 'ED tracker' (Excel spreadsheet), 6 February 2023, produced by the Tasmanian Government in response to a Commission notice to produce.

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2807 Tasmania Police, 'Child Abuse Review Team File Information: [redacted]', 9 November 2020, 1, produced by Tasmania Police in response to a Commission notice to produce; Tasmania Police, 'Child Abuse Review Team File Information: [redacted]', 9 November 2020, produced by Tasmania Police in response to a Commission notice to produce; Tasmania Police, 'Child Abuse Review Team File Information: [redacted]', 9 November 2020, 1, produced by Tasmania Police in response to a Commission notice to produce; Tasmania Police, 'Child Abuse Review Team File Information: [redacted]', 9 November 2020, produced by Tasmania Police in response to a Commission notice to produce.

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2809 Tasmania Police, 'Disclosure Report – Intel Submission ([Lester])', [date omitted], produced by Tasmania Police in response to a Commission notice to produce.

2810 Statement of Jonathan Higgins, 8 August 2022, Annexure JCH-001 (Updated list of victim-survivors, allegations and actions, Spreadsheet, 24 August 2022).

2811 Statement of Jonathan Higgins, 7 November 2022, 22 [58]; Statement of Michael Pervan, 23 August 2022, 38 [145]; Statement of Kathy Baker, 18 August 2022, 28 [157].

2812 Department for Education, Children and Young People, 'AYDC (01 Jan 2000 – 20 July 2021) Sexual Abuse Claims' (Spreadsheet), 11 October 2021, 4, produced by the Tasmanian Government in response to a Commission notice to produce.

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2814 Statement of Michael Pervan, 23 August 2022, 39 [148]; Statement of former Director of Strategy, Program Development and Evaluation, Department of Communities, 26 August 2022, 20 [89]. Statement of Jonathan Higgins, 8 August 2022, Annexure JCH-001 (Updated list of victim-survivors, allegations and actions, Spreadsheet, 24 August 2022).

2815 Statement of 'Alysha', 16 August 2022, 64 [326]; Statement of Stuart Watson, 11 November 2022, Attachment 3 (Email from 'Alysha' to Pamela Honan, 9 January 2020); Email from 'Alysha' to Manager, Human Resources and Workplace Relations, Department of Communities and Pamela Honan, 9 January 2020.

2816 Statement of 'Alysha', 16 August 2022, 66 [335–336]; Transcript of 'Alysha', 22 August 2022, 3071 [43–47]; Email from 'Alysha' to Pamela Honan et al, 9 January 2020, produced by the Tasmanian Government in response to a Commission notice to produce.

2817 Department of Communities, 'Preliminary Assessment of Complaint Made by [Alysha] Regarding Pamela Honan', 28 March 2022, 3, produced by the Tasmanian Government in response to a Commission notice to produce.

2818 Tasmania Police, 'Disclosure Report – Intel Submission ([Lester])', 10 September 2020, 1, produced by Tasmania Police in response to a Commission notice to produce.

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2820 Statement of Kathy Baker, 18 August 2022, 23–24 [131]; Kathy Baker, *Procedural Fairness Response*, 13 July 2023, 9.

2821 Email from Mandy Clarke to Kathy Baker et al, 21 September 2020, 1.

2822 Statement of Michael Pervan, 6 September 2022, 1 [4]; Department of Communities, 'ED tracker' (Excel spreadsheet), 6 February 2023, produced by the Tasmanian Government in response to a Commission notice to produce; Department of Communities, 'Employment Histories – AYDC', 29 March 2022, 10, produced by the Tasmanian Government in response to a Commission notice to produce.

2823 Statement of Michael Pervan, 6 September 2022, 1 [3–4]; Statement of Michael Pervan, 6 October 2022, 1 [2]; Transcript of Michael Pervan, 26 August 2022, 3498 [10–32]; Statement of Pamela Honan, 16 November 2022, 4 [9(a)].

2824 Statement of 'Alysha', 16 August 2022, 67 [346]; Statement of Pamela Honan, 18 August 2022, 36 [59.7]; Pamela Honan, *Procedural Fairness Response*, 25 July 2023.

2825 Transcript of Stuart Watson, 23 August 2022, 3186 [33–44].

2826 Transcript of Pamela Honan, 19 August 2022, 2976 [45–47].

2827 Statement of Kathy Baker, 18 August 2022, 26 [150].

2828 Kathy Baker and Mandy Clarke, *Procedural Fairness Response*, 26 July 2023, 8.

2829 Kathy Baker, *Procedural Fairness Response*, 13 July 2023, 9.

2830 Letter from Lawyer to Leanne McLean, 26 August 2020, 1.

2831 Email from Mandy Clarke to Kathy Baker et al, 21 September 2020, 1.

2832 Transcript of Mandy Clarke, 25 August 2020, 3408 [30–46].

2833 Email from Director, Child Abuse Royal Commission Response Unit to Mandy Clarke, 19 September 2020, produced by the Tasmanian Government in response to a Commission notice to produce; Department of Justice, 'Claims of Abuse in AYDC' (Spreadsheet), 19 September 2020, produced by the Tasmanian Government in response to a Commission notice to produce.

2834 Statement of Kathy Baker, 18 August 2022, 26 [150].

2835 Statement of Kathy Baker, 18 August 2022, 24 [135].

2836 Email from Jacqueline Allen to Jonathan Higgins, 6 November 2020, 1, produced by Tasmania Police in response to a Commission notice to produce; Statement of Jacqueline Allen, 15 August 2022, 83 [339(o)]; Statement of Michael Pervan, 23 August 2022, 42 [160].

2837 Statement of Jacqueline Allen, 15 August 2022, 83 [339(o)]; Email from Jacqueline Allen to Jonathan Higgins, 9 November 2020, produced by Tasmania Police in response to a Commission notice to produce.

2838 Department of Communities, 'Minute to the Secretary: [Lester] (the Employee) Referral for Consideration of Investigation into Alleged Breaches of the *State Service Act 2000* Code of Conduct and Suspension with Pay', 8 November 2020, produced by the Tasmanian Government in response to a Commission notice to produce.

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2840 Department of Communities, 'Minute to the Secretary: [Lester] (the Employee) Referral for Consideration of Investigation into Alleged Breaches of the *State Service Act 2000* Code of Conduct and Suspension with Pay', 8 November 2020, produced by the Tasmanian Government in response to a Commission notice to produce.

2841 Letter from Michael Pervan to 'Lester', 9 November 2020, produced by the Tasmanian Government in response to a Commission notice to produce.

2842 Statement of Michael Pervan, 6 September 2022, 1 [3–4]; Statement of Michael Pervan, 6 October 2022, 1 [2]; Statement of Pamela Honan, 16 November 2022, 4 [9(a)].

2843 Statement of Jacqueline Allen, 21 December 2022, Attachment 59 (Strengthening Safeguards Executive Working Group, Minutes, Department of Communities, 19 March 2021) 2.

2844 Department of Communities, 'ED tracker' (Excel spreadsheet), 6 February 2023, produced by the Tasmanian Government in response to a Commission notice to produce.

2845 Department of Communities, 'ED tracker' (Excel spreadsheet), 6 February 2023, produced by the Tasmanian Government in response to a Commission notice to produce; Statement of Jonathan Higgins, 8 August 2022, Annexure JCH-001 (Updated list of victim-survivors, allegations and actions, Spreadsheet, 24 August 2022); Statement of Jonathan Higgins, 8 August 2022, Annexure JCH-011 ('Reference material – additional information – [Lester]') 46.

2846 Statement of Jacqueline Allen, 21 December 2022, 4 [27]; Department of Communities, 'ED tracker' (Excel spreadsheet), 17 August 2022, produced by the Tasmanian Government in response to a Commission notice to produce; Statement of Michael Pervan, 23 August 2022, 33 [125].

2847 Statement of Michael Pervan, 23 August 2022, 33 [125].

2848 Statement of Jacqueline Allen, 15 August 2022, 83 [339(o)]; Email from Jacqueline Allen to Jonathan Higgins, 9 November 2020, produced by Tasmania Police in response to a Commission notice to produce; Statement of Jonathan Higgins, 8 August 2022, Annexure JCH-001 (Updated list of victim-survivors, allegations and actions, Spreadsheet, 24 August 2022).

2849 Transcript of Jonathan Higgins, 24 August 2022, 3250 [27–34].

2850 Statement of Peter Graham, 15 August 2022, Attachment 1 (Registration to Work with Vulnerable People Records Concerning Ashley Youth Detention Centre Staff, 15 August 2022) 44.

2851 Statement of Peter Graham, 15 August 2022, 5.

2852 Statement of Peter Graham, 15 August 2022, Attachment 1 (Registration to Work with Vulnerable People Records Concerning Ashley Youth Detention Centre Staff, 15 August 2022) 42, 45.

2853 The name 'Stan' is a pseudonym; Order of the Commission of Inquiry, restricted publication order, 18 August 2022; Department of Communities, 'Employment Histories – AYDC', 29 March 2022, 7, produced by the Tasmanian Government in response to a Commission notice to produce; Department of Communities, 'ED tracker' (Excel spreadsheet), 6 February 2023, produced by the Tasmanian Government in response to a Commission notice to produce.

2854 Department of Communities, 'Abuse of Children in State Care Assessment Process: Assessment Report', [date omitted], 4, produced by the Tasmanian Government in response to a Commission notice to produce.

2855 The name 'Ben' is a pseudonym; Order of the Commission of Inquiry, restricted publication order, 18 August 2022. Statement of 'Ben', 29 March 2022, Attachment [Ben]–001, 4.

2856 Statement of Jonathan Higgins, 8 August 2022, Annexure JCH–001 (Updated list of victim-survivors, allegations and actions, Spreadsheet, 24 August 2022).

2857 Email from Jacqueline Allen to Mandy Clarke et al, 23 September 2020, produced by the Tasmanian Government in response to a Commission notice to produce.

2858 State of Tasmania, *Procedural Fairness Response*, 27 July 2023, 8; Statement of Pamela Honan, 16 November 2022, Attachment 1.1 ('Meeting re AYDC HR concerns', Minutes, Strengthening Safeguards Working Group, 9 October 2020) 2.

2859 Statement of Jacqueline Allen, 15 August 2022, 64 [339(d)]; Department of Communities, 'ED tracker' (Excel spreadsheet), 29 July 2022, produced by the Tasmanian Government in response to a Commission notice to produce; Statement of Jacqueline Allen, 21 December 2022, Attachment 90.19 (Email from Jacqueline Allen to Jonathan Higgins, 21 October 2020).

2860 Department of Communities, 'ED tracker' (Excel spreadsheet), 29 July 2022, produced by the Tasmanian Government in response to a Commission notice to produce; Department of Communities, 'Minute to the Secretary: Allegations Raised Against Employee [Ira] through the Redress Scheme', 2 November 2020, produced by the Tasmanian Government in response to a Commission notice to produce.

2861 Department of Communities, 'ED tracker' (Excel spreadsheet), 29 July 2022, produced by the Tasmanian Government in response to a Commission notice to produce; Statement of Peter Graham, 15 August 2022, Attachment 1 (Registration to Work with Vulnerable People Records Concerning Ashley Youth Detention Centre Staff, 15 August 2022) 10.

2862 Letter from 'Ben's' lawyer to Department of Justice, Department of Health and Human Services and Office of the Solicitor-General, [date omitted] 2020, 3, produced by the Tasmanian Government in response to a Commission notice to produce.

2863 Statement of Jacqueline Allen, 15 August 2022, 63 [339(c)].

2864 Department of Communities, 'Minute to the Secretary: [Stan] (the Employee) Referral for Consideration of Investigation into Alleged Breaches of the *State Service Act 2000* Code of Conduct (Employment Direction No. 5) and Suspension with Pay (Employment Direction No. 4)', 8 November 2020, produced by the Tasmanian Government in response to a Commission notice to produce.

2865 Statement of Michael Pervan, 23 August 2022, 48 [188].

2866 Department of Communities, 'Notification regarding [redacted]', 15 September 2020, 1.

2867 Department of Communities, 'Notification regarding [redacted]', 15 September 2020, 2–3.

2868 Department of Communities, 'Abuse in State Care Support Service Application Report', [date omitted] 2017, 1–3, produced by the Tasmanian Government in response to a Commission notice to produce.

2869 Statement of Jacqueline Allen, 15 August 2022, 63 [339(c)]; Statement of Jacqueline Allen, 21 December 2022, Attachment 88 (Email from Jacqueline Allen to Jonathan Higgins, 7 October 2020); Department of Communities, 'ED tracker' (Excel spreadsheet), 17 August 2022, produced by the Tasmanian Government in response to a Commission notice to produce; Department of Communities, 'Minute to the Secretary: [Stan] (the Employee) Referral for Consideration of Investigation into Alleged Breaches of the *State Service Act 2000* Code of Conduct (Employment Direction No. 5) and Suspension with Pay (Employment Direction No. 4)', 8 November 2020, produced by the Tasmanian Government in response to a Commission notice to produce.

2870 Statement of Jacqueline Allen, 21 December 2022, Attachment 90.20 (Email from Tasmania Police Detective Inspector to Jacqueline Allen, 3 November 2020); Department of Communities, 'Minute to the Secretary: [Stan] (the Employee) Referral for Consideration of Investigation into Alleged Breaches of the *State Service Act 2000* Code of Conduct (Employment Direction No. 5) and Suspension with Pay (Employment Direction No. 4)', 8 November 2020, produced by the Tasmanian Government in response to a Commission notice to produce.

2871 Letter from Michael Pervan to 'Stan', 9 November 2020, produced by the Tasmanian Government in response to a Commission notice to produce; Department of Communities, 'Minute to the Secretary: [Stan] (the Employee) Referral for Consideration of Investigation into Alleged Breaches of the *State Service Act 2000* Code of Conduct (Employment Direction No. 5) and Suspension with Pay (Employment Direction No. 4)', 8 November 2020, produced by the Tasmanian Government in response to a Commission notice to produce.

2872 Department of Communities, 'Minute to the Secretary: [Stan] (the Employee) Referral for Consideration of Investigation into Alleged Breaches of the *State Service Act 2000* Code of Conduct (Employment Direction No. 5) and Suspension with Pay (Employment Direction No. 4)', 8 November 2020, produced by the Tasmanian Government in response to a Commission notice to produce.

2873 Letter from Michael Pervan to 'Stan', 9 November 2020, produced by the Tasmanian Government in response to a Commission notice to produce.

2874 Statement of Pamela Honan, 16 November 2022, 4 [9(a)]; Department of Communities, 'ED tracker' (Excel spreadsheet), 29 July 2022, produced by the Tasmanian Government in response to a Commission notice to produce.

2875 Statement of Jacqueline Allen, 21 December 2022, Attachment 80 ('Concerns regarding [Stan] and [Lester]', File note, 26 October 2020).

2876 Department of Communities, 'Instrument of Appointment – Investigation pursuant to Employment Direction No. 5', 12 February 2021, produced by the Tasmanian Government in response to a Commission notice to produce.

2877 Letter from Michael Pervan to 'Stan', 12 February 2021, produced by the Tasmanian Government in response to a Commission notice to produce.

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2879 Department of Communities, 'ED tracker' (Excel spreadsheet), 6 February 2023, produced by the Tasmanian Government in response to a Commission notice to produce.

2880 Statement of Jonathan Higgins, 8 August 2022, Annexure JCH-001 (List of victim-survivors, allegations and actions, Spreadsheet, 24 August 2022); Statement of Jacqueline Allen, 15 August 2022, 63 [339(c)].

2881 Statement of Jonathan Higgins, 8 August 2022, Annexure JCH-001 (Updated list of victim-survivors, allegations and actions, Spreadsheet, 24 August 2022); Transcript of Jonathan Higgins, 24 August 2022, 3235 [23–41], 3236 [37]–3237 [2].

2882 Transcript of Jonathan Higgins, 24 August 2022, 3237 [4–7].

2883 Statement of Jonathan Higgins, 8 August 2022, Annexure JCH-001 (Updated list of victim-survivors, allegations and actions, Spreadsheet, 24 August 2022).

2884 Statement of Jacqueline Allen, 21 December 2022, Attachment 88 (Email from Jacqueline Allen to Jonathan Higgins, 7 October 2020); Statement of Pamela Honan, 16 November 2022, Attachment 1.1 ('Meeting re AYDC HR concerns', Minutes, Strengthening Safeguards Working Group, 9 October 2020) 2.

2885 Statement of Peter Graham, 15 August 2022, Attachment 1 (Registration to Work with Vulnerable People Records Concerning Ashley Youth Detention Centre Staff, 15 August 2022) 9.

2886 Statement of Peter Graham, 15 August 2022, 5.

2887 Statement of Peter Graham, 15 August 2022, Attachment A (Letter from Peter Graham to 'Stan', 15 April 2021); Statement of Peter Graham, 15 August 2022, Attachment 1 (Registration to Work with Vulnerable People Records Concerning Ashley Youth Detention Centre Staff, 15 August 2022) 9.

2888 Statement of Peter Graham, 15 August 2022, Attachment 1 (Registration to Work with Vulnerable People Records Concerning Ashley Youth Detention Centre Staff, 15 August 2022) 9–12; Statement of Peter Graham, 15 August 2022, Attachment B (Letter from Peter Graham to 'Stan', 25 February 2022) 1–2.

2889 Statement of Peter Graham, 15 August 2022, Attachment B ('Notice of Proposed Cancellation of Registration – Reasons for Decision', 25 February 2022) 17.

2890 Statement of Peter Graham, 15 August 2022, Attachment B ('Notice of Proposed Cancellation of Registration – Reasons for Decision', 25 February 2022) 17–18.

2891 Statement of Peter Graham, 15 August 2022, Attachment 1 (Registration to Work with Vulnerable People Records Concerning Ashley Youth Detention Centre Staff, 15 August 2022) 12; Statement of Peter Graham, 15 August 2022, Attachment D ('Continuation of Positive Registration – Reasons for Decision', 7 July 2022), 1.

2892 Statement of Peter Graham, 15 August 2022, Attachment B ('Notice of Proposed Cancellation of Registration Reasons for Decision', 25 February 2022), 17–18; Statement of Peter Graham, 15 August 2022, Attachment D (Reasons for continuation of positive registration under the *Registration to Work with Vulnerable People Act 2013* in relation to 'Stan', 7 July 2022) 3.

2893 Statement of Peter Graham, 15 August 2022, Attachment D (Reasons for continuation of positive registration under the *Registration to Work with Vulnerable People Act 2013* in relation to 'Stan', 7 July 2022) 5.

2894 Department of Communities, 'ED tracker' (Excel spreadsheet), 29 July 2022, produced by the Tasmanian Government in response to a Commission notice to produce.

2895 Statement of Jacqueline Allen, 15 August 2022, 64 [339(d)].

2896 Statement of Peter Graham, 15 August 2022, Attachment 1 (Registration to Work with Vulnerable People Records Concerning Ashley Youth Detention Centre Staff, 15 August 2022) 34.

2897 Statement of 'Alysha', 16 August 2022, 66 [335–336]; Email from 'Alysha' to Pamela Honan et al, 9 January 2020, produced by the Tasmanian Government in response to a Commission notice to produce; Statement of Jacqueline Allen, 15 August 2022, 83 [339(o)].

2898 Letter from 'Ben's' lawyer to Department of Justice, Department of Health and Human Services and Office of the Solicitor-General, 24 June 2020, produced by the Tasmanian Government in response to a Commission notice to produce; Statement of Kathy Baker, 18 August 2022, 22 [120]; Statement of Kathy Baker, 18 August 2022, 33 [192].

2899 Transcript of Kathy Baker, 25 August 2022, 3421 [10–15]; Statement of Jacqueline Allen, 15 August 2022, 40 [214].

2900 Statement of 'Ben', 29 March 2022, 10 [46].

2901 Statement of Kathy Baker, 18 August 2022, 9 [30], 34 [194]; Transcript of Kathy Baker, 25 August 2022, 3406 [8–16], 3421 [4–15]; Transcript of Stuart Watson, 23 August 2022, 3187 [40–47]; Transcript of Jacqueline Allen, 25 August 2022, 3366 [23–27].

2902 Transcript of Stuart Watson, 23 August 2022, 3187 [47]–3188 [4]; Statement of Pamela Honan, 18 August 2022, 54 [84.2].

2903 Statement of Kathy Baker, 18 August 2022, 33 [193].

2904 Statement of Kathy Baker, 18 August 2022, 9 [30], 34 [194]; Transcript of Kathy Baker, 25 August 2022, 3406 [8–16], 3421 [4–16].

2905 Statement of Kathy Baker, 18 August 2022, 33 [193]–34 [194].

2906 Transcript of Kathy Baker, 25 August 2022, 3421 [10–15].

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2908 Department of Communities, 'ED tracker' (Excel spreadsheet), 29 July 2022, produced by the Tasmanian Government in response to a Commission notice to produce.

2909 Letter from 'Ben's' lawyer to Department of Justice, Department of Health and Human Services and Office of the Solicitor-General, [date omitted] 2020, 3, produced by the Tasmanian Government in response to a Commission notice to produce.

2910 Statement of Stuart Watson, 16 August 2022 (revised 23 August 2022), 3–4 [21].

2911 Transcript of Patrick Ryan, 7 September 2022, 3590 [10–12].

2912 Transcript of Patrick Ryan, 7 September 2022, 3590 [35–36].

2913 Transcript of Patrick Ryan, 7 September 2022, 3588 [45]–3689 [36].

2914 Transcript of Patrick Ryan, 7 September 2022, 3590 [17–21].

2915 Statement of Michael Pervan, 23 August 2022, 45 [173]; Statement of Pamela Honan, 16 November 2022, Attachment 1.3 ('Meeting re AYDC HR concerns', Minutes, Strengthening Safeguards Working Group, 25 September 2020) 1–2; Department of Communities, 'Minute to the Secretary: [Stan] (the Employee) Referral for Consideration of Investigation into Alleged Breaches of the *State Service Act 2000* Code of Conduct (Employment Direction No. 5) and Suspension with Pay (Employment Direction No. 4)', 8 November 2020, produced by the Tasmanian Government in response to a Commission notice to produce.

2916 Letter from 'Ben's' lawyer to Department of Justice, Department of Health and Human Services and Office of the Solicitor-General, [date omitted] 2020, produced by the Tasmanian Government in response to a Commission notice to produce; Statement of Jacqueline Allen, 15 August 2022, 63 [339(c)].

2917 Transcript of Jonathan Higgins, 24 August 2022, 3244 [13–21].

2918 Statement of Pamela Honan, 16 November 2022, Attachment 1.5 ('Meeting re AYDC HR concerns', Minutes (original), Strengthening Safeguards Working Group, 26 October 2020) 1–4; Department of Communities, 'Minute to the Secretary: [Lester] (the Employee) Referral for Consideration of Investigation into Alleged Breaches of the *State Service Act 2000* Code of Conduct and Suspension with Pay', 8 November 2020, produced by the Tasmanian Government in response to a Commission notice to produce.

2919 Statement of Kathy Baker, 18 August 2022, 9 [29].

2920 Statement of Mandy Clarke, 19 August 2022, 5–6 [6].

2921 Statement of Michael Pervan, 23 August 2022, 12 [42].

2922 Integrity Commission Tasmania, *Guide to Managing Misconduct in the Tasmanian Public Sector* (March 2021) 10.

2923 Statement of Michael Pervan, 14 June 2022, 68 [372].

2924 Department of Communities, 'AYDC Child Sexual Abuse Allegations' (Excel spreadsheet), 29 October 2021, produced by the Tasmanian Government in response to a Commission notice to produce. Some of these claims related to employees and others to contractors working at the Centre.

2925 Department of Communities, 'AYDC Child Sexual Abuse Allegations' (Excel spreadsheet), 29 October 2021, produced by the Tasmanian Government in response to a Commission notice to produce. The numbers are slightly different to those in Case Study 1 as we are referring here to allegations against staff only.

2926 Department of Communities, 'AYDC Child Sexual Abuse Allegations' (Excel spreadsheet), 29 October 2021, produced by the Tasmanian Government in response to a Commission notice to produce.

2927 'COVID-19 Public Health Emergency of International Concern (PHEIC) Global Research and Innovation Forum', *World Health Organization* (Web Page, 12 February 2020) <https://www.who.int/publications/m/item/covid-19-public-health-emergency-of-international-concern-(pheic)-global-research-and-innovation-forum>.

2928 Peter Gutwein, 'Ministerial Statement COVID-19 Response Measures' (Media Release, 17 March 2020) <https://www.premier.tas.gov.au/releases/ministerial_statement_covid-19_response_measures>.

2929 Statement of Kathy Baker, 16 November 2022, 3 [6]; Statement of Mandy Clarke, 16 November 2022, 3 [6(a)].

2930 Statement of Mandy Clarke, 16 November 2022, 4 [7(g), (h)]; Transcript of Kathy Baker, 25 August 2022, 3442 [21–32].

2931 Statement of Kathy Baker, 16 November 2022, 3–4 [6]; Statement of Pamela Honan, 16 November 2022, 3 [7(ii)].

2932 Statement of Pamela Honan, 16 November 2022, Attachment 1.1 ('Meeting re AYDC HR concerns', Minutes, Strengthening Safeguards Working Group, 9 October 2020); Statement of Pamela Honan, 16 November 2022, Attachment 1.4 ('Meeting re AYDC HR concerns', Minutes (amended), Strengthening Safeguards Working Group, 26 October 2020); Statement of Pamela Honan, 16 November 2022, Attachment 1.5 ('Meeting re AYDC HR concerns', Minutes (original), Strengthening Safeguards Working Group, 26 October 2020).

2933 Statement of Pamela Honan, 16 November 2022, Attachment 1.2 ('Meeting re AYDC HR concerns', Minutes, Strengthening Safeguards Working Group, 18 September 2020) 1.

2934 Statement of Pamela Honan, 16 November 2022, 3 [7(i)].

2935 Statement of Mandy Clarke, 19 August 2022, 13 [39.11]; Transcript of Kathy Baker, 25 August 2022, 3442 [18–32].

2936 Statement of Pamela Honan, 16 November 2022, Attachment 1.2 ('Meeting re AYDC HR concerns', Minutes, Strengthening Safeguards Working Group, 18 September 2020).

2937 Transcript of Kathy Baker, 25 August 2022, 3442 [18–32].

2938 Statement of Mandy Clarke, 16 November 2022, 6 [10(b)(iii)]; Statement of Kathy Baker, 16 November 2022, 5 [7].

2939 Statement of Pamela Honan, 16 November 2022, 5 [10(a)–(b)].

2940 Statement of Mandy Clarke, 16 November 2022, 6 [10(a)].

2941 Statement of Mandy Clarke, 16 November 2022, 6 [10(a)].

2942 Statement of Michael Pervan, 20 December 2022, 7 [26].

2943 Statement of Jacqueline Allen, 21 December 2022, 9–10 [66].

2944 Statement of Pamela Honan, 16 November 2022, Attachment 1.2 ('Meeting re AYDC HR concerns', Minutes, Strengthening Safeguards Working Group, 18 September 2020) 2, 4; Statement of Pamela Honan, 16 November 2022, Attachment 1.1 ('Meeting re AYDC HR concerns', Minutes, Strengthening Safeguards Working Group, 9 October 2020) 1.

2945 Statement of Pamela Honan, 16 November 2022, Attachment 1 (Email from Client Liaison Officer, Department of Communities to Pamela Honan, 27 September 2022); Statement of Jacqueline Allen, 21 December 2022, Attachment 80 ('Concerns regarding [Stan] and [Lester]', File note, 26 October 2020).

2946 Statement of Jacqueline Allen, 21 December 2022, Attachment 77 (Minutes from redress meeting, File note, 18 September 2020); Statement of Pamela Honan, 16 November 2022, Attachment 1.2 ('Meeting re AYDC HR concerns', Minutes, Strengthening Safeguards Working Group, 18 September 2020) 2.

2947 Statement of Jacqueline Allen, 21 December 2022, Attachment 77 (Minutes from 'Redress' meeting, File note, 18 September 2020) 2; Statement of Pamela Honan, 16 November 2022, Attachment 1.3 ('Meeting re AYDC HR concerns', Minutes, Strengthening Safeguards Working Group, 25 September 2020) 2–3; Statement of Pamela Honan, 16 November 2022, Attachment 1.5 ('Meeting re AYDC HR concerns', Minutes (original), Strengthening Safeguards Working Group, 26 October 2020) 3–4.

2948 Statement of Pamela Honan, 16 November 2022, Attachment 1.1 ('Meeting re AYDC HR concerns', Minutes, Strengthening Safeguards Working Group, 9 October 2020) 3; Statement of Pamela Honan, 16 November 2022, Attachment 1.2 ('Meeting re AYDC HR concerns', Minutes, Strengthening Safeguards Working Group, 18 September 2020) 4; Statement of Pamela Honan, 16 November 2022, Attachment 1.3 ('Meeting re AYDC HR concerns', Minutes, Strengthening Safeguards Working Group, 25 September 2020) 3; Statement of Pamela Honan, 16 November 2022, Attachment 1.4 ('Meeting re AYDC HR concerns', Minutes (amended), Strengthening Safeguards Working Group, 26 October 2020) 3.

2949 Statement of Pamela Honan, 16 November 2022, Attachment 1.3 ('Meeting re AYDC HR concerns', Minutes, Strengthening Safeguards Working Group, 25 September 2020) 3–4; Statement of Pamela Honan, 16 November 2022, Attachment 1.5 ('Meeting re AYDC HR concerns', Minutes (original), Strengthening Safeguards Working Group, 26 October 2020) 3–4.

2950 Statement of Pamela Honan, 16 November 2022, Attachment 1.3 ('Meeting re AYDC HR concerns', Minutes, Strengthening Safeguards Working Group, 25 September 2020) 2; Statement of Pamela Honan, 16 November 2022, Attachment 1.2 ('Meeting re AYDC HR concerns', Minutes, Strengthening Safeguards Working Group, 18 September 2020) 3; Statement of Pamela Honan, 16 November 2022, Attachment 1.5 ('Meeting re AYDC HR concerns', Minutes (original), Strengthening Safeguards Working Group, 26 October 2020) 1; Statement of Pamela Honan, 16 November 2022, Attachment 1.4 ('Meeting re AYDC HR concerns', Minutes (amended), Strengthening Safeguards Working Group, 26 October 2020) 1.

2951 Email from Department of Communities staff member to Mandy Clarke and Pamela Honan, 18 September 2020, produced by the Tasmanian Government in response to a Commission notice to produce.

2952 Email from Department of Communities staff member to Jacqueline Allen, 24 September 2020, produced by the Tasmanian Government in response to a Commission notice to produce.

2953 Department of Health and Human Services, *Review of Claims of Abuse of Children in State Care Final Report – Round 4* (Report, November 2014) 10; Transcript of Michael Pervan, 26 August 2022, 3501 [35–44].

2954 Statement of Michael Pervan, 7 June 2022, Annexure 21 ('Responding to Requests for Information relating to Claims under the National Redress Scheme', Draft Procedure, Children and Youth Services, undated) 2–3 [2.2–2.5]; Statement of Jacqueline Allen, 15 August 2022, 40 [211(f)].

2955 Transcript of Mandy Clarke, 25 August 2022, 3408 [15–22].

2956 Statement of Mandy Clarke, 19 August 2022, 10–11 [36]; Statement of Mandy Clarke, 19 August 2022, Annexure MC.004 (Meeting with Lawyer, Angela Sdrinis Legal, Draft Minutes, 31 August 2020) 1–2; Transcript of Mandy Clarke, 25 August 2022, 3408 [30–35].

2957 Refer, for example, to Department of Communities, 'National Redress Scheme (Tasmania) – Request for Information from Records Custodians – Response regarding [redacted]', 6 May 2019, produced by the Tasmanian Government in response to a Commission notice to produce; Department of Communities, 'National Redress Scheme (Tasmania) – Request for Information from Records Custodians – Response regarding [redacted]', 26 March 2019, produced by the Tasmanian Government in response to a Commission notice to produce.

2958 Department for Education, Children and Young People, 'Response to NTP-TAS-008', 20 January 2023, produced by the Tasmanian Government in response to a Commission notice to produce, 9 [33]–10 [34].

2959 Department for Education, Children and Young People, 'Response to NTP-TAS-008', 20 January 2023, produced by the Tasmanian Government in response to a Commission notice to produce, 9 [32]–10 [34].

2960 Statement of Jacqueline Allen, 21 December 2022, 2 [7–8]; Transcript of Jacqueline Allen, 25 August 2022, 3378 [5–13]; Statement of Kathy Baker, 18 August 2022, 21 [110]; Transcript of Kathy Baker, 25 August 2022, 3407 [47]–3408 [8].

2961 Jacqueline Allen, *Procedural Fairness Response*, 24 July 2023, 6–7 [19].

2962 Transcript of Jacqueline Allen, 25 August 2022, 3378 [10–13].

2963 Transcript of Jacqueline Allen, 25 August 2022, 3378 [24–37].

2964 Statement of Mandy Clarke, 19 August 2022, 9 [27].

2965 Statement of Mandy Clarke, 19 August 2022, 9 [27]; Statement of Mandy Clarke, 16 November 2022, 2 [5(a)]; Transcript of Mandy Clarke, 25 August 2022, 3408 [46]–3409 [7].

2966 Statement of Michael Pervan, 23 August 2022, 29 [106]; Statement of Kathy Baker, 18 August 2022, 21 [115].

2967 Department of Communities, 'AYDC Child Sexual Abuse Allegations' (Excel spreadsheet), 29 October 2021, produced by the Tasmanian Government in response to a Commission notice to produce.

2968 Statement of Kathy Baker, 18 August 2022, 21 [115]; Statement of Mandy Clarke, 16 November 2022, 2 [5(a)].

2969 Email from Director, Child Abuse Royal Commission Response Unit to Mandy Clarke, 19 September 2020, produced by the Tasmanian Government in response to a Commission notice to produce; Department of Justice, 'Claims of Abuse in AYDC' (Spreadsheet), 19 September 2020, produced by the Tasmanian Government in response to a Commission notice to produce; Statement of Jacqueline Allen, 21 December 2022, 17 [10].

2970 Email from Director, Child Abuse Royal Commission Response Unit to Mandy Clarke, 19 September 2020, produced by the Tasmanian Government in response to a Commission notice to produce; Department of Justice, 'Claims of Abuse in AYDC' (Spreadsheet), 19 September 2020, produced by the Tasmanian Government in response to a Commission notice to produce.

2971 Email from Mandy Clarke to Pamela Honan et al, 21 September 2020, produced by the Tasmanian Government in response to a Commission notice to produce; Department of Justice, 'Claims of Abuse in AYDC' (Spreadsheet), 19 September 2020, produced by the Tasmanian Government in response to a Commission notice to produce.

2972 Department of Justice, 'Claims of Abuse in AYDC' (Spreadsheet), 19 September 2020, produced by the Tasmanian Government in response to a Commission notice to produce.

2973 Statement of Pamela Honan, 16 November 2022, Attachment 1.1 ('Meeting re AYDC HR concerns', Minutes, Strengthening Safeguards Working Group, 9 October 2020) 1; Department for Education, Children and Young People, 'Response to NTP-TAS-008', 20 January 2023, 9–10 [34], produced by the Tasmanian Government in response to a Commission notice to produce.

2974 Statement of Jacqueline Allen, 21 December 2022, 2 [10].

2975 Department for Education, Children and Young People, 'Response to NTP-TAS-008', 20 January 2023, 10 [36], produced by the Tasmanian Government in response to a Commission notice to produce.

2976 Department for Education, Children and Young People, 'AYDC (01 Jan 2000 – 20 July 2021) Sexual Abuse Claims' (Spreadsheet), 11 October 2021, produced by the Tasmanian Government in response to a Commission notice to produce.

2977 Department for Education, Children and Young People, 'Response to NTP-TAS-008', 20 January 2023, 9–10 [34], produced by the Tasmanian Government in response to a Commission notice to produce.

2978 Statement of Jacqueline Allen, 21 December 2022, 13 [78].

2979 Statement of Jacqueline Allen, 21 December 2022, 13 [78].

2980 Statement of Mandy Clarke, 16 November 2022, 6 [11(a)–(c)]; Statement of Kathy Baker, 16 November 2022, 6 [11]; Statement of Pamela Honan, 16 November 2022, 8 [16]; Statement of Michael Pervan, 20 December 2022, 13 [47].

2981 Statement of Peter Graham, 15 August 2022, Attachment 1 (Registration to Work with Vulnerable People Records Concerning Ashley Youth Detention Centre Staff, 15 August 2022) 35.

2982 Statement of Jacqueline Allen, 21 December 2022, Attachment 84 (Email from Jacqueline Allen to Risk Assessment Officer, Registration to Work with Vulnerable People, 11 August 2020) 2–3.

2983 Statement of Jacqueline Allen, 21 December 2022, Attachment 84 (Email from Risk Assessment Officer, Registration to Work with Vulnerable People to Jacqueline Allen, 11 August 2020).

2984 Statement of Jacqueline Allen, 21 December 2022, 13 [84].

2985 Statement of Jonathan Higgins, 7 November 2022, 2 [2].

2986 Statement of Jonathan Higgins, 7 November 2022, 2 [2].

2987 Statement of Pamela Honan, 16 November 2022, Attachment 1.2 ('Meeting re AYDC HR concerns', Minutes, Strengthening Safeguards Working Group, 18 September 2020) 2.

2988 Statement of Jacqueline Allen, 21 December 2022, 13 [82], [84].

2989 Statement of Jacqueline Allen, 21 December 2022, 14 [87].

2990 Statement of Jacqueline Allen, 21 December 2022, 13 [85].

2991 Statement of Jonathan Higgins, 8 August 2022, 6 [13]; Statement of Jacqueline Allen, 21 December 2022, 14 [87].

2992 Statement of Jonathan Higgins, 8 August 2022, 22 [71].

2993 Statement of Michael Pervan, 14 June 2022, 56 [306]; Statement of Michael Pervan, 7 June 2022, 17 [109].

2994 Statement of Michael Pervan, 14 June 2022, 56 [306]; Statement of Michael Pervan, 7 June 2022, 17 [109].

2995 Statement of Jonathan Higgins, 8 August 2022, Annexure JCH-001 (Updated list of victim-survivors, allegations and actions, Spreadsheet, 24 August 2022); Statement of Jonathan Higgins, 8 August 2022, Annexure JCH-002 ('Reference material – additional information – [Stan]') 55–62.

2996 Statement of Pamela Honan, 16 November 2022, Attachment 1.2 ('Meeting re AYDC HR concerns', Minutes, Strengthening Safeguards Working Group, 18 September 2020) 1.

2997 Statement of Pamela Honan, 16 November 2022, Attachment 1.1 ('Meeting re AYDC HR concerns', Minutes, Strengthening Safeguards Working Group, 9 October 2020) 3; Statement of Michael Pervan, 7 June 2022, Annexure 21 ('Responding to Requests for Information relating to Claims under the National Redress Scheme', Draft Procedure, Children and Youth Services, undated); Statement of Michael Pervan, 7 June 2022, Annexure 22 ('Responding to Requests for Information relating to Claims under the NRS', Process Flowchart, Department of Communities).

2998 Statement of Pamela Honan, 16 November 2022, Attachment 1.1 ('Meeting re AYDC HR concerns', Minutes, Strengthening Safeguards Working Group, 9 October 2020) 3.

2999 Statement of Michael Pervan, 7 June 2022, Annexure 22 ('Responding to Requests for Information relating to Claims under the NRS', Process Flowchart, Department of Communities).

3000 Statement of Michael Pervan, 7 June 2022, Annexure 21 ('Responding to Requests for Information relating to Claims under the National Redress Scheme', Draft Procedure, Children and Youth Services, undated); Statement of Michael Pervan, 7 June 2022, Annexure 22 ('Responding to Requests for Information relating to Claims under the NRS', Process Flowchart, Department of Communities).

3001 Statement of Michael Pervan, 7 June 2022, Annexure 22 ('Responding to Requests for Information relating to Claims under the NRS', Process Flowchart, Department of Communities).

3002 Statement of Michael Pervan, 7 June 2022, Annexure 22 ('Responding to Requests for Information relating to Claims under the NRS', Process Flowchart, Department of Communities).

3003 Statement of Michael Pervan, 7 June 2022, Annexure 22 ('Responding to Requests for Information relating to Claims under the NRS', Process Flowchart, Department of Communities).

3004 Statement of Michael Pervan, 7 June 2022, Annexure 22 ('Responding to Requests for Information relating to Claims under the NRS', Process Flowchart, Department of Communities).

3005 Statement of Michael Pervan, 7 June 2022, Annexure 22 ('Responding to Requests for Information relating to Claims under the NRS', Process Flowchart, Department of Communities).

3006 Statement of Mandy Clarke, 19 August 2022, 11 [39]; Statement of Michael Pervan, 7 June 2022, Annexure 22 ('Responding to Requests for Information relating to Claims under the NRS', Process Flowchart, Department of Communities).

3007 Statement of Mandy Clarke, 19 August 2022, 11 [39(a)].

3008 Statement of Mandy Clarke, 19 August 2022, 11 [39(a)].

3009 Statement of Michael Pervan, 7 June 2022, Annexure 22 ('Responding to Requests for Information relating to Claims under the NRS', Process Flowchart, Department of Communities).

3010 Statement of Mandy Clarke, 19 August 2022, 12 [39.10].

3011 Transcript of *The Nurse* podcast, 2 November 2020, 56.

3012 Transcript of *The Nurse* podcast, 2 November 2020, 56.

3013 David Killick, 'Analysis: Culture of cover-up a cancer on Tasmania's democracy', *Mercury* (online, first published 20 November 2020) <https://www.themercury.com.au/news/tasmania/analysis-culture-of-coverup-a-cancer-on-tasmanias-democracy/news-story/d12f9021cb14a67add8a875010180fe7>.

3014 Peter Gutwein, 'Premier's Statement – Commission of Inquiry' (Media Release, 23 November 2020) <https://www.premier.tas.gov.au/site_resources_2015/additional_releases/progress_on_the_new_burnie_ambulance_station/premiers_statement_-_commission_of_inquiry>. Refer also to Statement of Kathrine Morgan-Wicks, 22 June 2022,15 [82]; Statement of Kathrine Morgan-Wicks, 22 June 2022, Annexure 48 (Email from Tasmanian Government Media Office to Department of Health employee, 23 November 2020).

3015 Tasmania, *Parliamentary Debates*, House of Assembly Estimates Committee A, 25 November 2020, 15–16 (Alison Standen) <https://search.parliament.tas.gov.au/search/isysquery/9cbf8c00-9f7a-46fa-bbee-2927d153e3ad/1/doc/>.

3016 Statement of Michael Pervan, 6 September 2022, Annexure MP.SUPP.001 ('Correction to Response to Question on Notice', Minute to the Secretary, 9 December 2020) 1.

3017 Statement of Michael Pervan, 6 September 2022, Annexure MP.SUPP.001 ('Correction to Response to Question on Notice', Minute to the Secretary, 9 December 2020).

3018 Statement of Michael Pervan, 23 August 2022, 34 [128]; Email from Michael Pervan to Jacqueline Allen et al, 8 November 2020, produced by the Tasmanian Government in response to a Commission notice to produce.

3019 Michael Pervan, *Procedural Fairness Response*, 31 July 2023, 3 [9(a)].

3020 Department of Communities, 'Minute to the Secretary: [Ira] (the Employee) Referral for Consideration of Investigation into Alleged Breaches of the *State Service Act 2000* Code of Conduct and Suspension with Pay', 8 November 2020, produced by the Tasmanian Government in response to a Commission notice to produce; Department of Communities, 'Minute to the Secretary: [Lester] (the Employee) Referral for Consideration of Investigation into Alleged Breaches of the *State Service Act 2000* Code of Conduct and Suspension with Pay', 8 November 2020, produced by the Tasmanian Government in response to a Commission notice to produce; Department of Communities, 'Minute to the Secretary: [Stan] (the Employee) Referral for Consideration of Investigation into Alleged Breaches of the *State Service Act 2000* Code of Conduct (Employment Direction No. 5) and Suspension with Pay (Employment Direction No. 4)', 8 November 2020, produced by the Tasmanian Government in response to a Commission notice to produce.

3021 Department of Communities, 'Minute to the Secretary: [Stan] (the Employee) Referral for consideration of Investigation into Alleged Breaches of the *State Service Act 2000* Code of Conduct (Employment Direction No 5) and Suspension with Pay (Employment Direction No. 4)', 8 November 2020, produced by the Tasmanian Government in response to a Commission notice to produce; Department of Communities, 'Minute to the Secretary: [Lester] (the Employee) Referral for Consideration of Investigation into Alleged Breaches of the *State Service Act 2000* Code of Conduct and Suspension with Pay', 8 November 2020, produced by the Tasmanian Government in response to a Commission notice to produce.

3022 Department of Communities, 'Minute to the Secretary: Allegations Raised Against Employee [Ira] through the Redress Scheme', 18 September 2020, 3–4, produced by the Tasmanian Government in response to a Commission notice to produce.

3023 Refer, for example, to Department of Communities, 'Minute to the Secretary: [Lester] (the Employee) Referral for Consideration of Investigation into Alleged Breaches of the *State Service Act 2000* Code of Conduct and Suspension with Pay', 8 November 2020, produced by the Tasmanian Government in response to a Commission notice to produce.

3024 Department of Communities, 'Minute to the Secretary: [Ira] (the Employee) Referral for Consideration of Investigation into Alleged Breaches of the *State Service Act 2000* Code of Conduct and Suspension with Pay', 8 November 2020, 4, produced by the Tasmanian Government in response to a Commission notice to produce.

3025 Department of Communities, 'Minute to the Secretary: [Ira] (the Employee) Referral for Consideration of Investigation into Alleged Breaches of the *State Service Act 2000* Code of Conduct and Suspension with Pay', 8 November 2020, 4, produced by the Tasmanian Government in response to a Commission notice to produce.

3026 Refer, for example, to Department of Communities, 'Minute to the Secretary: [Lester] (the Employee) Referral for Consideration of Investigation into Alleged Breaches of the *State Service Act 2000* Code of Conduct and Suspension with Pay', 8 November 2020, produced by the Tasmanian Government in response to a Commission notice to produce. Refer also to Department of Communities, 'Minute to the Secretary: [Stan] (the Employee) Referral for Consideration of Investigation into Alleged Breaches of the *State Service Act 2000* Code of Conduct (Employment Direction No. 5) and Suspension with Pay (Employment Direction No. 4)', 8 November 2020, produced by the Tasmanian Government in response to a Commission notice to produce; Department of Communities, 'Minute to the Secretary: Allegations Raised Against Employee [Ira] through the Redress Scheme', 18 September 2020, 4, produced by the Tasmanian Government in response to a Commission notice to produce.

3027 Department of Communities, 'Minute to the Secretary: [Ira] (the Employee) Referral for Consideration of Investigation into Alleged Breaches of the *State Service Act 2000* Code of Conduct and Suspension with Pay', 8 November 2020, produced by the Tasmanian Government in response to a Commission notice to produce.

3028 Department of Communities, 'Minute to the Secretary: [Ira] (the Employee) Referral for Consideration of Investigation into Alleged Breaches of the *State Service Act 2000* Code of Conduct and Suspension with Pay', 8 November 2020, produced by the Tasmanian Government in response to a Commission notice to produce.

3029 Email from Michael Pervan to Director of People and Culture et al, 8 November 2020, produced by the Tasmanian Government in response to a Commission notice to produce.

3030 Email from Michael Pervan to Director of People and Culture et al, 8 November 2020, produced by the Tasmanian Government in response to a Commission notice to produce.

3031 Statement of Michael Pervan, 23 August 2022, Annexure 37.001 (Email from Michael Pervan to legal adviser, Mandy Clarke and Kathy Baker, 14 December 2020).

3032 Statement of Michael Pervan, 23 August 2022, Annexure 37.001 (Email from Michael Pervan to legal adviser, Mandy Clarke and Kathy Baker, 14 December 2020); Statement of Michael Pervan, 23 August 2022, Annexure 26.1 ('Review of Claims of Abuse of Children in State Care: Notification Process', Department of Communities, 14 December 2020) 5; Statement of Michael Pervan, 23 August 2022, 35 [130].

3033 Statement of Michael Pervan, 6 September 2022, Annexure 37.001 (Email from Michael Pervan to legal adviser Mandy Clarke and Kathy Baker, 14 December 2020).

3034 Michael Pervan, *Procedural Fairness Response*, 31 July 2023, 3 [9(d)].

3035 Michael Pervan, *Procedural Fairness Response*, 31 July 2023, 3 [9(e)].

3036 Michael Pervan, *Procedural Fairness Response*, 31 July 2023, 3 [9(e)].

3037 Statement of Michael Pervan, 20 December 2022, 20–21 [78]; Statement of Jacqueline Allen, 21 December 2022, 7 [52].

3038 Statement of Michael Pervan, 23 August 2022, 35 [130].

3039 Statement of Jacqueline Allen, 21 December 2022, 7 [52].

3040 Statement of Jacqueline Allen, 21 December 2022, 7 [53].

3041 Statement of Jacqueline Allen, 21 December 2022, 7 [53].

3042 State of Tasmania, *Procedural Fairness Response*, 23 August 2023, 7–8.

3043 State of Tasmania, *Procedural Fairness Response*, 23 August 2023, 7–8.

3044 Email from Michael Pervan to former Solicitor-General, 24 November 2020, produced by the Tasmanian Government in response to a Commission notice to produce.

3045 Request for statement served on Michael Pervan, 2 August 2022, 13 [37(a)].

3046 Statement of Michael Pervan, 23 August 2022, 35 [130].

3047 Statement of Kathy Baker, 18 August 2022, 30 [172].

3048 Statement of Michael Pervan, 20 December 2022, 4–5 [17].

3049 Statement of Michael Pervan, 20 December 2022, 4 [16].

3050 Statement of Michael Pervan, 20 December 2022, 5 [17].

3051 Statement of Ginna Webster, 13 January 2023, 15–16 [28(e)].

3052 Statement of Jacqueline Allen, 21 December 2022, 8 [55]; Email from Michael Pervan to former Solicitor-General, 24 November 2020, produced by the Tasmanian Government in response to a Commission notice to produce.

3053 Department for Education, Children and Young People, 'Response to NTP-TAS-008', 20 January 2023, 5 [25], produced by the Tasmanian Government in response to a Commission notice to produce.

3054 Department for Education, Children and Young People, 'Response to NTP-TAS-008', 20 January 2023, 5 [26], produced by the Tasmanian Government in response to a Commission notice to produce.

3055 Emails between Ginna Webster, legal adviser and Michael Pervan, 10–14 December 2020, produced by the Tasmanian Government in response to a Commission notice to produce.

3056 Statement of Michael Pervan, 23 August 2022, Annexure MP.5.001 (Letter of Advice from Assistant Solicitor-General to Michael Pervan, 15 December 2020) 5 [21], [23].

3057 Statement of Michael Pervan, 23 August 2022, Annexure MP.5.001 (Letter of Advice from Assistant Solicitor-General to Michael Pervan, 15 December 2020) 3 [10].

3058 Statement of Michael Pervan, 23 August 2022, Annexure MP.5.001 (Letter of Advice from Assistant Solicitor-General to Michael Pervan, 15 December 2020) 3–4 [14]; Refer to *National Redress Scheme for Institutional Child Sexual Abuse Act 2018* s 97.

3059 Statement of Michael Pervan, 23 August 2022, Annexure MP.5.001 (Letter of Advice from Assistant Solicitor-General to Michael Pervan, 15 December 2020) 3 [12].

3060 *Personal Information Protection Act 2004*, Schedule 1, s 2(1)(d), (g) and (i).

3061 Statement of Kathy Baker, 18 August 2022, 11 [35–38]; Statement of Michael Pervan, 23 August 2022, 47 [183].

3062 Statement of Jacqueline Allen, 15 August 2022, 45 [258]; Transcript of Stuart Watson, 23 August 2022, 3160 [14–23].

3063 Statement of Michael Pervan, 23 August 2022, 13 [43–44], 35 [132]; Transcript of Jacqueline Allen, 25 August 2022, 3373 [1–4].

3064 Transcript of Jacqueline Allen, 25 August 2022, 3373 [7–10], [17–31].

3065 Transcript of Mandy Clarke, 25 August 2022, 3424 [15–31], [18–24]; Transcript of Pamela Honan, 19 August 2022, 2971 [41–40], 2977 [35–37].

3066 Notice to produce served on Tasmania Police, 29 July 2022, 5–6; Statement of Jonathan Higgins, 8 August 2022, 2–4; Statement of Jonathan Higgins, 8 August 2022, Annexure JCH-001 (Updated list of victim-survivors, allegations and actions, Spreadsheet, 24 August 2022).

3067 Letter from Michael Pervan to Deputy Commissioner, Tasmania Police, 18 February 2020, produced by the Tasmanian Government in response to a Commission notice to produce; Statement of Jonathan Higgins, 8 August 2022, Annexure JCH-001 (Updated list of victim-survivors, allegations and actions, Spreadsheet, 24 August 2022).

3068 Email from Jacqueline Allen to Jonathan Higgins, 9 November 2020, produced by Tasmania Police in response to a Commission notice to produce.

3069 Statement of Jonathan Higgins, 8 August 2022, Annexure JCH-001 (Updated list of victim-survivors, allegations and actions, Spreadsheet, 24 August 2022); Transcript of Jonathan Higgins, 24 August 2022, 3250 [6–25].

3070 Transcript of Jonathan Higgins, 24 August 2022, 3250 [21–25].

3071 Transcript of Jonathan Higgins, 24 August 2022, 3250 [27–34].

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Commission of Inquiry into the Tasmanian Government's Responses to Child Sexual Abuse in Institutional Settings

Who was looking after me? Prioritising the safety of Tasmanian children

Volume 5: Children in youth detention
Book 3

August 2023

Commission of Inquiry into the Tasmanian Government's Responses to Child Sexual Abuse in Institutional Settings Report

Volume 5
Children in youth detention (Book 3)

The Honourable Marcia Neave AO
President and Commissioner

Professor Leah Bromfield
Commissioner

The Honourable Robert Benjamin AM SC
Commissioner

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12 The way forward: Children in youth detention

1 Introduction

In this chapter, we make recommendations aimed at preventing child sexual abuse in youth detention and improving responses to such abuse when it occurs. Throughout this chapter, we draw on the seven case studies in Chapter 11, which paint a profoundly disturbing picture of youth detention in Tasmania over the past two decades—an institution where some children and young people experienced systematic harm and abuse. The case studies also highlight longstanding and entrenched problems with culture, leadership, staffing, policies and practices in the youth detention system. The Tasmanian Government has been aware of many of these problems for some time.

1.1 Our recommendations

Our recommendations in this chapter are informed by several principles, including the following:

- The most effective way to protect children and young people against the risk of sexual abuse in youth detention is to prevent them entering or re-entering detention—this should be achieved by prioritising strategies that divert children and young people from the youth justice system and from detention.

- To minimise risks to Aboriginal children and young people in detention, their substantial over-representation in detention and in the broader youth justice system must be urgently addressed through strategies underpinned by Aboriginal self-determination.
- Children and young people must be safe in youth detention. The risk of child sexual abuse in youth detention decreases when there is a child safe culture in detention that respects and promotes the rights of children and young people, and for which leadership is accountable.
- For children and young people to be safe in youth detention, staff must also be safe and their wellbeing supported. Staff must have the qualifications, attributes and skills to engage constructively with children and young people in detention. There must be enough staff to deliver a therapeutic model of care to children and young people and avoid lockdowns.
- If a child or young person experiences child sexual abuse in detention, they should feel able to speak up and know they will be listened to. Their complaints must be taken seriously and acted upon without them suffering any reprisal.

We also consider that an effective youth detention system is one that provides children and young people in detention with timely access to high-quality, developmentally appropriate therapeutic supports, education and health care, as well as support to address the underlying causes of their offending. We consider that these features are necessary to reduce reoffending and promote community safety.

We outline our recommendations below. Several of these recommendations will appear familiar from previous reviews of Ashley Youth Detention Centre and the youth justice system (discussed in Chapter 10). Too often these recommendations have been overlooked or implemented without achieving meaningful or enduring change. At other times they have been implemented through short-term initiatives that have later been discontinued.

System reform is urgently needed. We acknowledge that transforming a youth detention system that has been resistant to change over many years is not straightforward. It requires radical cultural change, strong leadership and a long-term commitment from the Government. It may take time, but we consider it is achievable.

Our recommendations include:

- closing Ashley Youth Detention Centre as soon as possible and creating a memorial to victim-survivors who experienced abuse at the Centre
- strengthening leadership in the youth detention system and improving governance arrangements for youth detention

- developing a participation and empowerment strategy for children in youth detention that includes establishing a new advisory group of children, young people and young adults with previous experience of detention
- ensuring staff in youth detention are appropriately qualified, trained and supported to deliver a therapeutic model of care to children in detention, with enough staff to keep children and staff safe
- increasing the minimum age of criminal responsibility to 14 years and working towards increasing the minimum age of detention to 16 years
- increasing opportunities for diversion and bail, and reducing the number of children and young people on remand
- ensuring a collaborative, multidisciplinary approach to meeting the complex needs of children and young people in detention, and providing access to high-quality mental health services and education
- establishing an integrated service for children and young people leaving detention to ensure they have safe and stable accommodation, access to physical and mental health support, and help with accessing education and/or employment after their release
- working with Aboriginal communities to develop an Aboriginal youth justice strategy, co-design new youth justice facilities and ensure Ashley Youth Detention Centre and any replacement facilities are culturally safe for Aboriginal children and young people
- establishing a policy framework to understand, prevent and respond to harmful sexual behaviours in detention, and providing access to timely, expert assessment and a range of appropriate, coordinated interventions, including therapeutic interventions
- improving laws, custodial procedures and practices for personal searches of children and young people in detention, isolation and the use of force
- ensuring children in detention, their family members and staff have appropriate mechanisms to raise child safety concerns and make complaints, and that all allegations against staff involving child sexual abuse and related conduct (including grooming and boundary breaches), or inappropriate searches, isolation or use of force are referred to the new Child-Related Incident Management Directorate for investigation and response (recommended in Chapter 6 at Recommendation 6.6)

- establishing an independent community visitor scheme to give children and young people in detention independent, trusted adults to whom they can speak regularly, with whom they can safely and confidently raise concerns, and who will advocate on their behalf (this scheme is also discussed in Chapter 9)
- strengthening and improving monitoring of Tasmania's youth detention system by giving the new Commission for Children and Young People (recommended in Chapter 18 at Recommendation 18.6) responsibility for inspecting detention facilities and monitoring the safety and wellbeing of children and young people in detention.

1.2 Structure of this chapter

This chapter is structured as follows.

Section 2 outlines the Tasmanian Government's proposed youth justice reforms over the next decade; these give important context for our recommendations.

Section 3 considers the legacy of abuse at Ashley Youth Detention Centre and makes recommendations to close the Centre as soon as possible, establish a memorial to victim-survivors who experienced abuse at the Centre, develop a process to preserve historical records relating to children, young people and staff at the Centre, and audit past claims of abuse.

Section 4 examines the culture at Ashley Youth Detention Centre and considers the changes needed in the areas of leadership, governance, children's participation and staffing to implement a child safe culture in youth detention where the risk of child sexual abuse is minimised.

Section 5 discusses ways to reduce the number of children and young people entering the youth detention system, including remand, so fewer children and young people are exposed to the risk of child sexual abuse in detention, and community safety is better served.

Section 6 focuses on the improvements needed to create an effective, child-focused detention system that meets the complex needs of children and young people in detention, minimises the risks of child sexual abuse and reduces reoffending.

Section 7 makes recommendations to address the over-representation of Aboriginal children and young people in detention and strengthen cultural safety in detention facilities, with a view to minimising the risk of sexual abuse for Aboriginal children and young people in detention.

Section 8 focuses on harmful sexual behaviours in youth detention (highlighted in Chapter 11, Case study 2) and makes recommendations to prevent these behaviours and significantly improve responses to them when they occur.

Section 9 examines the laws, standards, policies and procedures that apply to personal searches of children and young people in detention, isolation practices (highlighted in Chapter 11, Case study 3) and the use of force (highlighted in Chapter 11, Case study 4)—practices that sometimes involved or were connected to child sexual abuse.

Section 10 considers channels within the Department for Education, Children and Young People through which children and young people in detention, their families and staff of detention facilities can raise concerns or make complaints about child safety, including child sexual abuse, and the Department's responses to these concerns and complaints.

Section 11 examines independent oversight of the youth detention system and makes recommendations to strengthen independent advocacy for children and young people in detention and systemic monitoring of the youth justice system.

2 The Government's youth justice reform agenda

On 9 September 2021, the then Premier, the Honourable Peter Gutwein MP, announced that Ashley Youth Detention Centre would close 'in around three years' and be replaced by 'two new smaller facilities' because it was 'time for a major systemic change in our youth justice system'.[1] This announcement followed more than a decade of calls from stakeholders to close Ashley Youth Detention Centre.[2]

In August 2022, the Tasmanian Government reaffirmed its commitment to close Ashley Youth Detention Centre by the end of 2024.[3]

On 22 November 2022, the Minister for Education, Children and Youth, the Honourable Roger Jaensch MP, announced the Government's plans for reform of the entire youth justice system, stating that the Government was:

> … determined to build a nation-leading approach that engages at-risk young people early, directs them away from the youth justice system and supports young people who come into conflict with the law to become valued and productive members of our community.[4]

Minister Jaensch stated that, as part of these reforms, the Government would establish new youth justice facilities, including:

- a new statewide detention/remand centre in southern Tasmania that would 'provide intensive intervention and rehabilitation through a therapeutic model of care'
- two assisted bail facilities—one in northern Tasmania or the North West, and one in southern Tasmania—to 'reduce the number of young people remanded to a detention centre'

- two ‘supported residential facilities’—one in northern Tasmania or the North West, and one in southern Tasmania—to support ‘transition for young people from detention to independence’.[5]

We commend the Tasmanian Government for its decision to close Ashley Youth Detention Centre and for acknowledging the need to reform the youth justice system. We discuss the closure of Ashley Youth Detention Centre in Section 3.1.

In this section, we outline three documents the Tasmanian Government gave us towards the end of our Commission of Inquiry that describe the Government’s planned reforms to the youth justice system, including youth detention. We discuss specific elements of these documents throughout this chapter.

2.1 Keeping Kids Safe Plan

In late October 2022, the Tasmanian Government gave us a document titled *Keeping Kids Safe: A Plan for Ashley Youth Detention Centre until Its Intended Closure* (‘Keeping Kids Safe Plan’).[6] This document details existing and proposed safeguards for children and young people at Ashley Youth Detention Centre.

According to the Keeping Kids Safe Plan, existing safeguards include:

- the *Children, Youth and Families Practice Manual* (‘Practice Manual’), which provides ‘a comprehensive set’ of policies, procedures and practice requirements relevant to custodial youth justice[7]
- the *Ashley Youth Detention Centre Practice Framework*, which was developed in 2020 to guide therapeutic approaches at the Centre—this framework ‘utilises a strengths-based approach to assist in building relationships that foster safety, communication, respect and achievement of goals resulting in healthy children and young people and staff’[8]
- a *Learning and Development Framework*, which ‘sets expectations for learning and skill development of all staff’ at the Centre[9]
- upgrades to the Centre’s facilities between 2019 and 2022 to increase safety and to effect a therapeutic approach to detaining children and young people[10]
- independent oversight of the Centre by the Commissioner for Children and Young People and the Custodial Inspector.[11]

The Keeping Kids Safe Plan commits the Tasmanian Government to implementing more safeguards through a safety plan comprising 22 actions to meet the following objectives:

1. increasing safety and security for children and young people
2. maintaining an appropriate level of staff with the right experience and competencies

3. delivering a therapeutic service model
4. implementing practice improvements.[12]

A working group will oversee the implementation of actions under the Keeping Kids Safe Plan.[13]

2.2 Draft Youth Justice Blueprint 2022–2032

The Government also gave us its *Draft Youth Justice Blueprint 2022–2032: Keeping Children and Young People out of the Youth Justice System* ('Draft Youth Justice Blueprint').[14] This document is not yet publicly available, but the Government advised us that it will be finalised after the Government receives our final recommendations.[15] We refer to the Draft Youth Justice Blueprint throughout this chapter as the most current outline of the Government's reform plans for the youth justice system over the next decade.

The overarching goal of the Draft Youth Justice Blueprint is 'to reduce the involvement of children and young people in the youth justice system'.[16] Its key objective is 'to create a contemporary youth justice system' that:

- prevents children and young people's contact with the youth justice system
- addresses offending behaviour
- addresses the over-representation of Aboriginal children and young people in the youth justice system
- keeps children and young people in detention safe
- 'supports children and young people to re-enter the community through prosocial pathways'
- improves community safety.[17]

Eight principles underpin the Draft Youth Justice Blueprint. These principles emphasise the importance of children and young people's rights, safety and wellbeing.[18] The Draft Youth Justice Blueprint also notes the need to strengthen connection to family, community and culture for Aboriginal children and young people in the youth justice system and 'includes an increased focus on self-determination of Aboriginal communities'.[19]

The Draft Youth Justice Blueprint lists the following five strategies:

1. prioritise prevention and early intervention to reduce engagement with the youth justice system
2. ensure diversion from the justice system is early and lasting
3. establish a therapeutically based criminal justice response for children and young people

4. integrate and connect whole of government and community service systems
5. provide an appropriately trained and supported therapeutic workforce.[20]

It also foreshadows the development of a 'Blueprint Monitoring and Evaluation Plan'.[21]

The Draft Youth Justice Blueprint was developed in consultation with government agencies, representatives of Tasmania's Aboriginal communities, the Commissioner for Children and Young People, non-government organisations and children and young people with lived experience of the youth justice system, as well as their families.[22] The Government intends to engage with children and young people and Aboriginal communities to implement the Youth Justice Blueprint.[23]

Several action plans will support the Youth Justice Blueprint.[24] We give an overview of the *Draft First Action Plan 2023–2025* ('Draft First Action Plan') in the following section.

2.3 Draft First Action Plan 2023–2025

We received the Department's Draft First Action Plan, produced in January 2023, which is the first in a series of action plans designed to implement the Youth Justice Blueprint.[25]

The Draft First Action Plan aims to deliver seven 'priority' actions by 2025:

1. 'Enhance the safety and therapeutic approach' at Ashley Youth Detention Centre—this action focuses on responding to the public hearings of our Commission of Inquiry.[26]
2. 'Develop and implement a Youth Justice Model of Care' to 'facilitate therapeutic, trauma informed and culturally safe service delivery to improve the wellbeing of children and young people to reduce their involvement in the youth justice system'.[27]
3. Review the *Youth Justice Act 1997* ('Youth Justice Act')—this action includes legislative changes to implement the Government's commitment to increase the minimum age of detention from 10 to 14 years.[28]
4. 'Implement a range of diversion, bail support and community-based sentencing options'—this action includes developing a 'Diversionary Services Framework'.[29]
5. 'Design and construct new purpose-built youth justice facilities' to replace Ashley Youth Detention Centre.[30]
6. 'Operationalise' the new youth justice facilities—this action includes defining workforce requirements and recruiting staff.[31]
7. 'Develop and implement an alternative education model'—this action involves designing new approaches to meet the needs of children and young people who are at risk of disengaging from education.[32]

The Department for Education, Children and Young People is the lead agency for all seven actions.[33]

We turn now to our recommendations for reform.

3 Addressing the legacy of abuse

In Chapter 11, Case study 1, we describe what we heard about the nature and extent of abuse at Ashley Youth Detention Centre. While it was not possible for our Commission of Inquiry to test the veracity of every allegation outlined in victim-survivors' accounts, we were struck by the similarities and common themes across these accounts. In Case study 1, we find that, for decades, some children and young people detained at Ashley Youth Detention Centre experienced systematic harm and abuse—that many children were systematically dehumanised, brutalised and degraded while at the Centre. This finding is based on all the evidence we reviewed—from victim-survivors and their families, current and former Centre staff, senior management in the Department, the many prior reports and investigations into the Centre, allegations made through civil and redress scheme claims, and the insights of relevant experts into organisational misconduct. It is a sobering finding.

Child sexual abuse can have a profound and lasting impact on victim-survivors. Case study 1 describes the devastating ongoing trauma that the abuse at Ashley Youth Detention Centre has had on victim-survivors' mental and physical health. We heard that many victim-survivors have attempted suicide, experience significant mental health conditions, struggle with addictions to drugs and alcohol, have difficulties forming and maintaining relationships and have been incarcerated during their adult lives.

Child sexual abuse in institutions, particularly at the scale we heard alleged at Ashley Youth Detention Centre, also has a profound effect on the people working in those institutions, who may have been colleagues with those who have offended, or against whom allegations have been made. We discuss the impacts on staff in Section 4.7. In this section, we focus on addressing the impacts of abuse of this scale on children and young people in detention.

As noted in Chapter 11, Case study 1, victim-survivors and their family members told us that they wanted an acknowledgment from the Tasmanian Government about what has happened to them. On 8 November 2022, the Tasmanian Parliament delivered an apology to victim-survivors of child sexual abuse in government institutions, in which it:

> Expresse[d] its deep, unreserved sorrow on behalf of all Tasmanians, to all victims/survivors of institutional child sexual abuse and apologise[d] for the pain, suffering and trauma they have endured through previous actions and inactions by those in authority.[34]

The apology did not specifically refer to victim-survivors of abuse at Ashley Youth Detention Centre.

It is essential to ensure the systematic harm and abuse that occurred at Ashley Youth Detention Centre, and the pain, suffering and trauma endured by victim-survivors, are not forgotten. In his apology, the Premier, the Honourable Jeremy Rockliff MP, said:

> Over the past eight months throughout this inquiry we have heard about a very, very dark chapter in Tasmania's history. It is a chapter no-one should ever forget. Today we give a solemn undertaking to all Tasmanians to never allow a repeat of this abuse, of the secrecy and the suppression: to never allow a repeat of the failures that allowed such abuse to occur.[35]

In this section, we consider the legacy of abuse at Ashley Youth Detention Centre and recommend that the Tasmanian Government:

- closes the Centre and creates a memorial to victim-survivors who experienced abuse at the Centre
- ensures any person who has previously been detained at Ashley Youth Detention Centre is not detained or imprisoned at any new correctional facility on the same site (unless they so choose)
- preserves Ashley Youth Detention Centre records, so they are available for any victim-survivors who may wish to seek redress
- commissions an audit of allegations of child sexual abuse arising through state and national redress schemes, civil claims and complaints to ensure children and young people in detention, out of home care and other institutions are protected against any risks of child sexual abuse.

3.1 Closing Ashley Youth Detention Centre

Victim-survivors told us that Ashley Youth Detention Centre should be closed. One victim-survivor, Fred (a pseudonym), said:

> … just close this place down and start again, because … it's systemic, it's grown in that environment. You won't ever get rid of it by putting in new staff members or changing things: tear the place down and start again, the memories are too—just appalling.[36]

Similarly, Professor Robert White, Emeritus Distinguished Professor of Criminology, University of Tasmania, said:

> I would raze Ashley to the ground. I would destroy the physical infrastructure tomorrow, I wouldn't wait, and we don't have three years of transition: I would get rid of it immediately and transfer the children to other places, houses, secure houses or whatever, but I would certainly knock it down.[37]

As noted in Section 2, the Tasmanian Government has previously announced its intention to close Ashley Youth Detention Centre by the end of 2024. On 13 July 2023, Minister Jaensch cast doubt on this closure date. In evidence to a parliamentary inquiry on adult imprisonment and youth detention, the Minister said:

> When we announced our intention to not just replace Ashley with two smaller Ashleys, we also then realised that delivering this more sophisticated, better-practice model may take more time and so whilst we have remained committed to the ambition of closing Ashley as soon as possible, and 2024 is the date that was announced, we believe that is going to need to be updated. Now, what I do not want to do is to issue another political deadline. What I want to do, as soon as possible, and I hope to be able to do in coming months, is once we have confirmed the preferred site for the development of the southern detention facility, which is a critical component of the new facilities delivery model, once we have an actual site that we have locked in, then we can conduct the remaining site investigations, planning and design processes, then we will know how much it will cost and how long it will take to build that and my next step, in terms of clarifying time frames, will be to provide a firm, actual time frame based on those investigations, so I hope to do that in coming months.[38]

While we acknowledge the Government's restated commitment to closing Ashley Youth Detention Centre, we are gravely concerned by any suggestion of further delay. The Government must close Ashley Youth Detention Centre as soon as possible. We discuss the future use of the site in Section 3.3.

Recommendation 12.1

The Tasmanian Government should close Ashley Youth Detention Centre as soon as possible.

3.2 Creating a memorial to victim-survivors

As discussed in Chapter 15, child sexual abuse can constitute a collective trauma event, requiring a response that promotes community care and the restoration of trust. In acknowledging past wrongs and suffering, and providing space for grief, healing and remembrance, a memorial can be an important part of the response to such an event. The National Royal Commission observed that:

> Memorials can provide symbolic reparation and public recognition to victims and survivors in ways that can contribute to healing. Memorials honour those who have suffered and provide opportunities to remember the past and think about the future. They provide a specific place for families and wider society to reflect on the trauma

> of survivors and mourn the victims lost. They may also serve to educate future generations about what occurred in a society's history and provide a space for public awareness and remembrance.[39]

The National Royal Commission recommended that the Australian Government commission a national memorial for victims and survivors of child sexual abuse in institutional contexts to be located in Canberra and designed in consultation with victim-survivors.[40] A design for the national memorial was selected in January 2022.[41]

Memorials to victim-survivors of abuse have also been recommended in international inquiries on institutional child abuse, including inquiries in Ireland and Jersey.[42] In recommending a memorial to victim-survivors of child abuse in institutions, the Irish Commission to Inquire into Child Abuse said in 2009:

> It is important for the alleviation of the effects of childhood abuse that the State's formal recognition of the abuse that occurred and the suffering of the victims should be preserved in a permanent place …[43]

The Irish inquiry also recommended that the following words of apology be inscribed on the memorial:

> On behalf of the State and of all citizens of the State, the Government wishes to make a sincere and long overdue apology to the victims of childhood abuse, for our collective failure to intervene, to detect their pain, to come to their rescue.[44]

In 2017, the Independent Jersey Care Inquiry recommended 'some form of tangible public acknowledgment' for victim-survivors to 'allow experiences of those generations of Jersey children whose lives and suffering worsened because of failures in the care system to be respected and honoured in decades to come'.[45] That inquiry recommended that the form of this acknowledgment consider the views of victim-survivors.[46]

As noted, we heard that victim-survivors and their families wanted an acknowledgment of abuse that occurred at Ashley Youth Detention Centre and its devastating effects. As part of its apology to victim-survivors of child sexual abuse in institutions, and in recognition of the protracted, widespread and systematic nature of the abuse at Ashley Youth Detention Centre, we recommend that the Tasmanian Government creates a memorial to victim-survivors who experienced abuse at the Centre.

The Government should consult with victim-survivors to determine the form and location of the memorial—for example, a memorial garden could be established on part of the site, similar to the one established in memory of the 1996 Port Arthur massacre.[47] While we acknowledge the Government's plans to redevelop the Ashley Youth Detention Centre site (discussed in Section 3.3), we do not consider that this precludes creating a memorial at the site.

Recommendation 12.2

Once Ashley Youth Detention Centre is closed, the Tasmanian Government should establish a memorial to victim-survivors who experienced abuse at the Centre. The form and location of the memorial should be decided in consultation with victim-survivors of abuse at Ashley Youth Detention Centre.

3.3 Future use of the site—avoiding further trauma

In December 2021, the Honourable Elise Archer MP, Attorney-General and Minister for Corrections, released a statement indicating that the Department of Justice would begin a community consultation process to learn the views of the local community on the future use of the Ashley Youth Detention Centre site.[48] This statement revealed that an initial evaluation indicated the site would be 'well suited for a modern, state-of-the art correctional facility in Northern Tasmania with a rehabilitative focus'.[49] According to the Minister, the proposed correctional facility project would 'create jobs and investment in the North'.[50]

The Department of Justice is currently undertaking 'due diligence investigations required as part of the normal statutory planning process' for redeveloping the Ashley Youth Detention Centre site.[51] In particular, the Department of Justice has engaged 'social planning consultants' to prepare a social impact assessment for the project—this includes 'investigating issues raised by the community and … recommend[ing] ways to minimise potential impacts'.[52] At the time of writing, the Government had not published this assessment.

The community consultation undertaken by the Department of Justice in 2022 on the future use of the Ashley Youth Detention Centre site does not appear to have specifically sought the views of those who had previously been detained at the Centre.[53]

Victim-survivor Simon (a pseudonym) described his concerns at the prospect of converting the Ashley Youth Detention Centre facilities into a prison:

> Ashley shouldn't be put into a jail. What about people with memories, they're going to lay their head down and think they've been abused, you know what I mean?[54]

Media reports also indicate that some community members opposed the plan for a northern correctional facility at the Ashley Youth Detention Centre site during a consultation session held in February 2023.[55]

We are concerned by the Tasmanian Government's plans to turn the Ashley Youth Detention Centre site into an adult correctional facility. As discussed in Section 5.1.1, many children and young people detained at Ashley Youth Detention Centre go on to serve a term of imprisonment in an adult prison. We are therefore concerned that

victim-survivors of child sexual abuse at Ashley Youth Detention Centre may, as adults, be sent to an adult prison located on the site where that abuse occurred. As Simon indicated, this is likely to be retraumatising.

For these reasons we recommend that the Tasmanian Government ensures no person who has previously been detained at Ashley Youth Detention Centre be remanded or imprisoned at any adult correctional facility at the same site, unless they so choose—for example, to be close to family.

Recommendation 12.3

The Tasmanian Government should ensure no person who has been detained at Ashley Youth Detention Centre is detained or imprisoned in any redeveloped facility at the same site unless the person expresses a preference for this to occur.

3.4 Preserving Ashley Youth Detention Centre records

As discussed in Chapter 17 on civil litigation and redress, records are critically important to victim-survivors of child sexual abuse because they can offer important corroborative evidence for redress claims and help victim-survivors understand their past experiences.[56] Records can also provide an important evidentiary basis for initiating criminal or disciplinary proceedings. Inadequate records and record keeping contribute to failures in identifying and responding to risks and incidents of child sexual abuse, and exacerbate distress for victim-survivors.[57]

As discussed in Chapter 11, Case study 7, we heard that record keeping at Ashley Youth Detention Centre was deficient. In particular, we heard that records at the Centre were 'hard copy' rather than electronic and were stored in various locations at the Centre, including cabinets, unlabelled boxes and 'random places'.[58] Stuart Watson, Manager, Custodial Youth Justice ('Centre Manager'), told us that, in 2020, '[t]here was an entire room the size of a garage full of paper files that went back for years and years and years' in the 'Training Cottage' at Ashley Youth Detention Centre.[59] He indicated that these records and others had since been sent to 'central archiving' for electronic filing.[60]

Mr Watson also told us that '[t]here just wasn't easily accessible information and people didn't know where information was', suggesting that records at Ashley Youth Detention Centre were not filed, indexed, catalogued or archived appropriately.[61] We heard that some items, such as 'photographs, maps and rosters', may not have been understood to be official records and were therefore not filed appropriately.[62] The Department advised us that it lacked documented policies and procedures for record keeping.[63]

As discussed in Chapter 11, Case study 7, we heard that the Department's poor record-keeping practices contributed to delays in responding to allegations of child sexual abuse.[64] In particular, we heard that, because records had not been catalogued or indexed, accessing relevant information to establish facts, timeframes and key events relating to allegations—for example, to determine whether a person was employed at Ashley Youth Detention Centre at the time of the alleged abuse—was time-consuming and labour-intensive.[65]

Deficiencies in record keeping also meant that victim-survivors experienced difficulties and delays in obtaining their records from Ashley Youth Detention Centre, which caused distress, trauma, pain and frustration.[66]

The Department acknowledged the poor quality of its record keeping, stating that incident-recording processes at Ashley Youth Detention Centre were 'likely to have been unreliable for some of the period from 2002–2020'.[67]

In May 2021, the former Department of Communities initiated the Records Digitisation and Remediation Project to centralise historical records, with an initial focus on Ashley Youth Detention Centre records.[68] According to the 'Project Initiation Document', '[i]nitially, the intent was simply to digitise all hard copy holdings, including those at the Archives office of Tasmania and with off-site storage holders'.[69] However, early work revealed more than 8,000 boxes and 150,000 hard copy records, with 'a large variety and volume of documents in formats that are difficult to digitise and impossible to render text searchable', which led to the project's scope being refined.[70]

The objective of the refined project was to ensure the Department could 'access its historical records and meet its obligations to the Commission of Inquiry, National Redress [Scheme], victims, and the community'.[71] Its scope was described as '[s]canning and remediation of relevant or potentially relevant records from 1 January 2000 or relating to alleged incidents lodged after 1 January 2000'.[72] Key outputs of the project were described as digitising hard copy records and remediating legacy electronic or hard copy records that were 'potentially of interest to the Commission of Inquiry or immediately relevant to information requests which have been received'.[73]

According to the National Royal Commission, '[d]igitising archival records can be expected to increase search ability and reduce risk of loss', but 'digital technology also presents new challenges and risks, including costs of upkeep and updating, corruption and security of files and technological obsolescence'.[74]

We commend the Department's Records Digitisation and Remediation Project and acknowledge the enormity of the task. However, it is not clear to us that the Department has digitised all necessary records. In particular, we note that the project does not include records created before 2000. Also, while we appreciate the need to focus on responding to our Commission of Inquiry and to other information requests

received by the Department, we are concerned that important information in other records potentially relevant to future claims from victim-survivors may not have been captured. We are also unaware of what active steps are being taken to preserve records relating to children and young people in out of home care, some of whom may also have experienced youth detention.[75]

It is also not clear to us what the Department's plans are for retaining and maintaining the physical records it has digitised. Some physical records may hold tremendous personal significance for victim-survivors of abuse at Ashley Youth Detention Centre. However, we also recognise that adequately maintaining large volumes of physical records for extended periods may be impractical for the Department. Physical files require storage in appropriate conditions to prevent damage or destruction (for example, by fire, floods or vermin).[76] The National Royal Commission indicated that '[n]ot all records are, or should be, archived and retained in perpetuity, and it may be appropriate that certain records be destroyed'.[77]

In line with the National Royal Commission's recommended principle for maintaining records, the Department should, at a minimum, ensure its records are:

> ... up to date; indexed in a logical manner that facilitates easy location, retrieval and association of related information; and preserved in a suitable physical or digital environment that ensures the records are not subject to degradation, loss, alteration or corruption.[78]

More specifically, the Department must ensure it keeps records that may be relevant to future allegations of child sexual abuse. As outlined in Chapter 17, the National Royal Commission recommended that the National Archives of Australia and state and territory public records authorities guide government and non-government institutions on identifying records that, it is reasonable to expect, may become relevant to an actual or alleged incident of child sexual abuse, and on retaining and disposing of such records.[79]

In response to this recommendation, the Tasmanian Office of the State Archivist has outlined, for various institutions, the types of records 'that may become relevant for National Redress Scheme applicants, or for people taking legal action for abuse suffered when they were children'.[80] For youth justice, these records are:

- 'Youth offender case files, including investigations, prosecution, sentencing etc'
- 'Records of a youth offender's location, including custodial arrangements, community service activities and transport'
- 'Complaints and grievances'
- 'Records of at-risk youths'
- 'Restorative justice services to child victims of crime'.[81]

While these descriptions are broad, we consider that there are other records such as staff rosters and the daily roll that may include important information relevant to allegations of child sexual abuse in youth detention.

We recommend that the Department for Education, Children and Young People build on its Records Digitisation and Remediation Project by working with the Office of the State Archivist to establish an approach to preserving historical records relevant to children and young people and staff at Ashley Youth Detention Centre. A similar approach should be taken for records about other children in state care, including children in out of home care, as well as staff and carers connected with state care.

Managing this material will enable the Department to make all necessary reports to Tasmania Police, Child Safety Services, the Registrar of the Registration to Work with Vulnerable People Scheme and the Independent Regulator of the Reportable Conduct Scheme (this is discussed in Section 3.5).

Recommendation 12.4

The Department for Education, Children and Young People should work with the Office of the State Archivist to:

a. establish a process to identify, recover, restore, collate, digitise, index and catalogue all historical records relating to children and young people and staff at Ashley Youth Detention Centre, and all other children in, or staff or carers connected with, state care

b. ensure digitised records are searchable, retrievable, secure and protected against corruption or loss

c. determine which physical records should be retained following digitisation, and maintain these physical records in line with the National Royal Commission's record-keeping principles

d. determine protocols and guidance on how people who have been detained at Ashley Youth Detention Centre can access their records.

3.5 Undertaking an audit of allegations

The Tasmanian Government holds substantial information about allegations of child sexual abuse by current and former staff of Ashley Youth Detention Centre. As discussed in Chapter 11, Case study 1, this information arises from:

- claims made under the Abuse in State Care Program, which the Tasmanian Government ran between 2003 and 2013

- claims made under the Abuse in State Care Support Service, which the Tasmanian Government has run since 2013
- applications under the National Redress Scheme, run by the Australian Government since 2018
- civil claims made against the Tasmanian Government in respect of vicarious liability for the conduct of its staff, or liability for failing to protect a child from abuse
- complaints and allegations received by the Government directly from children and young people who are or were detained at Ashley Youth Detention Centre, or from others with knowledge of alleged abuse at the Centre
- sworn statements to our Commission of Inquiry from lived experience witnesses who were detained at Ashley Youth Detention Centre.

A significant number of allegations made in claims under the Abuse in State Care Program also concerned abuse by staff and carers in the out of home care system.[82] This is discussed in Chapter 8. There were also claims made about abuse in other state institutions, including hospitals and religious organisations.[83] Claims under the Abuse in State Care Support Service and the National Redress Scheme and civil claims may also relate to staff and carers in the out of home care system and other state institutions.

As highlighted by Chapter 11, Case study 7, claims made through all these schemes provide important information for a number of state agencies to perform their functions in protecting children. This includes Tasmania Police, Child Safety Services and the Registrar of the Registration to Work with Vulnerable People Scheme.

It is essential that the Department has processes in place to assess this information and to identify and act on any ongoing risks that may be posed by those who are the subject of allegations. We heard that the Government has previously taken steps to review allegations of child sexual abuse for these purposes. These are discussed in the following sections.

3.5.1 The 2020 'cross-check' review

As discussed in Chapter 11, Case study 7, the former Department of Communities undertook a review from September to November 2020 to crosscheck the names of alleged abusers identified in claims under the Abuse in State Care Program with current employees who had been working at Ashley Youth Detention Centre before 2010.[84] The review also identified what actions may have been taken where an employee had been named in an Abuse in State Care Program claim.[85]

The primary purpose of the review was to identify current staff who had been named in Abuse in State Care Program claims. The review did not cover all sources of information held by the Department. In particular:

- The review was limited to Abuse in State Care Program records and did not extend to allegations raised through the Abuse in State Care Support Service.[86]
- The Department limited its analysis to current employees who had been working at Ashley Youth Detention Centre before 2010. However, the Abuse in State Care Program ran until 2013 and the Department provided us with a spreadsheet indicating that the period of abuse that was raised in Abuse in State Care Program records spanned from 1995 to 2013.[87] This suggests there may have been current staff employed after 2010 who were not captured by the crosschecking exercise, and complainants may have raised allegations against staff members in respect of conduct that occurred between 2010 and 2013.
- The review did not include applications under the National Redress Scheme or civil claims.

It also did not consider out of home care system staff or carers, or staff in other government institutions.[88]

In September 2020, the Department identified that 127 Abuse in State Care Program claims had been made against Ashley Youth Detention Centre staff members (some of whom were named on multiple occasions) and that two current employees had been named as alleged abusers by multiple complainants.[89] While we understand that this review concluded in November 2020, it is unclear to us what more information was uncovered during this time.[90] Former Department Secretary Michael Pervan told us the review ultimately resulted in the identification of four current employees named in Abuse in State Care Program claims.[91]

3.5.2 The 2020 spreadsheet

As discussed in Chapter 11, Case study 7, in October 2020, a spreadsheet was prepared and circulated to various people in the Department that contained a list of all Ashley Youth Detention Centre staff named in the Abuse in State Care Program, the National Redress Scheme and in common law (civil) claims.[92]

We heard that the spreadsheet was then expanded to include allegations from information received from various sources about any alleged sexual, physical or emotional abuse, with the Department for Education, Children and Young People telling us the aim of the spreadsheet was to 'centralise all complaints/allegations to assist in identifying trends, patterns and cumulative allegations'.[93] The information sources included:

- allegations from the Abuse in State Care Program against Ashley Youth Detention Centre employees and from the Abuse in State Care Support Service where these were referenced in a National Redress Investigation Report

- National Redress Scheme applications and common law negligence claims (where there was an allegation against an Ashley Youth Detention Centre employee, Ashley Youth Detention Centre detainee or out of home care foster carer)
- allegations made directly through Ashley Youth Detention Centre (for example, historical records of detainee complaints made directly to Centre management or through the Ombudsman)
- a complaint made about an Ashley Youth Detention Centre employee that was made to the Children, Youth and Families Complaints Officer.[94]

We note that the source material for the spreadsheet did not include:

- all Abuse in State Care Program claims
- claims under the Abuse in State Care Support Service unless they were referred to in a National Redress Scheme Investigation Report
- claims under the National Redress Scheme or civil claims about staff in other government institutions.

We heard that the spreadsheet was held and maintained by the Department's Legal Services directorate.[95] The legal team performed checks through the online Government Directory Service to establish whether a particular person was still employed in the State Service, although concerns were raised that this was not a robust checking mechanism.[96] The Department indicated that discussions occurred between Mandy Clarke, former Deputy Secretary, Children, Youth and Families, and others about the employee status of those named in the spreadsheet.[97]

The Department also told us, in January 2023, that the Tasmanian Government and the Department were 'actively considering these issues and [would] work collaboratively to ensure that any risk to children is minimised'.[98]

Given the scope of these reviews and the variable exclusions in each, it appears the Department may not have identified all relevant allegations.

3.5.3 Child Sexual Abuse Joint Review Team

The Tasmanian Government set up the Child Sexual Abuse Joint Review Team in February 2021.[99] This team was tasked with 'conducting a multi-agency review to look for potential perpetrators from where there may be multiple information reports or references relating to an individual'.[100] An objective of this review was 'to identify potential child sex offenders in the community with a view to ensuring all avenues of investigation are exhausted so that offenders can be brought to justice'.[101] The Child Sexual Abuse Joint Review Team was led by Tasmania Police and overseen by a high-level steering committee.[102]

This review relied on data from the police intelligence database ('Atlas'), the Registration to Work with Vulnerable People database and the former Department of Communities Child Protection Information System and Children's Advice and Referral Digital Interface.[103] The review 'did not use a list of Officials from Ashley Youth Detention Centre as a base data set in the data matching work that was undertaken'.[104]

Jonathan Higgins APM, then Assistant Commissioner of Operations, Tasmania Police, told us the Child Sexual Abuse Joint Review Team's data-matching work involved comparing data and:

> ... where two or three point matches were identified, the information was reviewed. Reviews may have included individuals who were Officials from Ashley Youth Detention Centre however search parameters did not specifically target those individuals.[105]

Assistant Commissioner Higgins also stated that the Child Sexual Abuse Joint Review Team was not given separate material in respect of the Abuse in State Care Program.[106] As such, the Child Sexual Abuse Joint Review Team did not capture all relevant information pertaining to allegations of child sexual abuse at Ashley Youth Detention Centre or in out of home care (or, indeed, across government institutions).

Former Commissioner of Police Darren Hine AO APM told us the Child Sexual Abuse Joint Review Team reviewed 136,000 people who were registered to work with vulnerable people in Tasmania and 'did not identify children at current risk due to Tasmania Police or Department of Communities inaction at a point in time'.[107]

3.5.4 Process for notifying relevant agencies

As discussed in Chapter 11, Case study 7, when the Tasmanian Government receives allegations of child sexual abuse, it is obligated to notify various authorities, including Tasmania Police (about suspected criminal conduct) and the Registrar of the Registration to Work with Vulnerable People Scheme (about 'reportable behaviour' under the *Registration to Work with Vulnerable People Act 2013*).[108]

The former Registrar of the Registration to Work with Vulnerable People Scheme, Peter Graham, told us that 'a systemic review of past complaints or investigations' would likely reveal information that meets the definition of 'reportable behaviour'.[109] Notifying the Registrar of allegations that may constitute reportable behaviour is essential, so the Registrar can take appropriate action in respect of people who hold current registrations to work with children and young people.

There are also mandatory reporting obligations to report to Child Safety Services under sections 13 and 14 of the *Children, Young Persons and Their Families Act 1997* ('Children, Young Persons and Their Families Act') where there is a risk of child abuse or neglect.

In addition, a notification may be required to the Independent Regulator of the Reportable Conduct Scheme under the *Child and Youth Safe Organisations Act 2023* ('Child and Youth Safe Organisations Act') about a 'reportable allegation'.[110] A 'reportable allegation' is information that leads a person to form a reasonable suspicion that a worker of a relevant entity (including a youth detention facility) has committed 'reportable conduct' (including sexual misconduct), regardless of whether the alleged conduct occurred before the commencement of the Act.[111] The Reportable Conduct Scheme is discussed in detail in Chapter 18.

We are concerned that notifications to authorities have not always occurred in a timely manner for allegations in National Redress Scheme applications. In Chapter 11, Case study 7, we find that:

- the Department of Justice does not have an appropriate process to ensure information in National Redress Scheme applications is shared in a timely manner to protect children
- the Department of Communities did not take appropriate steps to make appropriate notifications
- Tasmania Police should improve its information-sharing and referral practices to ensure other agencies (including Child Safety Services and the Registrar of the Registration to Work with Vulnerable People Scheme) receive information, where appropriate, to enable those agencies to take steps to protect the safety of detainees.

The *National Redress Scheme for Institutional Child Sexual Abuse Act 2018* (Cth) permits the disclosure of 'protected information' obtained by a government institution if required for the enforcement of criminal law, the safety or wellbeing of children, or investigatory, disciplinary or employment processes related to the safety or wellbeing of children (among other purposes).[112] This enables government institutions (such as the Department of Justice) to comply with mandatory reporting legislation and reportable conduct schemes.[113]

Within the Tasmanian Government, the Department of Justice is often the first recipient of information about National Redress Scheme applications and the holder of the most complete information from those applications available to the Government.

As outlined in Chapter 17 and Chapter 11, Case study 7, the Child Abuse Royal Commission Response Unit in the Department of Justice coordinates the Tasmanian Government's response to National Redress Scheme applications.[114] Ginna Webster, Secretary, Department of Justice, told us that when the National Redress Scheme Operator identifies the Tasmanian Government as potentially responsible for the alleged abuse, the Operator notifies the Tasmanian Government of the application and gives it a limited time in which to provide necessary information in response.[115]

The Government told us the Department of Justice does not receive the full application from the National Redress Scheme Operator; rather, it receives 'redacted and curated components of the application'.[116]

In June 2022, Secretary Webster told us that the Child Abuse Royal Commission Response Unit summarises the application and sends the relevant department a 'National Redress Scheme – Request for Information' form, which includes the summary of the application and requests a records search.[117] The form has questions about whether the department holds records that document the abuse, whether there are any records of a prior payment to the complainant (for example, an ex gratia payment) and whether there are records that show the alleged abuser is still a government employee or working in a child-related activity.

Secretary Webster told us:

> In referrals to an Agency/agencies, [the Child Abuse Royal Commission Response Unit] include[s] details of the alleged abuser to enable the Agency to undertake enquiries as to whether the abuser is a current employee or a continuing risk to children. If the abuser is identified and remains affiliated with the Agency the matter is dealt with through the Agency's own internal policies.[118]

The summary of the National Redress Scheme application that is prepared by the Department of Justice's Child Abuse Royal Commission Response Unit and provided to the relevant department may contain insufficient details for that department to identify whether an allegation involves suspected criminal conduct or reportable behaviour. This includes where there is a lack of sufficient detail within the initial National Redress Scheme application.

In July 2023, the Government told us that, from mid-late 2020, the Department of Justice changed its practice and started providing departments with the 'full' National Redress Scheme application that it receives from the National Redress Scheme Operator, rather than a summary.[119] The Government also told us that, in January 2021, the Child Abuse Royal Commission Response Unit undertook an audit of National Redress Scheme applications received to date and agency responses 'to ensure all details were matched'.[120] We welcome these initiatives.

In response to our question as to what action the Tasmanian Government takes in relation to information acquired during the National Redress Scheme process beyond responding to the individual application (for example, reporting to Tasmania Police), Secretary Webster told us:[121]

> The Department [of Justice] does not use the information obtained through redress applications for any purpose outside responding to the [National Redress] Scheme Operator save for reporting on de-identified figures in annual reports.[122]

The Government told us that the National Redress Scheme is responsible for reporting to Australian law enforcement agencies.[123] According to the National Redress Scheme's *Operational Manual for Participating Institutions*, the National Redress Scheme reports child abuse to police where the applicant consents to such a report being made.[124] Consent is sought '[d]uring initial contact with the applicant or at any other relevant time during the assessment process'.[125]

In addition, the National Redress Scheme reports child abuse to police, regardless of the applicant's wishes, where:

- the applicant is under the age of 18 years
- the abuse occurred in the last 10 years
- there is any other reason that children may be at risk of being abused
- the alleged abuser is still working with children, or
- the alleged abuser has their own children.[126]

We note that whether the alleged abuser is still working with children, or there is any other reason that children may be at risk of being abused, are matters that the relevant jurisdiction may be better placed to identify than the National Redress Scheme Operator. This means that, often, the Operator will not have reported to Tasmania Police when the Tasmanian Government is aware of these risks and could make a report.

The Government told us that requiring the Department of Justice to report to Tasmania Police based on the information it receives from the National Redress Scheme Operator would be 'ineffectual' because:

> the Department could only provide the information that it received from the [National Redress Scheme]—information that Tasmania Police should already [be] in possession of, and likely have been in possession of, for an extended period (that is, several months).[127]

The Government also told us that requiring the Department of Justice to notify Child Safety Services or the Registrar of the Registration to Work with Vulnerable People Scheme of information from National Redress Scheme applications 'would have no impact at all as those entities are already in receipt of that information' following mandatory reporting triggered by the entry of allegations from the National Redress Scheme into Tasmania Police's intelligence system.[128] The Government said:

> Tasmania Police provides a broader capacity [than the Department of Justice] for the management of intelligence information (and has data arrangements with the registrar for registered persons).[129]

However, we note that the system for notifying police and other relevant authorities of information in National Redress Scheme applications has not always operated in the manner described by the Government. For example, in some cases we examined, the Department of Communities reported allegations from National Redress Scheme applications to Tasmania Police before Tasmania Police received the information from the National Redress Scheme Operator (refer to Case study 7).[130] We are not confident that the information-sharing framework for the National Redress Scheme is operating as intended.

We are also concerned that relying on other departments (such as the Department for Education, Children and Young People) to make appropriate notifications to relevant authorities may result in delay, which may create unnecessary risks to children and young people in institutions where alleged abusers may be currently employed or engaged, participate in sporting and social clubs with children, or have access to children in a familial context.

We understand the informational constraints under which the Department of Justice receives National Redress Scheme applications from the National Redress Scheme Operator. However, we consider that the Department of Justice should undertake its own reporting from the National Redress Scheme materials it receives (refer to Recommendation 12.5). This reporting should be additional to the existing reporting obligations of the National Redress Scheme Operator and others, and should not be limited by the possibility of duplicate reporting by other entities.[131] Such reporting should occur when the information received by the Department of Justice is, on its face, sufficient to meet established reporting thresholds.

3.5.5 Our recommendations

While we commend the Tasmanian Government for its attempts to review allegations of child sexual abuse among its various information holdings, the preceding discussion highlights that these reviews have not been comprehensive. We also heard that not all departments or agencies have undertaken such reviews.[132] As a result, we are concerned that there may still be people working with children who are the subject of child sexual abuse allegations.

This highlights the need for a comprehensive historical audit of all relevant records held by the Government to identify all allegations of child abuse, including child sexual abuse. Relevant records for the purposes of this audit should be claims made under the Abuse in State Care Program, the Abuse in State Care Support Service and the National Redress Scheme, and civil claims or complaints in relation to Ashley Youth Detention Centre or the out of home care system.

The purpose of the audit should be to identify all current and former staff in government institutions and carers in the out of home care system, so the Government can take steps to report to external authorities all information relating to current and former staff

and carers, and consider disciplinary action for current staff members as well as prioritise the safety of children. This audit is critical to ensuring the safety of children and young people in detention and out of home care.

The audit should be conducted by a person with appropriate experience, legal standing, seniority and no conflict of interest. This may mean appointing a person or body external to government. The person who conducts the audit should be given full access to all necessary systems and information.

Information obtained from the audit on individuals who are the subject of allegations of child sexual abuse should be captured in a single, central location. Secretary Pervan said the Department generally does not track allegations that are not made directly to it because information received through redress schemes and civil claims are not kept on employee files. He noted that this is an area for reform and improvement.[133]

In Chapter 20 on State Service disciplinary processes, we recommend that the Government maintains a central cross-government register of misconduct concerning allegations of child sexual abuse and related conduct (Recommendation 20.9). This register should contain records of substantiated and unsubstantiated matters, including those that did not proceed to investigation. We consider that information from the audit should be added to this register.

The Government also needs to ensure any reportable behaviour identified through the audit is reported to the Registrar of the Registration to Work with Vulnerable People Scheme and Child Safety Services, any suspected criminal behaviour is reported to Tasmania Police and any reportable conduct is reported to the Independent Regulator of the Reportable Conduct Scheme, so those agencies can take appropriate action.

The Government should also establish processes to monitor and manage allegations arising from future redress claims. In Chapter 17, we recommend that the Tasmanian Government advocates at a national level for the National Redress Scheme to apply to child sexual abuse in institutions experienced on or after 1 July 2018, and, if such an extension does not occur, that the Tasmanian Government itself establishes a redress scheme for victim-survivors of child sexual abuse in Tasmanian Government institutions (Recommendation 17.1).

We consider that the Department of Justice should ensure it meets its obligations to make appropriate notifications to Tasmania Police, Child Safety Services, the Registrar of the Registration to Work with Vulnerable People Scheme and the Independent Regulator of the Reportable Conduct Scheme (despite the fact that the Department of Justice may not be the head of the relevant entity under the Child and Youth Safe Organisations Act).

To assist other departments to identify alleged abusers who may still be working with children, and to take appropriate disciplinary action and make appropriate reports, the Department of Justice should continue to pass on full details of National Redress Scheme applications to other departments, rather than a summary.

In addition, the Government should advocate nationally for a review of the information-sharing framework in the *National Redress Scheme for Institutional Child Sexual Abuse Act 2018* (Cth) and the National Redress Scheme's *Operational Manual for Participating Institutions* to ensure information about current risks to children is reported to relevant authorities in the most timely manner and by the most appropriate entity, and to identify the most appropriate point in the process for the National Redress Scheme Operator to seek consent from applicants to share information with relevant authorities.

The Government should also make appropriate supports available to victim-survivors who disclose abuse at Ashley Youth Detention Centre and who come to its attention through any State-based redress scheme, civil claim or complaint. These supports should include warm referrals, with permission, to sexual assault counsellors who have training and experience in working with victim-survivors of child sexual abuse. Warm referrals involve personally assisting victim-survivors to access a service rather than simply providing them with information about how to seek support themselves.

Recommendation 12.5

The Tasmanian Government should:

a. conduct an audit of allegations arising from

   i. claims made under the Abuse in State Care Program, the Abuse in State Care Support Service and the National Redress Scheme

   ii. civil claims in relation to Ashley Youth Detention Centre or the out of home care system

   iii. complaints regarding Ashley Youth Detention Centre or the out of home care system

   to identify any current or former staff in government institutions or carers in the out of home care system who are the subject of child abuse allegations, including child sexual abuse

b. ensure the names and details of any staff or carers identified by the audit are added to the cross-government register of misconduct (including unsubstantiated allegations) concerning child sexual abuse (Recommendation 20.9)

c. ensure all relevant information derived from the audit is provided to Tasmania Police, Child Safety Services, the Registrar of the Registration to Work with Vulnerable People Scheme and the Independent Regulator under the *Child and Youth Safe Organisations Act 2023*, disciplinary action is considered, and the current safety of children in institutions prioritised

d. require the Department of Justice to

    i. pass on to the Department for Education, Children and Young People and other relevant departments as a matter of urgency the full details (rather than a summary) of any relevant National Redress Scheme application or claim under any future state redress scheme that the Department of Justice administers

    ii. make appropriate notifications to Tasmania Police, Child Safety Services, the Registrar of the Registration to Work with Vulnerable People Scheme and the Independent Regulator under the *Child and Youth Safe Organisations Act 2023* in relation to allegations in National Redress Scheme applications or claims under a future state redress scheme

e. advocate at a national level to review the information-sharing framework in the *National Redress Scheme for Institutional Child Sexual Abuse Act 2018* (Cth) and the National Redress Scheme's *Operational Manual for Participating Institutions* to

    i. ensure information about current risks to children is reported to police, child protection authorities, authorities responsible for registration to work with children and administrators of reportable conduct schemes in the timeliest manner and by the most appropriate entity

    ii. identify the most appropriate point in the process for the National Redress Scheme Operator to seek consent from applicants to share information with relevant authorities

f. implement systems to enable future monitoring of National Redress Scheme applications, claims under any future state redress scheme and civil claims to identify current staff in government institutions or carers in the out of home care system who are the subject of child abuse allegations, including by adding relevant information to the recommended register of misconduct concerning child sexual abuse (Recommendation 20.9)

g. make appropriate supports available to victim-survivors who disclose abuse at Ashley Youth Detention Centre, including warm referrals, with permission, to sexual assault counsellors who have training and experience in working with victim-survivors of child sexual abuse

h. remove any barriers to information sharing that would prevent the implementation of this recommendation.

4 Cultural change

In Chapter 11, Case study 1, we find that, for decades, some children and young people detained at Ashley Youth Detention Centre experienced systematic harm and abuse. In this section, we examine the organisational culture at the Centre that may have contributed to this abuse. We also describe the significant cultural change that is needed to protect children and young people in detention against the risks of child sexual abuse. As noted in Chapter 3, 'organisational culture' consists of the 'assumptions, values and beliefs, and norms that distinguish appropriate from inappropriate attitudes and behaviours in an organisation'.[134]

We heard that the problems with the culture at Ashley Youth Detention Centre were profound—they are evident in every case study in this volume. We summarise them in Section 4.2. These problems are not new—they have been brought to the Department's attention on numerous occasions. Despite this, we heard that there is still a need for effective cultural change at Ashley Youth Detention Centre.

As discussed in Chapter 18, the Child and Youth Safe Organisations Act requires that Child and Youth Safe Standards be implemented in institutions engaged in child-related work, including youth detention.[135] These standards require, among other things:

- child safety and wellbeing to be 'embedded in organisational leadership, governance and culture' in detention[136]
- children and young people in detention to participate in decisions affecting them and to be taken seriously[137]
- staff in detention to be 'equipped with the knowledge, skills and awareness to keep children and young people safe'.[138]

Full implementation of the Child and Youth Safe Standards and the creation of a child safe culture in youth detention will require a transformation of the culture into one that respects children's dignity and human rights, and prioritises child safety. Such a transformation cannot occur without changes to the foundations of the youth detention system. As a former Deputy Secretary of Children and Youth Services told us, the problems in youth detention will not be solved 'unless you address the culture, the context, the skills and capabilities, the experience and the knowledge base of the staff'.[139]

We acknowledge that cultural change in detention is a monumental and complex challenge and will take time—experts told us it could take five to 10 years.[140] However, it is crucial to ensuring children in detention are safe from ill-treatment and abuse.

Many of the recommendations in other sections of this chapter will support cultural change in detention. However, in this section, we focus on the key areas of leadership, governance, children's empowerment, children's participation, staffing, and standards of professional conduct. In particular, we recommend measures to:

- strengthen leadership in the youth detention system
- improve governance arrangements for youth detention, including establishing means to ensure accountability for cultural change
- strengthen children and young people's participation in detention, including establishing a new advisory group of children, young people and young adults with previous experience of detention
- ensure youth workers are appropriately qualified, trained and supported to deliver a therapeutic model of care to children and young people in detention, with enough staff to keep youth workers, children and young people safe
- establish a professional conduct policy for all people working in detention facilities that specifies expected standards of behaviour.

Before turning to the evidence of cultural problems in Ashley Youth Detention Centre and our recommendations for change, we outline the specific cultural factors that can heighten the risks of child sexual abuse and ill-treatment in detention environments.

4.1 Identifying and addressing cultural risk factors in youth detention

As discussed in Chapter 3, child sexual abuse can occur in any institution, but some institutional contexts and cultures enable sexual abuse.[141] 'Closed' or 'total' institutions such as youth detention—which exercise full control over a child's day-to-day life and where children are isolated from the outside world and depend entirely on the institution—'present a high cumulative risk of child sexual abuse'.[142] This is, in large part, due to cultural risk factors in youth detention.

As outlined in Chapter 10, the National Royal Commission identified the cultural characteristics of contemporary detention environments that may increase the risk of child sexual abuse.[143] These included:

- failing to prioritise children's welfare and wellbeing[144]
- failing to give children the opportunity to communicate their views—this reflects a culture in which children are not listened to and their views are not respected[145]

- disrespecting children—where children are seen as 'less worthy', staff may show discriminatory attitudes towards them[146]
- tolerating humiliating and degrading treatment of children—'[w]hen children are dehumanised, staff can become desensitised to children's needs, and cease seeing them as children in need of care and protection'[147]
- engendering a strong sense of group allegiance among staff—children are less likely to disclose abuse and less likely to be believed in institutions with strong group allegiance between adults.[148]

Also, cultural norms not to speak out or 'snitch' decrease the likelihood of children making complaints, particularly where they are experiencing harm caused by another child or young person in detention.[149]

Some of these characteristics echo those identified in a 2015 paper on institutional culture in detention prepared by Penal Reform International, an international non-government organisation, as a resource tool for bodies that monitor places of detention.[150] That paper identified aspects of culture in detention facilities that constitute risk factors for torture and other ill-treatment of detainees.[151] These factors include:

- the view that people deprived of liberty don't deserve rights
- the loss of the detained person's status as an individual
- the view that security is paramount
- a culture of violence
- an 'us and them' attitude between staff and detainees
- a culture of impunity, where there is a general tolerance of human rights abuses.[152]

The case studies in this volume indicate that many of these characteristics have been present at Ashley Youth Detention Centre.

The 2015 Penal Reform International paper listed the components of 'human rights culture change' in places of detention, defined as 'the process of moving an organisation to be more inclusive and to fully respect and accommodate the dignity, worth and rights of all people'.[153] These were:

- implementing change through participatory processes involving staff, detainees and (where appropriate) members of the community[154]
- ensuring leaders are committed to change[155]
- articulating and communicating a new organisational vision statement or management philosophy that is people-centred and based on human rights principles[156]

- adjusting the operational structure of the detaining organisation to ensure appropriate responsibility and accountability for the detention system[157]
- updating policies and procedures to reflect the wider purpose of the organisation and human rights principles[158]
- implementing a 'dynamic security' approach that recognises that 'positive staff-prisoner relationships combined with fair treatment and positive activities' enhance security and good order[159]
- changing symbols and language, where there is a need to break with the past—this could include changing the name of an organisation[160]
- improving the physical environment to support the implementation of human rights[161]
- recruiting staff whose skills and experience 'reflect the values, policies, new operational structures and roles' of the organisation and 'dismissing staff who are not suitable for the role or new organisation'[162]
- training staff to ensure they understand the new vision, policies and procedures[163]
- ensuring adequate supervision of staff and reinforcement of changes[164]
- addressing resistance and 'emphasis[ing] that a human rights culture will be better for everyone'.[165]

Several of these components are addressed by recommendations in other sections of this chapter. For example, in Section 6, we discuss the physical environment of detention facilities, the relationship between operational staff and children and young people, and implementing a therapeutic model of care in youth detention. In this section, we recommend changes that address the remaining components identified here.

Professor Donald Palmer, an expert on the causes, processes and consequences of wrongdoing in organisations, told us that cultural change to support implementing child safe policies and procedures can be hard to achieve. He said that it:

> … requires that attention be given to the complex process through which members of an organisation come to embrace … assumptions about the way the world operates, values and beliefs about what is good and bad, and norms about how people should think and act.[166]

According to sociologist Dr Samantha Crompvoets, organisational change requires examining power within organisational structures:[167]

> This means understanding how power operates within different levels of the organisation, asking who and what has power, and how does power shape, influence, and obstruct change. To enact organisational change, you cannot rely on the tools, mechanisms and structures already in practice that have been used to oppress the powerless. Organisational structures are comparable to the

scaffolding which holds cultures of misconduct and existing power structures in place. To change culture, you need to change the rules that dictate the distribution of power.[168]

4.2 The culture at Ashley Youth Detention Centre

The following discussion identifies problems with the culture at Ashley Youth Detention Centre, including concerns expressed about operational staff. It is important to acknowledge that youth workers at Ashley Youth Detention Centre work in an extremely challenging environment. Many youth workers are deeply committed to supporting the wellbeing of children and young people in detention, many of whom have highly complex needs and challenging behaviours. The following discussion is not intended as a criticism of these youth workers.

4.2.1 Past reviews and recommendations

As noted in Chapter 10, the evidence and material available to our Commission of Inquiry included 17 reports, internal and external reviews and briefings about Ashley Youth Detention Centre since 2003. Many of these documents identified problems with the culture and/or staffing at the Centre.

In summary, we are aware of the following concerns that have previously been raised about the culture at Ashley Youth Detention Centre:

- In 2007, a Legislative Council Select Committee examining the youth justice system and longstanding problems at Ashley Youth Detention Centre found that management 'struggle[d] to maintain a well-trained, professional, and committed staff' and that 'from time to time there [were] violent aggressive episodes involving both residents and staff'.[169] The committee made 32 recommendations. These included addressing the 'continuing low morale' among staff at Ashley Youth Detention Centre.[170]
- In 2011, the Serious Incident Investigation Committee, established by the former Department of Health and Human Services to examine the circumstances of the death of a young person at Ashley Youth Detention Centre, found that: youth workers at the Centre were unprofessional; not all staff had completed the induction program; there was no ongoing culture of education and training; and the training provided to staff was inadequate for responding to critical incidents.[171] The committee also found that while there had been some changes to recruitment processes, 'there [was] a strong likelihood the pervading cultural norms and practices may be undermining this' change.[172] The committee recommended that the youth worker role be reviewed and that immediate action be taken to address concerns about the culture at the Centre.[173]

- In 2015, an independent review of Ashley Youth Detention Centre found that its culture leaned more towards punishment than restoration and rehabilitation, with a preference for using force to manage children and young people rather than the de-escalation techniques taught in training.[174] The review commented on the long tenure of staff and referred to a culture of 'passive resistance' to change and a lack of visibility and communication from leadership and senior management.[175] The review made 13 recommendations, including recommendations aimed at improving leadership and training.[176]
- In 2016, an options paper on potential custodial youth justice models prepared by Noetic Solutions noted that some staff at Ashley Youth Detention Centre were sceptical of a therapeutic approach to managing young people in detention.[177]
- In 2016, a 'Minute' prepared by a senior employee of the former Department of Health and Human Services for Secretary Pervan referred to the 'negative culture' at Ashley Youth Detention Centre, attributable to multiple reviews of the Centre, uncertainty surrounding its future, an 'outdated understanding or lack of understanding from some staff that [sub]scribe to a punitive approach in dealing with young people' and 'a historical lack of transparent practice'.[178] The Minute also identified concerns about governance, leadership, staffing capability and compliance with legislation and human rights obligations and indicated that issues had remained 'embedded' at the Centre 'for a significant period'.[179] The Minute noted that a significant number of staff had been at the Centre for many years and recommended a 'significant change management process', including 'profiling of the required skill base … in order to establish staffing needs for the future'.[180] This Minute is discussed at length in Chapter 11, Case study 3.
- In 2016, a report prepared by the former Department of Health and Human Services to the then Minister for Human Services about violent incidents at Ashley Youth Detention Centre noted an apparent excessive use of force by a youth worker and made several recommendations, including appointing a senior change manager and developing a proposal to strengthen the use of multidisciplinary teams to support a therapeutic approach.[181] This report is discussed in detail in Chapter 11, Case study 4.
- In 2019, the Ombudsman submitted a report to Secretary Pervan after receiving a complaint about excessive use of force by staff at Ashley Youth Detention Centre against a young person in December 2017. In this report, the Ombudsman noted that 'the training and the transition over recent years from a corrections focus to a rehabilitation and therapeutic focus [were] often at odds and despite significant training some staff continue[d] to operate from a corrections philosophy'.[182]

- In 2020, the former Department of Communities' Serious Events Review Team identified 'a toxic workplace culture at [the Centre] characterised by distrust, suspicion, conflict, and frustration'.[183] The review made 17 recommendations, including training and developing a strategy to address workplace culture 'as a matter of urgency'.[184] This review is discussed in Chapter 11, Case study 2.
- In 2020, the Australian Childhood Foundation prepared the *Through the Fence* report, which summarised consultations with a range of stakeholders about developing a trauma-informed operating model for Ashley Youth Detention Centre.[185] Consultations indicated that the Centre's culture was 'risk averse, focussed on containment and punitive in nature'; the operational environment of the Centre was reactive, ad hoc and unsafe for staff and young people; awareness and understanding of the Ashley Youth Detention Centre Model of Care (introduced in 2019) was very low; and support for change among staff was mixed, with a lack of support influenced by past ineffective efforts to facilitate change.[186] The report noted a 'significant paradigm shift' would be required to implement a trauma-informed practice framework in detention.[187]

Despite these reviews and recommendations, meaningful cultural change does not appear to have been achieved. This lack of change is evidenced in the following discussion.

4.2.2 What we heard about the culture in detention

The evidence we heard reflects many of the findings of the earlier reviews outlined in Section 4.2.1.

Security as the paramount consideration

Stuart Watson, the previously mentioned Centre Manager, told us that youth workers at Ashley Youth Detention Centre:

> … represent a parent-like person who assists the young people to meet their daily goals, including making their beds, cleaning, laundry, pro-social conversation and recreational activities such as playing cards or kicking the football.[188]

By contrast, several other witnesses commented on the primary purpose of the youth worker role appearing to be to maintain security and keep children and young people contained. Mark Morrissey, former Commissioner for Children and Young People, observed that, during his time as Commissioner between 2014 and 2017, youth workers at Ashley Youth Detention Centre seemed to be primarily concerned with the custodial rather than the therapeutic aspects of their role.[189] Mr Morrissey referred to this as a '"detention centre" culture'.[190]

Professor White, who had extensive exposure to Ashley Youth Detention Centre from 2010 to 2012 as a member of the Serious Incident Investigation Committee (referred to in Section 4.2.1), commented on the inappropriateness of the title 'youth worker', given the security focus of the role:

> … they were called youth workers but I think … that's a euphemism … the so-called 'youth workers' saw their role [as]… basically to provide security and, in their terms security meant … to make sure that the kids are locked up and that there's secure movement through the institution … it's a misnomer to call them youth workers because the usual sense of the word 'youth worker' means it's a professional youth and community worker who works to support children and to address their immediate needs. This is by no means what we mean by youth worker in the case of Ashley.[191]

Similarly, Mr Morrissey referred to the youth workers as 'guards'.[192]

These observations are reinforced by the practices of the Department in engaging private security companies to address staff shortages in the recent past.[193]

Madeleine Gardiner, who worked at Ashley Youth Detention Centre until 2019 as Manager, Professional Services and Policy, reflected that the 'operational need [at Ashley Youth Detention Centre] appeared at times to take priority over the rehabilitation needs of the young people'.[194] She expressed concern that trauma-informed responses and therapeutic practices were not well understood by some operational staff.[195]

We heard that prioritising security over therapeutic practices and trauma-informed responses to children and young people contributed to conflict between operational staff and professional services staff in decision-making forums at Ashley Youth Detention Centre. Ms Gardiner said that 'differences in professional opinion' about the care and management of young people at Ashley Youth Detention Centre were often the source of conflict between professional services staff and operational staff.[196] In Ms Gardiner's opinion, professional services staff operated from a 'theory and evidence base', but operational staff 'came from a practice of, "This is what we've always done and this is what we do to … operate the centre and to keep the centre safe"'.[197]

In Chapter 11, Case study 2, we observe that there was an apparent prioritising of operational concerns over protecting young people from the risk of harmful sexual behaviours. We also observed that the advice of staff, who had knowledge and experience of harmful sexual behaviours and the management of such behaviours, appears not to have been given as much sway as the concerns and views of operational staff.

A punitive culture

The case studies in this volume detail the extensive evidence we heard about alleged abusive practices by staff at Ashley Youth Detention Centre. As discussed in Chapter 11, Case study 1, we heard about a longstanding corrosive staff culture at the Centre

that valued coercive and punitive responses to children and young people, including using force, strip searches and isolation techniques, and enabled abusive practices and human rights violations to occur. Those accounts suggest the culture at the Centre was at odds with a therapeutic model of care that supports trauma-informed responses to the challenging behaviours of children and young people in detention. In Section 6, we make recommendations for implementing such a model of care.

A former manager of Ashley Youth Detention Centre told us that when he first started in his role in the early 2000s, he observed that the Centre worked on a system run by fear and total control by staff and the belief that young people 'could only be managed through intimidation and coercion'.[198]

Professor White observed that using punishment, segregation and isolation at Ashley Youth Detention Centre was inconsistent with the care, understanding and mentoring that children and young people typically require when they act out.[199] Professor White told us he was particularly struck by 'the apparent lack of empathy' some staff showed towards residents, referring to a 'sense of coldness and indifference' among those staff.[200]

Professor White further stated:

> … there was no sense of a rehabilitation, welfare or restorative mission. The orientation was towards social control and a lock-up mentality, rather than attempting to make institutional conditions that would foster a more pleasant place in which to live and/or provide opportunities for individual betterment.[201]

Dr Michael Guerzoni, Indigenous Fellow—Academic Development, University of Tasmania, an expert in criminology and juvenile justice, told us that he understood the culture at Ashley Youth Detention Centre to be 'punitive', describing it as a culture that:

> … is informed by a view that the children in their care are bad people who do not deserve to be treated well. These views and assumptions are further strained by the difficulties of working in criminal justice, intensifying the default view of children in this context and contributing to a culture that routinely overlooks and disregards policies and procedures.[202]

Mr Morrissey told us he had observed the 'heavy handed and excessive' restraint of children and young people by certain staff when he visited the Centre as Commissioner for Children and Young People.[203] He also described verbal abuse from some staff towards children and young people detained at the Centre:

> On several occasions I witnessed incidents of verbal abuse and belittling of the young people by certain staff. I reported these incidents to management however was not advised of the outcome. The custodial staff involved in this abuse remained on staff at [Ashley Youth Detention Centre]. It concerned me that such verbal abuse had become normalised …[204]

Both Mr Morrissey and Professor White conveyed their astonishment and concern that some staff would engage so openly in poor behaviour towards young people.[205]

Alysha (a pseudonym), a former Clinical Practice Consultant at Ashley Youth Detention Centre from late 2019 to mid-2020, was critical of some staff at the Centre, describing them as 'highly punitive' and 'often verbally abusive, sometimes physically abusive or excessively forceful' towards children and young people.[206] Alysha recalled 'many instances of staff going out of their way to humiliate or belittle children'.[207] She said that it seemed to her that staff intended to show young people 'who was in control'.[208]

Alysha further stated:

> I felt like they [staff] … didn't respect the children; certainly didn't have—and again, not all staff, but the majority—I'm confident in saying that the majority did not look to meet their needs, did not care about what they could do to best support individual young people in their rehabilitation, how they could best support them; that wasn't something that entered the conversation.[209]

Alysha's impressions of the culture and approach at Ashley Youth Detention Centre largely echoed those of Professor White, despite their experiences at the Centre being several years apart.

Victim-survivors told us about their impressions of youth workers in detention, whom they also called 'guards'. Simon (a pseudonym), who was detained at Ashley Youth Detention Centre in the early to mid-2000s, said:

> I can sit here and tell you right now the guards at Risdon Prison are a lot better than the Ashley Youth Detention Centre ones; they treated people like shit. You shouldn't be doing that, you know what I mean, they're children at the end of the day.[210]

Victim-survivor Warren (a pseudonym), who was detained at Ashley Youth Detention Centre in the mid to late 2000s, told us:

> Other guards would bring their bad mood to work. If they didn't like you, they would be physical with you. If you gave them a little bit of lip, they would restrain you and nearly snap your arm behind your back.[211]

These comments are consistent with some of the accounts provided in the context of the research we commissioned to understand how children and young people perceived safety in institutional contexts, including youth detention.[212] Some young people spoke about being assaulted by staff members, often in the context of being restrained or after a critical incident.[213] These accounts are discussed in Chapter 10.

Inconsistent treatment of children and young people

An anonymous professional who worked at Ashley Youth Detention Centre from the mid to late 2010s told us that the Centre's Behaviour Development System, which assigned colour ratings to children and young people based on their behaviour, was at times misused by staff. They observed that staff 'favoured' some young people, with ratings

assigned accordingly.[214] They also observed that the nature of a young person's offending or alleged offending often affected how incidents at the Centre were reviewed and ratings assigned—'a young person on rape charges at times was treated more harshly because staff didn't like the charges'.[215]

Similarly, Ms Gardiner told us she 'was aware that young people felt that some staff were harsher or more lenient on some detainees than others' in relation to the Behaviour Development System.[216] In Chapter 11, Case study 3, we discuss how, at times, the 'Blue Program', once a part of the Behaviour Development System, would have resulted in some children experiencing isolation practices as punishment. We discuss the Behaviour Development System and its later iteration, the Behaviour Development Program, in Section 6.3.

Socialisation of new staff into a longstanding culture

As discussed in Chapter 11, Case study 1, the longstanding tenure of many staff at Ashley Youth Detention Centre contributed to entrenching problematic attitudes and normalising the poor treatment of children and young people. Dr Guerzoni told us he understood that 'the evidence suggests that new workers at Ashley Youth Detention Centre have been socialised into a punitive culture'.[217]

Mr Morrissey told us that, during his time as Commissioner for Children and Young People, new staff regularly entered Ashley Youth Detention Centre with energy and positive ideas, but were overwhelmed by the existing and longstanding culture:

> … I think they often had a choice of adopting the prevailing longstanding culture or moving on. It was a very—culture, as we know, is very critical, but the culture at Ashley was a very powerful culture that was very difficult for just a few people to overcome and change …[218]

Similarly, victim-survivor Max (a pseudonym), who was detained at the Centre for periods from the late 2010s to the early 2020s, told us that even if a youth worker started with positive intentions, they would soon be socialised into the dominant culture at Ashley Youth Detention Centre:

> Like, the new ones, the new ones that they've brought, like, what I seen is, like, I don't know what they're like now, but after being there a year and that, they normally turn into the same as the other ones … Yeah, it was the best thing when a new one started because they were actually nice and they never used to do any of that, and the youth workers would gradually ease them into it, like, they'd sort of ease them into showing them all this stuff.[219]

In Chapter 11, Case study 1, we find that some staff likely felt peer pressure to conform to the poor practices of others (for example, in relation to strip searching) and took part reluctantly on this basis but, also, to avoid becoming targets for abusive or bullying behaviour from colleagues (refer to the following discussion). We consider that some of this behaviour reflects a highly traumatised and dysfunctional workforce.

Bullying and unprofessional behaviour

We heard evidence of bullying and unprofessional behaviour among staff at Ashley Youth Detention Centre. Fiona Atkins, Assistant Manager at the Centre, agreed with a suggestion put to her by Counsel Assisting our Inquiry that there was a 'top-down command and control culture of management' at the Centre in 2019 when she was in operations and training roles.[220] She also said that she had personally been subjected to 'bullying behaviours' by some of the management group around this time.[221]

Mr Watson, who began in the role of Assistant Manager at the Centre in early 2020, told us about difficulties he experienced with a colleague.[222] He explained:

> [The colleague] didn't vacate the office for, I think it was four days, and when they did vacate the office they left it really dirty and grotty, and a voodoo doll hanging from the monitor with pins through the heart of the voodoo doll. I was also informed by staff up there that it was [the colleague's] belief that they could drive me out and then they could assume the position of Assistant Manager, and that that was their intention.[223]

Mr Watson also stated that, when he started as Assistant Manager, staff felt 'unsafe', 'oppressed' and 'bullied' by members of the management group and people were generally scared to speak up to that group at that time.[224]

Similarly, Veronica Burton, a former Serious Events Review Team reviewer, told us that staff felt 'very intimidated to raise issues' with this management group:[225]

> They described incidences of verbal abuse, being yelled at, being physically assaulted on a couple of occasions by being pushed, and prevented from leaving a room, and being spoken over the top of in meetings when they tried to express concerns about decisions that were being made in meetings.[226]

Alysha told us that, during meetings of the Centre Support Team (a decision-making forum discussed in Chapter 10 and Section 6.4), some staff engaged in 'voice raising, swearing, name calling, silencing, excluding, speaking over, belittling, eye rolling, finger pointing or other intimidating gestures', usually aiming such behaviours at professional services staff.[227]

A former Manager, Professional Services and Policy (not Ms Gardiner) told us that some staff, particularly those recruited many years ago, were 'not restrained and guided by professional value sets'.[228] Ms Burton described an interaction with a staff member who told her that he had made a comment to some young people in detention about their genitals.[229] Ms Burton said she was 'taken aback' because:

> … it's not a professional comment to make, it's not a way that you would talk to another professional from an external service reviewing, you know, the Centre; it just seemed at the very least inappropriate and uncomfortable. And at the worst, I guess, it felt uncomfortable that he would be talking about the boys' genitals and joking about that.[230]

Resistance to change

Mr Morrissey said the prevailing culture at Ashley Youth Detention Centre had remained unchanged for decades.[231] He referred to a 'static institutional culture that was by its very nature unable to be forward thinking or offer therapeutic care that was in the best interests of children'.[232]

The unchanged culture at Ashley Youth Detention Centre may have been related to the lengthy service of some staff members, which we discuss in several case studies in Chapter 11. We heard that several current staff have been working at Ashley Youth Detention Centre since the early 2000s.[233]

The entrenched culture may also have been reinforced by the fact that many of the staff at the Centre were drawn from the local community, where they were connected through sporting and social clubs.[234] As Professor Richard Eccleston, University of Tasmania, stated, strong social and professional connections can result in interdependencies that 'make it particularly difficult to maintain integrity and a commitment to process and ethical conduct'.[235] In Chapter 11, Case study 1, we find that familial and personal connections between some staff created strong social disincentives to challenge, question or report poor behaviour of staff towards children and young people.

Victim-survivor Erin (a pseudonym) commented on this dynamic:

> I would describe the staff at Ashley as being like a pack of animals. Some of them had been working there for 30 years. They all went to school together. They were all from [the local area], which was a small country town. They all looked after each other.[236]

Alysha expressed the view that ongoing failures to implement therapeutic approaches to managing children and young people at Ashley Youth Detention Centre were, in part, due to a general unwillingness among most staff to 'consider new approaches' and to change the way in which the Centre operated.[237]

Similarly, Adjunct Associate Professor Janise Mitchell, Deputy Chief Executive Officer, Australian Childhood Foundation, who authored the *Through the Fence* report (discussed in Section 4.2.1), referred to the absence of an 'authorising environment' to 'try to do things differently' at Ashley Youth Detention Centre.[238] She also referred to a lack of 'unity of vision' among some staff:[239]

> There are the 'old guard' as some would call them, and then there's the new guard. There's people who are more up for giving something different a go, and then there's the dyed in the wool, 'This is the way we've always done it, this is the way I'm going to keep doing it, this is what's going to make a difference'...[240]

Mandy Clarke, former Deputy Secretary, Children, Youth and Families in the former Department of Communities, told us the attitudes and practices of staff at Ashley Youth Detention Centre may be difficult to shift:

> It is possible that [staff] may at times refer to stories of the old days which could be an ongoing challenge for the Centre management in their efforts to redefine a workplace culture characterised by therapeutic practice approaches.[241]

Secretary Pervan conceded that departmental leadership did not understand the extent of cultural issues at Ashley Youth Detention Centre and acknowledged some staff members' resistance to change:

> In retrospect, those cultural issues are far harder to change … I think myself personally didn't understand the depth and strength of, if not the culture of the institution, the culture around a group of individuals and their resistance to change.[242]

Staffing challenges and an unsafe environment for youth workers

As discussed in Chapter 10, longstanding systemic challenges related to staffing at Ashley Youth Detention Centre appear to have contributed to the persistent problems in the culture and in the treatment of children detained there. These challenges include difficulties in fully staffing the Centre due to resourcing, staff turnover and unplanned staff absences, and difficulties attracting, retaining and training an appropriately skilled and qualified workforce to work at the Centre. These challenges have also contributed to creating an unsafe work environment for youth workers, which in turn risks the safety of children and young people.

We received statements from current and former Ashley Youth Detention Centre employees that tell a story of staff trying to do their best in highly challenging operational circumstances. Several staff members told us that on-the-job training was haphazard, poorly attended and did not equip staff to effectively respond to workplace incidents. Sarah Spencer, a youth worker at Ashley Youth Detention Centre since 2011, provided evidence to us in August 2022. She told us:

> Staff are assaulted on site regularly, consistently … We're trying to get more staff: we're not supported. We don't get debriefings after critical incidents, we don't get breaks as I've already said. We do not get clinical supervision … We've got inexperienced staff who are not trained properly, who are only going to make more mistakes, and then it's going to be their fault again, and it shouldn't be.[243]

Ms Spencer added: 'We have not had the support, we have not had the care that we have required or the professional training or the professional supervision or anything that we needed'.[244] Ms Spencer said that she felt caught up in a persistent cycle of trauma at the Centre, which left little time for ensuring young people got the rehabilitative attention they needed to stop them being detained again.[245]

Colleen Ray, a youth worker who has been at Ashley Youth Detention Centre since 2002, told us that there had been ongoing staff shortages at the Centre, particularly in the previous four years, and that a significant cohort of staff worked multiple

overtime shifts each week.[246] Similarly, Ms Spencer said that staff were often required to work long shifts with few or no breaks, to the point where some staff brought spare underwear to work in anticipation of a lack of necessary bathroom breaks.[247]

Ms Spencer told us that implementing restrictive practices (lockdowns) at the Centre due to staff shortages meant that when young people were eventually released from their rooms or units, they were considerably more difficult to manage, which created more risks to the safety of staff:

> Well, when you're working with staff who can't restrain aggressive young people, who at the moment due to the fact that we're in restricted practices, so rolling lockdowns because we don't have the staff, when they do come out, obviously they're heightened, and we get that, but we can't—the few people that were managing them couldn't manage them, and so, the whole shift was just horrific …[248]

In Chapter 11, Case study 1, we find that the highly pressured, stressful and occasionally frightening conditions in which staff sometimes had to work, coupled with inadequate training and professional development for some staff, made it more likely for staff to deviate from best practice when seeking to manage the behaviour of children and young people. We also find that difficult behaviours displayed by children and young people likely contributed to staff holding negative attitudes towards them. We consider that this context would facilitate new staff becoming absorbed into an existing punitive culture.

The risks to staff safety at Ashley Youth Detention Centre appear to be ongoing. In a submission to a parliamentary inquiry into adult imprisonment and youth detention in Tasmania in March 2023, a former police officer who worked for several months at Ashley Youth Detention Centre in late 2022 described the Centre as 'an abusive and violent working environment where youth workers … are subjected to verbal and physical abuse [from young people] daily'.[249] This submission also referred to the prevalence of absenteeism among youth workers and the substantial proportion of youth workers who were suspended or on leave due to workers compensation claims.[250]

We discuss support for staff, staff shortages and a range of other issues related to staffing in Section 4.7.

Efforts to address cultural problems at Ashley Youth Detention Centre

Ms Gardiner said a 'change manager' employed at Ashley Youth Detention Centre in 2018 undertook work to develop a therapeutic approach at the Centre and improve working relationships.[251] According to Ms Gardiner, this work was collaborative, staff were receptive to it and 'there was an energy and an appetite for making some significant improvements in the centre'.[252] However, the change manager role was defunded in June 2018.[253]

Mr Watson expressed the view that the culture at Ashley Youth Detention Centre had changed in recent years:

> I believe that at this time at Ashley that [the] culture isn't as it's been suggested. I believe that it has been in the past, but the staff changes over the last two years that I've been there have been incredible. There's very few of the staff that were there when I started now.[254]

In August 2022, Pamela Honan, Director, Strategic Youth Services, told us that the relationship between operational staff and professional services staff had improved, describing it as 'respectful, supportive, collaborative and equal'.[255] Ms Honan attributed the improved relationship to appointing new senior managers in both teams, a 'shift to a more accountable and collaborative style of leadership and decision making' supported by the new *Ashley Youth Detention Centre Practice Framework* (discussed in Section 6.3.3) and increased accountability across all staff for case management, incident reporting and policy compliance.[256] Ms Honan said organisational change didn't 'happen overnight', particularly in the context of 'years and years of a poor culture'.[257] However, she believed positive change had begun.[258]

Similarly, Secretary Pervan told us positive change was already underway at Ashley Youth Detention Centre, although he acknowledged that genuine cultural change would take time:

> We're on the way. It'll take a decade before what you've got there is at least a benchmark facility and service, whether it's at Ashley or it's, you know, at the … new facilities. Changing those cultures are not just about changing people's attitudes; in many respects they're about changing the people themselves.[259]

Given the depth of the cultural problems identified in this section, we consider that more significant reform of the youth detention system is required to achieve meaningful cultural change. This should occur immediately, given the number of past reviews that have shown incremental reform to be ineffective.

4.3 The Government's proposed reforms

As noted in Section 2, the Tasmanian Government has announced plans to close Ashley Youth Detention Centre and 'transition to contemporary therapeutic facilities and models of care by the end of 2024'.[260]

The Government's Draft Youth Justice Blueprint, Draft First Action Plan and Keeping Kids Safe Plan each contain proposed reforms that broadly seek to address the cultural problems we have identified.[261] For example:

- A principle underpinning the Draft Youth Justice Blueprint is to 'create a culture that fosters child safety and wellbeing across the youth justice system in Tasmania'.[262]

- An aim of Strategy 5 ('Provide an appropriately trained and supported therapeutic workforce') of the Draft Youth Justice Blueprint is to develop 'an ongoing culture of learning, inquiry and continuous improvement, including collaborative opportunities for professional development, supervision, support; and opportunities for best practice to be shared and supported'.[263]
- The Draft First Action Plan refers to an 'increased culture of safety for staff and children and young people' and 'increased professionalism of [the] workforce' as expected outcomes of Action 1 ('Enhance the safety and therapeutic approach at [Ashley Youth Detention Centre]') and Action 2 ('Develop and implement a Youth Justice Model of Care').[264]
- The Keeping Kids Safe Plan states that the Department for Education, Children and Young People 'will continue to focus on delivering practice improvement, professionalisation of centre operations and the workforce, and importantly, culture change'.[265]

We refer to more specific proposed reforms from these documents throughout this section. We turn now to our recommendations for change.

4.4 Strong and active leadership

Strong and active leadership is critical to creating a child safe culture. Leaders should instil a culture that 'inhibits the perpetration of child sexual abuse, speeds the detection of abuse, and enhances the response to abuse'.[266] Professor Palmer stated that leaders 'demonstrate cultural content' in several ways—by the people they hire and fire; the behaviour they reward and punish; the matters they focus on; the way they respond to crises; and the attitudes and behaviours they display.[267]

4.4.1 Leadership roles in youth detention

As outlined in Chapter 10, the Secretary of the Department is responsible for the security and management of Ashley Youth Detention Centre and the safe custody and wellbeing of children and young people in detention.[268]

In October 2022, responsibility for youth justice services was transferred from the former Department of Communities to the Department for Education, Children and Young People.[269] Since this restructure, the position of Executive Director, Services for Youth Justice, which was created in August 2022, has been responsible for Ashley Youth Detention Centre and broader youth justice services.[270] Initially, the Executive Director reported directly to the Secretary; however, the Department has advised us that, since the restructure, the Executive Director reports to an 'Associate Secretary'.[271]

The current Executive Director, Services for Youth Justice is Christopher Simcock. In oral evidence, Mr Simcock told us that he has two direct reports—Ms Honan

(Director, Strategic Youth Services, sometimes also referred to as the Director, Youth and Family Violence Services) and the 'Director of Custodial'.[272] We understand this to be a reference to the Director, Custodial Operations—a new role that has been 'filled through a secondment from 5 September 2022 for a 12 month period to focus on additional staff and operational support at [Ashley Youth Detention Centre]'.[273]

We understand that, since the October 2022 restructure, the Manager, Custodial Youth Justice ('Centre Manager'), who is based at Ashley Youth Detention Centre, continues to report to the Director, Strategic Youth Services. The Centre Manager is responsible for managing the day-to-day operations of Ashley Youth Detention Centre, the development and leadership of a management team, and providing direction for programs at the Centre.[274] As at May 2022, the Centre Manager role was a Band 8 in the Tasmanian State Service and had four direct reports.[275]

4.4.2 Strengthening leadership

A paradigm shift is required in youth detention in Tasmania to move from a punitive, custodial model to a therapeutic model of care. The Government has outlined a major youth justice reform agenda for the next 10 years, including reviewing the Youth Justice Act, closing Ashley Youth Detention Centre and building new youth justice facilities. Effective and timely implementation of these measures will require active, expert and decisive leaders who are committed to achieving the necessary cultural change to support reform and create a child safe culture in detention.

Adjunct Associate Professor Mitchell stressed the importance of committed leadership in changing an entrenched culture:

> Leadership sets the environment within which the work happens. So, if you don't have leadership that is on board with what you're trying to achieve operationally, then you are doomed to fail.[276]

Ms Clarke told us that 'very, very strong leadership' was necessary to implement a therapeutic practice framework in youth detention and that such leadership 'must be grounded in understanding and an absolute commitment to therapeutic practice'.[277] Similarly, Ms Burton indicated that leadership in implementing a therapeutic framework in detention was crucial:

> … it needs to be a top-down approach to change, otherwise the barriers will remain. If the framework, whatever it ends up being, and the therapeutic service is not embraced by executive, it won't be successful.[278]

Objective 2 of the Keeping Kids Safe Plan refers to developing a Youth Justice Services Workforce Strategy (discussed in Section 4.7.2) with 'a strong leadership focus'.[279] The plan also refers to establishing several new leadership positions 'to manage specific areas' at Ashley Youth Detention Centre, including Director, Custodial Operations (referred to in Section 4.4.1); Director, Clinical Services; Assistant Manager,

Case Management; and Assistant Manager, Security, Risk, Training and Audit.[280] We are pleased to see these new leadership roles being introduced. We are unclear whether these roles will be located at the Centre or the Department or both, noting that strong leadership will be necessary in both the Department and Ashley Youth Detention Centre (and any future detention facility).

As noted in Section 4.4.1, the Executive Director, Services for Youth Justice reports to an Associate Secretary, who reports to the Secretary.[281] The Associate Secretary's three other direct reports are Deputy Secretaries.[282] We are concerned about this lack of parity in seniority among the leaders in the Department. In such a large department, it is vital that the youth justice leader has enough seniority to represent the significant risk carried by that portfolio involving Tasmania's most vulnerable children. However, we acknowledge that in a small jurisdiction such as Tasmania it may not be feasible to elevate this role to that of a Deputy Secretary.

At a minimum, we consider that the Executive Director, Services for Youth Justice must have knowledge and understanding of youth justice and therapeutic models of care in youth justice, as well as experience in providing strategic direction and leadership. This is essential to achieving meaningful cultural change in youth detention.

The Executive Director should be an active leader who frequently visits detention and other youth justice facilities to ensure they are aware of and understand the risks to children and young people in those facilities, and are accountable for addressing those risks.

The Executive Director should also be responsible for cultural change at Ashley Youth Detention Centre. Cultural change in youth detention should be included in the Executive Director's key performance indicators and in those of the Associate Secretary and Secretary. We discuss governance arrangements in Section 4.5.

Also, we consider that the role of Centre Manager should be more senior than it currently is, reflecting the complexity and expectations of the role. As noted, detention is a highly complex and challenging environment. The Centre Manager's operational responsibilities for the day-to-day care, supervision and safety of children and young people in detention—many of whom have extremely complex needs—as well as for the safety and supervision of staff, are significant. The current classification of this role does not adequately reflect these responsibilities or the risks associated with them. We recommend a reclassification of this role to accurately reflect its responsibilities.

We also recommend that the Centre Manager's position description and performance measures include implementing cultural change in youth detention.

Recommendation 12.6

The Department for Education, Children and Young People should:

a. have appropriate processes in place to ensure leaders in youth detention have the knowledge, skills, aptitude and core capability requirements to effectively manage people and to lead a child safe organisation

b. ensure the person who holds the position of Executive Director, Services for Youth Justice, has knowledge and understanding of youth justice and therapeutic models of care in youth justice, and experience in providing strategic direction and leadership

c. ensure cultural change in youth detention is included in the key performance indicators of the Secretary, Associate Secretary and Executive Director, Services for Youth Justice

d. reclassify the position of Manager, Custodial Youth Justice from Band 8 in the Tasmanian State Service Award to at least a Senior Executive Service Level 1

e. ensure the position description and performance measures for the role of Manager, Custodial Youth Justice include implementing cultural change in youth detention.

4.5 Governance

Good governance is essential to creating a child safe culture in youth detention. As discussed in Chapter 9, the National Royal Commission defined 'governance' as 'encompass[ing] the systems, structures and policies that control the way an institution operates, and the mechanism by which the institution, and its people, can be held to account'.[283]

We consider that good governance for youth detention requires senior leadership to be aware of what is occurring in detention facilities and to be accountable for addressing risks to children and young people in detention. This, in turn, requires transparency from the facility's management and a clear understanding of what information should be escalated to whom and in what circumstances, particularly about adverse incidents in detention and the use of isolation, force, restraints and searches.

Good governance also requires structures and systems to enable monitoring and evaluation of progress towards clear goals for cultural change and broader system reform.[284] Professor White referred to the importance of monitoring reforms, stating:

> … you can have a whole bank of new standard operating procedures, but if you don't do your monitoring and auditing, then they can just be ignored like the previous ones were.[285]

Dr Crompvoets highlighted the need for 'tangible accountability'—for a particular role holder with 'skin in the game' to be ultimately responsible for implementing change.[286]

We asked Secretary Pervan to describe the Department's governance arrangements for Ashley Youth Detention Centre. He told us that:

- Senior executives in the Department undertake '[a]dministrative, managerial and operational oversight' of the Centre.[287]
- The Custodial Inspector and the Commissioner for Children and Young People provide external oversight.[288]
- 'Additional "external" resources may be provided for the review of significant incidents', including activating a Serious Events Review Team to undertake an investigation when a child or young person has experienced a 'serious event' (death, serious injury or a 'near miss' event).[289] The findings of a Serious Events Review Team would be provided to a 'multi-disciplinary panel of clinical and practice experts'—the Serious Events Review Committee—which includes members from external agencies and advises the Secretary on system-wide recommendations.[290]

We discuss external oversight in Section 11 and the Department's responses to critical incidents in detention in Section 10. In those sections, we make recommendations to strengthen independent oversight of youth detention and to improve departmental responses to allegations of child sexual abuse and other serious incidents in detention. In Section 9, we consider how certain incidents are reported in the Department.

Here, we discuss managerial and operational oversight of Ashley Youth Detention Centre by senior executives in the Department and mechanisms for monitoring cultural change and system reform.

4.5.1 A lack of transparency

Counsel Assisting our Inquiry asked Secretary Pervan how he satisfied himself that his delegates were exercising the powers delegated to them appropriately.[291] In his answer, Secretary Pervan referred to two processes—'the reporting line through the Deputy Secretary down to the Director and their reports back to me' and 'that assumption of competence and trust going down the line to exercise those delegations in accordance with the policies that are set for the relative power'.[292]

These processes rely on appropriate reporting by the facility to the Department, so relevant information about the facility can be conveyed to the executive. We heard that this has not always occurred. Ms Honan told us that the relationship between Ashley Youth Detention Centre management and the Department was 'pretty guarded' when she took up her role in 2019.[293] She described a closed culture at the Centre:

> I felt that … the Centre operated as a satellite … it was very inward facing; there wasn't a lot of connection with, not just the department, but other services in the community. It was very closed, very wary, and defensive, I would say …[294]

Ms Honan also referred to a lack of trust and transparency in reporting by the Centre Manager to the Department (and external oversight bodies):

> My impression was that there was also a high degree of mistrust and selectivity in what and how information was reported by the Manager up to the executive to ensure the operating of the centre was positively regarded. The relationship with independent statutory bodies appeared to be wary and uncooperative.[295]

Ms Clarke agreed with these assessments.[296]

In her statement to our Inquiry in August 2022, Ms Honan indicated that transparency at Ashley Youth Detention Centre had improved significantly since 2020 due to a range of measures.[297] These include:

- improved recording and reporting of information to the executive—Ms Honan told us she received 'monthly reports pertaining to searches, restraint, isolation or use of force'[298]
- improvements in incident reporting and the recording of information in isolation, restraint and search registers and in case notes—incidents are escalated to the Department if they involve injury or harm to a child or young person or 'if there is a significant event such as sexual/physical assault, damage to property, disturbance, self-harm, escape'[299]
- 'open and transparent reflection and review of incident management to continuously improve and support best practice'[300]
- the development and implementation of the *Ashley Youth Detention Centre Practice Framework*[301]
- weekly visits by Ms Honan to the Centre, during which she speaks and listens to staff and children and young people[302]
- appointment of a 'Senior Business Partner' (we did not receive more information about this role)[303]
- 'considerable investment in building staff (including managers') understanding and application of the Agenc[y's] values and expected workplace behaviours'.[304]

During the hearings, Ms Honan conceded that other, more significant improvements were needed to fully address the problems at Ashley Youth Detention Centre:

> The changes we have put in place are still to some degree not enough. The entirety of reform that needs to happen for Ashley is systems reform. So, what we have managed to do is be more accountable, more transparent, increase the level of

> safety around children … there are more CCTV cameras, there are better practices, I think people feel more comfortable in discussing things that they have concerns about as opposed to them being suppressed … there is more collaboration around decision making. All of those things help to reduce risk, but they are certainly not reform on the scale that needs to occur.[305]

We welcome the changes that have been implemented at Ashley Youth Detention Centre to improve reporting to the Department, transparency and accountability. However, we agree with Ms Honan that more improvements are needed to bring about meaningful cultural change in youth detention and create an environment that is safe for children and young people and staff.

The Keeping Kids Safe Plan refers to the Department establishing an 'Incident Review Committee' at Ashley Youth Detention Centre in September 2022 to 'review incidents on a weekly basis for compliance with policy and procedure, follow up actions based on review findings and to identify learning areas to support staff'.[306] This committee is chaired by the Director, Custodial Operations, and its members include the Director, Youth and Family Violence Services and the Centre Manager.[307] We discuss this committee in Section 9.3.4.

4.5.2 Monitoring of youth justice reforms

The Tasmanian Government has developed a Youth Justice Reform Governance Framework to support youth justice reform in Tasmania.[308] This framework 'recognises [that] a transformed youth justice system requires a whole-of-government, all of service system, and whole-of-community approach'.[309] The governance framework comprises:

- the 'Children, Young People and Families Safety and Wellbeing Cabinet Sub Committee', whose role is to oversee the development and implementation of the Youth Justice Blueprint (among other matters)[310]
- the 'Youth Justice Reform Steering Committee', comprising Secretaries and/or Deputy Secretaries of all relevant departments—the role of this committee is to provide advice to the Cabinet Sub Committee and the Youth Justice Reform Project Team[311]
- the multidisciplinary 'Youth Justice Expert Advisory Panel', whose role is to provide advice to the Youth Justice Reform Steering Committee on the transition to a therapeutic model and the development of new custodial facilities in Tasmania, and whose members include representatives of relevant departments and non-government organisations—this panel 'has expertise in key areas relating to youth justice services, child and adolescent development, psychological research, child rights, education, trauma and abuse'[312]

- the 'Youth Justice Blueprint Community Consultative Working Group', whose role is to provide advice on implementing the Youth Justice Blueprint and to '[a]ssist the Tasmanian Government in monitoring the implementation of the Blueprint and Youth Justice Reform in the community'—members of this group include representatives of 'key youth at risk/youth justice community service organisations and stakeholders'.[313]

Also, as noted in Section 2.1, the Keeping Kids Safe Plan states that a 'Working Group' has been established to oversee and monitor that plan's implementation.[314] The plan does not specify the membership of this group, nor does it explain the relationship between this group and the governance framework outlined here.

According to the Draft Youth Justice Blueprint, a 'Blueprint Monitoring and Evaluation Plan' will be developed to measure progress 'against the intent of the Blueprint and short and long term outcomes across each of the five strategies'.[315] Annual reports will be released providing information on implementation and the effectiveness of actions.[316] Also, the Government's Draft First Action Plan refers to an 'Outcomes Framework that will increase our ability to track, monitor and report change over the life of the Blueprint'.[317]

The Draft Youth Justice Blueprint states that some of the indicators of its success will include diversion of children and young people from the criminal justice system and completion of appropriate professional development by staff working in the youth justice system 'to ensure a children and young person centred, therapeutic and trauma informed response to youth offending'.[318]

It appears that these governance structures will not continue beyond implementing the youth justice reforms. In our view, ongoing governance structures to monitor the performance and culture of Ashley Youth Detention Centre and any future youth detention facilities are essential.

4.5.3 Accountability for cultural change

Given the history of cultural problems at Ashley Youth Detention Centre, and the continuing need for change in detention to create a child safe culture, we consider that measures are needed to monitor cultural change and to ensure leaders are accountable for change.

In particular, we recommend that the planned monitoring and evaluation of implementation of the Government's youth justice reforms specifically include monitoring and evaluation of cultural change in detention. As part of the proposed Outcomes Framework under the Draft Youth Justice Blueprint, objective metrics should be identified or developed to measure cultural change. These should include measures relating to adverse incidents in detention (such as assaults and self-harm), staff absences, workers compensation claims, sick leave, staff retention and grievance procedures.

Self-reporting measures such as staff surveys should also be included, but these should not be the sole measures of cultural change, given previously identified barriers to the reporting of concerns in detention. We also recommend that information from exit interviews conducted by independent community visitors with children and young people leaving detention should be used to measure cultural change (refer to Section 11.4 for a discussion of independent community visitors).

The Government should also ensure there is an ongoing governance structure to oversee and monitor the functioning of the youth justice system, including the performance and culture of youth detention, beyond the implementation of the youth justice reforms.

The Centre Manager (and the manager of any future detention facility) should be responsible for driving cultural change in detention and ensuring the environment is safe for children and staff. However, we consider that a position based at Ashley Youth Detention Centre to assist the Centre Manager in this function would be beneficial. As noted in Section 4.2.2, Ms Gardiner told us that when she started working at Ashley Youth Detention Centre in 2018, there was a change manager at the Centre whose work made a positive impact on the culture of the Centre.[319] She said that after this position was defunded, '[w]ithout someone driving the cultural change and relationship building from a leadership perspective, this cultural change was not maintained'.[320]

We recommend that the Department immediately appoints a culture change manager at Ashley Youth Detention Centre and that this position be maintained beyond the closure of the Centre for as long as monitoring indicates there is a need for this position.

Recommendation 12.7

The Tasmanian Government should:

a. develop measures to monitor and evaluate progress towards cultural change in youth detention and include these in the Outcomes Framework under the Youth Justice Blueprint and associated action plans

b. include monitoring and evaluation of progress towards cultural change in youth detention in the Youth Justice Reform Governance Framework

c. urgently begin data collection and monitoring of progress towards cultural change

d. ensure there is an ongoing governance structure to oversee and monitor the functioning of the youth justice system, including the performance and culture of youth detention, beyond the implementation of the youth justice reforms

e. fund the Department for Education, Children and Young People to immediately appoint a culture change manager at Ashley Youth Detention Centre reporting to the Centre Manager and whose role is to work with and support the Centre Manager to

   i. drive cultural change in youth detention

   ii. create a child safe organisation

   iii. establish a positive, collaborative and supportive working environment

f. maintain the culture change manager position or function beyond the closure of Ashley Youth Detention Centre for as long as monitoring indicates there is a need for it.

4.6 Empowerment and participation of children and young people in detention

As noted, a child safe culture is one in which children and young people are empowered to express their views about matters that affect them and where those views are taken seriously. In this section, we discuss children and young people's participation in systemic processes or decision making in youth detention. Children's participation in individual decision-making processes in youth detention (such as case planning, case management and exit planning) is addressed in Section 6.4.

4.6.1 Principles for children's participation

Principle Two of the *National Principles for Child Safe Organisations* requires organisations to ensure '[c]hildren and young people are informed about their rights, participate in decisions affecting them and are taken seriously'.[321] As noted earlier, the Child and Youth Safe Organisations Act includes an identical principle as a Child and Youth Safe Standard.[322]

The Victorian Commission for Children and Young People has noted that to comply with the equivalent Victorian standard an organisation must ensure: children and young people are informed about their rights; support from peers and friendships is recognised and encouraged; and organisations have strategies in place to develop a culture that facilitates participation and responds to the input and contributions of children and young people.[323]

As noted earlier, we commissioned research into children and young people's perceptions of safety in government funded organisations in Tasmania.[324] This research—the *Take Notice, Believe Us and Act!* report—highlighted the importance of children and young people's empowerment and participation in institutions. It found that:

> To feel confident, children and young people need to be respected, to be affirmed and to be equipped to identify and seek help when they are at risk of harm. This requires them to be informed and educated. It requires organisations to promote cultures that value children and young people and empower them as individuals and as a group.[325]

The report also found that 'to feel safe and to have confidence in adults and organisations children and young people need to feel involved':

> Groups of young people can also play a role in identifying the concerns of their peers and providing feedback on an organisation's approach to preventing and responding to abuse. Fundamental to individual and 'collective' engagement is for something to change. For 'participation' to be 'protective', children and young people must see how their views have been valued, acted on and how adults and organisations have built their appreciation of their needs and embedded them in their child safe strategies.[326]

Experts who gave evidence to our Commission of Inquiry also commented on the importance of children's participation in organisations. Professor Palmer stated that children should be explicitly involved in the design of child safety measures and have the same status, in terms of rights and obligations, as adults, particularly the right to be believed.[327]

As we discuss elsewhere in our report, in 2021, the Victorian Commission for Children and Young People released *Empowerment and Participation – A Guide for Organisations Working with Children and Young People*.[328] According to this guide, the four key elements of participation for children and young people in organisations are:

- space—children and young people feel safe when they are in an environment where it is safe to speak up[329]
- voice—children and young people are not always used to being asked about their experience or about what they want, so organisations need to support them to feel comfortable speaking up and provide opportunities to do so[330]
- audience—adults and young people are effectively collaborating when adults in an organisation take young people's views seriously and allow them to inform the way the organisation works[331]
- influence—for participation to be meaningful, participants should know the intention is to make changes that keep children and young people safe in the organisation.[332]

The New South Wales Office of the Advocate for Children and Young People published *A Guide to Establishing a Children and Young People's Advisory Group* in 2021.[333] This guide identifies several principles for children's participation, including:

- Membership of any advisory group should reflect children and young people's diversity.
- Organisations should develop the capacity of children and young people to participate.
- Children and young people's participation must be voluntary and informed.
- Participation should bring children and young people no harm—for example, children and young people who become distressed during meetings may need psychological support.
- Organisations should anticipate ethical issues that might arise from children's participation, including keeping any information shared by children and young people confidential.[334]

We also note *Youth Matter: A Practical Guide to Increase Youth Engagement and Participation in Tasmania*, published by the former Department of Communities in 2019.[335]

4.6.2 Participation at Ashley Youth Detention Centre

We identified that Ashley Youth Detention Centre has a procedure about a Resident Advisory Group ('Resident Advisory Group Procedure').[336] This procedure explains that the Resident Advisory Group is a forum:

> … designed to give young people detained at [Ashley Youth Detention Centre] a say about the things that affect them. This includes listening to their views on the physical amenity of the site, detention processes, standard of care, treatment and program options and how safe they feel.[337]

The purposes of this group include '[c]reating safety by ensuring young people's voices are heard', '[s]upporting quality improvement processes', '[p]roviding input into policy and procedure development' and '[i]nformation sharing around on-site developments'.[338]

The Resident Advisory Group Procedure states that the group meets every six weeks and is attended by the Centre Manager and two staff from the Department's Quality Improvement and Workforce Development unit (this unit no longer exists).[339] All children and young people are eligible to attend unless a risk assessment undertaken by the Operations Manager indicates otherwise.[340] Participation is voluntary.[341] A Resident Advisory Group meeting may comprise several small group sessions or, in some cases, a session with an individual child or young person.[342]

The Resident Advisory Group Procedure contains detailed rules for convening and conducting meetings, ensuring safety for children and young people and staff, and reporting and responding to issues that emerge in meetings.[343]

In particular:

- If a child or young person discloses abuse or neglect, the procedure directs staff to notify Child Safety Services.[344]
- If a child or young person makes a complaint during a meeting, the Centre Manager must instigate 'the complaints process' (this is discussed in Section 10.2).[345]
- The Centre Manager must prepare a response to all issues raised and provide this to the Department within five working days of the next Resident Advisory Group meeting.[346]

The Australian Childhood Foundation's *Through the Fence* report recommended strengthening the role of the Resident Advisory Group 'to ensure that young people have a voice in the [therapeutic practice] model development and within [Ashley Youth Detention Centre] generally'.[347] We did not receive any specific evidence about the operation of the Resident Advisory Group, or children and young people's experiences with this group.

The Draft Youth Justice Blueprint states that the youth justice system should:

> … actively engage with, and seek the views of children, young people and their communities and provide ongoing opportunities for children and young people with lived experience to be heard.[348]

However, it does not specify how this will be achieved for children and young people in detention. None of the Government's reform documents refer to the Resident Advisory Group or any other participation or consultation mechanism for children and young people in detention.

4.6.3 Strengthening children's participation in the detention system

It is critical to develop a culture that empowers children and young people in detention and enables them to safely share their views on a range of issues, including policies, procedures, programs, services, system reforms and what makes them feel safe or unsafe. Such a culture should aim to build children and young people's awareness, skills and knowledge to support their participation.

Given the previous lack of children's participation at Ashley Youth Detention Centre, we consider that the Department for Education, Children and Young People should develop an empowerment and participation strategy for children and young people in detention, in consultation with the new Commission for Children and Young People (recommended in Chapter 18 at Recommendation 18.6 and discussed in Section 11.3). In our view, the guides to children's empowerment and participation recently developed in Victoria and New South Wales provide appropriate tools to inform this strategy.

The Resident Advisory Group appears to be a positive way to seek feedback from children and young people in youth detention. However, there are several factors that limit its effectiveness as an ongoing consultation forum for children and young people to express their views. These include the vulnerability of children and young people in detention, the recent history of children and young people feeling unsafe or reluctant to raise concerns or express their views at Ashley Youth Detention Centre and the fact that children and young people may only be in detention for a relatively short period, leading to a lack of stability in the group's membership.

Accordingly, we recommend establishing a separate advisory group comprising children, young people and young adults up to the age of 25 years with previous experience of detention. While the terms of reference for this group should be set in consultation with young people, it should provide a forum for those with lived experience of youth detention to share their views on measures to empower children and young people in detention and create a child safe culture.

Membership of this advisory group should reflect the diversity of the detention population, and in particular should include Aboriginal people and people with disability. The advisory group should be convened by the Department for Education, Children and Young People and be attended by a senior representative of the Department. However, the group should be chaired by a person who is independent of the Department and has experience in working and consulting with vulnerable young people.

We also recommend a review of the Resident Advisory Group to ensure it conforms with best practice principles for children's participation and provides a safe forum for children and young people in detention to provide feedback and express their views.

Recommendation 12.8

The Department for Education, Children and Young People should, in consultation with the new Commission for Children and Young People (Recommendation 18.6), develop an empowerment and participation strategy for children and young people in detention, having regard to best practice principles for children's participation in organisations. The strategy should include:

a. the establishment of a permanent advisory group that

   i. includes children, young people and young adults up to the age of 25 years with previous experience of youth detention in Tasmania, including Aboriginal people and people with disability

   ii. has clear terms of reference developed in consultation with young people with experience of detention

iii. enables its members to participate in a safe and meaningful way and express their views on measures to empower children and young people in detention (including the role and purpose of the Resident Advisory Group) and achieve cultural change in detention

iv. meets regularly and is chaired by a person independent of the Department and attended by a senior departmental leader

v. is adequately funded and resourced

b. a review of the Ashley Youth Detention Centre Resident Advisory Group to ensure it conforms with best practice principles for children's participation and provides a safe forum for children and young people in detention to express their views, including on measures to achieve cultural change in detention, without fear of reprisal

c. a consultation forum for children and young people in any youth detention facility that replaces Ashley Youth Detention Centre

d. mechanisms to ensure children and young people in detention are aware of their rights

e. regular monitoring and evaluation of the effectiveness of the empowerment and participation strategy.

4.7 Staffing

Another key component of cultural change in detention is ensuring youth workers are appropriately qualified, skilled, trained, supported and resourced to engage with and respond constructively to children and young people in detention, and their attitudes and personal attributes align with a therapeutic model of care for youth detention.

As discussed in Section 6, the best-performing youth detention facilities have highly skilled staff who actively engage with children and young people, model positive behaviour and can manage difficult behaviours through trauma-informed responses and de-escalation techniques. In these facilities, staff engagement with children and young people is key to supporting them to address their behaviours.

In Section 6.3.1, we describe models:

- in Spain, where the staff who have the day-to-day care of children and young people in secure facilities run by the Diagrama Foundation are known as 'social educators'—these are specialists qualified to degree level who act as encouraging and supportive role models for children and young people, while setting 'consistent, clear and fair boundaries to help young people understand the positive and negative consequences of their behaviour'[349]

- in Missouri and elsewhere in the United States, where staff who are responsible for the care and safety of children and young people in secure facilities are known as 'youth specialists'—these staff undergo an intensive recruitment process to determine whether they are committed to helping children and young people succeed and have the necessary attributes for the role, and are also required to complete 236 hours of training in their first two years, including multiple sessions on youth development, family systems and group facilitation.[350]

In Section 6.3.4, we recommend that the Government ensures staff in youth detention facilities have the skills needed to undertake trauma-informed, child-centred interventions with children and young people, including the skills to anticipate, de-escalate and respond effectively to challenging behaviours without resorting to the use of force or restrictive practices (Recommendation 12.18).

In the following discussion, we consider the qualifications and professional development necessary for youth workers in Tasmanian detention facilities to meet this standard. We also discuss staff shortages and recruitment.

4.7.1 Staff qualifications and professional development

Youth workers' qualifications and training

Almost all the previous reviews into Ashley Youth Detention Centre summarised in Section 4.2.1 highlighted problems with youth worker capability, skills and training.

As noted in Section 4.2.2, we heard that most youth workers at Ashley Youth Detention Centre live in the local area. We also heard that many youth workers had minimal relevant qualifications (with a highest level of education of year 10 or year 12), had minimal previous relevant experience other than caring for their own children or being involved in a sporting club, and had found out about the youth worker position through word of mouth.[351]

According to Dr Guerzoni:

> … historically the workforce at Ashley Youth Detention Centre have not been required to hold appropriate qualifications. Further, I understand that they have not been trained in working with juveniles and the facilitation of healthy relationships with children.[352]

In contrast, we also heard that some youth workers had relevant qualifications and experience when they started working at Ashley Youth Detention Centre. For example, Ms Spencer had a Certificate IV in Youth Justice and had worked at a youth detention centre in another state, while Ms Ray had youth worker qualifications from New Zealand and experience in working with children and young people.[353]

According to Recommendation 15.8 of the National Royal Commission:

> State and territory governments should ensure that all staff in youth detention are provided with training and ongoing professional development in trauma-informed care to assist them to meet the needs of children in youth detention.[354]

Ms Ray told us that she was meant to have two weeks of training when she started at Ashley Youth Detention Centre (in 2002) but 'only got four days because there was a riot. So, after day four I got put into a unit with 15 boys and three staff … and 20 minutes later it all kicked off'.[355]

The *Ashley Youth Detention Centre Learning and Development Framework* ('Learning and Development Framework'), introduced in 2020, refers to a 'Beginning Practice program' for new staff, to be completed over six weeks, which includes:

1. Online introduction units, to be completed prior to first day of onsite training
2. Class based training sessions covering each competency unit
3. Class based and onsite introduction to the varying roles throughout the centre
4. Eight days of onsite 'buddy shifts' across all shift types working alongside mentors and opinion leaders who have been specifically selected for their practice abilities and leaderships skills (specific training provided to mentors)
5. Buddy shifts with Ashley Team Support to gain exposure to varying roles within the centre
6. Individual supervision sessions
7. Teamwork activities
8. Group supervision.[356]

The Learning and Development Framework also specifies several mandatory training requirements for Ashley Youth Detention Centre staff. These include units called 'Child and Adolescent Development', 'Respond Safely to Critical Situations' and 'Engagement, De-escalation and Restraint'.[357]

While we agree with the importance of training and professional development for youth workers, we are also conscious of the fact that many previous reviews have made recommendations for staff training and yet problems have continued to exist. We note, in particular, the Ombudsman's observations in 2019 that the various reports on Ashley Youth Detention Centre 'appear to be demonstrating that there has been training provided but that there is an underlying cultural issue affecting its adoption'.[358]

Qualifications and induction programs in other jurisdictions

In his evidence, Mr Simcock stated that the Department was seeing if it could 'replicate' some of the qualifications of the youth justice workforce in the Northern Territory, where he was previously employed.[359] In the Northern Territory, youth justice officers do not need to have a qualification before applying for the position, but all officers are employed first through a 12-month contract, during which time they must complete a Certificate IV in Youth Justice, which is funded by the department.[360] This was a recommendation of the 2017 Royal Commission and Board of Inquiry into the Protection and Detention of Children in the Northern Territory ('Northern Territory Royal Commission').[361]

In May 2022, the Northern Territory Government published its *Northern Territory Youth Detention Centres Model of Care*.[362] This document identifies several personal attributes as essential to enable youth justice centre staff to implement a therapeutic model of care.[363] These include:

- genuine care and compassion for young people in detention
- the belief that young people are in detention to be rehabilitated, not punished
- the capacity to build and maintain positive relationships with young people while maintaining professional boundaries
- the ability to model and uphold prosocial behaviour
- willingness to take a strengths-based approach and actively engage with and take part in all aspects of a young person's rehabilitation.[364]

Other jurisdictions adopt a variety of approaches to qualifications and induction programs for youth detention centre staff. For example:

- in New South Wales, no substantive qualifications are required to become a youth officer, and new recruits undergo three weeks of full-time training to prepare them for entry-level duties[365]
- in Queensland, no substantive qualifications are required to become a detention youth worker, but 'a Certificate IV in Youth Justice or a Diploma of Youth Justice are highly desirable' and new recruits 'must meet all competencies and standards' specified in five weeks of induction training before being confirmed in the role[366]
- in Victoria, the Department of Justice and Community Safety provides youth justice worker recruits with 'eight weeks of fully paid foundational training including a Certificate IV in Youth Justice' to prepare them for their first day—once they begin service, youth justice workers 'continue to earn [their] Certificate IV qualifications'[367]
- in South Australia, '[i]t is not essential to already have a Certificate IV in Youth Justice' and the Department of Human Services 'may be able to support eligible candidates to complete the required training'[368]

- in Western Australia, no substantive qualifications are required to become a youth justice officer, but new recruits must undertake a nine-month full-time training program that includes 'on-the-job' and 'off-the-job' training, and written and practical assessments.[369]

Alison Grace, Deputy Centre Manager, Bimberi Youth Justice Centre in the Australian Capital Territory, told us that '[i]ndividuals applying for employment do not require any previous training or experience, other than a willingness to work with young people and make a difference'.[370] She said that operational staff must complete a seven-week induction program to be eligible for permanent appointment.[371] This induction is followed by two weeks of 'buddy shifts' before staff start in their role.[372]

Ms Grace said that a dedicated Training Officer was appointed at Bimberi Youth Justice Centre in March 2020.[373] In addition, the 'Principal Practitioner' provides training to staff to ensure services are trauma-informed and therapeutic, including mandatory training for all new operational staff on 'professional boundaries and self-disclosure, self-care and resilience and working with [Child and Youth Protection Services]'.[374]

Efforts to strengthen youth worker qualifications and skills in Tasmania

The Draft Youth Justice Blueprint and Draft First Action Plan acknowledge that an effective youth justice system requires a 'highly qualified and trained workforce', although the Draft Youth Justice Blueprint also notes that Tasmania's population size creates a challenge to ensuring suitably qualified staff.[375]

The Draft Youth Justice Blueprint also refers to the goals of '[b]uilding capacity within the workforce so that all staff have the required skills and capabilities for their role' and '[s]trengthening professional learning opportunities in trauma-informed and therapeutic approaches to practice'.[376] The Draft First Action Plan refers to the '[i]ncreased professionalism of [the] workforce', '[i]ncreased staff training and skill development' and '[i]ncreased safety for staff, children and young people' as expected outcomes of key actions under the plan.[377]

According to the Keeping Kids Safe Plan, '[t]he intent is that all youth workers have appropriate qualifications for the roles they are undertaking, underpinned by a trauma informed therapeutic approach'.[378] The plan commits to providing the Certificate IV in Youth Justice, delivered by the Australian Childhood Foundation, to existing staff and 'any new staff who require the qualification'.[379]

During the hearings, Professor White observed that:

> … usually a Certificate IV is a basic qualification, and often, but not always, it's a tick and flick exercise … So it's substantively not particularly onerous and doesn't really do much more than provide minimal training, but it's not training as a youth worker, it's training as a custodial [worker], and there's a big difference.[380]

The 2016 Noetic Solutions options paper similarly indicated that stakeholders 'overwhelmingly suggested' that the Certificate IV qualification was not sufficient to support young people with complex needs in a custodial setting.[381] Professor White emphasised the need for both 'in-service and pre-service' education and training for youth workers.[382]

According to the Keeping Kids Safe Plan, the Department contracted the Australian Childhood Foundation in September 2022 to review the Learning and Development Framework and undertake a workforce analysis, which included examining '[m]inimum qualifications of all roles' and '[p]osition descriptions and core capabilities'.[383] We have not been provided with the results of this review or analysis.

Before turning to our recommendations on staff qualifications, we discuss staff shortages and recruitment.

4.7.2 Staff shortages and recruitment

Understaffing and resourcing challenges in detention

As noted in Section 4.2.2, we heard extensive evidence about understaffing and resource challenges at Ashley Youth Detention Centre.

Fiona Atkins, who started working at the Centre in 2000, recalled in her evidence that staffing pressures emerged in the early 2000s as a result of reduced funding.[384] She explained that, around this time, Ashley Youth Detention Centre began relying more heavily on private security personnel to cover shifts in response to staffing shortages.[385]

The 2007 report of the Legislative Council Select Committee (referred to in Section 4.2.1) observed that mandated staffing levels at Ashley Youth Detention Centre were not being maintained or were inadequate to ensure the safety and security of young people and existing staff.[386]

We heard that staff shortages at Ashley Youth Detention Centre have only worsened since then and that understaffing has created unsafe conditions for staff and for children and young people in detention.[387]

Mr Morrissey told us that, during his time as Commissioner for Children and Young People (2014 to 2017), there were instances where he made unannounced visits to Ashley Youth Detention Centre to check on the children and young people detained there.[388] Mr Morrissey recalled there were occasions when he had difficulty accessing the Centre, and left without having spoken to any young people—a situation he assumed to be related, in part, to reduced staffing levels.[389] He also told us he was aware of children and young people being locked in their rooms alone for periods of up to two weeks or more due to staffing shortages, which he characterised as a 'form of torture'.[390]

Understaffing also inevitably leads to reduced supervision of children and young people by a smaller pool of staff. This increases the vulnerability of children and young people in detention to physical or sexual abuse by staff or other detainees—a fact acknowledged by Lucas Digney, Assistant State Secretary, Health and Community Services Union (Tasmania Branch), during our hearings.[391]

Victim-survivor Max told us about an incident where he alleged that he was physically abused by another young person while there was only one staff member available to supervise.[392] He told us that '[h]aving only one worker means that if there is an incident, they can't do anything other than call a code black and wait for other youth workers to arrive'.[393]

As noted in Section 4.2.2, Ms Ray referred to ongoing staff shortages over a period of several years before 2022:

> … you want the best out of a young person you need to nearly have one-on-one staff ratio to residents … there was always constraints over budget, over staffing, they never did enough recruitment, we couldn't keep enough people, so for a whole period of four years there was quite a cohort of staff who were working three and four 12-hour shifts a week. Now, under those circumstances, in a 24/7 alert level situation, that's a lot for the human brain to take on for a long period of time.[394]

Ms Spencer told us that, at the time of our hearings in August 2022, children and young people were on 'rolling lockdowns' due to staff shortages—this meant confining children and young people to their rooms or units for longer than usual and releasing them at staggered times rather than all together.[395] We discuss lockdowns in detail in Section 9.2.

Ms Atkins attributed recent staff shortages to several factors: the standing down or suspension of staff in response to allegations made against them; the forthcoming closure of Ashley Youth Detention Centre; COVID-19 restrictions; the perception among some staff that young people at the Centre may make false allegations against them; an increase in workers compensation claims; and negative depictions of Ashley Youth Detention Centre in media reporting.[396]

Mr Digney identified staff shortages as a management issue caused by under-resourcing, poor working conditions, employment-related injuries and a lack of staff retention.[397] He stated:

> Staff shortages damage employee morale and heighten workloads. It creates a significant safety risk. This consequentially harms the standard of service which employees can provide to detainees. Further, detainees see it as isolation, which, in the view of [the Health and Community Services Union], it is. This can often make them agitated and more difficult to engage with. It leads to frustration and confrontation between staff and detainees.[398]

At our hearings, Mr Digney said that, while there had been some recent improvement in the staffing situation at the Centre, the shortages continued, with the Centre relying on staff working overtime to cover the minimum shifts required.[399] This continued to place the safety of children at risk.

Secretary Pervan acknowledged that staff shortages had been a longstanding problem at Ashley Youth Detention Centre and referred to several barriers to recruitment:

> I do not recall a time when the levels of staff with the necessary skills [were in place] to support the transformation of the [Ashley Youth Detention Centre] service. This is a function of both available funding and our ability to recruit and retain staff with the necessary skills. Since I became Acting Secretary, we have similarly not had staffing numbers to support [Ashley Youth Detention Centre] staff to undertake substantial periods of training away from the workplace without leaving the Centre chronically understaffed. This is the practical reality within which we operate given our budget, the location of the facility, staff turnover levels, the difficulty of these jobs and the high levels of sick leave. It also reflects the financial reality of our State with Government having to determine funding from fixed revenues across intensely competing demands in health, education, justice and so on.[400]

Secretary Pervan expanded on his comments at the hearings:

> In an ideal world you would have sufficient staffing so that you could maintain full safe staffing while you had other staff away from the service undertaking training and development and bringing them up to speed with an emerging area which is therapeutic care. The dynamic at Ashley is that, because of staff turnover, we've never actually ever been able to get a full permanent workforce up there so that there has been times, as we all know, when we've been unable to maintain full safe staffing without using overtime and double shifts and things like that.[401]

We understand that, as recently as July 2023, lockdowns related to staff shortages continued at the Centre, with children and young people locked in their rooms or units for up to 23 hours each day.[402]

Efforts to address staff shortages in detention

In June 2022, a health and safety representative at Ashley Youth Detention Centre issued a Provisional Improvement Notice to the Centre on the basis that the Department was not taking enough action on staff shortages and there was an 'imminent risk to [union] members' health and safety'.[403] In August 2022, Mr Digney stated that there had been no support from the safety regulator WorkSafe Tasmania on this issue, nor had the Department provided immediate contingency staff.[404]

Correspondence from Mr Digney in June 2022 to Jacqueline Allen, former Acting Executive Director, People and Culture in the Department of Communities, stated that staffing at Ashley Youth Detention Centre was at a point where it was 'dangerous for workers and young people alike'.[405] In her response to this email, Ms Allen indicated that

a number of measures were being implemented, including recruiting new youth workers, support from other service areas, health and wellbeing support and 'appropriate restrictions on movement of young people' in recognition of the current staffing levels.[406] The reference to 'restrictions on movement of young people' appears to be a reference to lockdowns.

The Draft Youth Justice Blueprint refers to the aim of 'maintaining staffing levels with experienced and competent staff'.[407] Similarly, the Draft First Action Plan states that it aims to maintain an 'adequate staffing complement' and identifies '[i]ncreased staffing' as one of its intended outcomes.[408]

Objective 2 of the Keeping Kids Safe Plan is to maintain 'an appropriate level of staff with the right experience and competencies' at Ashley Youth Detention Centre.[409] This includes the following action items:

- developing and implementing a 'Youth Justice Services Workforce Strategy', to be implemented by January 2023[410]
- appointing a Director, Custodial Operations for 12 months from September 2022 (referred to in Section 4.4.1)[411]
- seconding five youth workers from the Northern Territory for 12 months from October 2022 to supplement staffing at the Centre[412]
- employing retired police officers from September 2022 to assist youth workers in a 'support and mentor capacity'[413]
- making a concentrated effort to recruit more youth workers[414]
- restructuring the workforce at the Centre from the end of 2022 to 'ensure all relevant roles are geared to a strong trauma informed and therapeutic service delivery approach'[415]
- appointing more leadership positions at the Centre from the end of 2022.[416]

In February 2023, Timothy Bullard, Secretary, Department for Education, Children and Young People, advised us that:

- two Assistant Managers, one Operations Manager and 13 youth workers had been appointed for 12 months 'to provide an immediate boost' to the workforce[417]
- in terms of ongoing recruitment, 10 youth workers had been appointed in October 2022 and had completed a five-week induction course in January 2023, with another 25 applicants to be interviewed 'shortly'[418]
- since 13 December 2022, Ashley Youth Detention Centre had been 'sufficiently staffed to cease restrictive practices, enabling school attendance and full daily programs for young people'.[419]

We have not been advised whether other pending action items under Objective 2 of the Keeping Kids Safe Plan have been completed.

On 12 July 2023, the Commissioner for Children and Young People, Leanne McLean, informed us that, since August 2022, there had been a deterioration of conditions for children and young people in detention, with 'isolation practices and unit-specific lockdowns, operating outside an accepted policy framework, and restrictive practices for operational reasons' continuing to be used at Ashley Youth Detention Centre.[420] She advised that, over the previous six months, her office had observed (among other practices):

- An increase in incidents involving extensive damage to property (e.g., flooding cells, lighting fires, activating fire sprinklers) and/or self-harm (e.g., swallowing batteries, cutting) during extended periods of lockdown; and
- Young people's access to the school, programs, fresh air, exercise, medical treatment, contact with their legal representatives and visits being restricted due to lockdowns.[421]

Commissioner McLean also said that '[t]he promotion of children's human rights is trumped time and time again by staff shortages or workplace health and safety considerations, euphemistically referred to as "operational reasons"'.[422] This information is extremely concerning.

We note that Commissioner McLean has previously called on the Government to 'urgently establish a rapid response crisis team on the ground at Ashley Youth Detention Centre, inclusive of specialist leadership skills and child safe practitioner expertise', which should focus on 'the wellbeing of detainees and the wellbeing of the staff who remain at the centre'.[423]

In response to Commissioner McLean's July 2023 comments, the Government acknowledged that, despite the employment of additional staff at Ashley Youth Detention Centre, the Centre 'continue[d] to experience critically low staff numbers turning up to work on some days'.[424] Secretary Bullard stated that restrictive practices:

> are implemented only when absolutely necessary and are structured to ensure young people at [Ashley Youth Detention Centre] have continued access to education, phone calls and health appointments.[425]

Secretary Bullard also said that the Government was continuing to work on measures to address staff shortages at the Centre, including commencing another recruitment round for youth workers, exploring the reasons for high rates of absenteeism and recruiting additional leadership roles into the Youth Justice portfolio.[426]

Support for staff

Institutional child sexual abuse has profound effects on the staff of an institution, who have been colleagues with those who have offended or against whom allegations have been made, and who have worked within the culture of the institution that enabled the abuse. The impact on staff is particularly acute in the context of Ashley Youth Detention Centre, where there are numerous staff who are the subject of allegations (refer to Chapter 11, Case studies 1 and 7).

Counsel Assisting our Inquiry asked Ms Honan what supports had been put in place for staff at Ashley Youth Detention Centre in response to the serious allegations against their colleagues.[427] Ms Honan said there was a health and wellbeing officer on site, staff had been accessing counselling and support services, and Ms Honan had also increased her presence on site to be available to speak to staff.[428]

As discussed in Chapter 15, the sexual abuse of a child in an institution, particularly by a staff member who has worked in that institution for an extended period, can be understood as a critical incident. In that chapter, we recommend that the Department of Health develops and implements a critical incident response plan for human-caused traumatic events, including incidents relating to child safety such as child sexual abuse (Recommendation 15.19). Among other matters, this plan should:

- identify who is responsible for leading the response to a critical incident and set out the applicable reporting arrangements
- provide for early communication of information about the incident
- provide psychological first aid to affected people and extra support from skilled psychologists on an 'as needs' basis
- facilitate communication and support among affected people as a means of social support
- provide for critical incident debriefing facilitated by a neutral and trained expert where appropriate
- provide for a review of the Department of Health's response to the critical incident
- provide for an evaluation of any actions to be implemented as part of the Department's response to the critical incident.

We note that the Department already has procedures for responding to incidents in detention, which we discuss in Sections 9.3 and 10.2. However, we consider that aspects of Recommendation 15.19 should be adapted to ensure staff at Ashley Youth Detention Centre dealing with the ramifications of extensive allegations of abuse against colleagues and their subsequent suspensions (and actual or potential terminations) receive the necessary support.

4.7.3 Our recommendations

As noted throughout this chapter, most children and young people in detention have highly complex needs and challenging behaviours. The practice of employing youth workers at Ashley Youth Detention Centre with limited qualifications or experience in working with vulnerable children and young people has, without doubt, contributed to many of its cultural problems. Failing to equip unqualified staff with the skills needed to provide appropriate care and support for children and young people in detention has clearly exacerbated these problems.

Staffing is a critical component in implementing meaningful cultural change in youth detention—change cannot occur if youth workers resist it. As we have seen time and again, reviews and recommendations have failed to result in effective change to the culture at Ashley Youth Detention Centre. As Dr Crompvoets observed:

> Sometimes an organisation needs a complete reset, and there are definitely examples across the world where an organisation or a part of an organisation are actually completely shut down and rebuilt from the ground up to be fit for purpose …[429]

Staff who work with children and young people in detention must be appropriately qualified and trained, and have the necessary attributes, attitudes and skills to build positive relationships with children and young people and create a child safe culture. In our view, this cannot be achieved in Tasmania without a thorough review of current staffing qualifications, personal aptitudes, capabilities and training.

To this end, we recommend that the Department initiates a change management process that includes identifying the aptitudes, attitudes and capabilities expected of youth workers, and requires all current staff to reapply for their positions. We consider that such a process is essential to change the culture in youth detention. It will also enable staff who are reappointed to clearly identify themselves as being a part of Tasmania's future youth detention system, rather than its past. The Government should consider whether the change management process should also apply to other staff at Ashley Youth Detention Centre.

As noted, the Australian Childhood Foundation is undertaking a workforce analysis in respect of Ashley Youth Detention Centre, which includes examining the minimum qualifications of all roles, position descriptions and core capabilities.[430] We welcome the Department's initiative to provide a Certificate IV qualification for youth workers. However, we are concerned that this qualification does not provide the right degree of skill to provide a therapeutic response to children with complex needs. Nevertheless, we accept that it may not be feasible at present to require all youth workers to hold a higher qualification.

In our view, youth workers should hold or be supported to obtain a relevant Certificate IV as a minimum qualification. The Department should also support youth workers to

undertake further education such as a diploma or bachelor-level qualification, graduate certificate or micro-credentials. Youth workers who complete higher qualifications should be eligible for promotion to a new role of senior youth worker, with a higher level of remuneration. Senior youth workers must also have consistently demonstrated the attributes, attitudes and skills to build positive relationships and a commitment to rehabilitation and working therapeutically with children and young people in detention.

Existing staff reapplying for a youth worker position through the recommended change management process should not be required to hold a Certificate IV, but the Department should support reappointed youth workers to obtain such a qualification within 12 months of reappointment as a condition of continuing employment.

We also recommend adopting a more rigorous method of recruitment for youth workers that considers a person's attributes (such as empathy, care, compassion and listening skills), attitudes to children and young people in detention, and relationship-building skills.[431] As Adjunct Associate Professor Mitchell advised, relationship building is a critical skill for a youth worker:

> … a relationship-based approach would be part of a practice framework. It says to the youth workers or the custodial staff: Your job is not to stand back and watch; your job is to be engaged with and use your relationship as a vehicle for change; your job is not to stand back and do nothing until you have to intervene to de-escalate something. So it sets the tone and the orientation for how change happens, for how learning happens and how we set goals and measure success.[432]

We also welcome the Department's review of the Learning and Development Framework. Induction programs and ongoing training and professional development for youth workers should reflect best practice in youth detention. They should focus on children and young people's human rights, particularly in relation to the use of isolation, force and personal searches, with training in all custodial policies and procedures. However, they should also include approaches to setting fair, clear and firm boundaries for children and young people's behaviour. Youth workers should also benefit from supervision from qualified professionals and opportunities for reflective practice.

Newly recruited youth workers should not be eligible to start work until they have satisfactorily completed the induction program. This should be followed by two weeks of 'buddy shifts' before starting in their role.

Also, to support ongoing cultural change in youth detention, the Department should develop a clear policy on the appropriateness of providing training, counselling or direction to detention centre staff members who have repeatedly demonstrated resistance to change.

We recommend that the Department maintains a sufficient level of youth workers to implement the therapeutic model of care in youth detention discussed in Section 6.3 (Recommendation 12.18) and to support a child safe culture in detention. In particular, this level of staffing should be high enough to:

- ensure children and young people's human rights are respected (including their right not to be subjected to unlawful isolation or unnecessary lockdowns) and their health, cultural and educational needs are met
- support the safety and wellbeing of youth workers, including allowing time for rest breaks, reporting, debriefs on critical incidents and handovers
- enable youth workers to undertake ongoing professional development.

We also recommend that the Department undertakes an ongoing biannual recruitment process to maintain adequate staffing levels.[433]

We acknowledge that these recommendations, which are aimed at long-term reform, may not meet the urgent need to address immediate and ongoing staff shortages. We also acknowledge that our recommendation for a change management process may add to pressure on staffing levels in the short term. The Government must urgently develop a staffing contingency plan for youth detention to ensure children and young people in detention are not subjected to unnecessary lockdowns and that their rights are not trumped by 'operational' considerations.

The Government should also consider other ways to attract youth workers, such as a salary allowance or loading that reflects the regional location of Ashley Youth Detention Centre and the current high-risk environment of youth detention.

We also recommend strengthening the Department's support for staff at Ashley Youth Detention Centre in dealing with the fallout of the allegations of abuse against their colleagues and the intense scrutiny of the Centre arising from our Commission of Inquiry. More broadly, we recommend extra support for youth workers and other staff at detention facilities following critical incidents in detention, including riots, assaults, attempted suicide and self-harm. This should include providing psychological first aid, additional support from skilled psychologists on an 'as needs' basis and, where appropriate, critical incident debriefing facilitated by a neutral and trained expert.

Recommendation 12.9

The Department for Education, Children and Young People should:

a. initiate a change management process that includes identifying the aptitudes, attitudes and capabilities expected of youth workers, and requires all current youth workers to reapply for their positions

b. ensure individuals recruited to the youth worker role hold a relevant Certificate IV qualification before starting or complete such a qualification within a year of starting, and have appropriate attributes, attitudes and skills to build positive relationships and work therapeutically with children and young people in youth detention

c. create incentives for ongoing professional development by supporting youth workers to complete higher qualifications and providing for operational career progression to a senior youth worker role

d. maintain a sufficient level of youth workers to implement a therapeutic model of care in youth detention and to ensure the safety and wellbeing of children, young people and staff

e. establish an ongoing biannual recruitment process for youth workers

f. ensure the induction program and continuing professional development for youth workers are based on best practice principles and include

    i. expected standards of behaviour in interacting with children and young people

    ii. a focus on children and young people's human rights, particularly in relation to isolation, force, restraints and personal searches

    iii. approaches to setting fair, clear and firm boundaries for children and young people's behaviour within a therapeutic, trauma-informed framework

    iv. training in all custodial policies and procedures

g. ensure newly recruited youth workers are not eligible to start work until they have satisfactorily completed the induction program, followed by two weeks of 'buddy shifts'

h. develop a clear policy on the appropriateness of providing training, counselling or direction to detention centre staff members who have repeatedly demonstrated resistance to change

i. urgently develop a staffing contingency plan to ensure children and young people in detention are not subjected to lockdowns caused by staff shortages

j. consider introducing mechanisms to attract more youth workers, such as an allowance or loading that reflects the regional location of Ashley Youth Detention Centre and the current high-risk environment of youth detention

k. implement other supports for Ashley Youth Detention Centre staff in relation to allegations of child sexual abuse against their colleagues and strengthen support for youth workers and other detention centre staff following critical

incidents in detention, such as riots, assaults, attempted suicide and self-harm, by providing psychological first aid, additional support from skilled psychologists on an 'as needs' basis and, where appropriate, critical incident debriefing facilitated by a neutral and trained expert.

4.8 A professional conduct policy

The National Royal Commission identified an increased risk of institutional child sexual abuse when expectations of conduct between staff and children are not clear or consistently enforced.[434] This clarity and consistency can be achieved through a code of conduct for staff. As part of an institution's governance framework, a code of conduct can contribute to creating a child safe culture and facilitate child safe outcomes for the children in an institution.[435]

As discussed in Chapter 20, the State Service Code of Conduct, contained in section 9 of the *State Service Act 2000*, and the State Service Principles, found in section 7 of that Act, establish standards of behaviour and conduct that apply to all State Service employees. In her evidence, Ms Allen acknowledged that one of the limitations on the People and Culture team's ability to investigate complaints or take disciplinary action was the absence of provisions in the State Service Code of Conduct relating directly to child safety or child abuse.[436]

In Chapter 20, we recommend that each Head of Agency whose department provides services to children develops a professional conduct policy for the department's employees (Recommendation 20.2). This policy should:

- explain what behaviours are unacceptable, including concerning conduct, misconduct or criminal conduct
- define and prohibit child sexual abuse, grooming and boundary violations
- acknowledge the challenge of maintaining professional boundaries in small communities and provide clear identification of, instructions about, and examples of how to manage conflicts of interest and professional boundaries in small communities
- provide guidance on identifying behaviours that indicate child sexual abuse, grooming and boundary violations relevant to the particular organisation
- outline behaviours that must be reported to authorities, including what behaviours should be reported to Tasmania Police, Child Safety Services, the Registrar of the Registration to Work with Vulnerable People Scheme, the Independent Regulator of the Reportable Conduct Scheme or other relevant agencies
- provide that not following reasonable directions is a breach of professional standards

- provide that a failure to report a breach or suspected breach of the policy may be taken to be breach of the policy
- outline the protections available to individuals who make complaints or reports in good faith
- provide and clearly outline response mechanisms for alleged breaches of the policy
- specify the penalties for a breach, including that a breach of the policy may be taken to be a breach of the State Service Code of Conduct, without needing to assess whether a separate provision of the Code has been breached, and may result in disciplinary action
- refer to any other policies, procedures and guidelines that support, inform or otherwise relate to the professional conduct policy, for example, complaints handling or child protection policies, or other codes of conduct relevant to particular professions.

The professional conduct policy should also be:

- easily accessible to everyone in the agency and communicated by a range of mechanisms
- explained to, acknowledged and signed by all employees
- accompanied by a mandatory initial training session and regular refresher training
- communicated to children and young people and their families through a range of mechanisms, including on the agency's website.

There appears to be no professional conduct policy that applies to staff at Ashley Youth Detention Centre. There is also no mention of a code of conduct or professional conduct policy in the Draft Youth Justice Blueprint, Draft First Action Plan or Keeping Kids Safe Plan.

In implementing Recommendation 20.2, the Department should ensure it develops a separate professional conduct policy for staff who have contact with children and young people in youth detention and other residential youth justice facilities. This professional conduct policy may specify general standards of behaviour as well as those specific to particular roles such as youth workers, education staff or health staff working in youth detention or other youth justice facilities.

The professional conduct policy for youth detention should specify expectations outlined in other relevant custodial policies and procedures, including those regarding personal searches of children and young people in detention and the use force and isolation (discussed in Section 9).

Recommendation 12.10

The Department for Education, Children and Young People, in developing a professional conduct policy (Recommendation 20.2), should ensure:

a. there is a separate professional conduct policy for staff who have contact with children and young people in detention facilities and other residential youth justice facilities

b. the professional conduct policy for detention facilities and other residential youth justice facilities, in addition to the matters set out in Recommendation 20.2, specifies expectations outlined in other relevant custodial policies and procedures, including those on the use of force, isolation and personal searches of children and young people in detention

c. the professional conduct policy for youth detention and other residential youth justice facilities spells out expected standards of behaviour for volunteers, contractors and sub-contractors

d. the Department uses appropriate mechanisms to ensure compliance by volunteers, contractors and sub-contractors with the professional conduct policy.

5 Reducing the number of children in youth detention

Children and young people in youth detention facilities are at increased risk of child sexual abuse by adult abusers and children and young people engaging in harmful sexual behaviours.[437] An important mechanism to minimise this risk is to reduce the number of children and young people entering detention. This requires a range of strategies to prevent children and young people becoming involved with the youth justice system, divert those who come into contact with police away from formal criminal justice processes, and ensure children and young people who do face criminal proceedings are supported to address their offending behaviour in the community rather than in detention.

As noted in Section 2, the Draft Youth Justice Blueprint and Draft First Action Plan emphasise prevention, early intervention and diversion. The broad directions of the Government's youth justice reform agenda are positive, but many of the proposed reforms are yet to be developed in detail.

Accordingly, in this section, we recommend specific measures to reduce the number of children and young people entering detention by:

- raising the minimum age of criminal responsibility to 14 years and working towards raising the minimum age of detention to 16 years

- updating the principles of the Youth Justice Act
- increasing opportunities for pre-court diversion
- improving access to bail for children and young people and reducing the number of children and young people on remand
- ensuring detention is a sentence of last resort for children and young people.

While these measures would apply to all children and young people who come to the attention of the criminal justice system, our view is that the heightened risk of child sexual abuse in youth detention justifies us making recommendations to keep children and young people out of detention.

5.1 Age-appropriate responses to children and young people

5.1.1 Minimum age of criminal responsibility

The minimum age of criminal responsibility in Tasmania is 10 years.[438] This means children as young as 10 can be arrested, questioned, searched, detained by police, charged, subjected to forensic procedures, remanded in custody, convicted of an offence and sentenced to a range of dispositions, including detention. While the legal presumption of *doli incapax* (meaning 'incapable of crime') applies to children under the age of 14 years, as it does across Australia, the Victorian Commission for Children and Young People has observed that this is an ineffective safeguard for children aged 10 to 13 years against the harmful effects of criminal justice processes.[439]

According to data published by the Australian Institute of Health and Welfare in March 2023, there were five children aged 10 to 13 years in detention and seven children aged 10 to 13 years under community-based youth justice supervision in Tasmania during the 2021–22 year.[440] Ms Atkins told us that, in August 2022, at least one child as young as 11 was being held on remand.[441]

Research indicates that detaining children and young people is damaging, has a criminalising effect and does not reduce reoffending.[442] According to Vincenzo Caltabiano, former Director of Tasmania Legal Aid:

> An incredibly high number of children who are detained at Ashley Youth Detention Centre find themselves back at Ashley Youth Detention Centre within a relatively short period of time. Over half of children aged 10–16 years return to supervised detention within 12 months of release. The general experience is that, if a child goes to Ashley Youth Detention Centre and spends any length of time there, their odds of staying in the system increase dramatically.[443]

There is a growing consensus among legal, human rights, medical and health organisations—in particular Aboriginal organisations—that such a low minimum age of criminal responsibility is harmful and unacceptable.[444] According to the Law Council of Australia:

> The current low minimum age of criminal responsibility is out of step with international human rights standards and the most recent medical evidence on child cognitive development. It also ignores the large body of social research highlighting the harmful effects of early contact with the criminal justice system, including entrenchment and recidivism, and a correlation with being less likely to complete education or find employment. Further, it ignores the social determinants that lead to certain cohorts, such as First Nations children, children in out-of-home care, and children with significant health issues, being disproportionately represented in the criminal justice system.[445]

In its 2021 inquiry into the over-representation of Aboriginal children and young people in the Victorian youth justice system, the Victorian Commission for Children and Young People found that Victoria's low minimum age of criminal responsibility—also 10 years—disproportionately harms Aboriginal children.[446] It recommended that Victoria's minimum age of criminal responsibility be increased to 14 years, without exceptions.[447]

This followed other Australian children's commissioners, including Tasmania's Commissioner for Children and Young People, recommending, in 2019, an increase in the minimum age of criminal responsibility to at least 14 years.[448] Tasmania Legal Aid and the Tasmanian Aboriginal Legal Service have also advocated implementing this change in Tasmania.[449]

Also in 2019, the United Nations Committee on the Rights of the Child recommended that the Australian Government raise the age of criminal responsibility to the 'internationally accepted level … of 14 years'.[450] The former Council of Attorneys-General formed a working group to develop a nationally consistent approach to this issue and, in 2021, agreed to develop a proposal to raise the age of criminal responsibility from 10 to 12 years.[451] In December 2022, the Australian Government released a draft report prepared by the working group in 2020 for the Council of Attorneys-General that recommended the Commonwealth, state and territory governments raise the age of criminal responsibility to 14 years without exception, noting that jurisdictions did not reach consensus on this issue.[452]

Some jurisdictions have not waited for a national consensus to be reached. In November 2022, the Northern Territory Parliament passed legislation to increase the minimum age of criminal responsibility in the Northern Territory to 12 years.[453] In April 2023, the Victorian Government announced that Victoria would raise the minimum age of criminal responsibility to 12 years by late 2024, and to 14 years by 2027.[454] In May 2023, a Bill was introduced to the Australian Capital Territory Legislative Assembly, which was then referred to a committee inquiry, to raise the minimum age of criminal responsibility to 12 years upon commencement, and to 14 years by July 2025.[455]

The Tasmanian Government has committed to increasing the minimum age of detention to 14 years by the end of 2024 (discussed in Section 5.1.2), but has said that it will continue to consider the minimum age of criminal responsibility through the national Meeting of Attorneys-General, given the Tasmanian Government's preference for a nationally consistent position on this issue.[456]

In response to a request for advice from the Commissioner for Children and Young People, in April 2022, the Tasmania Law Reform Institute published a research paper examining the law reform considerations associated with raising the minimum age of criminal responsibility in Tasmania.[457] Among other questions, the Law Reform Institute considered what additional law reform would be required to ensure community safety and to promote the wellbeing of children under the minimum age of criminal responsibility who exhibit harmful behaviours.[458] The Law Reform Institute's recommendations included expanding the definition of when a child is 'at risk' under the Children, Young Persons and Their Families Act, so a child protection approach could be taken to children under the age of criminal responsibility who are engaging in 'serious or persistent "offence like" conduct' and/or whose behaviour 'generates a risk' to the child or other people.[459]

In our view, children under the age of 14 years who are engaging in harmful or antisocial behaviour should receive a child protection or a health system response rather than a criminal justice system response. Criminalising children in this age group increases the likelihood they will 'become entrenched in the youth justice system'.[460] It also increases the likelihood they will serve a custodial sentence in adult prison.[461] Increasing the age of criminal responsibility to 14 years would help protect younger children against these risks and the increased risk of sexual abuse as a result of that exposure to the youth justice system.

In relation to exceptions for children under the age of 14 years who engage in certain categories of harmful behaviour, we note that the United Nations Committee on the Rights of the Child has indicated it:

> … is concerned about practices that permit the use of a lower minimum age of criminal responsibility in cases where, for example, the child is accused of committing a serious offence. Such practices are usually created to respond to public pressure and are not based on a rational understanding of children's development. The Committee strongly recommends that States parties abolish such approaches and set one standardized age below which children cannot be held responsible in criminal law, without exception.[462]

We agree with this approach.

5.1.2 Minimum age of detention

As noted in Section 5.1.1, the Tasmanian Government has committed to increasing the minimum age of detention to 14 years, with '[e]xceptions for serious crimes, and in the interest of community safety', to be identified during development.[463] As part of this commitment, the Government has indicated that it will develop new bail and sentencing options for children under 14 years, and that as 'new initiatives are developed and implemented, we will be able to remove detention as an option for this younger, more vulnerable cohort'.[464]

The United Nations Committee on the Rights of the Child recommends that:

> … no child be deprived of liberty, unless there are genuine public safety or public health concerns, and encourages State parties to fix an age limit below which children may not legally be deprived of their liberty, such as 16 years of age.[465]

Tasmania Legal Aid and the Tasmanian Aboriginal Legal Service both support an increase to the minimum age of detention to 16 years in Tasmania.[466] In 2021, the Victorian Commission for Children and Young People also recommended that the minimum age of detention in Victoria be increased to 16 years.[467]

We agree with this approach, but note the need for alternatives to detention—for example, inpatient mental health or drug and alcohol treatment (discussed in Section 6.5.2)—to be developed for children aged 14 and 15 years who commit serious offences against the person before such a change can be implemented.

Recommendation 12.11

The Tasmanian Government should:

a. introduce legislation to increase the minimum age of criminal responsibility to 14 years, without exception

b. develop and provide a range of community-based health, welfare and disability programs and services that are tailored to meet the needs of children and young people under the age of 14 years who are engaging in antisocial behaviour, and to address the factors contributing to that behaviour

c. work towards increasing the minimum age of detention (including remand) to 16 years by developing alternatives to detention for children aged 14 and 15 years who are found guilty of serious violent offences and who may be a danger to themselves or the community.

5.2 Updating the principles of the Youth Justice Act

The Government has committed to reviewing the Youth Justice Act as a priority under its Draft Youth Justice Blueprint, with a Bill to be delivered by 2025.[468] The purpose of the review is to 'realign the legislation to a public health approach to youth justice and to be reflective of contemporary youth justice practice'.[469] The review will consider the following issues (among others):

- aligning the legislation with key human rights and youth justice principles
- adopting a trauma-informed, child-focused approach
- reflecting the importance of restorative justice and rehabilitation
- increasing the focus on early intervention and diversion away from the youth justice system
- expanding the range of community sentencing options.[470]

The review will also consider the legislative changes needed to increase the minimum age of detention to 14 years (as discussed in Section 5.1).[471]

We support the proposed review of the Youth Justice Act to achieve these purposes. We consider the review to be an opportunity to modernise the Act and include updated principles that emphasise rehabilitation, treatment and age-appropriate responses to children in the youth justice system.

Section 5 of the Youth Justice Act contains general principles that are relevant to the exercise of powers under the Act (refer to box).

Youth Justice Act 1997, section 5: General principles of youth justice

1. The powers conferred by this Act are to be directed towards the objectives mentioned in section 4 with proper regard to the following principles:
   a. that the youth is to be dealt with, either formally or informally, in a way that encourages the youth to accept responsibility for his or her behaviour;
   b. that the youth is not to be treated more severely than an adult would be;
   c. that the community is to be protected from illegal behaviour;
   d. that the victim of the offence is to be given the opportunity to participate in the process of dealing with the youth as allowed by this Act;

e. guardians are to be encouraged to fulfil their responsibility for the care and supervision of the youth and should be supported in their efforts to fulfil this responsibility;

f. guardians should be involved in determining the appropriate sanction as allowed by this Act;

g. detaining a youth in custody should only be used as a last resort and should only be for as short a time as is necessary;

h. any sanctioning of a youth is to be designed so as to give him or her an opportunity to develop a sense of social responsibility and otherwise to develop in beneficial and socially acceptable ways;

i. any sanctioning of a youth is to be appropriate to the age, maturity and cultural identity of the youth;

j. any sanctioning of a youth is to be appropriate to the previous offending history of the youth.

2. Effect is to be given to the following principles so far as the circumstances of the individual case allow:

a. compensation and restitution should be provided, where appropriate, for victims of offences committed by youths;

b. family relationships between a youth, the youth's parents and other members of the youth's family should be preserved and strengthened;

c. a youth should not be withdrawn unnecessarily from his or her family environment;

d. there should be no unnecessary interruption of a youth's education or employment;

e. a youth's sense of racial, ethnic or cultural identity should not be impaired;

f. an Aboriginal youth should be dealt with in a manner that involves his or her cultural community.

The current youth justice principles recognise, to some extent, that children are to be treated differently from adults in the criminal justice system, that responses to children must consider a child's age and that children's relationships with family members are important. However, we agree with Tasmania Legal Aid that the principles also place 'a heavy emphasis on sanction and punishment, rather than rehabilitation, restoration, and reintegration'.[472]

We consider that an updated Youth Justice Act should include principles that reflect contemporary understandings of effective youth justice systems. For example, in New Zealand, the *Oranga Tamariki Act 1989* (NZ) ('Oranga Tamariki Act') includes general principles that apply to care and protection proceedings and youth justice proceedings.[473] These principles are closely aligned with international human rights instruments covering children and include the following:[474]

- The wellbeing of a child or young person must be at the centre of decision making that affects them.
- The child or young person's rights must be respected and upheld and the child or young person must be treated with dignity and respect at all times.
- The child or young person's need for a safe, stable and loving home should be addressed.
- A child or young person must be encouraged and assisted, wherever practicable, to participate in and express their views about any proceeding, process or decision affecting them, and their views should be taken into account.
- A holistic approach should be taken that sees the child or young person as a whole person, including their developmental potential, educational and health needs, cultural identity, gender identity, sexual orientation, age and any disability.
- The primary responsibility for caring for and nurturing the wellbeing and development of the child or young person lies with their family and cultural group and, wherever possible, those relationships should be strengthened and maintained.
- The child or young person's place within their community should be recognised and the impact of a decision on the stability of a child or young person (including the stability of their education and of their connections to community) should be considered.[475]

The Oranga Tamariki Act also lists additional principles to be applied in exercising youth justice powers.[476] These include:

- Unless the public interest requires otherwise, criminal proceedings should not be instituted against a child or young person if there is an alternative means of dealing with the matter.
- A child or young person who commits an offence or is alleged to have committed an offence should be kept in the community so far as that is practicable and consonant with the need to ensure the safety of the public.
- A child or young person's age is a mitigating factor in determining whether to impose sanctions in respect of offending by a child or young person and the nature of any such sanctions.

- Any sanctions imposed on a child or young person who commits an offence should take the least restrictive form that is appropriate in the circumstances and take the form that is most likely to promote their development within their family and cultural group.
- Any measures for dealing with offending by a child or young person should, as far as practicable, address the causes underlying their offending.[477]

In addition, the Oranga Tamariki Act requires a court or person exercising powers in relation to youth justice to weigh four 'primary considerations'—these are the wellbeing and best interests of the child or young person, the public interest, the interests of any victim, and the accountability of the child or young person for their behaviour.[478]

We consider that the updated Tasmanian youth justice legislation should include similar principles that reflect contemporary understandings of child development, children's antisocial behaviour and children's needs. These principles should apply to the exercise of any power under the new legislation, including sentencing, which is discussed in more detail in Section 5.5.

Recommendation 12.12

The Tasmanian Government should ensure legislation to replace or amend the *Youth Justice Act 1997* contains updated general principles of youth justice that reflect contemporary understandings of child development, children's antisocial behaviour and children's needs.

5.3 Expanding opportunities for pre-court diversion

In this section, we focus on diversionary processes that are available in Tasmania once a child or young person comes into contact with police, although we agree with the Tasmanian Commissioner for Children and Young People that:

> Greater attention must be given to recognising that the concept of diversion … can and should begin *before* contact with police and *before* an offence or harmful behaviour has occurred … There are a range of non-government organisations that do, and can, play an important role in providing diversionary options for children and young people in this area. This needs to be better recognised and appropriately resourced.[479]

According to the United Nations Committee on the Rights of the Child:

- Measures that divert children from the formal criminal justice system (and avoid resorting to judicial proceedings) 'should be the preferred manner of dealing with children in the majority of cases' because such measures avoid stigmatising children, produce positive results for them, are cost-effective and are 'congruent with public safety'.[480]

- ‘Opportunities for diversion should be available as early as possible after [initial] contact with the [criminal justice] system, and at various stages throughout the process’.[481]
- ‘States parties should continually extend the range of offences for which diversion is possible, including serious offences where appropriate’.[482]

Currently, a child or young person who is alleged to have committed an offence in Tasmania may be eligible for diversion from the criminal justice system under the Youth Justice Act by means of an informal caution, a formal caution or a community conference.[483] We discuss each of these mechanisms in the following sections. There is also a school-based process for ‘informal diversion for unlawful occurrences on school grounds within the behaviour management response of schools’.[484]

A child or young person who is alleged to have committed a ‘prescribed offence’ under the Youth Justice Act is not eligible for diversion.[485] Prescribed offences are offences in respect of which the Magistrates Court (Youth Justice Division) does not have jurisdiction, and which are instead determined by the Supreme Court or the Magistrates Court’s adult jurisdiction.[486] A child or young person found guilty of a prescribed offence by an adult court can be sentenced under the *Sentencing Act 1997*—including to a term of imprisonment—or the Youth Justice Act.[487]

For all children and young people, murder, manslaughter and attempted murder are prescribed offences.[488] Also:

- for children or young people aged 14 years or older, prescribed offences include rape, aggravated sexual assault, persistent sexual abuse of a child, armed robbery and aggravated armed robbery[489]
- for young people aged 17 years, prescribed offences also include driving offences such as negligent driving causing death or serious injury, reckless driving, drink driving, drug driving and offences for excessive noise or smoke for vehicles and racing a vehicle.[490]

We note that this is an extensive list of offences, not all of which can be described as serious. For example, the offence of operating a vehicle ‘in a manner that emits unnecessary and unreasonable noise’, ‘in an unnecessary execution of speed’ or ‘in a race against another vehicle’ is punishable by a maximum penalty of imprisonment for three months and/or a fine.[491] It is unclear why a young person alleged to have committed this offence should be automatically excluded from diversion.

For eligible offences—that is, non-prescribed offences—a child or young person can only be diverted under the Youth Justice Act where they admit to committing the alleged offence.[492]

5.3.1 Informal caution

Where a police officer believes that a matter 'does not warrant any formal action' under the Youth Justice Act (and the child or young person admits to committing the offence), the officer may informally caution the child or young person against further offending, and no more proceedings may take place in respect of the matter.[493]

The Tasmania Police Manual states that children and young people must not be informally cautioned for 'any assault'.[494]

5.3.2 Formal caution

Where a police officer believes that a matter warrants a more formal action than an informal caution, the officer may require that the child or young person be formally cautioned against further offending.[495] The main difference between an informal caution and a formal caution is that the police officer may require the child or young person to enter an undertaking as part of a formal caution (described below), whereas this is not available for informal cautions.[496]

The Youth Justice Act specifies various procedural requirements that must be met before a formal caution may be issued—these include a requirement that the police officer explains to the child or young person that they are entitled to legal advice and to have the matter dealt with in court.[497] A formal caution cannot be administered unless the child or young person agrees to the caution.[498]

Where the child or young person to be cautioned is Aboriginal, the formal caution must, 'if practicable', be administered by an Elder of an Aboriginal community or a representative of a 'recognised Aboriginal organisation' in the presence of an authorised police officer.[499]

As part of a formal caution, the police officer may require the child or young person to enter into an undertaking to apologise to the victim, perform community service, pay compensation, make restitution or 'do anything else that may be appropriate in the circumstances'.[500]

Police keep a record of formal cautions and a formal caution may be treated as evidence of the commission of an offence by a police officer, community conference or court if the child or young person has to be dealt with for a subsequent offence.[501]

5.3.3 Community conference

Where a police officer believes that a matter warrants a more formal action than an informal caution, the officer may, as an alternative to a formal caution, require the Secretary of the Department for Education, Children and Young People to convene a 'community conference' to deal with the matter.[502] A community conference cannot be convened unless the child or young person signs an undertaking to attend the conference.[503]

A community conference includes a facilitator, the child or young person and their guardians, any relative or other person with a close association to the child or young person who may be able to participate usefully in the conference, any victim(s) of the offence, the police officer who initiated the conference and a youth justice worker.[504] Where the child or young person is Aboriginal, an Aboriginal Elder or another representative of the child or young person's community must be invited to attend the conference.[505]

The Youth Justice Act does not specify the purpose or aim of a community conference, but it would appear to be to decide 'an appropriate sanction' for a child or young person.[506] A community conference may impose one or more sanctions on the child or young person, including:

- requiring the child or young person to apologise to the victim, perform community service or pay compensation to the victim for any injury suffered or any damage to property
- administering a caution to the child or young person, or
- requiring the child or young person to 'enter into an undertaking to do anything else that may be appropriate in the circumstances'.[507]

A child or young person cannot be prosecuted for the offence if they perform their obligations arising from the undertakings decided by the community conference.[508]

5.3.4 Declining rates of diversion in Tasmania

Data published by the Productivity Commission in its *Report on Government Services* indicates a downward trend in the use of diversion in Tasmania.[509] Overall, youth diversions (including informal cautions) as a proportion of alleged youth offenders aged 10 to 17 years fell from 52 per cent in 2012–13 to 43.3 per cent in 2021–22.[510] For Aboriginal children and young people, youth diversions as a proportion of alleged offenders decreased substantially from 45 per cent in 2012–13 to 22.5 per cent in 2021–22.[511] The Productivity Commission does not provide data on separate categories of diversion.

In 2021, the Sentencing Advisory Council reported that data from Tasmania Police showed a reduction between 2010–11 and 2018–19 in the proportion of youth files diverted, with reductions in the use of informal cautions and community conferences, and a corresponding increase in the proportion of briefs sent to prosecution.[512]

The Sentencing Advisory Council identified the following possible reasons for the decline in diversions over time:

- the involvement of schools for lower-level offending behaviour (presumably resulting in fewer low-level matters reaching the attention of police)[513]

- a decline in the overall number of young offenders, together with 'a corresponding concentration on a smaller cohort of more frequent youth offenders', meaning that matters escalated through the system more quickly[514]
- a '"class" factor', whereby the response of young people to police, and parental attitudes and support, may influence the use (or non-use) of diversion by police[515]
- the perception among some children and young people with knowledge of the youth justice system that there were likely to be 'harsher results' from the undertakings imposed through formal cautions and community conferences than from outcomes in the Magistrates Court[516]
- the absence of diversion programs across Tasmania.[517]

In relation to parental support for diversion, Commissioner McLean has observed that:

> ... the current model assumes a support network exists around the child or young person that is resourced to be able to support the child to lead a different lifestyle. For many children and young people, this is simply not their reality ... a family which has multiple risk factors may find it very difficult to support a young person through a diversionary process without strong support.[518]

Children and young people who do not have a family support network—for example, children and young people under the guardianship of the State—may not be able to access diversion for these reasons.

Commissioner McLean has also noted that the discretionary nature of diversion under the Youth Justice Act 'can result in variation between individual police officers, and regions'.[519]

5.3.5 The need for more diversion programs

The 2016 *Custodial Youth Justice Options Paper* produced by Noetic Solutions found that Tasmania did not have the 'breadth or depth' of diversionary services required to address the complex needs of children and young people.[520] More recently, Tasmania Legal Aid has advocated for diversionary programs to be made available in rural and regional areas of Tasmania, and for the development of 'universal programs' to 'avoid the postcode injustice that flows from a patchwork of options around the State'.[521]

In its 2021 report on sentencing young offenders, the Sentencing Advisory Council referred to a range of programs Tasmania Police uses to support diversion by way of caution or community conference.[522] These include prescribed courses at the Brain Injury Association of Tasmania, the 'Junior Fire Lighter Intervention Program' (through the Tasmanian Fire Service), the 'bike rebuilding program', Men's Shed programs and the First Tee program through the Police Citizens Youth Club.[523]

However, Mr Caltabiano told us that Tasmania does not have structured pre-court diversionary programs for children that apply uniformly across the State.[524] Children should be able to access effective diversionary programs regardless of where they live in Tasmania.

5.3.6 Youth justice reforms

The Draft Youth Justice Blueprint includes a significant focus on diversion. One of its principles is to 'divert children and young people from the youth justice system wherever possible' and Strategy 2 is to 'ensure diversion from the justice system is early and lasting'.[525] The Draft Youth Justice Blueprint describes diversion as aiming to 'provide pathways through which children and young people with limited or no criminal history and who have committed low level offences can be directed away from the justice system'.[526]

The Tasmanian Government's diversion strategy aims to reduce the involvement of children and young people in the youth justice system by (among other commitments):

- providing a range of developmentally appropriate responses for children and young people under the minimum age of criminal responsibility, who are exhibiting behaviours that would otherwise be considered an offence
- providing a range of diversionary options and programs for children and young people who come into contact with the justice system
- ensuring Aboriginal children and young people have access to Aboriginal-led diversionary services
- ensuring children and young people have access to services to address their mental health, disability and alcohol and other drug dependence needs.[527]

Action 4 under the Government's Draft First Action Plan includes commitments to:

- review current diversionary options to 'identify what is working, what needs strengthening to ensure maximum impact and where there are service gaps'[528]
- develop a Diversionary Services Framework to 'guide and support the delivery of a range of diversionary programs across the continuum in Tasmania'[529]
- engage with Aboriginal communities to ensure a range of appropriate, culturally safe and Aboriginal-led services for Aboriginal children and young people[530]
- deliver new diversion programs by 2025.[531]

In February 2023, Secretary Bullard advised us that the Department for Education, Children and Young People had begun researching diversion programs in other jurisdictions.[532] We note that research indicates:

> While there is no 'one size fits all' approach to preventing youth offending, programs that have a strong theoretical basis, consider the individual needs of young people, are culturally sensitive to Indigenous Australians where relevant, and reflect on practice through iterative evaluation will be best placed to address the underlying causes of offending.[533]

5.3.7 Our recommendations

We note with concern the decreasing rates of diversion in Tasmania, particularly for Aboriginal children and young people. In Section 7.1, we recommend developing an Aboriginal youth justice strategy to examine and establish evidence-based, Aboriginal-led diversion programs for Aboriginal children and young people in contact with police (Recommendation 12.27).

We commend the Department for committing to create a Diversionary Services Framework and new diversion programs. In our view, this presents an opportunity to carefully examine the effectiveness of existing diversion processes to ensure opportunities for pre-court diversion in Tasmania can be maximised. In particular, the Government should examine the use of police discretion in referring children and young people to diversion and the use and effectiveness of undertakings imposed with formal cautions and sanctions imposed by community conferences.

The Government should also reconsider the current list of prescribed offences to ensure opportunities for pre-court diversion can be maximised. In addition, the Government should ensure prescribed offences do not exclude children engaging in harmful sexual behaviours from broader therapeutic and diversionary opportunities. We discuss other diversionary mechanisms in Chapters 16 and 21.

We note that the Commissioner for Children and Young People has advocated for repealing prescribed offences from the Youth Justice Act, so 'all types of offences including serious offending [can] be dealt with in a trauma informed, child centred way that is consistent with best practice'.[534] We discuss court specialisation for children and young people in Section 5.5.4.

Recommendation 12.13

1. The Tasmanian Government, in reviewing current diversion processes and developing a Diversionary Services Framework, should:
    a. examine the exercise of police discretion to determine whether opportunities for cautioning and community conferencing are being maximised, particularly for Aboriginal children and young people, and children and young people without a strong family support network

b. commission research to examine the effectiveness of formal cautions imposed with undertakings and the sanctions imposed by community conferences, to ensure they are proportionate to the alleged offending and not unnecessarily onerous

c. introduce legislation to widen the range of alleged offences in respect of which diversion may be pursued and create a presumption in favour of pre-court diversion for children and young people.

2. The Tasmanian Government should begin statewide delivery of new diversion programs under the Diversionary Services Framework by 2025.

5.4 Increasing access to bail for children and young people

A child or young person whom police do not consider suitable for diversion may be arrested and charged with an offence. Police must release the child or young person on bail 'unless there is reasonable ground for believing that such a course would not be desirable in the interests of justice'.[535] If police refuse bail, the child or young person must be brought before a magistrate or a justice of the peace 'as soon as practicable'.[536]

During business hours, the child or young person will appear before a magistrate for a bail hearing. After hours, the child or young person will generally be brought before a 'bench justice'—a justice of the peace who is rostered by the Chief Magistrate to deal with out of hours bail hearings (among other matters)—although magistrates can also sit out of hours at the discretion of the Chief Magistrate.[537] A child or young person who is refused bail by a justice of the peace is remanded into youth detention until they can be brought before the Magistrates Court (Youth Justice Division).[538]

A child or young person who is refused bail by a magistrate is also remanded into youth detention until the criminal charge against them is heard in court. A child or young person may also be remanded after they have been found guilty of an offence, while awaiting sentencing.

According to data published by the Australian Institute of Health and Welfare, on an average day in 2021–22, there were eight children and young people aged 10 to 17 years in detention in Tasmania and, of these, six were on remand.[539] In August 2022, Ms Atkins told us that 10 of the 11 children and young people held at the Ashley Youth Detention Centre at the time were on remand.[540] Ms Atkins described this proportion of remanded children and young people as 'a regular occurrence'.[541] Other Australian jurisdictions have similarly high proportions of children and young people on remand.[542] In 2021–22, children and young people who were unsentenced (on remand) spent an average of 57.5 days in detention in Tasmania.[543]

We note that, more recently, there has been a substantial increase in the number of children and young people in detention in Tasmania. In June 2023, Commissioner McLean told us that, as at 5 June 2023, there were 21 children and young people held at Ashley Youth Detention Centre, of whom 18 were on remand.[544]

According to Tasmania Legal Aid, 'it is commonly the case' that once the charges against a child who has been remanded are heard, 'the child is released without serving any further time in custody'.[545]

Research has demonstrated that remand is disruptive and harmful to children and young people and has little rehabilitative benefit.[546] According to the Victorian Sentencing Advisory Council, for children and young people, remand:

> … can lead to separation from family and community, disruption to education and employment, association with sentenced young offenders, being held in inappropriate facilities, being unable to access therapeutic programs, having an increased chance of being placed on remand if arrested again, and having an increased chance of receiving a custodial sentence compared with young people who are granted bail.[547]

5.4.1 Drivers of remand

We heard from victim-survivors, lawyers and policy experts that the absence of safe accommodation and support options was a key reason that children and young people were being denied bail and remanded.

Professor White referred to the 'longstanding issue' in Tasmania of remanding children and young people 'mainly due to lack of adequate housing or alternative places to put kids'.[548] Similarly, Mr Caltabiano told us that magistrates often wished to include a condition of bail requiring the child or young person to reside at a specific address, and that where accommodation was not available, bail was harder to obtain.[549]

In its submission to the former Department of Communities on proposed reforms to the youth justice system, Tasmania Legal Aid stated that:

> Children in Tasmania are often refused bail because of problems with accommodation that are outside their control. This could include situations where the child is homeless, is under the care of child safety and without effective supervision, or because of mental health or drug problems.[550]

Hannah Phillips, a lawyer with experience working with youth in the Tasmanian justice and child safety systems, told us that children and young people with substance misuse, undiagnosed mental illness or with disability may be remanded because there were no available treatment facilities for children and young people in Tasmania.[551]

We also heard that whether a child or young person is granted bail may depend on whether they appear before a justice of the peace or a magistrate. Mr Caltabiano observed that children and young people refused bail by a justice of the peace at

an after-hours bail hearing were 'commonly' granted bail when they appeared before a magistrate the following business day.[552] He indicated that this may be 'due to the Magistrates' broader understanding of the legislative framework and greater experience dealing with young people'.[553]

Similarly, research undertaken by the Australian Institute of Criminology on bail and remand for children and young people in Australia described some Tasmanian stakeholders as suggesting that the bail decisions of justices of the peace tended to be 'more punitive and risk averse in response to community attitudes towards youth crime'.[554] That research acknowledged that, in some jurisdictions, a more detailed case may be presented to a magistrate than to a justice of the peace and, while decisions by justices of the peace may seem punitive, it could be the case that magistrates are simply provided with more and better information with which to make decisions.[555] However, some stakeholders pointed to the need to educate justices of the peace on the role of bail in the criminal justice system and using detention as a last resort for children and young people.[556]

We also heard about the importance of legal representation for children and young people in bail hearings to minimise the risk of remand. Ms Phillips described a situation where the Tasmanian Aboriginal Legal Service appeared out of hours for an Aboriginal young person who was on a child safety order and had multiple bail conditions across several matters:

> If I had not been there, the young person would have had to argue for their own bail, with only the Justice of the Peace, prosecutor, and a representative of Youth Justice present. Child Safety Service were not present at Court for the young person. The young female was ultimately bailed, but it was late at night and she had no way of getting home. If we were not there to advocate for this young person, it was highly likely she would have been remanded at Ashley Youth Detention Centre for the night … This highlights two things; the first is the importance of representation in out of hours Court but also the need to ensure guardians or parents are actively present for young people, when possible, in out of hours Court, in this instance Child Safety Service.[557]

The Tasmanian Aboriginal Legal Service is not funded to appear out of hours for Aboriginal children and young people, but does appear on occasions if it is 'particularly concerned for a young person's welfare and [has] capacity to assist'.[558]

Mr Caltabiano told us that there was only one after-hours duty lawyer service (for adults and children) operating in Tasmania—this service is funded by Tasmania Legal Aid from funding allocated by the Tasmanian Government and is provided by the Hobart Community Legal Centre at the Hobart Magistrates Court on Friday evening, Saturday and Sunday.[559] The Tasmanian Government's 2021–22 State Budget allocated $320,000 over four years to provide children and young people appearing in court after hours in Burnie, Devonport and Launceston with access to a duty lawyer.[560]

5.4.2 Bail support programs

Commissioner McLean has referred to a lack of appropriately resourced bail support programs for children and young people in Tasmania.[561]

Non-government organisation Save the Children provides the statewide 'Supporting Young People on Bail' program—a voluntary program where youth workers support children and young people aged 10 to 17 years on bail 'to achieve their recreational, educational and vocational/employment goals during their bail period and beyond' and to avoid further interaction with the youth justice system.[562] In its submission to the former Department of Communities on the proposed youth justice system reforms, the Tasmanian Aboriginal Legal Service described the positive experience of an Aboriginal young person in this program, who was taken fishing on several occasions by a youth worker while on bail, which allowed them 'to create a bond and gave the young person something to look forward to'.[563]

Although it is a voluntary program, a magistrate may order a mandatory meeting of the child or young person with Save the Children workers, who create a bail support plan for the child or young person.[564] In her 2022 submission on the proposed youth justice reforms, Commissioner McLean indicated that, in some instances, young people had been remanded for several weeks to enable bail support plans to be prepared, in circumstances where a sentence of detention may not have been imposed—a practice that she noted appeared to be contrary to the aim of using detention as a last resort.[565]

Previously, the Save the Children bail support program was not available for children and young people with child protection involvement, but it is not clear whether this is still the case.[566] Bail support programs should be widely available to children and young people, regardless of their involvement with other service systems.

The Commissioner for Children and Young People, Tasmania Legal Aid and the Tasmanian Aboriginal Legal Service have all advocated to expand bail support programs in Tasmania.[567] Commissioner McLean and Tasmania Legal Aid have indicated that this should include bail support workers who can coordinate support services and access brokerage funds for accommodation.[568]

5.4.3 Conditions of bail

Section 24B of the Youth Justice Act provides that a magistrate, justice of the peace or police officer who intends to admit a child or young person to bail must consider the youth justice principles in section 5 of the Act (extracted in Section 5.2) in deciding whether to impose any conditions of bail.[569]

Despite this provision, Commissioner McLean has drawn attention to the difficulties for many children and young people in complying with bail conditions requiring them to:

- submit to a curfew—such conditions can be particularly problematic for young people who are couch surfing, living in unstable accommodation or are otherwise at risk of homelessness
- not attend particular venues or locations—such conditions may restrict young people's access to essential areas such as bus terminals and supermarkets
- report to police or youth justice workers—such conditions can pose difficulties for young people due to a lack of transport and other practical challenges.[570]

Similarly, the Tasmanian Aboriginal Legal Service has indicated that children and young people on bail may have difficulty keeping a mobile phone charged or maintaining mobile phone credit, which can be a barrier to accessing support services:

> In many instances, our lawyers are aware referrals have been made to support services for a young person but then they are non-contactable, leading to the referral being closed. This can mean little progress is made during adjournment periods in court to support and rehabilitate young people … [which] ultimately increase[s] the chance of young people ending up in detention.[571]

In the absence of coordinated and consistent support, such as support to get to appointments, children and young people may breach their conditions of bail and be remanded in custody.

5.4.4 Child-specific bail laws

With the exception of section 24B of the Youth Justice Act (outlined in Section 5.4.3), children and young people in Tasmania are essentially subject to the same legislation as adults in terms of bail.

Mr Caltabiano advocated for Tasmania adopting child-specific bail laws similar to those in Victoria.[572] Section 3B of the *Bail Act 1977* (Vic) states that, in making a determination under the Act, a bail decision maker must take into account:

- the need to consider all other options before remanding the child in custody
- the need to strengthen and preserve the relationship between the child and the child's family, guardians or carers
- the desirability of allowing the living arrangements of the child to continue without interruption or disturbance
- the desirability of allowing the education, training or employment of the child to continue without interruption or disturbance
- the need to minimise stigma to the child resulting from being remanded in custody
- the likely sentence should the child be found guilty of the offence charged

- the need to ensure the conditions of bail are no more onerous than are necessary and do not constitute unfair management of the child.[573]

The *Bail Act 1977* (Vic) also provides that:

- 'bail must not be refused to a child on the sole ground that the child does not have any, or any adequate, accommodation'[574]
- where a bail decision maker has to consider the 'surrounding circumstances', this must include 'any special vulnerability of the accused, including being a child or an Aboriginal person, being in ill health or having a cognitive impairment, an intellectual disability or a mental illness'.[575]

We note that, despite these provisions, the number of children and young people on remand on an average day in Victoria doubled between 2010 and 2019.[576] While child-specific bail laws alone are not sufficient to prevent or address concerningly high numbers of children and young people on remand, we see them as an important part of reducing remand numbers.

In 2021, the Tasmanian Government consulted on a draft Bail Bill, which did not include child-specific provisions for making bail determinations.[577] The Commissioner for Children and Young People expressed concerns about the likely impact of the Bill on children and young people in Tasmania.[578] At the time of writing, the Bail Bill 2021 had not been introduced into the Tasmanian Parliament.

5.4.5 Youth justice reforms

The Draft Youth Justice Blueprint:

- acknowledges that appropriate bail support options, including accommodation options, are needed to avoid unnecessary detention[579]
- acknowledges that all other states and territories have some form of statewide bail assistance program, which includes three common key components—an after-hours support service, bail supervision and accommodation support[580]
- indicates that the Government aims to reduce the number of children and young people re-entering the youth justice system by 'delivering effective support that meets the individual needs and circumstances of children and young people on bail through a range of assisted bail options'.[581]

As noted in Section 2, the Government has committed to establishing two assisted bail facilities to:

> … provide safe stable accommodation, assistance managing bail conditions and support to address underlying issues that are contributing towards harmful, antisocial or offending behaviours.[582]

Information released by the Government on the proposed assisted bail facilities indicates that they will:

- be managed by the Government or a non-government organisation
- be 'semi secure to encourage compliance noting that [the] young person is not legally bound to stay there unless [this is a] condition of bail'
- have individual self-contained units, with one support and administration unit for staff and 'some recreational spaces'
- be targeted at young people who are 'likely to have no suitable bail address and/or require support for mental health, drug and alcohol, etc.', with charges for offences 'likely to be non-violent/lower seriousness', and who are unlikely to receive a custodial sentence if found guilty
- be available to a young person who is granted bail by a magistrate or a justice of the peace, including in situations where the young person has previously been remanded, and where the young person would otherwise not have been remanded but 'the extra support is warranted'
- have '24/7 onsite support provided by Government or [a non-government organisation]'.[583]

The Government advised us that 'the use of the term semi-secure in the proposed facilities model refers to the need to limit those who enter the facility to ensure the safety of all people onsite'.[584] We note that this is not entirely consistent with the above reference to 'encourag[ing] compliance'.

In February 2023, Secretary Bullard told us that planning consultants had been engaged to identify suitable sites across the State to accommodate all of the proposed new youth justice facilities (including the assisted bail facilities) and that an action plan for delivering the new infrastructure had been developed, with 'visioning' workshops scheduled for February 2023.[585]

5.4.6 Our recommendations

The high proportion of children on remand in Tasmania is extremely concerning. Remand should only be used in the most serious cases, where the child or young person poses an immediate danger to others, 'and even then only after community placement has been carefully considered'.[586] It must only be used as a measure of last resort and for the shortest possible period.[587]

We commend the Government for its intention to establish assisted bail facilities that will involve 24-hour onsite support for children and young people, including mental health and drug and alcohol support. We recommend that these facilities:

- have the capacity to deal with children and young people with complex needs
- include wraparound services such as health, education and employment
- engage specialist, therapeutically trained bail support workers to help children and young people attend programs and services, and to comply with conditions of bail.

Also, these facilities must be culturally safe for Aboriginal children and young people (cultural safety is discussed in Section 7.3).

To ensure they do not become de facto remand centres, children and young people should not be prevented from leaving the assisted bail facilities (subject to any conditions of bail).

The size of the proposed assisted bail facilities has not yet been specified, but they are unlikely to accommodate every child or young person on bail who needs support. While we did not receive any evidence about the statewide Supporting Young People on Bail program run by Save the Children, we note that the Tasmanian Aboriginal Legal Service is supportive of this program. As part of its youth justice reforms, the Government should examine the effectiveness of this program, consider the appropriateness of its eligibility criteria, and determine whether it needs increased funding, so more children and young people can be assisted with more intensive support, or whether additional bail support programs should be established.

The fate of a child or young person should not depend on whether their bail hearing occurs during business hours or after hours, or whether they appear before a magistrate or a justice of the peace. We recommend that the Government establishes a statewide 24-hour bail system for children and young people with bail decision makers (whether magistrates or justices of the peace) who have received specialist training in child development, trauma and disability (including communication deficits), and the issues faced by many Aboriginal children and young people, to ensure a consistent, trauma-informed and child-focused approach to decision making. Specialist training should contribute to ensuring bail conditions for children and young people are not unnecessarily onerous.

Children and young people should have access to legal representation in after-hours bail hearings. The bail system should also include access to bail support services after hours.

In Chapter 9, we recommend that, for children in out of home care, their child safety officer or another departmental representative with knowledge of the child attends any criminal proceedings involving the child in their role as the child's legal guardian, responsible for the child's care and protection (Recommendation 9.27). This should include bail hearings.

Finally, we recommend introducing child-specific bail laws that clearly outline the relevant considerations for bail decision making for children and young people.

Recommendation 12.14

The Tasmanian Government, to maximise opportunities for children and young people to be admitted to bail and minimise the number of children and young people on remand, should:

a. introduce legislation to

    i. require bail decision makers to consider the matters specified in section 3B of the *Bail Act 1977* (Vic) when determining bail for a child, as well as the child's age (including their developmental age at the time of the alleged offence), Aboriginal status and any previous experience of trauma or out of home care

    ii. prohibit the refusal of bail to a child on the sole ground that the child does not have any, or any adequate, accommodation

b. examine the effectiveness of the existing bail support program with a view to expanding its capacity and funding additional bail support programs

c. establish and fully resource a statewide 24-hour bail system for children and young people with

    i. specialised and trained decision makers who have knowledge of children and young people, Aboriginal children and young people, and the impact of trauma

    ii. access to corresponding bail support services

    iii. access to legal representation for children and young people

d. ensure its proposed assisted bail facilities

    i. are small, homelike and, subject to bail conditions, do not place restrictions on the movements of children and young people

    ii. have the capacity to deal with children and young people with complex needs

    iii. are designed to include wraparound services, such as health, education and employment

    iv. are culturally safe for Aboriginal children and young people

    v. include specialist, therapeutically trained bail support workers to help children and young people attend programs and services, and to comply with their conditions of bail.

5.5 Ensuring detention is a sentence of last resort

According to the Committee on the Rights of the Child, youth justice laws:

> … should contain a wide variety of non-custodial measures and should expressly prioritize the use of such measures to ensure that deprivation of liberty is used only as a measure of last resort and for the shortest appropriate period of time.[588]

5.5.1 Tasmania's sentencing framework

If a child or young person is found guilty of an offence by the Magistrates Court (Youth Justice Division), the court must sentence the child or young person under the Youth Justice Act, defer sentencing or make an order that the child or young person attend a community conference convened by the Secretary of the Department for Education, Children and Young People.[589]

Section 47 of the Youth Justice Act lists sentencing orders that the court may impose. These are not expressed or described as a hierarchy. The court can:[590]

- dismiss the charge and impose no further sentence[591]
- dismiss the charge and 'reprimand' (formally warn) the child or young person[592]
- dismiss the charge and require the child or young person to enter into an undertaking to 'be of good behaviour'—this is a form of conditional, unsupervised release where the child or young person undertakes to do or refrain from doing acts specified in the undertaking for a period of no more than six months[593]
- release the child or young person and adjourn the proceedings on conditions—sentencing is postponed for a period of no more than 12 months on conditions set out by the court that must be 'reasonable in the circumstances'[594]
- impose a fine—maximum amounts vary depending on the age of the child or young person[595]
- make a probation order—this is an order supervised by a youth justice worker requiring the child or young person to report to, receive visits from and obey the instructions of the youth justice worker, and to comply with any 'special conditions' specified in the order, including attending school or rehabilitation programs, abstaining from drinking alcohol or using drugs, residing at a specified address, submitting to a curfew and undergoing drug counselling and treatment[596]
- make a community service order—this is an order requiring the child or young person to perform a 'community service activity' approved by the Secretary and assigned by a youth justice worker, and to comply with special conditions like those available for probation orders[597]

- make a detention order not exceeding two years—the court may also order that part or all of the period of detention be 'suspended' (enabling the child or young person to be released), subject to conditions including reporting to a youth justice worker, attending programs directed by the worker, submitting to drug and alcohol testing, as well as any special conditions that the court imposes[598]
- in the case of a family violence offence, make a rehabilitation program order—this is an order to attend and take part in a rehabilitation program and comply with the reasonable directions of a person employed or engaged to conduct such a program[599]
- adjourn the proceedings, grant bail to the child or young person and defer sentencing until a date specified in the order, for the purpose of assessing the capacity of the child or young person and their prospects for rehabilitation, allowing them to participate in an 'intervention plan' or for other purposes.[600]

Alternatively, as noted, instead of sentencing the child or young person, the court can order that the child or young person attends a community conference convened by the Secretary.[601] The procedure for the community conference is similar to the procedure for pre-court diversionary community conferences (discussed in Section 5.3.3).[602] If the child or young person fulfils all the undertakings entered into at the community conference, the court will dismiss the charge against the child or young person.[603]

In determining what sentencing order to make, the court must:

- ensure the rehabilitation of the child or young person is 'given more weight than is given to any other individual matter'[604]
- consider all the circumstances of the case, including the nature of the offence, the child or young person's age, any sentences or sanctions previously imposed on them and the 'impact any orders made will have on the youth's chances of finding or retaining employment or attending education and training'[605]
- not impose a sentence that is more severe than would be imposed on an adult who committed the same offence.[606]

Sentencers must also consider the 'general principles of youth justice' contained in section 5 of the Youth Justice Act (set out in Section 5.2 of this chapter). While most of these principles are potentially relevant to sentencing, we note in particular the following:

- Detention should only be used as a last resort and only for as short a time as necessary.[607]
- Any sanctioning is to be appropriate to the age, maturity and cultural identity of the child or young person.[608]

- Any sanctioning is to be designed to give a child or young person an opportunity to develop a sense of social responsibility and otherwise to develop in beneficial and socially acceptable ways.[609]

The Youth Justice Act does not explicitly require sentencers to consider any trauma or disadvantage experienced by the child or young person, although one of the objectives of the Act is to ensure that, 'whenever practicable, a youth who has committed, or is alleged to have committed, an offence is dealt with in a manner that takes into account the youth's social and family background'.[610] Trauma-informed sentencing is discussed in Section 5.5.3.

5.5.2 Sentencing children and young people in Tasmania

In October 2021, the Tasmanian Sentencing Advisory Council published a report on the sentencing of children and young people in Tasmania between 2014–15 and 2019–20.[611] The Sentencing Advisory Council found that, during this period:

- 90.7 per cent of sentencing orders made under the Youth Justice Act were non-custodial[612]
- the most frequently used sentencing order was 'release on conditions' (26 per cent)[613]
- supervised orders (probation and community service orders) accounted for 24 per cent of all sentencing orders[614]
- detention or suspended detention accounted for 9 per cent of sentencing orders.[615]

Data published by the Australian Institute of Health and Welfare indicates that there were 57.3 children and young people aged 10 to 17 years under community-based youth justice supervision in Tasmania on an average day in 2021–22, compared with 8.1 children and young people aged 10 to 17 years in youth detention on an average day in the same period.[616]

The number of children and young people under community-based youth justice supervision in Tasmania has decreased since 2012–13, when there were 144.9 children and young people aged 10 to 17 years under community-based supervision on an average day.[617] Despite this reduction, Tasmania has the fourth-highest rate of children and young people under community-based youth justice supervision after the Northern Territory, Queensland and Western Australia.[618]

According to Mr Caltabiano, '[i]t is a small step to go from a formal supervisory order to detention'.[619] This comment may refer to the fact that a child or young person who breaches a supervised sentencing order is at risk of being resentenced to detention.

Former Noetic Solutions consultant, Anthony McGinness, who has expertise reviewing youth justice systems nationally, told us that when the Tasmanian Government commissioned him to examine the custodial youth justice system in Tasmania in 2016, he observed the absence of a 'graduated model' in sentencing (which would give young people opportunities to be diverted from detention).[620] Mr McGinness referred instead to a 'blunt jump' between the sentencing options available and detention:

> From my experience working in youth justice, an ideal model would involve incremental steps in sentencing – however, young people at Ashley Youth Detention Centre were less likely to have been given these diversionary options, and more likely to quickly progress from warnings to custody. There are complex factors behind this, and it was not the primary focus of our analysis, but this is likely contributed to by the availability of alternatives and options, and practice by police and the justice system.[621]

We did not receive any specific evidence on the use of non-custodial sentencing orders under the Youth Justice Act, or the operation of Community Youth Justice (the area of the Department responsible for diversion and rehabilitation programs for young people under youth justice supervision in the community).[622] However, we note that the Youth Justice Act lists a range of community-based sentencing options for children and young people, all of which appear to be in use.[623] Without an analysis of the sentencing histories of individual children and young people, it is difficult to assess whether Mr McGinness's comment about the 'blunt jump' to detention is accurate. Nevertheless, we consider that there is scope to amend the Youth Justice Act to make it clearer that detention must be an option of last resort.

Also, we note that the Sentencing Advisory Council referred in its 2021 report to the absence of services to support conditions attached to community-based sentencing orders:

> In stakeholder consultations, concern was raised about the lack of services to support the conditions made in orders imposed by the court. There may not be the appropriate services at all or wait lists may be too long to allow the young person to access the program or service in a timely way.[624]

An effective youth justice system must deliver targeted therapeutic services to support community-based sentencing, including community-based education programs. An example is the Ignatius Learning Centre in Melbourne—a Catholic specialist secondary school operated by Jesuit Social Services for young men aged 15 to 17 years who are involved in the youth justice system and are disengaged, or at risk of disengaging, from education.[625] This program is available to young men who are being considered for a supervised community-based sentencing order (such as a youth supervision order or a youth control order) under the *Children, Youth and Families Act 2005* (Vic) or who are on remand and facing a custodial sentence.[626] Attendance at the Ignatius Learning Centre may become a condition of the sentencing order.[627] The Ignatius Learning Centre

'provides a safe, holistic and therapeutic learning environment' and supports its students to complete the Victorian Certificate of Applied Learning.[628]

As well as the need for therapeutic services, the Commissioner for Children and Young People has, as discussed in Section 5.4.3, expressed concerns about attaching curfew conditions, reporting conditions and non-attendance conditions to bail orders. We note that similar concerns could apply to the conditions of community-based sentencing orders.

5.5.3 Trauma-informed sentencing

Between June 2019 and June 2020, the Victorian Sentencing Advisory Council published three reports on 'crossover kids', whom it defined as children who have been sentenced or diverted through the justice system and are also known to the Victorian Child Protection Service.[629] This research identified that children known to child protection were substantially over-represented among sentenced and diverted children, and Aboriginal children were 'substantially over-represented at the intersection of the child protection and youth justice systems'.[630]

These findings are broadly consistent with research published by Tasmania Legal Aid in its 2021 *Children First* report.[631] Tasmania Legal Aid found that, while only 10 per cent of its child clients who had a child safety file also had a youth justice file (defined in the report as 'crossover children'), crossover children accounted for 24 per cent of all youth justice files, and each crossover child had close to twice as many youth justice files as other children in the youth justice system.[632] Fifteen per cent of crossover children identified as Aboriginal.[633] Forty-one per cent of children first charged with an offence before the age of 14 years were crossover children.[634] In Chapter 9, we discuss the substantial crossover between children in out of home care and children in detention in Tasmania.

In its third report on crossover children, the Victorian Sentencing Advisory Council considered the sentencing of children who have experienced trauma, finding that:

> There is now broad consensus that trauma can affect children's neurological, psychological and even physical development. Children are particularly vulnerable to the effects of trauma: their brains are still developing, and trauma can interrupt or alter that process. In this context, trauma becomes a particularly relevant factor to consider in sentencing. It affects children's culpability, their ability to comply with court-ordered conditions and their capacity to be rehabilitated …[635]

In light of its research, the Victorian Sentencing Advisory Council suggested a range of other matters which courts should consider in sentencing children and young people in Victoria.[636] These included the child's experience of trauma; any child protection involvement; removal of the child from their family of origin (including siblings, extended family, culture and community); disruptions to the child's living situation or education;

any experience of out of home care; mental illness, neurological difficulties and developmental issues arising from, or exacerbated by, experiences of trauma; and the child's chronological age and developmental age at the time of sentencing.[637]

The Victorian Sentencing Advisory Council also suggested other considerations relevant to sentencing Aboriginal children, namely the consequences of intergenerational trauma; historical discriminatory policies; general and systemic racism; and any relevant cultural factors such as previous culturally inappropriate responses to Aboriginal children that may have worsened the effects of trauma.[638]

In addition, the Victorian Sentencing Advisory Council proposed several practical measures to reduce the over-representation of crossover children in the Criminal Division of the Children's Court and 'to strengthen the capacity of sentencing courts to be fully appraised of a child's [child] protection history and experience of trauma'.[639] These measures included:

- strengthening information sharing between the Family Division (which deals with child protection matters) and the Criminal Division of the Children's Court
- introducing a 'crossover list' in the Children's Court that would deal with the child protection and criminal matters of children involved in both systems
- providing dedicated child protection workers in the Criminal Division to facilitate access to reports about a young person's child protection history
- empowering the Criminal Division to compel child protection case workers to attend court and/or support a child in cases where the Secretary of the Department of Health and Human Services has parental responsibility for the child.[640]

As noted, in Chapter 9, we recommend that, in its role as guardian of a child in care responsible for the child's care and protection, the Department for Education, Children and Young People ensures a child safety officer or other departmental representative with knowledge of the child attends any criminal proceedings against the child in the Magistrates Court to support them in court and to inform the court of the child's background and child protection history (Recommendation 9.27). For the purposes of sentencing, this would give the court an understanding of any previous trauma the child has experienced. We consider court specialisation in the following section.

5.5.4 Court specialisation for children and young people

According to the United Nations Committee on the Rights of the Child, the 'continuous and systematic training of professionals in the child justice system is crucial' to uphold the guarantees in the Convention on the Rights of the Child that every child receives a fair trial.[641] Such professionals should be 'well informed about the physical, psychological, mental and social development of children and adolescents, as well as about the special needs of the most marginalized children'.[642]

As noted, the Youth Justice Division of the Magistrates Court deals with most criminal charges against children and young people. A single magistrate in each registry hears all youth justice matters.[643] Also, the Youth Justice Division maintains a 'specialist list' of cases involving children and young people 'with alcohol and drug abuse, mental health problems, or any other particular problem or combination of problems where the Court might appropriately intervene'.[644] According to the Sentencing Advisory Council, the Youth Justice Division adopts a therapeutic, strengths-based, collaborative and 'largely non-adversarial' approach, with coordination and cooperation between the various agencies involved in the youth justice system.[645]

The Children's Division of the Magistrates Court, also referred to as the 'Children's Court', deals with child protection matters.[646] Professor White told us that there were two magistrates who are designated as Children's Court magistrates and who are 'essentially specialist magistrates'.[647] However, Commissioner McLean told us that she is not aware of any specialisation in respect of the Children's Division, and that—other than those magistrates who may be recused (unable to hear a matter) due to a conflict of interest—all magistrates deal with Children's Division matters statewide.[648]

The Magistrates Court does not appear to have a specific 'crossover list' for children and young people with criminal matters who also have child protection involvement. Commissioner McLean told us that where a child or young person is the subject of both child protection and youth justice proceedings:

> … different magistrates, in different courtrooms, may deal with each matter, which results in low confidence that the courts have a shared or consistent view on how best to address the offending behaviour and child protection needs of the young person.[649]

As noted in Section 5.3, charges for prescribed offences against children and young people are dealt with in the Supreme Court or the Magistrates Court's adult jurisdiction, and sentencing for such offences may occur under the *Sentencing Act 1997* rather than the Youth Justice Act. In 2021, the Sentencing Advisory Council observed that:

> The low number of youth offenders sentenced in the Supreme Court has [a] bearing on infrastructure provision as well as the level of specialist knowledge of judges in dealing with young people.[650]

Some stakeholders consulted by the Sentencing Advisory Council expressed the view that 'the process in the Supreme Court generally treats children as "mini adults"'.[651]

Professor White said he would value 'more therapeutic oriented judges and magistrates in Tasmania who are specially trained, fostered by specialist court divisions that could support this'.[652]

Despite the existence of a Children's Division and a Youth Justice Division in the Magistrates Court, Tasmania Legal Aid has described Tasmanian courts as 'imposing,

adult environments' where '[i]t is common for children to be waiting for their case in the same area with adults charged with criminal offences'.[653] Tasmania Legal Aid has advocated for establishing a separate, standalone Children's Court in Tasmania to deal with youth justice and child protection matters.[654] Mr Caltabiano said that a specialist Children's Court should be physically designed for children and staffed by dedicated magistrates.[655]

The Commissioner for Children and Young People has also indicated that 'serious consideration should be given to establishing a standalone Children's Court in Tasmania with jurisdiction to hear all matters involving children and young people', including charges for prescribed offences.[656] As noted, charges for prescribed offences are currently excluded from the jurisdiction of the Youth Justice Division of the Magistrates Court. We note that, before establishing the Youth Justice Division of the Magistrates Court in 1997, Tasmania had a separate Children's Court.[657]

We consider that a specialist Children's Court in Tasmania would significantly benefit children and young people. While separate court facilities for children and young people are ideal, we acknowledge that these may be impractical in Tasmania given its population size. In Section 5.5.6, we recommend establishing a new specialist division of the Magistrates Court to deal with child protection matters and criminal charges against children and young people.

5.5.5 Youth justice reforms

Strategy 3 of the Draft Youth Justice Blueprint is to 'establish a therapeutically based criminal justice response for children and young people' that 'provides a range of interventions and support options that address criminogenic needs, target the driving factors behind offending behaviours and build upon strengths'.[658] This includes '[e]nsuring the availability of graduated sentencing options' to reduce the number of children and young people re-entering the criminal justice system.[659]

Action 4 of the Draft First Action Plan is to '[i]mplement a range of diversion, bail support and community based sentencing programs'.[660] In his February 2023 update, Secretary Bullard advised that work had begun on:

- researching community-based sentencing programs in other jurisdictions
- implementing a pilot program within Community Youth Justice 'to trial an intensive care team support program with a small number of children and young people who are engaged with the youth justice system and have complex needs'.[661]

5.5.6 Our recommendations

The Government's proposed review of the Youth Justice Act offers an opportunity to reconsider the suite of sentencing options available for children and young people and to clarify the sentencing hierarchy. As well as the updated youth justice principles recommended in Section 5.2 (Recommendation 12.12), the new Youth Justice Act should include sentencing principles that identify rehabilitation as the primary purpose of sentencing. In determining an appropriate sentence for a child or young person, courts should be required to consider factors related to a child or young person's trauma background and their child protection and out of home care history.

In developing new community-based sentencing orders, the Government should ensure children and young people on such orders have access to appropriate rehabilitation programs and are supported to comply with the conditions of their orders.

To increase court specialisation for children and young people, we recommend establishing a new specialist division of the Magistrates Court to hear and determine child protection matters (currently heard by the Children's Division) and criminal matters against children and young people (currently heard by the Youth Justice Division). This new division should be constituted by at least three dedicated, full-time specialist magistrates—one based in Hobart, one in Launceston and one in Devonport and Burnie—drawn from the existing pool of magistrates. The specialist magistrates should have an understanding of child and adolescent development, trauma, child and adolescent mental health, children's cognitive and communication deficits, and Aboriginal cultural safety.

The Government should support the Magistrates Court to arrange for the new specialist children's division to be independently evaluated after three years to examine the adequacy of its resourcing.

The Government should also ensure any future redevelopments of Tasmanian court facilities consider modifications to make those facilities less formal and intimidating, and more child-friendly.

Finally, we recommend that the Government funds professional development for judicial officers in adult jurisdictions hearing criminal charges against children and young people.

Recommendation 12.15

The Tasmanian Government should:

a. ensure any legislation designed to amend or replace the *Youth Justice Act 1997* provides that

i. rehabilitation is the primary purpose of sentencing a child

ii. the list of sentencing options is a hierarchy and a sentencer can only impose a sentence at a particular level of the hierarchy if satisfied that it is not appropriate to impose a sentence that is 'lower' in the hierarchy

iii. a sentence imposed on a child should be the minimum intervention required in the circumstances

iv. a custodial sentence must only be imposed as a last resort and for the minimum period necessary

v. in sentencing a child the court must consider the child's experience of trauma, any child protection involvement or experience of out of home care, disruptions to the child's living situation or education, any mental illness, neurological difficulties or developmental issues experienced by the child, and the child's chronological age and developmental age at the time of sentencing

vi. in sentencing an Aboriginal child, the court must consider additional factors including the consequences of intergenerational trauma, historical discriminatory policies, general and systemic racism, and any previous culturally inappropriate responses that may have worsened the effects of trauma on the child

vii. there is a presumption against imposing restrictive conditions (such as curfews and non-association conditions) with community-based sentencing orders, which may increase a child's likelihood of breaching a sentencing order and being sentenced to detention

b. ensure children who are sentenced to a supervised community-based order receive adequate support to comply with the conditions of the order from therapeutically trained, culturally competent staff

c. assist and support the Magistrates Court to establish a new division of the Court to hear and determine both child protection matters and criminal charges against children and young people, which should be constituted by at least three dedicated full-time magistrates with specialist knowledge and skills relating to children and young people

d. support the Magistrates Court to arrange for the implementation and operation of the Court's new specialist division to be independently evaluated after three years

e. fund the Magistrates and Supreme Courts to provide professional development for judicial officers hearing matters involving children and young people in the adult jurisdiction, in areas including child and adolescent development, trauma, child and adolescent mental health, cognitive and communication deficits, and Aboriginal cultural safety.

6 Creating a child-focused youth detention system

As discussed in Section 4.1, youth detention environments that deprive children and young people of their liberty, dislocate them from family and community, and impose strict rules, discipline and punishment expose children and young people to 'a unique set of factors that may heighten their risk of being sexually abused'.[662]

The case studies in this volume reveal the cruel, inhumane and degrading environment and culture at Ashley Youth Detention Centre, where some children and young people were subjected to human rights violations, violence, abuse and neglect, including child sexual abuse. In Section 3, we discuss measures to acknowledge this abuse. Here, we focus on measures to protect against such abuse occurring in the future.

In Section 4.2, we note stakeholder views that Ashley Youth Detention Centre resembles an adult correctional facility rather than a youth justice facility focused on rehabilitating children and young people. Former Commissioner for Children and Young People Mark Morrissey told us of a commonly held view among Centre staff that 'their role was to be custodians first and foremost, akin to prison officers', with rehabilitation 'very much a lower order priority'.[663]

We also heard evidence from multiple experts across the areas of law, psychology, social work and criminology that children and young people in detention have complex needs arising from cognitive disability, exposure to family violence, neglect, abuse, trauma, mental illness, substance misuse issues, homelessness, involvement in the child protection system, disrupted education and significant socioeconomic disadvantage.[664]

A detention environment that responds to such needs with punishment, bullying and intimidation—through isolation, force, restraints and unnecessary searches—rather than with trauma-informed, therapeutic care risks further traumatising and marginalising already vulnerable children and young people. It also significantly increases their risk of experiencing child sexual abuse in detention.[665] Such an approach is also ineffective in reducing offending and enhancing community safety.[666]

As noted in Section 5, to minimise the risk of child sexual abuse in detention, every effort must be made to divert children and young people from remand and custodial sentences.[667] However, where a child or young person cannot be, or is not, diverted from remand or a custodial sentence, it is essential that they receive the support and care they need while in detention to turn their life around and avoid returning to detention. This is necessary to protect children and young people against the continuing risk of child sexual abuse in detention, to reduce the risk that they will eventually enter adult prison and to increase community safety by reducing the likelihood of recidivism.[668]

The United Nations Convention on the Rights of the Child states that:

> Every child deprived of liberty shall be treated with humanity and respect for the inherent dignity of the human person, and in a manner which takes into account the needs of persons of his or her age.[669]

In this section, we consider the reforms required in Tasmania to achieve a fundamental shift from a punitive, correctional approach to youth detention to an effective, humane, child-focused system that recognises that children and young people are developmentally different from adults and have the unique potential for rehabilitation, given the right support. The Draft Youth Justice Blueprint describes this as a 'therapeutic approach' that 'frames children and young people as vulnerable and in need of support and healing, as opposed to punishment or fear'.[670]

The Northern Territory Royal Commission examined international best practice for youth detention facilities and identified the following key features of effective systems, where violent incidents were rare and recidivism rates were low:

- small, 'normalised' facilities that reflect a residential design[671]
- intensive therapeutic services that address the immediate causes of a young person's offending and the problems in a young person's life, such as drug and alcohol misuse and homelessness, that make offending more likely[672]
- high-quality education (including vocational training) as a central part of the facility's operations[673]
- structured, full days and a wide range of activities to keep children and young people busy[674]
- highly skilled staff who actively engage with children and young people, model positive behaviours and can manage difficult behaviours[675]
- security that is achieved primarily through relationships between children and young people and staff, rather than through 'the use of fences, locks, isolation and restraints'[676]
- community involvement in the day-to-day operation of the facility[677]

- strong leadership from senior managers who are 'committed to the vision of reform'[678]
- evidence-based decision making in youth justice reform, noting that 'the evidence often points the opposite way to what many people intuitively assume is the best approach'.[679]

As outlined in Section 2, the Tasmanian Government has announced a substantial youth justice reform agenda, encapsulated in its Draft Youth Justice Blueprint, Draft First Action Plan and Keeping Kids Safe Plan.[680] This reform agenda follows several earlier reviews and unsuccessful attempts at youth justice system reform (outlined in Chapter 10), including attempts to implement a therapeutic model of care in youth detention in 2017 and 2018 via the 'Ashley Model' and the 'Ashley+ Model' (also referred to as the 'Ashley+ Approach').[681]

Given that we did not undertake a full inquiry into the youth detention system, we do not make detailed recommendations on all aspects of youth detention. Instead, we focus primarily on the issues that stood out in the evidence we received as the most relevant to preventing child sexual abuse while a child or young person is in detention. Our recommendations in this section address:

- the design of the detention facility intended to replace Ashley Youth Detention Centre
- measures to increase safety for children and young people in detention through the use of closed-circuit television cameras, body-worn cameras and viewing panel swipe readers
- the need for highly skilled staff who can apply a trauma-informed and therapeutic model of care
- implementing a multidisciplinary approach to meeting the needs of children and young people in detention
- access to health care for children and young people in detention
- children and young people's access to high-quality education in detention
- promoting connections between children and young people in detention and their families and communities
- effective exit planning and support for children and young people after their release from detention
- the process for transferring children and young people from youth detention to adult prison facilities.

Our recommendations to ensure youth detention in Tasmania is culturally safe for Aboriginal children and young people are in Section 7.3. We discuss leadership in the youth detention system in Section 4.4.

6.1 Designing a contemporary, best practice detention facility

As outlined in Section 2, the Government has announced that it intends to replace Ashley Youth Detention Centre with several new facilities, including one 'detention/remand centre' in southern Tasmania.[682] According to the Government's Draft First Action Plan, this facility will be 'purpose-built' and will 'provide the opportunity for intensive intervention and rehabilitation through a therapeutic model of care'.[683]

We note that international human rights instruments require children and young people on remand to be separated from children and young people who have been convicted and sentenced.[684] We acknowledge that if the total package of our recommendations was implemented as intended, there would be a very small group of older children whose danger to the community could not be managed in community settings, who would be remanded in custody. Although it is undesirable for children on remand to be detained with children who have been sentenced, we recognise that the small numbers involved may make separating these groups impractical and could effectively result in isolation.

6.1.1 Physical design

According to the United Nations Committee on the Rights of the Child, children deprived of liberty should be 'provided with a physical environment and accommodation conducive to the reintegrative aims of residential placement'.[685] As noted, the most effective youth detention facilities are those that have 'moved away from the institutional prison model … towards more normalised, home like facilities'.[686] This is in part because physical design affects behaviour. In a facility based on a residential design, young people and staff perceive themselves and others more positively than in an institutional design, and as a result, the atmosphere is calmer, stress is reduced and behaviour improves.[687]

Elena Campbell, Associate Director, Research, Advocacy and Policy at the Centre for Innovative Justice, referred positively to the approach of the Diagrama Foundation in Spain, which runs 35 centres for children and young people remanded or sentenced to custody.[688] According to a report prepared by the Diagrama Foundation for the Northern Territory Royal Commission:

> As far as possible we make our centres feel like a normal environment with young people engaged in their decoration, upkeep, gardening; with everyday furniture rather than 'prison' furniture and a daily rhythm that is appropriate to the age of the young person – a normal 9:30 or 10:00pm bedtime. This provides young

> people with greater opportunities to learn and they go to bed tired and sleep better. We also have fewer problems caused by the frustration of boredom or loneliness. All of the above contributes to making our centres feel like safe, normal environments where disruptions and use of force are low. Young people can focus on their progression and build skills for successful life in the community.[689]

While the Diagrama Foundation report refers to six months as being the 'minimum time recommended' in its centres, it notes that 'even for young people who are with us for short periods, however, we expect some degree of progression towards developing positive behaviours'.[690] Its approach is therefore not inconsistent with an approach that also seeks to ensure detention is for as short a time as possible.

Anthony McGinness, former Noetic Solutions consultant, cited the example of the 'Missouri Model', which has been adopted in several United States jurisdictions and has recidivism rates as low as 15 per cent.[691] This model uses small, homelike secure facilities that are 'designed to look like schools rather than prisons' and incorporate pets and live plants.[692]

In recommending new secure facilities for Darwin and Alice Springs, the Northern Territory Royal Commission concluded that:

> Each facility should be designed on a campus model that has facilities for the accommodation, education, training and basic service delivery for the detained population within a secure perimeter. The facilities should be built and finished to a standard that would be considered acceptable in a new fee-for-service boarding school.[693]

The Victorian Commission for Children and Young People has also emphasised the importance of secure youth justice facilities closely resembling a home, where children and young people have ready access to communal spaces, including a kitchen, lounge area and outdoor spaces, and where soft furnishings, artwork, books and games contribute to a homelike environment.[694] We agree with these approaches.

Also, the physical design of the new facility should address the needs of girls and young women, gender diverse children and young people, and children and young people with disability. We discuss the needs of Aboriginal children and young people in detention in Section 7.

The new facility should also incorporate features that keep children and young people safe from sexual abuse. The National Royal Commission recognised that building and design features, such as the location of closed-circuit television cameras, could improve the observation of children's interactions with each other, as well as interactions with staff.[695] An expert in harmful sexual behaviours told us that there are design strategies available in various institutions to reduce the opportunity for harmful sexual behaviours—for example, positioning toilets in a central area where everyone can see who is entering and exiting, and locating staff near high-risk areas such as bathrooms or bedrooms.[696]

We discuss harmful sexual behaviours in detention in Section 8. We discuss closed-circuit television cameras and related issues in Section 6.2.

6.1.2 Size

The best-performing youth detention facilities tend to be small.[697] The largest secure facility in Missouri has 36 beds, while the Diagrama Foundation's centres range from small 12-bed facilities to larger facilities for around 70 young people.[698] The Northern Territory Royal Commission rejected any suggestion that a large facility be built 'for the sake of having spare capacity in case of an unexpected increase in the number of young people committed to detention'.[699] It recommended a total capacity of 46 beds across two proposed facilities (in Darwin and Alice Springs), with 'an additional 13 beds available to accommodate for higher than average days'.[700] It also recommended that each facility have small accommodation units with four to six bedrooms each.[701]

As noted in Section 5.4, on an average day in 2021–22, there were eight children and young people aged 10 to 17 years in detention in Tasmania.[702] Ashley Youth Detention Centre has 40 beds.[703] This is too large. Even with the more recent increase in remand numbers (outlined in Section 5.4), Tasmania's small youth detention population lends itself to establishing a smaller secure facility.

In Section 5.1, we recommend that the Government increases the minimum age of criminal responsibility to 14 years and works towards increasing the minimum age of detention (including remand) to 16 years (Recommendation 12.11). In that section, we also recommend adopting diversionary and sentencing processes to reduce the number of children and young people entering detention. The combined effect of these measures would be that, even in the short term, only young people aged 14 to 17 years would be eligible for remand or a custodial sentence, and the detention population would be smaller than at present.

As outlined in Section 5.1.2, the Tasmanian Government has committed to increasing the minimum age of detention to 14 years, although it will not do this until 'new bail and sentencing options [are] developed to better support children and young people under the age of 14'.[704] This is likely to take time because it appears to be intended to form part of the Government's proposed review of the Youth Justice Act.[705] Until such changes are implemented, children as young as 10 could continue to be remanded or sentenced to detention. Nevertheless, this does not alter our view that any new detention facility should be small.

6.1.3 Location

In March 2023, the Government announced that two sites had been shortlisted for the new detention facility, identified due to their:

> … substantial size, separation from major residential areas, their proximity to Hobart, the limited visibility (or with capacity for screening) from surrounding properties and their appropriate zoning under the relevant planning scheme.[706]

At the time of writing, a site for the new detention facility had not been selected. We note that one of the shortlisted sites is in Risdon. The Northern Territory Royal Commission said that new secure youth detention facilities should not be located on, or close to, adult prison precincts.[707] We agree. Locating youth detention facilities near adult prisons risks undermining the distinctive approach of effective youth detention systems, which focus on rehabilitation and recognise that children and young people have unique needs based on their age and stage of development.

We note that locating a new detention facility in or near Hobart will have the effect of dislocating some children and young people from their communities and families. As discussed in Chapter 10, in 2016, Noetic Solutions recommended establishing two new purpose-built detention facilities to replace Ashley Youth Detention Centre to keep detained children and young people closer to their families and communities.[708]

However, we also note that the small Tasmanian youth detention population may not justify multiple detention facilities and that locating a single new facility in Hobart has the advantage of providing improved access to services and being more likely to attract a larger pool of professional staff than a regional location.[709] In Section 6.7, we discuss the need to support families to visit children and young people in detention.

Recommendation 12.16

The Tasmanian Government should ensure its proposed new detention facility (and any future detention facilities) are small and homelike and incorporate design features that reflect best practice international youth detention facilities. This includes features that:

a. promote the development of trusting and therapeutic relationships between staff and children and young people

b. facilitate and enhance trauma-informed, therapeutic interventions for children and young people

c. minimise stigma to children and young people

d. facilitate and promote connections between children and young people, and their families and communities

e. protect children and young people against the risks of child sexual abuse (including harmful sexual behaviours)—for example, by enabling line-of-sight supervision as far as possible, without infringing on children and young people's privacy.

6.2 Security measures to increase children's safety in detention

If therapeutic interventions are to be effective, children and young people in detention must feel safe. As noted, in best practice youth detention facilities, security—and therefore feelings of safety—are achieved primarily through positive relationships between staff and young people and through constant, active supervision by staff, rather than through security features such as surveillance that are common in adult prisons (refer to the discussion in Section 6.3.1). However, establishing such an approach in Tasmania is likely to take time, particularly in a system that has previously adopted a highly punitive approach to youth detention.

Surveillance cameras in youth detention facilities enable internal and external oversight of interactions in the facility, improve staff accountability and help to prevent potential abuses of power.[710] According to the Northern Territory Royal Commission, '[t]he availability of video evidence of use of force incidents provides the best objective evidence of what has occurred'.[711] It recommended that:

- closed-circuit television cameras cover all parts of youth detention centres other than bathroom facilities[712]
- all closed-circuit television camera footage be retained for at least 12 months[713]
- body-worn video cameras that record both video and sound be introduced in youth detention centres.[714]

As described in Chapter 11, Case study 1, several victim-survivors who had been detained in Ashley Youth Detention Centre told us they had been sexually abused in parts of the Centre where there were no surveillance cameras; they advocated strongly for extra cameras to keep children and young people safe. Some victim-survivors also told us that staff had watched them while they were showering through 'viewing panels' designed to enable observation of a child or young person at risk of suicide or self-harm.[715]

The Government's Keeping Kids Safe Plan commits it to making the following improvements to security and safety at Ashley Youth Detention Centre:

- updating closed-circuit television coverage and installing more cameras to cover blackspots[716]
- installing a closed-circuit television control room with trained personnel to monitor coverage[717]
- developing and implementing a security risk management plan with supporting policies and procedures[718]
- investigating the use of body-worn cameras and 'viewing panel swipe readers', requiring an access control card to be read on a reader before the viewing panel can be opened[719]
- moving from paper records to an electronic records management system.[720]

Most of these actions were due to be completed by December 2022. Recommendations from the investigation into body-worn cameras were due to be implemented by July 2023.[721] In February 2023, Secretary Bullard advised us that the security risk management plan had been completed and that all other actions were 'underway'.[722]

In June 2023, the Department told us that although it has explored installing closed-circuit television across Ashley Youth Detention Centre, it has been advised that it is not possible to implement coverage across the entire current site.[723] The Department said it is investigating other forms of video and audio surveillance and that '[a]ppropriate surveillance will be a key consideration in the design of the new youth detention facilities'.[724] It is not clear to us why it is not possible to implement closed-circuit television coverage across the entire current site, nor what other forms of video and audio surveillance the Department may be exploring.

While we are encouraged by the Department's commitments and activities in relation to security at Ashley Youth Detention Centre and the proposed detention facility, we are concerned that there are still parts of Ashley Youth Detention Centre that are not covered by surveillance cameras. The Department must ensure all public areas of the Centre are subject to effective electronic surveillance. This should not include children's rooms, bathrooms or other parts of the Centre where children's privacy may be infringed, such as spaces where children may be viewed undergoing a partially clothed search (although surveillance should cover staff who conduct the search).

We support introducing viewing panel swipe readers at Ashley Youth Detention Centre. We also support the introduction of body-worn cameras at the Centre to supplement closed-circuit television cameras because body-worn cameras have the advantage of recording sound, which we consider will provide more information on incidents, improve staff accountability and strengthen oversight of youth detention.

In recommending these security features, we are persuaded by the voices of victim-survivors who told us that more cameras were needed to keep children and young people in detention safe. However, we do not consider that such security features should be necessary indefinitely. We are mindful of the fact that a strong focus on surveillance is not consistent with the best practice approach of achieving security in youth detention facilities primarily through constructive relationships between staff and children and young people.

Therefore, we recommend that the continuing use of surveillance cameras in youth detention be the subject of regular annual reviews by the new Commission for Children and Young People (recommended in Chapter 18, Recommendation 18.6). These investigations should seek the views of children and young people in detention about whether surveillance cameras make them feel safe, and whether such mechanisms should be used in the proposed new detention facility intended to replace Ashley Youth Detention Centre.

Footage from surveillance cameras needs to be properly managed to support effective oversight. We note that the Keeping Kids Safe Plan does not address the issue of management or retention of closed-circuit television camera footage.

The Ashley Youth Detention Centre procedure on 'CCTV Surveillance Cameras' states that the primary function of surveillance cameras is 'to provide recorded footage that may be viewed in the event of an incident or allegation' and that '[f]ootage will be reviewed, recorded and stored securely by the [Fire, Safety and Security Coordinator] on a regular basis'.[725] The procedure also indicates that footage of incidents required for investigation will be 'downloaded to disc' and 'retained footage will be transferred to portable hard drive on a regular basis'.[726] These requirements should be clarified and strengthened.

The National Royal Commission recommended that institutions that engage in child-related work implement a series of principles for record keeping, including creating and keeping full and accurate records of all incidents affecting child safety and wellbeing, and maintaining those records appropriately.[727] The National Royal Commission also recommended that public records authorities guide institutions on identifying records that may become relevant to an actual or alleged incident of child sexual abuse and on retaining and disposing of such records (Recommendation 8.3).[728]

In 2019, in response to Recommendation 8.3, the Tasmanian Office of the State Archivist issued a notice of a 'disposal freeze' on records relating to children.[729] The stated basis for the freeze was 'the complexity of identifying records that may be relevant for future disclosures of child abuse', noting that some children and young people take time to disclose abuse, and the State should ensure all relevant records are retained.[730]

The disposal freeze requires all organisations and agencies providing services to children to 'keep all records that contain the best information about children, services provided to them, and employees that provide the service, until 2029'.[731] We consider that this would include footage from surveillance cameras and body-worn cameras in youth detention. The Office of the State Archivist will review the disposal freeze before the National Redress Scheme ends.[732]

Recommendation 12.17

1. The Tasmanian Government, to enhance the safety of children and young people in Ashley Youth Detention Centre and any new detention facility, should:
    a. ensure all public areas of the facility are subject to electronic surveillance
    b. introduce viewing panel swipe readers
    c. introduce body-worn cameras, supported by comprehensive policies and procedures for their use by staff
    d. develop and implement a policy for managing and retaining surveillance footage that
        i. takes account of the record-keeping principles identified by the National Royal Commission and the disposal freeze on records relating to children issued by the Office of the State Archivist
        ii. promotes transparency of staff conduct and enables regular audits of staff performance to be undertaken
        iii. requires footage to be made available on a timely basis on the lawful request of a government department or oversight body.
2. The Commission for Children and Young People (Recommendation 18.6) should annually review the use of electronic surveillance in detention to determine whether it increases children and young people's feelings of safety in detention and should continue to be used. The initial review should seek the views of children and young people at Ashley Youth Detention Centre on whether electronic surveillance should be deployed in the proposed new detention facility.

6.3 Highly skilled staff applying a therapeutic model of care

6.3.1 Best practice

As noted, the best-performing youth detention facilities have highly skilled staff who actively engage with children and young people, model positive behaviour and can manage difficult behaviours through trauma-informed responses and de-escalation techniques.

At secure centres run by the Diagrama Foundation, highly qualified specialist staff known as 'social educators' work to 'build warm, parenting relationships' with young people by acting as encouraging and supportive role models, while setting 'consistent, clear and fair boundaries to help young people understand the positive and negative consequences of their behaviour'.[733] This reflects a model of care that is 'centred around the themes of relationships and emotions, cognition, behaviour and progression'.[734]

'Progression' in this context refers to a system of rewards and privileges used in Diagrama facilities that 'encourages young people to progress through a five-staged model from induction through to autonomy'.[735] Rewards include opportunities to work, study and socialise in the community. Young people can lose these privileges and then have to re-earn them.[736]

The Diagrama Foundation states that social educators 'genuinely care about the young people they work with' and support them throughout every aspect of their day.[737] Each Diagrama centre has separate security staff who 'act as a last resort in incident management' and 'stay in the background' as far as possible—they are not involved in the day-to-day care of children and young people.[738]

According to the Diagrama Foundation, its secure centres are:

> … stable and orderly places where young people feel safe and there are very low levels of disruptions. Therefore use of restraint and force are uncommon in our centres: in 2018, only 9.51% of young people across our centres were restrained and only 6.85% committed a serious incident [including verbal abuse and threatening behaviour] beyond their first two months in custody.[739]

In the Missouri Model, staff in detention facilities are known as 'youth specialists', who are responsible for the 'safety, personal conduct, care and therapy' of children and young people.[740] Staff undergo an intensive recruitment process to determine whether they are committed to helping children and young people succeed and have the necessary attributes for the role, such as good listening skills, empathy and an ability to create respect.[741] Youth specialists must complete 236 hours of training in their first two years, including multiple sessions on youth development, family systems and group facilitation.[742]

Youth specialists engage in constant, active, 'eyes-on, ears-on' supervision of children and young people—talking to them, engaging in activities with them and noticing any changes in their facial expressions and body language or in group dynamics that may indicate that intervention is required.[743] Youth specialists are also extensively trained in conflict management and techniques 'designed to defuse potential trouble and foster a safe environment'.[744]

We discuss the recruitment of a highly skilled workforce for Tasmanian youth detention facilities in Section 4.7.

6.3.2 Our evidence

In contrast with the approaches outlined in Section 6.3.1, the case studies in Chapter 11 describe the culture that existed at Ashley Youth Detention Centre, where we heard that some staff used threats of physical violence against children and young people, subjected them to unnecessary strip searches and sometimes placed them in forms of isolation, often as punishment and sometimes using force or restraints (refer also to Sections 4.2 and 9). As noted in Chapter 11, Case study 1, such practices may have further traumatised and criminalised children and young people.

In Chapter 10 and Chapter 11, Case study 3, we also describe the ways in which the Behaviour Development System—an incentive-based behaviour management protocol that allocated 'benefits' or 'restrictions' to a young person based on a colour ranking—and in particular the 'Blue Program', were used to punish and isolate children and young people. The Blue Program created another ranking that was lowest on the behaviour management spectrum and reserved for the children and young people displaying the most challenging behaviours. It took various forms over many years, but, in 2019, it was described as involving a young person being 'fully segregated from Ashley School, daily programs and activities, other young people in their Unit (subject to risk assessment) and the normal routine of the Centre'.[745]

Restrictions on the 'red' level in the Behaviour Development System included a bedtime of 7.30 pm (compared with a bedtime of 10.00 pm for a young person on the 'green' level), with young people confined to their rooms until breakfast at 8.00 am the following day.[746]

As discussed in Section 4.2.2, we heard concerns from staff that some children and young people were singled out by staff for unfavourable treatment through the Behaviour Development System because they were disliked.[747]

Also, as described in Section 4.2.2, we heard that some operational staff at Ashley Youth Detention Centre saw themselves as being akin to prison guards. Professor White told us that, in his view, formed while taking part in an investigation into the death of a young person at Ashley Youth Detention Centre in 2010, the operational staff were:

> … basically "lockup people". Their role is essentially a prison guard role, and that role is reflected in both their approach and their training … It is not tied directly to the rehabilitation or restoration ideals which are commonly associated with youth justice.[748]

Our case studies illustrate that this observation is still relevant to more recent practices. Former Ashley Youth Detention Centre staff member Alysha (a pseudonym) indicated she did not observe in 'any way, shape or form' a culture at the Centre that valued rehabilitation and restorative practices.[749] We also heard that operational staff have historically not been required to hold appropriate qualifications.[750] We discuss the practices, qualifications, training, recruitment and impact of operational staff in Section 4.7.

6.3.3 Practice improvements

The *Ashley Youth Detention Centre Practice Framework* ('Practice Framework')—developed in 2020, with implementation starting in 2021—describes itself as a 'therapeutic, evidence-based framework' to guide how staff 'work in a therapeutic way with young people in detention'.[751] It includes a section on 'therapeutic and trauma-informed practice', which refers to the importance of staff working in ways that acknowledge children and young people's experiences of trauma, recognise their responses and provide opportunities to learn new responses and behaviours.[752]

The Practice Framework has six practice principles that emphasise building healthy and positive relationships, creating an environment where young people and staff feel safe and secure, providing opportunities for young people to connect with their families and communities, and giving young people a voice in decisions that affect them.[753] The Practice Framework is supported by the Centre's Learning and Development Framework, which specifies mandatory professional development requirements for staff.[754]

Pamela Honan, Director of Strategic Youth Services, said that implementation of the Practice Framework was in its 'early stages' and acknowledged that, without the appropriate skill set to work with children and young people demonstrating challenging behaviours, staff may fall back on punitive practices.[755] The Government has contracted the Australian Childhood Foundation to review the Practice Framework and the Learning and Development Framework.[756]

In 2021, Ashley Youth Detention Centre revised the Behaviour Development System and renamed it the Behaviour Development Program.[757] According to Ms Honan, the revised program was piloted and a new procedure for its use finalised in June 2022.[758] Secretary Pervan told us that the new Behaviour Development Program was 'a more positively focused and less punitive system'.[759]

The Government has also:

- contracted the Australian Childhood Foundation to deliver training for the Certificate IV in Youth Justice for staff at Ashley Youth Detention Centre who do not already have qualifications in youth work (refer to Section 4.7.1)[760]
- engaged an external provider to deliver training for all staff at Ashley Youth Detention Centre in 'positive behaviour support', 'positive approaches to behaviour and safer de-escalation' and 'physical intervention' by June 2023.[761]

In addition, the Government has committed to developing and implementing standard operating procedures for security, including a review of existing procedures for using handcuffs.[762] The Department has also updated its procedure on personal searches of children and young people in detention in light of legislative changes to the requirements for searches in December 2022—these issues are discussed in Section 9.1.

More broadly, the Government has committed to developing a 'Youth Justice Model of Care' by 2025 to outline its approach to caring for children and young people across the youth justice system (not just in detention) and to establish an operating philosophy, service objectives and service standards based on therapeutic, trauma-informed care.[763]

6.3.4 Our recommendations

As noted, Tasmania's youth detention system needs to undergo a fundamental shift from a punitive approach to one that is centred on rehabilitation. Staff are central to this change. Operational staff must be equipped with the skills needed to undertake trauma-informed, culturally safe, child-centred interventions with children and young people, including the skills to anticipate, de-escalate and respond to challenging behaviours without resorting to force.

The Government's practice improvements described in Section 6.3.3 are positive, but more needs to be done. In Section 4.7.3, we recommend several changes to ensure staff at Ashley Youth Detention Centre and any new detention facility are appropriately trained and qualified, and have the right skills and attitudes to work positively and effectively with children and young people in detention.

Also, in Section 7.3.5, we recommend that staff be equipped with the knowledge and skills to provide a culturally safe environment for Aboriginal children and young people, including through trauma-informed and culturally safe responses to children and young people engaging in self-harm or other challenging behaviours.

To support these recommendations, we consider that the Youth Justice Model of Care should include a specific custodial operating philosophy that is centred on rehabilitation and non-punitive, child-focused, therapeutic practice, and that recognises that this is the most effective strategy to support children and young people to make lasting behavioural changes, and thereby ensure community safety.

The Youth Justice Model of Care should also directly address the use of force, restraints and isolation in detention to ensure these tools are used minimally and only where other strategies in response to challenging behaviours have not worked. These tools should never be used as a punishment. This is discussed in Section 9.

Further consideration is needed on behaviour management programs in youth detention. As outlined in Section 6.3.2, the Behaviour Development System was used in a punitive way and does not appear to have been effective in promoting positive behaviour. We are not convinced that its replacement, the Behaviour Development Program, is different enough to warrant its continued use in Ashley Youth Detention Centre, or its use in any future youth detention facility.

However, we are also aware that carefully designed behaviour management systems based on incentives and rewards are in use in youth justice systems in jurisdictions with best practice detention facilities, such as those run by the Diagrama Foundation. We also note that the Northern Territory Royal Commission recommended that a 'continuum of behaviour management tools' be developed for youth detention 'to ensure that staff have a range of measures available to them to respond to inappropriate behaviour by young people without the use of force', including an incentive system designed to encourage responsible behaviours.[764] It indicated that behaviour management tools should be simple, fair and clear to staff and to children and young people, and that any incentive system should not restrict a young person's access to rehabilitation programs, education or physical exercise.[765]

We note that the *Inspection Standards for Youth Custodial Centres in Tasmania* include standards for behaviour management programs.[766] We recommend that these standards be reviewed in light of international best practice and research on age-appropriate responses to children and young people with trauma backgrounds and emotional regulation challenges.

Recommendation 12.18

1. The Tasmanian Government should ensure:
    a. use of the Behaviour Development Program is discontinued in Ashley Youth Detention Centre and not adopted in any new detention facility
    b. the Youth Justice Model of Care planned to be developed by 2025 includes a specific operating philosophy, service objectives and service standards for detention facilities that are based on non-punitive, child-centred, trauma-informed, culturally safe practice and reflect international best practice in youth justice

c. staff in youth detention facilities have the skills needed to undertake evidence-based, trauma-informed, child-centred interventions with children and young people, including the skills to anticipate, de-escalate and respond effectively to challenging behaviours without resorting to force or restrictive practices

d. implementation of the Youth Justice Model of Care and updated Practice Framework for youth detention is monitored by the governance structure outlined in Recommendation 12.7.

2. The Custodial Inspector, or the body responsible for inspection standards for youth detention centres in Tasmania, should review standards and guidelines on the appropriate use in youth detention of behaviour management programs that incorporate incentives and rewards, having regard to international best practice and research on effective responses to children and young people with trauma backgrounds and emotional regulation challenges.

6.4 A collaborative, multidisciplinary approach to meeting children's needs

As noted, we heard that most children and young people in detention have highly complex needs arising from cognitive impairment, exposure to neglect or abuse, trauma and mental illness. Most also have drug and alcohol misuse issues.[767] Many have a history of involvement with the child protection system.[768] As discussed in Section 7, Aboriginal children and young people are over-represented in youth detention because of the impacts of colonisation and intergenerational trauma, and have distinct cultural needs.

We also heard that, over the past decade, the needs of children and young people in the youth justice system in Tasmania and elsewhere have become greater and more complex, and their offending has become more serious.[769] Professor James Ogloff AM, University Distinguished Professor of Forensic Behavioural Science, told us that youth justice systems across Australia have not kept pace with this changing cohort.[770]

An effective youth detention system must address the complex needs of children and young people, as well as the factors contributing to their offending behaviour.[771] This requires comprehensive assessments on admission, child-centred case planning and case management, and delivery of individualised therapeutic services that address health, wellbeing and criminogenic needs, including interventions to address offending behaviour. Such work requires a multidisciplinary approach.

Adjunct Associate Professor Mitchell told us that it is essential to look at 'the whole child' and adopt a common language and approach across all professionals (or disciplines) working with children in detention:

> If we … brought all of the key stakeholders (justice, disability, mental health, education and so on) together to support these kids in a way that is coordinated and collaborative, we will get better outcomes than if we try to work separately. These young people have complex needs across every domain of their life and it's going to require a concerted, comprehensive and sustained approach to guide them through the next chapter of their life if we want to change the trajectory from them ending up in adult prison.[772]

In Spain, each Diagrama secure facility has a 'technical team'—comprising teachers, psychologists and social workers—which is responsible for developing and delivering an individualised plan for each child or young person.[773] These plans are tailored to the child or young person's offending behaviour and include interventions that are a mix of one-on-one counselling, 'follow-up after an emotional outburst' and group work.[774]

6.4.1 Multidisciplinary approaches and case management at Ashley Youth Detention Centre

Secretary Pervan told us that Ashley Youth Detention Centre 'operates as a multi-disciplinary centre' and that operational and other staff 'work collaboratively through multidisciplinary teams, weekly review meetings, and program meetings'.[775]

We heard about professionals, teams and policies that might have been able to support a multidisciplinary approach and case management at Ashley Youth Detention Centre, including:

- the 'Professional Services Team', whose role was to provide 'therapeutic supports and services to young people in detention', including developing case and care plans, arranging restorative case conferencing, making referrals to other services and advising operational staff on behaviour management strategies[776]
- a Case Management Officer or Case Manager who was part of the Professional Services Team[777]
- the 'Multi-Disciplinary Team', whose role was to provide 'clinical assessment, review, case planning and referral of the complex needs of young people in custody'[778]
- the 'Centre Support Team' (or, since 2022, the 'Weekly Review Meetings'), which met weekly to assess children and young people against the Behaviour Development Program, consider incidents at the Centre, make placement decisions and consider requests from young people[779]
- Case Management Guidelines, dated 2014, which outline that each child or young person must undergo, among other things, a 'Case Management Assessment' within two working days of admission, to be completed by the 'Case Manager'.[780]

It was not clear to us how these different roles, teams and policies operated in practice to achieve a multidisciplinary approach to meeting the needs of children and young people in detention. The extent to which children and young people experienced a highly skilled, professional, multidisciplinary response as part of their daily routine was also unclear.

We heard that the Multi-Disciplinary Team had previously not worked effectively.[781] Ms Honan told us that, before 2021, meetings of the Multi-Disciplinary Team consisted mostly of operational staff, with limited representation from the Professional Services Team, and that, as a result, 'operational pressures dominated decision making and appear to have "trumped" the therapeutic needs of young people'.[782] Similarly, Ms Gardiner told us that, during her time at the Centre in 2018, meetings of the Multi-Disciplinary Team 'rarely made any therapeutic recommendations'.[783]

Ms Honan also referred to tensions between the operational and professional services staff on the Multi-Disciplinary Team:

> There was a noticeable lack of professional regard and collaboration between the two streams with little to no external involvement from stakeholders in Multi-Disciplinary Team (MDT) meetings. Because of this dynamic and the dominance of operational staff represented at MDT, the multi-disciplinary process was ineffective. Practices had become punitive resulting in the moving or containment of residents in response to incidents, rather than understanding and responding in a trauma informed way to triggers and escalating behaviours. The two streams were philosophically opposed and silo[ed]. I would describe much of the workforce as disempowered.[784]

Secretary Pervan told us that a Multi-Disciplinary Team meeting must be held in respect of each young person at Ashley Youth Detention Centre every four weeks, at minimum.[785] While this requirement was stated in an earlier version of the Multi-Disciplinary Team's terms of reference, it does not appear in the current terms of reference.[786] Rather, the current terms of reference only require that a young person be discussed at a Multi-Disciplinary Team meeting on admission 'if behavioural or concerning behaviours are identified' and three weeks before their release.[787] The Multi-Disciplinary Team's terms of reference do not explain what kind of behaviours might give rise to the need for such a discussion. The nature of this multidisciplinary response appears very different from the multidisciplinary approach to working with children and young people in Spain's Diagrama model (discussed previously).

According to Ms Honan, the Centre Support Team also did not work as effectively as it should have, with 'therapeutic interventions competing with operational pressures' and documentation relating to decisions and actions poorly recorded or not recorded at all.[788] Ms Honan acknowledged that the Centre Support Team had previously operated in a punitive manner.[789] Ms Gardiner observed that the Centre Support Team was 'driven by the agenda' of operational staff and did not consider or incorporate the views of the Multi-Disciplinary Team.[790]

The Ashley Youth Detention Centre Case Management Guidelines provide for the participation of children and young people in case management processes in the following terms:

> Young people are encouraged to participate in all Case Management processes. They should be included in decision-making forums and processes and the development, implementation and review of their Case Plans and casework strategies.[791]

Despite this, it is not clear to us that children and young people were given the opportunity to participate in case management processes at Ashley Youth Detention Centre.

6.4.2 Practice improvements

Ms Honan said that when she began in her role in October 2019, there was a 'tense divide' between the Professional Services Team and operational staff, which was 'exacerbated by the command and control management style of senior managers'.[792] However, at the time of her statement to our Commission of Inquiry in August 2022, she described the relationship between the two teams as 'respectful, supportive, collaborative and equal'.[793] Ms Honan attributed the changes in the relationship to a range of factors, including implementing the Practice Framework, appointing new senior managers in both teams and 'the shift to a more accountable and collaborative style of leadership and decision making'.[794]

Ms Honan also told us that, following a review of its terms of reference in 2021, the Multi-Disciplinary Team became more broadly representative and was well attended by staff from the Ashley Youth Detention Centre School, the Department of Health and the then Department of Communities.[795]

In February 2023, the Department advised us that it:

- had contracted the Australian Childhood Foundation to provide 'clinical review and support services, including specialist clinical services for young people covering emotional regulation, trauma-informed counselling and therapeutic supports'[796]
- was establishing a multidisciplinary Clinical Services Team to deliver 'therapeutic clinical services for assessment, support and rehabilitation of young people in contact with the youth justice system, with a strong initial focus' on detention.[797]

These are positive steps, but it is not clear to us how the Clinical Services Team will fit within and work with existing groups at Ashley Youth Detention Centre—particularly the Professional Services Team, the Multi-Disciplinary Team and the Weekly Review Meetings.

6.4.3 Services for children and young people on remand

As discussed in Section 5.4, children and young people on remand make up a large proportion of the youth detention population in Tasmania. In that section, we make several recommendations aimed at increasing opportunities for bail and diverting children and young people from remand. We also recommend that the Tasmanian Government works towards increasing the minimum age of detention, including remand, to 16 years. Implementing these recommendations would significantly reduce the number of children and young people on remand in Tasmania.

Nevertheless, following these changes, there may still be a small number of young people who would be denied bail and remanded due to the complexity of their needs and their high risk of offending while on bail. While we acknowledge the practical challenges associated with providing services to children and young people who may only be on remand for a short period, in our view, remand presents an opportunity for therapeutic intervention that should be seized wherever possible. The United Nations Standard Minimum Rules for the Administration of Juvenile Justice (referred to as the 'Beijing Rules') require that children and young people on remand:

> … receive care, protection and all necessary individual assistance—social, educational, vocational, psychological, medical and physical—that they may require in view of their age, sex and personality.[798]

However, it is also important to note that, while all children and young people who are on remand have been charged with an offence, those whose charges have not yet been determined have not been found guilty of an offence and are therefore entitled to the presumption of innocence. Professor Ogloff referred to the need to ensure children and young people on remand can openly discuss their behaviour with clinicians without incriminating themselves.[799]

The 2017 review of the Victorian youth justice system undertaken by Professor Ogloff and Penny Armytage considered the issue of services for children and young people on remand.[800] The review report noted that, despite introducing education for children and young people on remand in Victoria, there remained 'a concerning lack of activity and programs' delivered to remandees, which, combined with the lack of an effective custodial operating model and daily routine, had 'led to a largely unsettled and tense environment for all young people—on remand and sentenced alike'.[801]

The Victorian review described the reluctance to address offending behaviour while young people were on remand as 'a missed opportunity to deal early and effectively with criminogenic risk and needs' and observed that programs could be delivered that address offending behaviours without needing to explicitly address offence types.[802] It recommended that rehabilitation programs and interventions be offered to children and young people on remand, with legislative protections to prohibit using disclosures made during such programs or interventions as evidence of guilt at trial.[803] We agree with this approach.

6.4.4 Our recommendations

An effective youth detention system requires a coordinated, multidisciplinary, child-centred approach to meeting the needs of each child or young person in detention, including—to the extent practicable—those on remand. All children and young people in detention should experience highly skilled, professional, multidisciplinary supports as part of their daily routine. A multidisciplinary approach must bring together all the services necessary to fully support each child or young person and must not allow operational concerns to trump rehabilitation and therapeutic interventions. It must also provide genuine opportunities for each child or young person to participate in the decision making that affects them.

While we are encouraged by the Government's recent and proposed practice improvements, we are concerned that case management processes are unclear. The large number of teams involved in the care and management of each young person in detention creates scope for confusion and disagreement. A clearer, simpler approach is needed.

We also recommend developing a memorandum of understanding between all key stakeholders across justice, health, education, child protection and disability support services to enshrine a therapeutic approach to caring for children and young people in detention. We note that there is an existing memorandum of understanding between departments, but it is limited to delivering health services to children and young people in detention.[804]

The new memorandum of understanding should set out each agency's role and responsibilities and should address assessment, case planning, case management and exit planning (discussed in Section 6.8). It should also address processes for reporting incidents, managing complaints (including those involving child sexual abuse) and resolving disputes.

Recommendation 12.19

The Tasmanian Government should:

a. establish clear processes and guidelines for assessment, case planning and case management for children and young people in detention, to enable the delivery of tailored, multidisciplinary, therapeutic responses to each child and young person as part of their daily routine, which meet their health and wellbeing needs and address the factors contributing to their offending behaviour

b. implement a collaborative, multidisciplinary approach to responding to each child and young person in detention that includes all relevant service providers and, to the greatest extent possible, the child or young person's family

c. develop a memorandum of understanding between agencies involved in delivering services to children and young people in detention, including child protection, health, disability support and education that

   i. describes the roles and responsibilities of each agency in case planning and case management

   ii. commits to agencies adopting a collaborative, child-centred approach

   iii. contains clear protocols for record keeping, information sharing, incident reporting and dispute resolution

d. ensure each child or young person in detention (and/or their representative) is given the opportunity to participate in case planning and case management processes, express their views and have those views given due weight

e. ensure each child and young person on remand has access to therapeutic services and supports, with statutory protections that prohibit using disclosures made during interventions and programs on remand as evidence of guilt.

6.5 Health services for children in detention

As discussed in Chapter 10, the death of a young person at Ashley Youth Detention Centre in 2010 triggered several reviews and inquiries into the Centre, including a coronial inquest. These reviews and inquiries identified problems with access to health care at Ashley Youth Detention Centre at the time and resulted in the Department initiating several positive, health-related reforms. In this section, we identify other changes that should be made to improve children and young people's access to health care in detention.

6.5.1 Current health services

Barry Nicholson, Group Director, Forensic Mental Health and Correctional Primary Health Services, told us that recommendations made after the death in detention were implemented by November 2013.[805] The recommendations included transferring the functions of the Ashley Youth Detention Centre health service to the then Department of Health and Human Services' Correctional Primary Health Services, increasing nursing capacity and establishing a health care information system to store and share all client information in one place.[806]

Mr Nicholson described the health services currently available to children and young people at Ashley Youth Detention Centre.[807] Under the supervision of a Nurse Unit Manager who is based at the Centre, Correctional Primary Health Services provide:

- an initial health assessment of a child or young person on admission to the Centre to determine the level of health care they will need while in detention[808]
- management of 'active health problems including review of medications, treatment of existing conditions, drug and alcohol issues and mental health assessments'[809]
- drug and alcohol detoxification and relapse prevention, and management of injections, injuries and other conditions requiring low- to medium-level health care[810]
- outpatient allied health service referrals, including forensic mental health, physiotherapy, dental and optometry services[811]
- sexual health education, drug and alcohol education, immunisation and other preventive health programs.[812]

Nurse-led clinics staffed by 3.5 full-time-equivalent nursing staff are available from 7.00 am to 7.00 pm each day, and nurses are available on-call outside these hours.[813] A doctor, who also has responsibilities outside Ashley Youth Detention Centre, is available twice weekly and is on-call outside these sessions.[814]

Also, the Alcohol and Drug Service provides support, counselling and harm minimisation education for children and young people wanting to address their substance use.[815] Mr Nicholson told us that, at the time of his statement in August 2022, there was 'no [alcohol and drug service] coverage due to shortages' in the service.[816]

A forensic psychologist is based full-time at Ashley Youth Detention Centre to 'address young people's criminogenic needs and provide therapy'.[817] The forensic psychologist also 'provides risk assessments for suicide and self-harming ideation' and 'education on prosocial attitudes and behaviour modification'.[818] In his statement, Mr Nicholson told us that this position had been vacant since November 2021.[819] In oral evidence, he acknowledged the challenges of recruiting to such a position—including the various employment options available to psychologists and the negative media coverage of conditions at Ashley Youth Detention Centre—but indicated that an August 2022 recruitment process for the position had been successful.[820]

A child psychiatrist attends Ashley Youth Detention Centre one day a month to assess, diagnose, treat and review children and young people.[821]

6.5.2 Increasing access to mental health services

We consider the level of children and young people's access to mental health services while at Ashley Youth Detention Centre to be insufficient.

Professor Ogloff told us that, while not all children and young people in detention had 'conventional psychiatric illness', they all had 'significant behavioural or mental health problems or cognitive problems that required professional intervention'.[822]

Mental health challenges among children and young people in the youth justice system commonly co-occur with other complex health and social problems.[823]

The former Head of Department for Statewide Forensic Mental Health Services highlighted the importance of having a specialist child and adolescent psychiatrist and psychologist at Ashley Youth Detention Centre:

> These mental health professionals have specific training, knowledge, skills and experience regarding normal childhood development and the complexities encountered in children and adolescents with mental health conditions in addition to their offending behaviours. This includes … specialty knowledge of mental illness, co-morbid Substance Use Disorders, +/- Intellectual Disabilities +/- Specific Learning Difficulties and trauma histories.
>
> They are best placed to assess a young person within their developmental stage, identify their specific risk factors for problematic behaviours, and assist the [Multi-Disciplinary Team] develop and implement specific management plans to mitigate these identified risk factors and minimise problematic behaviours. These interventions are targeted at treating and managing their complex mental health conditions, comorbidities and subsequent behaviours; the focus being on attempting to change their trajectory so that they do not become involved with the Adult Criminal Justice System.[824]

Professor Ogloff said that psychologists at Ashley Youth Detention Centre were 'often poorly trained' to manage the complex needs of children and young people in detention.[825] As noted in Section 6.5.1, we heard that the position of forensic psychologist at Ashley Youth Detention Centre had been vacant for some time.[826]

Professor Ogloff also referred to the limited psychiatric care available at Ashley Youth Detention Centre.[827] The Nurse Unit Manager at Ashley Youth Detention Centre similarly commented that:

> More psychiatry services at [Ashley Youth Detention Centre] would improve service delivery. [The psychiatrist] is funded for sessional work. By the time we have hand over and she goes through clinic notes it does not leave a lot of time. If she has court reports to complete as well this encroaches on her clinic time. [The psychiatrist] often has to write her clinic notes in her own time once she returns to Victoria. Fortnightly clinics would be beneficial.[828]

In 2018, the Custodial Inspector recommended that Ashley Youth Detention Centre 'increase the dedicated psychiatry time for young people in detention and links to external psychiatry services to assist young people on release' and 'increase the dedicated clinical psychology time for young people in detention'.[829]

The Director of Nursing, Statewide Forensic Mental Health Services, told us that children and young people in detention can be transferred to a psychiatric facility from Ashley Youth Detention Centre.[830] Under section 134A of the Youth Justice Act, the Secretary may direct that a detainee who, in the opinion of a medical practitioner or psychologist,

appears to be suffering from a mental illness be removed from a detention centre to a 'secure mental health unit' if this is in the best interests of the detainee, other detainees or staff, or if the detainee has requested to be moved to a secure mental health unit.[831] The Secretary must have considered a report of the Chief Forensic Psychiatrist before making such an order.[832]

Tasmania has one secure mental health unit—the Wilfred Lopes Centre.[833] This is a specialised mental health facility for adults involved with the criminal justice system (including remandees, prisoners and those found not guilty by reason of being unfit to plead), with 35 beds located near Risdon Prison.[834] The Wilfred Lopes Centre does not provide specialist child and adolescent mental health treatment. It is highly problematic and inconsistent with human rights standards to send children and young people from detention to a facility accommodating adult prisoners.[835]

Hannah Phillips, a lawyer with experience working with youth in the Tasmanian justice and child safety systems, indicated that the absence of a dedicated mental health facility for children and young people in Tasmania means youth detention is instead being used to manage children and young people with mental health problems who are engaging in offending behaviours that risk community safety.[836]

Professor Brett McDermott, Statewide Specialty Director, Child and Adolescent Mental Health Service, told us that proposed reforms to the Child and Adolescent Mental Health Service included establishing a dedicated adolescent and youth inpatient facility and day hospital.[837] The 2020 Child and Adolescent Mental Health Services Review undertaken by Professor McDermott recommended a 'discrete mental health inpatient unit for children and adolescents' as part of Stage 3 of the Royal Hobart Hospital redevelopment.[838]

According to the review, the new mental health inpatient unit for children and adolescents should be 'for consumers who have severe and complex mental health challenges, who often present with an acute risk to themselves or others'.[839] It is not clear whether this new unit would have the capacity to receive children and young people from detention under section 134A of the Youth Justice Act.

Victoria has a Custodial Forensic Youth Inpatient Unit that is a three-bed ward located on the grounds of Footscray Hospital in Melbourne, providing 'acute inpatient services through a range of therapeutic interventions and programs to young people in custody'.[840] This service is delivered by Orygen Youth Health.[841] We consider that the proposed mental health inpatient unit for children and adolescents in Hobart should similarly provide for children and young people in custody.

More broadly, we heard that there have 'traditionally been many barriers to accessing mental health services for young people involved in the youth justice system'.[842]

Professor McDermott told us that, as part of the proposed reforms to child and adolescent mental health services in Tasmania, a dedicated specialist Youth Forensic Mental Health Service would be created for children and young people under the age of 18 years who are involved in the youth justice system, or are at risk of becoming involved in this system.[843] This was also a recommendation of the 2020 Child and Adolescent Mental Health Services Review.[844]

The new Youth Forensic Mental Health Service would 'offer specialist mental health assessment, treatment and support at multiple stages of a young person's journey via a number of avenues' and would comprise the following three elements delivered by a multidisciplinary team:

- a youth forensic 'consultation and liaison service' to provide services where the Magistrates Court (Youth Justice Division) exercises its power under the Youth Justice Act to adjourn a criminal proceeding to enable a child or young person who appears to be suffering from a mental illness to be 'observed and assessed' (among other situations)[845]
- a specialised multisystemic therapy program
- 'in reach assessment and treatment for youth in or exiting youth detention'.[846]

It is important that services provided by the proposed Youth Forensic Mental Health Service take account of any existing mental health plan that a child or young person may have.

In oral evidence, Professor McDermott told us that the 'in reach' services for children and young people in youth detention would address neurological as well as psychiatric issues:

> For instance, the rate of things like fetal alcohol syndrome in detention populations is actually very high. The rate of some types of genetic presentation are actually very high. The rates of … speech and language issues and the need for remedial education are high. So, the input to [detention] will be sort of neuropsychological as well as psychiatric, and hopefully the two arms of this service will talk to each other. For instance, you could get some assessment and work in detention and then be discharged to [a community-based multisystemic therapy] team.[847]

Professor McDermott indicated that a pilot Youth Forensic Mental Health Service would be in operation by December 2022.[848] At the time of writing, we had not received any information on whether this service had begun operating.

We are encouraged by these proposed reforms to mental health support for children and young people in detention and in the youth justice system more broadly, which we consider will offer another layer of protection for children and young people who are at risk of sexual abuse in those settings.

Recommendation 12.20

The Tasmanian Government should ensure:

a. there are appropriate mechanisms and pathways for children in contact with the criminal justice system to be diverted to the mental health system for assessment and treatment

b. the proposed Youth Forensic Mental Health Service provides timely referral and access to mental health treatment, care and support for children and young people when appropriate, whether they are under community-based supervision, in detention or not yet sentenced (including on remand)

c. children and young people in detention have daily access to an onsite child and adolescent psychologist and fortnightly access to an onsite child and adolescent psychiatrist

d. the proposed mental health inpatient unit for children and adolescents in Hobart provides for children and young people in detention.

Recommendation 12.21

The Tasmanian Government should ensure children and young people in detention (including on remand):

a. receive a mental and physical health assessment on admission to the detention facility, and when needed while in detention

b. have access to 24/7 medical care

c. have a say in their mental and physical health care.

6.6 Education in detention

According to the Beijing Rules, the objective of detention facilities should be to 'provide care, protection, education and vocational skills, with a view to assisting [children and young people] to assume socially constructive and productive roles in society'.[849] As noted, the best-performing youth detention facilities make education and training a central feature of their operating models and provide a full, structured day to keep children and young people busy. This reduces boredom, which can 'exacerbate negative outcomes and increase [the] likelihood of negative behavioural incidents occurring'.[850] We also consider that engaging in education in detention is likely to be a protective factor against the risk of child sexual abuse in detention.

6.6.1 Ashley School

In Tasmania, most children and young people in detention have experienced significant disruptions to their schooling, with some having completely disengaged from education.[851] Many have a diagnosed learning disability or other learning difficulties.[852]

Ashley School, which is a Tasmanian Government school on the Ashley Youth Detention Centre site, opened in 1999.[853] School classes run from 9.00 am to 2.30 pm each weekday, and there is an expectation that children and young people will attend classes if they can.[854] Each class has a maximum of four students, usually with one teacher and one teacher assistant (another teacher may attend depending on availability or the needs of students on a given day).[855]

Samuel Baker, Principal of Ashley School, told us that the curriculum at the school is based on the curriculum in mainstream Tasmanian schools, with literacy and numeracy making up about 30 per cent of each student's classes, and the remaining time used for specialist classes such as woodwork, cooking, physical education, health, 'fit gym' (weights and conditioning), art, Aboriginal studies and 'STEM' (science, technology, engineering and mathematics).[856]

Mr Baker told us that each school day has a physical education component 'to negate the confines of unit life, promote a healthy lifestyle … [and] develop social connections, team work and regulation'.[857] Ashley School offers no extracurricular activities outside standard school hours.[858]

We did not hear any evidence about vocational training programs offered to young people at Ashley School. The Custodial Inspector's 2019 *Families, Community and Partnerships Inspection Report* indicated that Ashley Youth Detention Centre had previously obtained 'start up' training from TasTAFE—such as Certificate I and II in Kitchen Operations courses—at no cost, but that these were no longer provided.[859] In his statement, Mr Baker referred to supporting vocational qualifications such as barista training or Responsible Service of Alcohol training for young people who did not wish to return to mainstream school after leaving detention.[860]

According to Mr Baker, teachers at Ashley School use a range of strategies to support student learning and create a calm and predictable classroom environment—these include individual student learning plans, high ratios of teachers to students and 'highly differentiated and individualised learning tasks'.[861]

Mr Morrissey described Ashley School during the time he was Commissioner for Children and Young People as 'an exemplar of high-quality teaching staff achieving good outcomes for highly disadvantaged and traumatised young people' and said that young people consistently told him 'how much they valued the school'.[862] Ms Phillips told us she had 'not had negative reviews about the schooling at Ashley Youth Detention Centre' from children and young people, and suggested that this was:

> … largely because the learning is at their level, they are around other young people who have low literacy and [low] previous education outcomes, and that they do not feel put in the back corner or 'different'.[863]

The current Commissioner for Children and Young People, Leanne McLean, has observed that, while Ashley School provides a positive experience for children and young people in detention, 'many positive educational gains that are made while a young person is detained … invariably end when they leave' because there are few or no links to education outside Ashley Youth Detention Centre.[864] Commissioner McLean indicated that any new custodial model must include detailed consideration of how young people can be supported to stay engaged with education once they leave detention, suggesting that much could be learned from Victoria's work on this issue (discussed in Section 6.6.3).[865]

6.6.2 Restrictions on access to education

We heard that there were restrictions on children and young people's access to some classes depending on their colour rating under the Behaviour Development Program. For example, Mr Baker told us that children and young people who were assessed as being on 'green', 'yellow' or 'orange' levels in the Behaviour Development Program were allowed to take part in 'Team Sport' on Fridays, whereas children and young people on 'red' were excluded from this activity.[866]

According to Mr Baker, for children and young people on 'red':

> There is the option to engage in a work pack from school if that's what they'd like to do. It's not any more punitive other than they miss out. So, certainly there's no other punitive measures put in place for that young person; they still would engage with their workers back there; that could be social games, it could be some kind of sport in their courtyard, it could be table tennis, it could be lots of other things that interest that particular person individually.[867]

Mr Baker also stated that children and young people on 'red' were not entitled to attend woodwork, art or 'fit gym' due to 'the availability of equipment that could be used as a weapon'.[868] Where students were excluded from these classes, there was alternative work available for them to do in their unit with educational staff, but Mr Baker told us that students rarely take this up.[869] Mr Baker acknowledged that children and young people on 'red' would not receive as many hours of educational programming as those on other levels.[870]

As noted in Section 6.3.2, we also heard that children and young people on the Blue Program under the previous Behaviour Development System were 'fully segregated from Ashley school'.[871] This is discussed in detail in Chapter 11, Case study 3.

Also, a child or young person may be excluded from school if a significant incident has led to the child or young person being assessed as 'not safe to attend' school for part

of that day.[872] Mr Baker described this as 'a last resort and not a punishment but an essential mitigation strategy to keep everyone safe and ensure students are regulated and able to access learning'.[873]

We heard that access to face-to-face schooling for children and young people at Ashley Youth Detention Centre was significantly reduced in 2022 due to staff shortages and 'rolling lockdowns'.[874] During that period, Ashley School allocated staff to units for one-on-one sessions with each young person, normally for only 45 minutes or an hour per day, which is significantly less than the legal requirement that young people attend school for the whole of each school day.[875] Depending on the availability of youth workers to supervise in-unit schooling, Ashley School staff were sometimes only present in one unit at a time.[876]

We also heard that during staff shortages the allocated time for education overlapped with the limited time that young people had outside of their rooms each day. As a result, Ashley School staff could not deliver the core curriculum to some young people at all and instead engaged them in social games or specialist work in art and other areas, or left the young person alone.[877] Mr Baker agreed with the assertion that even if a young person engaged in schooling for the 45 minutes to an hour available during staff shortages, this was not enough to deliver the curriculum.[878]

Ms Phillips told us that it was her understanding that the schooling provided to young people during the staff shortages was 'nowhere near sufficient' and she suspected many young people in detention cannot read or do not have the capacity to learn in their units on their own.[879]

As noted in Section 4.7.2, lockdowns related to staff shortages continued to occur at Ashley Youth Detention Centre in July 2023, with children and young people locked in their rooms or units for up to 23 hours each day.[880] We discuss staff shortages in more detail in Section 4.7.2 and lockdowns in Section 9.2.

6.6.3 Other models of education in detention

At the secure facilities operated by the Diagrama Foundation, children and young people have a full day of education and activities every day:

> Young people are involved in learning in every aspect of their day – how to get ready for the day, how to share meals together, play sports together, how to care for and decorate their environment – not just at formal classes and workshops. Supported by social educators, qualified teachers and vocational (VET) instructors there is vocational education and training as well as classes, daily sports, and constructive leisure activities – music, art, gardening, animal husbandry and cultural activities.[881]

Ms Campbell also referred positively to Parkville College, the school for children and young people in Victorian youth justice centres, which:

> … provides education by qualified teaching staff and makes education the predominant focus within the facility. The college's foundational principles take a strengths-based approach to supporting education, with all teachers trained in trauma-informed approaches. The college delivers the Victorian Certificate of Education and Victorian Certificate of Applied Learning, which the majority of its students undertake. It also has auspice arrangements to provide vocational training.[882]

Parkville College also delivers the Victorian Pathways Certificate, an inclusive year 11 and 12 standards-based certificate for students who require flexibility in their educational experiences, and the Victorian Certificate of Education—Vocational Major, a vocational and applied learning program designed to be completed over a minimum of two years, which provides students with a senior secondary certificate and notes that their educational pathway was centred around vocational learning.[883]

Parkville College students have six hours of structured classes each weekday, including literacy, numeracy, personal development skills, physical education, art and music.[884] On Friday afternoons, Saturdays and during term breaks, Parkville College operates an intensive vocational education and training timetable.[885]

Parkville College has developed the 'Parkville College Model', which it describes as:

> … a pedagogy underpinned by trauma theory, trauma-informed practice, attachment theory, culturally responsive practice, and an extensive research-base of knowledge about effective instructional practices. At the heart of the model is a critically conscious independent learner.[886]

The Parkville College Model articulates five practice principles that emphasise staff self-awareness and growth; strong, secure relationships and culturally safe spaces; responsive instructional practice; student empowerment and voice; and connection to community and culture.[887]

The Parkville Youth Justice Precinct also includes the 'STREAT café'—a partnership between Parkville College, the STREAT social enterprise and the Victorian Department of Justice and Community Safety—which delivers hospitality training and employment pathways for young people in the youth justice system.[888]

In addition, Parkville College has a Transitions Team, which is responsible for education transition planning for children and young people leaving detention.[889] This team seeks school records for each young person in detention, alerts their last known school that they are in detention, works with the young person and their parents or carers to establish educational goals, develops a student plan and an individual education plan for the young person, and engages with the young person's destination school, including alerting it of the young person's release date.[890]

Parkville College also operates 'O-Street', a flexible learning centre in the community that can support children and young people who have left detention to transition into mainstream schooling.[891]

6.6.4 Proposed reforms in Tasmania

As part of its recent commitments to prioritise prevention, early intervention and diversion of children and young people from the criminal justice system, the Tasmanian Government has committed to developing and implementing an 'alternative education model' for children and young people whose educational needs are not being met.[892] Alternative approaches to be explored may include 'continued emphasis on needs assessments and learning plans, flexible education models and vocational pathways'.[893]

According to the Draft First Action Plan, 'new alternative education programs' will be developed by 2024.[894] There is no discussion of whether these programs will also be delivered in detention, or what the Government's plans for education in its proposed new detention facility are more broadly.

6.6.5 Our recommendations

Education for children and young people in detention, including those on remand, is a right, not a privilege.[895] It should be the central feature of a young person's experience in detention.

While we acknowledge that the safety of students and educational staff is essential, we are concerned that access to education for some children and young people at Ashley Youth Detention Centre has been unnecessarily limited by disciplinary measures imposed in response to challenging behaviours.

As discussed in Section 6.3.2, the Behaviour Development System was applied in a punitive manner, and we consider that the replacement Behaviour Development Program should not continue to be used (Recommendation 12.18). We also agree with the Northern Territory Royal Commission that any new behaviour management program or incentive system that may be adopted in future should not restrict children and young people's access to education, physical exercise or rehabilitation programs.[896]

We are also highly concerned about restrictions on children's access to education because of lockdowns relating to staff shortages. We discuss recruitment of staff in Section 4.7.2 and lockdowns in Section 9.2.

We also consider that more work is needed to support children and young people who leave detention to remain engaged with work, training or study. This is discussed in Section 6.8 in the context of exit planning and support after release from detention.

Recommendation 12.22

The Department for Education, Children and Young People should:

a. ensure the Youth Justice Model of Care emphasises the central importance for children and young people in detention of access to high-quality education and vocational training that is tailored to their individual learning needs and that includes learning life skills

b. make education programs and other structured activities accessible to all children and young people in detention (including on remand)

c. ensure a child or young person's access to educational programs or physical exercise in detention is not linked to, or limited by, their ranking in behaviour management programs

d. develop and establish partnerships with community organisations to create employment and training opportunities for children and young people leaving detention.

6.7 Facilitating links to family and community

Every child deprived of liberty has the right to stay in contact with their family and with the wider community.[897] Children and young people in detention need to be supported to maintain or build connections to their families and communities because such connections can provide important prosocial factors to help children and young people stop offending after they are released from detention.[898] It is particularly important for Aboriginal children and young people in detention to maintain connections with family, community and culture—this is discussed in Section 7.3.

As noted, many children and young people in detention have a history of involvement with the child protection system. Some have been removed from their families of origin by court order and may no longer be in contact with them. For such children and young people, contact with extended family and other trusted adults while they are in detention is particularly important. Support for rebuilding connections with immediate family should also be provided, where appropriate.

The primary mechanisms to enable children and young people in detention to stay connected to their families and communities are visits, temporary leave and phone calls.

6.7.1 Visits

Standard Operating Procedure No. 9 for Ashley Youth Detention Centre states that:

- all children and young people have the right to regular contact with identified family members, 'significant others' such as partners and children, members of the community and professionals such as lawyers[899]
- management can refuse a visit if it believes that the 'security, safety or good order of the Centre or the health or well-being of the young person may be adversely affected by allowing the visit'[900]
- when visits are not approved, the young person must be advised of the situation, including the reasons for non-approval[901]
- visits last 45 minutes and must be supervised closely by staff at all times unless approval has been given for an alternative form of supervision.[902]

The *Inspection Standards for Youth Custodial Centres in Tasmania* state that visits must not be 'withheld as a sanction as part of any behaviour management regime'.[903]

The Custodial Inspector's 2019 *Families, Community and Partnerships Inspection Report* found that, although Ashley Youth Detention Centre staff did not actively 'pursue' families and friends to visit children and young people in detention or review the frequency of visits to individual children and young people, the Centre's facilitation of visits by family and friends was 'commendable'.[904] However, the Custodial Inspector also observed that the visit room was 'sparse' and there were no outside facilities for visits or play areas for young children, recommending that the visiting facilities be updated to 'make visits more relaxed and family friendly'.[905]

The Department told us of infrastructure upgrades to Ashley Youth Detention Centre since the Custodial Inspector's 2019 report was published, which have resulted in a 'softening' of the visitors' entrance and a new purpose-built visit room with an adjacent covered outdoor area with a barbecue.[906]

We heard of two occasions in 2019 where Aboriginal young people in detention were denied visits that were therapeutically important for them (discussed in Section 7.3.3).[907]

The Custodial Inspector's 2019 report stated that 'there was nothing to indicate to the inspection team that visits are ever withheld, or used as a tool to manage the young person's behaviour'.[908]

As discussed in Chapter 10, Ashley Youth Detention Centre is in a location that is not accessible for many families. Upon induction to the Centre, children and young people are advised that if their family cannot afford to travel to Ashley Youth Detention Centre to visit, management can help with travel costs.[909] We did not hear whether families had been provided with such support in practice.

6.7.2 Temporary leave

Temporary leave can be used to ease a child or young person's transition into the community after release by enabling 'visits to specialist service providers within the community, and activities to maintain their connection to family'.[910] Exit planning is discussed in Section 6.8.

Standard Operating Procedure No. 22 provides for temporary leave from Ashley Youth Detention Centre for children and young people.[911] It states that all temporary leave applications must undergo a thorough risk assessment and be approved by the Centre Manager.[912] Risk factors to be considered include the nature of the young person's offending, the young person's 'behaviour and attitude at or near the time of the proposed leave', any history of threats or attempts to abscond, and the young person's 'recent and current colour status' under the Behaviour Development Program.[913]

6.7.3 Phone calls

As part of their induction to Ashley Youth Detention Centre, children and young people are told that they are allowed to make seven phone calls each week.[914] Phone calls are no longer than 10 minutes long.[915] Children and young people are entitled to extra calls if they achieve 'yellow' or 'green' status in the Behaviour Development Program.[916]

In 2019, the Custodial Inspector recommended that the (former) Department of Communities consider 'implementing video visits for young people at [Ashley Youth Detention Centre] by means of communication tools such as Skype and FaceTime to further facilitate family and community contact'.[917] On our site visit to Ashley Youth Detention Centre we were told that there was no FaceTime in the visitors' room and families often did not use Zoom. We also observed a small screen on the wall in the visitors' room at a height that would have been uncomfortable for either sitting or standing. We were also told that there were problems with internet connectivity at the Centre.

6.7.4 Practice improvements

One of the practice principles in the Ashley Youth Detention Centre Practice Framework is to 'provide opportunities for young people, their families and communities to connect and support to heal and strengthen relationships'.[918] As noted in Section 6.3.3, the Practice Framework is under review.

According to the Keeping Kids Safe Plan, the Government has (as noted in Section 6.7.1) 'soften[ed]' the entrance to Ashley Youth Detention Centre, created a new reception area for visitors and improved visitor and family spaces.[919]

In June 2023, the Department informed us that it had 'recently procured mobile phones for young people within Ashley Youth Detention Centre', which would give them 'the

ability to make personal and professional calls from the privacy of their bedrooms or the Centre's outside spaces or meeting rooms, outside of school hours'.[920] The mobile phones were expected to be provided to children and young people in July 2023.[921] We welcome this initiative. However, we did not receive information or guidelines on the proposed use of the mobile phones by children and young people in detention.

6.7.5 Our recommendations

More needs to be done to enable children and young people in detention to build and maintain connections with their families and communities. This is 'a key aspect of a therapeutic model of care'.[922] In our view, the Department should develop a policy on supporting children and young people in detention to remain connected to their families and communities via visits, temporary leave and phone and video calls. There should be no restrictions on contact between children and young people and their families arising from security classifications or rankings in behaviour management systems.[923]

We consider that, overall, moving the detention facility to Hobart will increase accessibility for family and friends. However, there will still be challenges for some families (such as those living in very remote areas) to visit children and young people in detention. In these circumstances, the Government should help family members or Aboriginal community members to visit children and young people in detention.

We also recommend in Section 6.1 that any new youth detention facility in Tasmania be designed to facilitate and promote connections between children and young people, and their families and communities (Recommendation 12.16).

We consider technology-facilitated family contact to be a practical suggestion to enhance children and young people's connection with their families. We recognise that children and young people in detention are more likely to have complex family structures such as separated parents and siblings living away from one or both parents, including in out of home care. Unlimited technology-facilitated access to family is an important aspect of any strategy designed to maintain and strengthen family connection for children and young people in detention.

Finally, we note Mr McGinness's suggestion that there may be opportunities for families and communities to become involved with service delivery in youth detention.[924] We agree that this should be explored.

Recommendation 12.23

The Department for Education, Children and Young People should:

a. develop and implement a policy that recognises the importance to children and young people in detention of maintaining or building connections with their family and community and

   i. specifies ways to promote such connections, including through visits, temporary leave and phone or video calls

   ii. clearly states that entitlements to visits, temporary leave and phone or video calls cannot be denied on the basis of a child or young person's behaviour

b. provide reasonable assistance (including financial help) to members of a child or young person's family or Aboriginal community to enable them to visit the child or young person frequently, where families or Aboriginal community members have barriers to accessing the youth detention facility.

6.8 Exit planning and support after release

Effective youth justice systems prioritise exit or transition planning and continuity of care following a young person's release from detention, often referred to as 'throughcare' services. The Northern Territory Royal Commission observed that:

> A well-planned and supported transition from detention can be the circuit-breaker in a cycle of reoffending. Without adequate planning for release, the system is [setting a young person up to fail]. Without post-release support, the likelihood of failure inevitably increases.[925]

The Northern Territory Royal Commission recommended establishing 'an integrated, evidence-based throughcare service' for children and young people in detention in the Northern Territory to deliver:

- adequate planning for release—including safe and stable accommodation, access to physical and mental health support, access to substance abuse programs and assistance with education and/or employment—with planning to start on entry into detention
- improved post-release services to be made available to all children and young people detained more than once or for longer than one week
- a comprehensive wraparound approach facilitated by cross-agency involvement.[926]

Mr McGinness similarly endorsed the notion of commencing exit planning 'from the moment a young person comes into custody', creating links to community-based service providers and families, and actively supporting young people in their transition back into the community.[927] He also referred to the benefits of an 'integrated model' that would allow:

> … caseworkers and youth justice personnel to assist [young people] in building connections with educators outside the youth justice system, so that the young person can maintain this relationship once they leave detention. The same concept applies to health services, such as psychologists and occupational therapists. Integrated Through Care delivered under a therapeutic justice model ensures continuity of care when a young person's detention ends.[928]

6.8.1 Exit planning and post-release support in Tasmania

Ashley Youth Detention Centre has a procedure on exit planning for children and young people that provides that:

- Wherever possible, exit planning must begin six weeks before the young person's earliest release date, and where this is not possible, it must begin 'with sufficient time to engage all relevant stakeholders and develop a formal plan'.[929]
- Exit planning meetings must identify services and supports that 'may enhance the young person's capacity to reintegrate into the community and reduce the risk of reoffending' and set out 'appropriate goals and case planning strategies to assist the young person reduce the risk of reoffending'.[930]
- While exit planning is to be coordinated by Ashley Youth Detention Centre case management staff, a Community Youth Justice worker must take part in exit planning meetings. Their role is to 'assist in the exit planning process'.[931]
- If the young person is subject to a child protection order, 'a Child Protection Worker' must be invited to take part in exit planning.[932]
- The young person's nominated parent, carer or guardian must be contacted and invited to attend exit planning meetings. Where this is not possible or appropriate, the young person's case manager and nominated Community Youth Justice worker must 'endeavour to identify and engage an appropriate and meaningful adult to support and assist the young person through the exit planning process and upon release from custody'.[933]

The exit planning procedure also states that, when a young person is not released under community supervision, 'every effort will be made in the exit planning process to connect the young person to a community organisation for support upon release'.[934]

The exit planning procedure does not indicate how the various other services required to support a child or young person in the community are to be involved in the exit planning process. We also note that the procedure requires 'a Child Protection Worker'—rather than the young person's current child protection worker, or one who knows the young person and their circumstances—to be 'invited to participate' in exit planning, suggesting that their attendance is not strictly required. This is problematic, given that some young people are released from detention without stable accommodation, which increases their risk of returning to detention.[935]

We heard that there was a lack of effective throughcare support for children and young people leaving detention in Tasmania.[936] Vincenzo Caltabiano, former Director, Tasmania Legal Aid, told us that children and young people needed more help to re-establish their lives following release from detention, as many find themselves returning there within 12 months of release.[937]

Similarly, Adjunct Associate Professor Mitchell told us that children and young people face various challenges on release from detention, noting that 'anecdotally … a lot of kids will offend again to get back to Ashley, because it's the closest thing to a bed and food that they have'.[938] We heard similar comments from participants in our consultations with Aboriginal communities, which we discuss in Section 7.4 on the lack of post-release support for Aboriginal children and young people.

Commissioner McLean has advocated for continuity of support for detained children and young people who are involved in the out of home care system. She has noted that:

> … there are some contractual arrangements that can prevent the provision of supports being continued by non-government providers once a young person is on a detention order and housed at [Ashley Youth Detention Centre].[939]

Also, as outlined in Section 6.6.1, Commissioner McLean has observed that substantial work needs to occur in Tasmania to ensure children and young people who leave detention stay connected to education.

Save the Children's Transition from Detention program is a voluntary mentoring program for children and young people leaving detention in Tasmania that 'bridges the gap between the detention centre and outside services that are not funded or are unable to provide services within the centre'.[940] According to Commissioner McLean, children and young people leaving detention 'value being able to participate in pro-social activities as part of this program', but current resourcing for the program has limited the ability of youth workers to attend Ashley Youth Detention Centre and engage with young people there.[941]

In its submission to the Tasmanian Government on the proposed youth justice reforms, Save the Children advocated for service providers to be granted greater access to detention centres throughout a young person's period in custody, 'so they can build trust and commence sustainability planning as early as possible'.[942]

6.8.2 Practice improvements

Strategy 4 of the Draft Youth Justice Blueprint is to 'integrate and connect whole of government and community service systems'.[943] An aim of this strategy is to achieve:

> … a throughcare approach for children and young people that facilitates and supports transition between services, facilities and the community in a responsive and children and young person-centred manner.[944]

The Draft Youth Justice Blueprint adopts a broader approach to 'throughcare' than one focused solely on leaving detention:

> A throughcare approach that commences service planning at the earliest possible opportunity and follows the young person's engagement with youth justice services can provide stability for the young person. Consistent case management and client centred planning across the continuum, as well as ongoing access to support services with whom the young person is engaged enables the development of rapport and stability that is not dependent upon the young person's place within the continuum i.e., detention.[945]

Also, as noted in Section 2, the Tasmanian Government has announced it will establish two supported residential facilities as part of the suite of facilities that will replace Ashley Youth Detention Centre.[946] One pathway into this type of facility will be where the child or young person has left detention on a supervised release order with a condition to 'attend' the supported residential facility.[947] It would appear that the Government anticipates these facilities could serve as temporary or transitional accommodation for children and young people released from detention.

As noted in Section 6.6.4, the Government has also committed to developing new alternative education programs by 2024.[948] It is possible that these could be accessed by children and young people following their release from detention, but the Government's documentation does not specifically address this.

6.8.3 Our recommendations

The Government's proposed reforms to support children leaving detention are welcome. The proposed supported residential facilities are also promising, but more detail is needed about how they will operate to support children and young people after their release.

There is an immediate and urgent need for housing, mental health, education and other support for children and young people leaving detention. As discussed in Section 7.4, there is a particularly urgent need for post-release support for Aboriginal children and young people. We consider that the Government should prioritise developing effective, coordinated exit planning and post-release support services for children and young people leaving detention. This should be addressed in the Youth Justice Model of Care

for detention recommended in Section 6.3.4 (Recommendation 12.18). Throughcare support services must be culturally safe for Aboriginal children and young people and respond to their needs (refer to the discussion in Section 7.4).

We agree with Save the Children's call for community-based post-release service providers to have greater access to detention centres throughout a young person's period in custody to build trust with the young person and start planning for post-release as early as possible.

Providing exit planning and post-release services for children and young people should be supported by a comprehensive exit planning procedure and a memorandum of understanding that specify clear requirements for how the various services required to support an individual young person in the community must work together to ensure the young person has stable accommodation, links to education or work, and ongoing support for mental health, disability and other needs.

There is a particularly urgent need for coordination and collaboration with child protection services. Alison Grace, Deputy Centre Manager, Bimberi Youth Justice Centre in the Australian Capital Territory, referred to the model of 'single case management' provided by Child and Youth Protection Services, whereby children and young people under the guardianship of the state have the same case manager in the youth justice system, whether under community-based supervision or in custody.[949] She said this provided 'a consistent voice and seamless service delivery to young people throughout their involvement in the youth justice system'.[950] We consider that such an approach could have considerable benefit in Tasmania.

Considerable work is also needed to meet the educational needs of children and young people following their release from detention. In this respect, we note the benefits of schools such as Parkville College in Victoria (discussed in Section 6.6.3), whose Transitions Team supports children and young people to move from education in detention to education in the community, and the Berry Street School—a specialist independent school with four campuses across Victoria that offers a flexible and individualised learning approach and a transition program for students who have been excluded from education and who need support to re-engage.[951] We consider that engagement in education is a protective factor against child sexual exploitation in the community.

Recommendation 12.24

The Tasmanian Government should:

a. establish an integrated throughcare service for children and young people in detention that

   i. begins exit planning as soon as possible after a child or young person enters detention for the provision of safe and stable accommodation, access to physical and mental health support, and assistance with education or employment after release to facilitate their reintegration into the community

   ii. provides increased access to the detention facility for staff of community-based providers of post-release services

   iii. adopts a collaborative, child-centred, cross-organisation approach involving child protection, housing, health, disability support and education services, supported by a memorandum of understanding and clear policies and procedures

   iv. involves the child or young person and, to the greatest extent possible, their parent, guardian or other significant adult in exit planning

   v. includes post-release wraparound support services for children and young people

   vi. is culturally safe for Aboriginal children and young people

b. deliver community-based schooling options for children and young people with complex behavioural challenges, including those who are or have been involved in the youth justice system, to provide appropriate learning environments for children to transition to when they leave detention.

6.9 Transfers to prison

Children and young people may be detained in an adult prison facility or transferred from Ashley Youth Detention Centre to an adult prison facility in certain circumstances. The Youth Justice Act states that a child or young person under the age of 19 years who is refused bail can be detained in an adult prison facility if the Secretary of the Department for Education, Children and Young People determines it is not practicable to detain them in a youth detention centre.[952]

In this section, we focus on the transfer of children and young people from Ashley Youth Detention Centre to the adult prison system. While we have not examined the use of the Secretary's discretion under the Youth Justice Act to detain a young person in an

adult prison facility at the time they are refused bail, we encourage the Government to consider our recommendation in relation to transfers broadly and implement it consistently in relation to all avenues by which children and young people may be detained in adult facilities.

The Youth Justice Act does not specify a process for transfers; rather, they are managed administratively under a memorandum of understanding between the former Department of Health and Human Services and the Department of Justice.[953] The Manager of Ashley Youth Detention Centre can make a request to the Director of the Tasmania Prison Service to transfer a child or young person to a Tasmania Prison Service facility.[954] The Director may agree to accept the child or young person for a specified period.[955]

According to the memorandum of understanding, a transfer to prison may be appropriate for a child or young person requiring a 'high level of secure care', where:

> Secure care relates to the level of security required as a result of the low level of pro social behaviour demonstrated by the youth. These youths may be described as high risk/high needs.[956]

Under the memorandum of understanding, grounds for transferring a child or young person from detention to prison include:

- that the child or young person represents a high risk to the safety and security of themselves, other children and young people, staff, visitors, the facility or 'day to day management and operations of the site'[957]
- 'special reasons' listed in Schedule 2—these include '[v]iolence, disruptive behaviour or behaviour issues unable to be treated on site', 'escape attempts and actual escape' and 'serious detention centre offences'[958]
- that the child or young person requires specialist assessment or treatment not available outside major urban areas.[959]

Where a child or young person is transferred to prison for more than 14 days, a 'Transfer Assessment Panel' is convened to review the transfer and determine whether it should be continued.[960] This panel includes representatives of the Tasmania Prison Service, Youth Justice Services (including professional services staff from Ashley Youth Detention Centre) and Correctional Primary Health Services, but it does not include an oversight body or anyone who is independent of government.[961]

A transfer to prison may be continued where the Transfer Assessment Panel classifies the child or young person as '[n]ot benefiting from the Behavioural Development Program and [Ashley Youth Detention Centre] case management model' and as being 'not suitable for detention' at the Centre, having regard to several criteria.[962] These include age, gender, cultural background, 'security and safety assessment', 'level of social responsibility', the number and nature of incidents the young person has been

involved in, and whether their behaviour indicates they are 'likely to create a serious management problem' at the Centre.[963] The criteria do not include the best interests of the child or young person.

This process can be contrasted with the process for transferring children and young people from youth detention to an adult prison in other jurisdictions. For example, in Victoria, the *Children, Youth and Families Act 2005* (Vic) gives the Youth Parole Board the power, on the application of the Secretary of the Department of Justice and Community Safety, to direct that a young person who has been sentenced to detention in a youth justice centre be transferred to a prison.[964] The Youth Parole Board is chaired by a judge of the County Court of Victoria and includes two people with 'experience in matters relating to child welfare'.[965]

In determining whether to make a direction to transfer a young person, the Victorian Youth Parole Board must consider 'the antecedents and behaviour of the person', their age and maturity, as well as a report from the Secretary that sets out the steps that have been taken to avoid the need for the transfer to prison.[966] The Youth Parole Board must also be satisfied that the young person has 'engaged in conduct that threatens the good order and safe operation of the youth justice centre' and 'cannot be properly controlled in a youth justice centre'.[967]

In Victoria, only young people aged 16 years or older can be transferred to prison, unlike in Tasmania, where there do not appear to be any age limits on the transfer of children and young people.[968]

We did not request or receive any evidence on the frequency of transfers from Ashley Youth Detention Centre to adult prison facilities. However, in Chapter 11, Case study 2, we find that Ashley Youth Detention Centre was not equipped to meet the complex needs of children and young people, resulting in at least one being transferred to adult prison.

Housing children and young people with adults in the criminal justice system is contrary to international human rights instruments (discussed throughout this chapter). Children and young people with challenging behaviours and complex needs—particularly cognitive disabilities—are highly vulnerable to abuse, including child sexual abuse, in prison.

We are deeply concerned that children and young people can be transferred from youth detention to adult prison in Tasmania without any oversight from a court, tribunal, parole board or other independent body. We are also concerned that a child or young person can be transferred solely for operational reasons, or based on the young person's complex and difficult behaviours, without considering their best interests or the likely impact on them of being transferred to prison. This approach fails to recognise the effects of trauma on children and young people's ability to regulate their emotions and behaviour. It risks children and young people who have been abused or who have

experienced neglect or other adverse childhood experiences feeling as though others consider they are beyond help. It may have the effect of punishing them for the failure of the youth justice system to support them to address their challenges.

As discussed in Section 6.3, we do not consider the Behaviour Development Program to be an appropriate or effective tool for responding to children and young people's complex behaviours in detention. A child or young person's failure to 'benefit' from this program is therefore not an appropriate basis upon which to transfer them to prison or to decide to keep them in a youth detention facility. We recommend that this program be discontinued in youth detention (Recommendation 12.18).

We recommend that the Tasmanian Government adopts a new process for managing transfers from youth detention, requiring approval from a body that is independent of government. Given Tasmania does not have a youth parole board, we recommend that the Department for Education, Children and Young People be required to seek approval from the Magistrates Court for any transfers. In Section 5.5.6, we recommend establishing a new specialist division of the Magistrates Court to hear child protection matters and children's criminal matters. Applications for transfers from detention to prison should be made to a magistrate of this new division, and until this division is established, to a magistrate of the Youth Justice Division.

Transfer applications should only be made in respect of young people aged 16 years or older. In determining whether to approve a transfer, the Magistrates Court should be required to consider (among other matters):

- what steps the Department has taken to avoid the need for the transfer
- whether the transfer is in the young person's best interests
- the views of the new Commission for Children and Young People (Recommendation 18.6) on the appropriateness of the transfer.

The Department should be required to notify the Commission for Children and Young People of any proposed transfer.

Also, we are concerned about the transfer to prison of young people aged 18 years or older who are serving their sentence in youth detention. Young adults are extremely vulnerable in prison. The Victorian Ombudsman has noted that 'young prisoners are at significant risk of post-traumatic stress disorder arising from the conditions of their detention, and at high risk of rape and assault from older prisoners'.[969]

In a 2019 report on the sentencing of young adult offenders, the Victorian Sentencing Advisory Council stated that:

> … holding young adults in adult prisons can be counterproductive to their treatment and rehabilitation. It can expose them to harms (such as risks to their safety from older adults) and can restrict their participation in mandatory prosocial, constructive activities that are typically available in youth-focused facilities (such as improved educational opportunities, targeted programs and specialist transition resources). This poses risks to the community, which is better served by approaches that maximise the potential for an offender's rehabilitation.[970]

The Tasmanian Government should consider allowing vulnerable young people aged 18 years or older who are serving their sentence in youth detention to stay in detention rather than being transferred to an adult prison. This would be consistent with broader trends to increase the age limit on services for vulnerable young people beyond 18 years—for example, extending out of home care services to the age of 21 years.[971]

Recommendation 12.25

The Tasmanian Government should introduce a new process for approving transfers of young people from youth detention to an adult prison facility that:

a. limits transfers to young people aged 16 years or older

b. requires the Department for Education, Children and Young People to notify the Commission for Children and Young People (Recommendation 18.6) of any proposed transfer

c. requires the Department to apply to the Magistrates Court (Youth Justice Division) or the new specialist children's division of the Magistrates Court (Recommendation 12.15) for approval to transfer

d. requires the Magistrates Court, in determining whether to approve the transfer, to consider, among other matters, the steps the Department has taken to avoid the need for the transfer, whether the transfer is in the young person's best interests and the views of the Commission for Children and Young People on the appropriateness of the transfer.

6.10 Auditing custodial periods

In 2016, the Tasmanian Government issued a media release stating that prisoners had been released from Risdon Prison on the incorrect date on seven occasions due to 'administrative errors when dealing with and interpreting warrants issued by the Courts'.[972] These errors were said to be 'the result of long-term process issues within the Justice system', 'a heavy reliance on paper based forms used in Court operations' and the manual calculation of release dates by the Tasmania Prison Service.[973]

In 2021, a media report indicated that, in the preceding four years, nine prisoners had been released from Risdon Prison before or after their release dates.[974] We heard of similar concerns about youth detention from a former employee of the Department.[975]

In June 2023, the Department informed us that magistrates now calculate each young person's 'earliest release date'.[976]

We would be extremely concerned if children and young people were being detained for longer than is required by their custodial orders. The Government should take steps to ensure this is not occurring.

Recommendation 12.26

The Auditor-General should undertake an audit of the length of custodial stays at Ashley Youth Detention Centre to determine whether they align with sentencing orders.

7 Aboriginal children in youth detention

Aboriginal children and young people are vastly over-represented in Tasmania's youth justice system, particularly in youth detention. We understand this to be a direct and continuing impact of colonisation. As one participant in our consultations with Aboriginal communities told us, youth detention creates lasting damage for Aboriginal children and young people:

> A very high percentage of our young people have been to Ashley. Those young people then started getting into trouble as adults. Once they came out [of Ashley Youth Detention Centre], they should have been proud of who they are and have aspirations of what they want to do, but they were so mistreated in there. It's another layer of abuse—layer upon layer upon layer.[977]

According to data published by the Australian Institute of Health and Welfare, on an average day in youth detention in Tasmania in 2021–22, Aboriginal children and young people aged 10 to 17 years accounted for 44 per cent of the detention population (sentenced and unsentenced) in that age group, despite constituting 10 per cent of all Tasmanian children and young people aged 10 to 17 years.[978] This figure is broadly consistent with what we heard in evidence.[979]

Aboriginal children and young people are similarly over-represented in the remand population. On an average day in youth detention in Tasmania in 2021–22, 42 per cent of children and young people aged 10 to 17 years on remand were Aboriginal.[980]

Aboriginal children and young people are also over-represented among children and young people who are known to the child protection and youth justice systems—known as 'crossover children'.[981] As noted in Section 5.5.3, Tasmania Legal Aid's 2021 *Children First* report—which examined how many of its clients had both a child safety file and a youth justice file—found that 15 per cent of children in this category identified as Aboriginal.[982]

According to the National Royal Commission, research shows that the over-representation of Aboriginal children and young people in youth detention in Australia is a result of 'historical factors, systemic racism, policing practices and a range of socioeconomic factors'.[983]

Similarly, in its 2021 *Our Youth, Our Way* inquiry report, the Victorian Commission for Children and Young People found that the over-representation of Aboriginal children and young people in Victoria's youth justice system stemmed from colonisation, dispossession, the forced removal of children from their families, broken connection to Country and culture, intergenerational trauma, over-policing, systemic racism in service systems and ongoing government intervention in Aboriginal people's lives.[984] These factors can cause Aboriginal families to experience poverty and socioeconomic disadvantage, housing instability, low educational attainment, mental illness, drug and alcohol misuse, family violence and intergenerational cycles of child protection involvement, each of which increases the risk that a child will enter the youth justice system.[985]

The National Royal Commission observed that, while Aboriginal children were not inherently more vulnerable to child sexual abuse in institutions than non-Aboriginal children, Aboriginal children were:

> … more likely to encounter circumstances that increased their risk of abuse in institutions, reduced their ability to disclose or report abuse and, if they did disclose or report, reduced their chances of receiving an adequate response.[986]

Reducing the number of Aboriginal children and young people in Tasmania's youth justice system is essential to minimising the risk they will experience child sexual abuse in detention. The 2020 *National Agreement on Closing the Gap* aims to reduce the rate of Aboriginal children and young people in detention by at least 30 per cent by 2031 (Target 11).[987] The Tasmanian Government has committed to two actions to meet this target: a focus on police diversion and building partnerships with Aboriginal people. But much more needs to be done.[988]

The Draft Youth Justice Blueprint (outlined in Section 2.2) is promising in its references to prevention, early intervention and diversion as strategies to 'change[e] the pathways for children and young people at risk of, or who are engaged in offending behaviours'.[989] However, there is scope for a greater focus on the specific needs of Aboriginal children and young people in this blueprint.

In Section 5, we make several recommendations covering all children and young people in detention that would contribute to achieving Target 11, namely:

- increasing the minimum age of criminal responsibility to 14 years and working towards increasing the minimum age of detention to 16 years (Recommendation 12.11)
- increasing pre-court diversion opportunities for children and young people (Recommendation 12.13)
- strengthening the bail system to increase the likelihood that children and young people charged with criminal offences will receive bail and comply with their bail conditions, and to reduce the number of children and young people on remand (Recommendation 12.14)
- ensuring sentencers have an appropriate hierarchy of community-based sentencing options, so detention is an option of last resort (Recommendation 12.15).

Further, in Chapter 9, we recommend changes to reduce the number of Aboriginal children entering the out of home care system, including more investment in Aboriginal-led targeted early intervention and prevention services for Aboriginal families (Recommendation 9.15). Improved support for Aboriginal families will also help reduce the number of Aboriginal children and young people entering the youth justice system.

In this section, we also recommend that the Tasmanian Government develops an Aboriginal youth justice strategy to ensure its proposed reform of the youth justice system includes a strong focus on the needs of Aboriginal children and young people and their families. This strategy should be founded on the principle of self-determination, and it should commit to actions that will prevent Aboriginal children from entering the youth justice system and divert them from detention.

For Aboriginal children who experience youth detention, the National Royal Commission recommended that state and territory governments consider strategies that would provide for their cultural safety, including:

- recruiting and developing Aboriginal staff to work at all levels of the youth justice system, including in key roles in complaints-handling systems
- ensuring all youth detention facilities have culturally appropriate policies and procedures that facilitate connection with family, community and culture, and reflect an understanding of, and respect for, cultural practices in different clan groups
- employing, training and professionally developing culturally competent staff who understand the particular needs and experiences of Aboriginal children, including the specific barriers that Aboriginal children face in disclosing sexual abuse.[990]

The Tasmanian Government is yet to fully implement this recommendation.

On the contrary, the evidence we received raises our concerns about cultural safety for Aboriginal children and young people in Ashley Youth Detention Centre. We heard that some Aboriginal children and young people received little or no cultural support in detention and, in some cases, were denied contact with family or community members.[991]

The Tasmanian Government has made announcements about the facilities that will replace Ashley Youth Detention Centre, but it has given little attention to the needs of Aboriginal children and young people in these announcements.[992] Similarly, the Keeping Kids Safe Plan does not refer to Aboriginal children and young people or include any specific plans to ensure their safety.[993]

It is important that any new facilities be co-designed with Aboriginal communities to ensure they are culturally safe and enable Aboriginal children and young people to connect with family, community and culture. However, Ashley Youth Detention Centre also needs to be culturally safe while it continues to operate.

Accordingly, in this section, we make recommendations for improving the cultural safety of Aboriginal children and young people who are remanded or sentenced to youth detention, covering:

- cultural support for Aboriginal children and young people in detention, including regular contact with family and community members, and access to cultural programs
- the recruitment of Aboriginal staff to support Aboriginal children and young people in detention
- appropriate professional development for staff of youth detention facilities to ensure they are aware of the unique experiences and needs of Aboriginal children and young people.

We also discuss support for Aboriginal children and young people leaving detention.

7.1 An Aboriginal youth justice strategy

As noted, Aboriginal children and young people are more likely than non-Aboriginal children and young people to encounter circumstances that increase their risk of abuse in institutions, including youth detention. It is therefore incumbent on the Tasmanian Government to take active steps to limit Aboriginal children and young people's entry into youth detention. This requires a commitment to prevention, early intervention and diversion strategies focused on Aboriginal children and young people and their families. As one participant in our consultations with Aboriginal communities told us:

> What about diversion programs rather than going to detention? To me it was pivotal that I went to a diversion program with Aboriginal Elders, instead of going to Ashley for 12 months. If I had been in there it would have changed my life in terrible ways, instead I got to stay with community and it helped me.[994]

As described in Section 2.2, the Draft Youth Justice Blueprint identifies five strategies of focus from 2022 to 2032. They are to:

- prioritise prevention and early intervention to reduce engagement with the youth justice system
- ensure diversion from the justice system is early and lasting
- ensure a therapeutically based criminal justice response for children and young people
- integrate and connect whole of government and community service systems
- provide an appropriately trained and supported 'therapeutic workforce'.[995]

Some of these strategies include specific goals for Aboriginal children and young people. For example, the Draft Youth Justice Blueprint aims to:

- support Aboriginal communities to develop programs that promote wellbeing and sustain connectedness with community and culture[996]
- ensure Aboriginal children and young people have access to Aboriginal-led diversionary services[997]
- provide Aboriginal children and young people with therapeutic responses that meet their needs[998]
- increase 'cultural competence across the youth sector to enable staff to identify and work in culturally appropriate ways' to support and respond to the needs of Aboriginal children and young people in the youth justice system.[999]

These goals are positive. However, they are general and do not identify specific actions to achieve them.

The Draft First Action Plan acknowledges that the approach to diverting Aboriginal children and young people from the youth justice system may be different from general diversionary processes. It states that engagement with Aboriginal children, young people and communities will be essential to ensure culturally safe, Aboriginal-led diversion services.[1000] The Draft First Action Plan also indicates that the proposed Youth Justice Model of Care (discussed in Section 6.3) will be co-designed with Aboriginal communities.[1001]

In February 2022, the Victorian Government published *Wirkara Kulpa*, Victoria's Aboriginal youth justice strategy, whose development was led by Victoria's Aboriginal Justice Caucus.[1002] The strategy is underpinned by Aboriginal self-determination and has a series of guiding principles, which are to:

- amplify the voice and participation of Aboriginal children and young people, and promote and protect their rights

- value the strengths of Aboriginal children and young people
- support child- and family-centred approaches
- embed trauma-informed healing approaches
- centre Aboriginal cultural values and connection.[1003]

Wirkara Kulpa identifies five key priorities or 'domains' for 2022 to 2032—including diverting Aboriginal children and young people from the youth justice system, addressing over-representation and working towards Aboriginal-led justice responses—and commits to more than 70 actions across these domains.[1004]

In its *Our Youth, Our Way* inquiry report, the Victorian Commission for Children and Young People found that services designed, controlled and delivered by the Aboriginal community have the greatest potential to produce the best outcomes for Aboriginal children and young people.[1005] Aboriginal communities in Tasmania told us that Aboriginal input into services for and decisions about Aboriginal children and young people is essential.[1006]

We consider that the Tasmanian Government should build on the commitments in its Draft Youth Justice Blueprint by developing an Aboriginal youth justice strategy in partnership with Aboriginal communities. In its submission to our Commission of Inquiry, the Tasmanian Aboriginal Legal Service recommended creating such a strategy.[1007] A carefully and collaboratively developed Aboriginal youth justice strategy would help the Tasmanian Government to achieve its goal of reducing Aboriginal over-representation in youth detention in line with Target 11.

The development of the Aboriginal youth justice strategy must be led by Aboriginal communities across Tasmania and underpinned by the principle of self-determination in the youth justice system, whereby Aboriginal communities have authority in respect of Aboriginal children and young people. We note that the Draft Youth Justice Blueprint refers to an 'increased focus on self-determination' and commits to partnering with Aboriginal communities to determine the most appropriate responses to address Aboriginal over-representation in the youth justice system.[1008] The Tasmanian Government should ensure Aboriginal communities and organisations are supported and resourced to participate in developing the Aboriginal youth justice strategy.

The Aboriginal youth justice strategy should identify actions that will prevent Aboriginal children and young people entering the Tasmanian youth justice system, enable early intervention for Aboriginal families whose children are engaging in antisocial behaviour, and divert those children and young people who are already in contact with police away from the youth justice system and, in particular, from detention. This should include:

- strategies to increase the use of cautions for Aboriginal children and young people
- the development of more pre-court diversion programs for Aboriginal children and young people, delivered by Aboriginal organisations

- strategies to minimise the number of Aboriginal children on remand through culturally safe supported bail accommodation and other bail assistance programs
- support for Aboriginal children and young people on community-based orders, aimed at helping them comply with the conditions of their orders and avoid escalation into custodial sentences.

In Chapter 9, we recommend an expanded role for 'recognised Aboriginal organisations' in child safety decision making under the Children, Young Persons and Their Families Act. In particular, we recommend that the Tasmanian Government partners with Aboriginal communities to develop models for transferring child safety decision-making authority for Aboriginal children to recognised Aboriginal organisations, and create a statutory framework to facilitate such transfer (Recommendation 9.15).

To enable this to occur, we recommend in Chapter 9 that:

- the new Executive Director for Aboriginal Children and Young People in the Department for Education, Children and Young People promotes and facilitates the establishment of recognised Aboriginal organisations (Recommendation 9.7)
- the Tasmanian Government invests in capacity building to ensure recognised Aboriginal organisations are fully resourced and their workforces fully equipped and supported to participate in child safety and out of home care decision-making processes for Aboriginal children, and to manage any transfer of decision-making authority (Recommendation 9.15).

Recognised Aboriginal organisations also have a role under the Youth Justice Act, namely to administer formal cautions to Aboriginal children or young people where requested by authorised police officers (we discuss cautions in Section 5).[1009] However, as noted in Chapter 9, the Tasmanian Government does not appear to have declared any organisations to be 'recognised Aboriginal organisations' for the purposes of the Children, Young Persons and Their Families Act (or, consequently, the Youth Justice Act). In that chapter, we recommend that the Tasmanian Government partners with Aboriginal communities to promote and support the establishment of recognised Aboriginal organisations.

We consider there could be a broader role for recognised Aboriginal organisations in youth justice processes in respect of Aboriginal children and young people. This could include delivering local diversionary programs for Aboriginal children and young people, leading conferencing under the Youth Justice Act, and designing and administering community-based youth justice options, including alternatives to custody for Aboriginal children and young people. These options should be examined under the auspices of the proposed Aboriginal youth justice strategy.

Recommendation 12.27

1. The Tasmanian Government, to protect Aboriginal children and young people against the risk of sexual abuse in youth detention, should urgently develop, in partnership with Aboriginal communities, an Aboriginal youth justice strategy that is underpinned by self-determination and that focuses on prevention, early intervention and diversion strategies for Aboriginal children and young people. Aboriginal communities should be funded to participate in developing the strategy.
2. The strategy should consider and address, among other matters:
    a. legislative reform to enable recognised Aboriginal organisations to design, administer and supervise elements of the youth justice system for Aboriginal children and young people
    b. capacity building and funding for recognised Aboriginal organisations to participate in youth justice decision making in relation to Aboriginal children and young people, and to deliver youth justice services to Aboriginal children and young people
    c. the use of police discretion in the investigation and processing of Aboriginal children and young people, including cautioning, arrest, custody, charging and bail
    d. alternative pre-court diversionary options for Aboriginal children and young people
    e. mechanisms to increase the likelihood of Aboriginal children and young people receiving bail and minimise the number of Aboriginal children and young people on remand, including culturally responsive supported bail accommodation and other bail assistance programs, and legislative reform to require bail decision makers to consider a child's Aboriginal status
    f. mechanisms to support Aboriginal children and young people to comply with the conditions of community-based youth justice orders, to minimise their likelihood of breaching conditions and entering detention.

7.2 Design of new youth justice facilities

As outlined in Section 2, the Government intends to replace Ashley Youth Detention Centre with a 'detention/remand centre', two assisted bail facilities and two supported residential facilities for children and young people leaving detention on a supervised release order (among other pathways in).[1010] The supporting documentation for these facilities does not indicate how they will meet the specific needs of Aboriginal children and young people.

Participants in our consultations with Aboriginal communities told us that, as a general principle, there should be institutions specifically for Aboriginal children, run by Aboriginal communities:

> We need our own Aboriginal people involved with a system to handle our Aboriginal children. Or at least have some Aboriginal Elders on these groups who can have some input. Trained professionals that have a cultural understanding and not just a textbook understanding—we need those people to guide and make and create those places.[1011]

One participant suggested establishing an alternative to Ashley Youth Detention Centre where children and young people are guided by Elders in a homelike environment:

> … where children are treated with respect, and treat us with respect … they need to be with their people … in a place where they are safe mentally and emotionally.[1012]

Another participant referred to a system where Aboriginal children and young people are 'sent to "healing" places for Aboriginal people rather than jail'.[1013] Other participants highlighted the need for an alternative to Ashley Youth Detention Centre, where Aboriginal children and young people can be 'reconnected with their culture'.[1014]

Some participants referred to an earlier program for Aboriginal children and young people that was run by the Tasmanian Aboriginal Centre on Lungtalanana/Clarke Island in Bass Strait.[1015] There were mixed views among Aboriginal community members about this program. Heather Sculthorpe, Chief Executive Officer, Tasmanian Aboriginal Centre, told us that there were challenges in managing this program:

> … we got funding so that kids didn't have to go to Ashley, kids didn't have to get sent away. In the end the State defunded that because not enough kids were using it, and we tried to say, well, we can't just put people on that island to look after kids. When Ashley decides to let a kid leave, we can't just find people then, we have to have them all the time and equipped to look after the children who are there. There's also some difficulty in young people not wanting to be isolated there and wanting to spend time with their mates, so it was not well attended but it was certainly not well funded: I think it got $140,000 a year.[1016]

In 2007, a Select Committee of the Tasmanian Parliament recommended that the Government assess the 'efficiency and benefits of alternate strategies such as the diversion of Aboriginal youth to Clarke Island-based programs'.[1017] In its response to the Select Committee's report, the Government noted that retaining and developing programs such as those on Clarke Island was 'extremely important'.[1018]

Ms Sculthorpe indicated that after the Clarke Island program ended, the Tasmanian Government began sending Aboriginal children to the Many Colours One Direction program in the Northern Territory, which was highly problematic.[1019] That program is discussed in Chapter 9.

In its *Our Youth, Our Way* inquiry report, the Victorian Commission for Children and Young People found that Victoria's youth justice centres were harmful, often unsafe environments for Aboriginal children and young people.[1020] It examined best practice youth justice facilities internationally and concluded that small, homelike residences could:

- reduce young people's stress, improve their behaviour and increase the likelihood that they will engage in rehabilitation
- allow staff to build relational security rather than relying on physical restraints, resulting in fewer adverse incidents
- provide the opportunity to place children and young people closer to their families
- enable flexibility for community members to be part of the daily life of the residence
- give children and young people more opportunities to build social skills and connections that could improve their chances of successfully returning to the community.[1021]

The Victorian Commission for Children and Young People recommended that, as a step towards having no Aboriginal child or young person in custody, the Victorian Government should work with Aboriginal communities to establish three small, homelike facilities for Aboriginal children and young people serving custodial sentences.[1022] The recommended facilities should each have no more than six beds and allow for Aboriginal children and young people to connect with their culture and community.[1023]

The facilities would need to provide therapeutic, trauma-informed care, including mental health support and drug and alcohol treatment, as well as access to education.[1024] They should also employ Aboriginal staff who are trained to resolve conflict through restorative justice approaches.[1025]

The Victorian Commission for Children and Young People indicated that, while there should be Aboriginal community involvement in setting up and managing these facilities—possibly via a 'joint government and community management model'—it was not aware of an Aboriginal community or Aboriginal organisation in Victoria that wanted to fully manage a closed facility for sentenced Aboriginal children and young people.[1026]

The Victorian Commission for Children and Young People separately recommended establishing two small, homelike, non-secure facilities to provide therapeutic and culturally appropriate care for Aboriginal children and young people with highly complex needs who were likely to be refused bail based on their high risk of further offending.[1027] These facilities would be based on the Oranga Tamariki remand homes in New Zealand.[1028]

In Chapter 9, we recommend that the Tasmanian Government works with Aboriginal communities to establish fully resourced, Aboriginal-led, therapeutic residential programs for Aboriginal children who have been removed from their families under the Children, Young Persons and Their Families Act, and for whom an appropriate placement with an Aboriginal carer cannot be found (Recommendation 9.15). Such residential programs should be separate from any facilities designed for Aboriginal children who are on remand or serving a custodial sentence.

We acknowledge that creating residential facilities specifically for Aboriginal children and young people in the youth justice system may be impractical in a jurisdiction such as Tasmania, where the custodial sentenced and remand populations are small. There is a risk that Aboriginal children and young people would feel 'siloed' in such facilities. We also note that it may not be appropriate for an Aboriginal organisation to manage a secure facility for sentenced Aboriginal children and young people in Tasmania. These issues require more consideration, in partnership with Aboriginal communities.

Regardless of whether a detention or remand facility specifically for Aboriginal children and young people is established, it is important to ensure any new facilities are culturally safe and designed to meet the specific needs of Aboriginal children and young people.

Cultural safety (discussed in Section 7.3) is affected by the physical design of custodial facilities—well-designed indoor and outdoor cultural spaces can 'provide opportunities for education, reflection, sharing stories and mentoring' and promote strong connection to culture for Aboriginal children and young people.[1029] Such connection is essential for the wellbeing of Aboriginal children and young people and is a protective factor against child sexual abuse.

Poorly designed spaces can have the opposite effect. An Aboriginal Elder told us that when she visited Ashley Youth Detention Centre, she was not given a culturally appropriate space (for example, outdoors) to spend time with Aboriginal young people, describing the environment as 'too institutionalised'.[1030]

Cultural safety for Aboriginal children and young people in detention also requires:

- the availability of cultural programs delivered by Aboriginal organisations
- regular and consistent access to family and community members
- the presence and support of Aboriginal staff.

These issues are discussed in more detail in Section 7.3.

The Tasmanian Aboriginal Legal Service has recommended that:

> Tasmania's Aboriginal communities be included as co-designers of facilities, infrastructure, programs and intended outcomes for replacement(s) for the Ashley Youth Detention Centre in order to ensure that facilities are culturally safe for Aboriginal children and young people as well as trauma- and sexual-abuse-informed and sensitive to other specific needs including disability and drug and alcohol problems.[1031]

We agree, and recommend that these issues be examined in the context of the Aboriginal youth justice strategy recommended in Section 7.1.

Recommendation 12.28

The Tasmanian Government should ensure:

a. any new facilities intended to replace Ashley Youth Detention Centre are co-designed with Aboriginal communities and include culturally enriching environments for Aboriginal children and young people that promote connection to family, community and Country

b. the Aboriginal youth justice strategy (Recommendation 12.27) considers whether a small, homelike facility that has Aboriginal staff, provides trauma-informed care and enables Aboriginal children and young people to connect with culture through the involvement of local Aboriginal communities, should be established specifically for Aboriginal children and young people who are remanded or serving a custodial sentence. Careful consideration should be given to the most appropriate management model for such a facility.

7.3 Cultural safety in youth detention

According to SNAICC – National Voice for our Children, and the Victorian Aboriginal Child Care Agency, 'cultural safety' is:

> … the positive recognition and celebration of cultures. It is more than just the absence of racism or discrimination and more than 'cultural awareness' and 'cultural sensitivity'. It empowers people and enables them to contribute and feel safe to be themselves.[1032]

A culturally safe environment for Aboriginal children and young people is one where they are supported to connect with their culture and develop their identity.[1033] As one participant in our consultations said:

> Culture is the way to come out of it. That's what makes me feel safe. I believe that culture is the answer.[1034]

The *Take Notice, Believe Us and Act!* report we commissioned found that most Aboriginal children and young people interviewed for the report did not know what cultural safety was, which suggests that it is not embedded in the organisations with which they interact.[1035] That report concluded:

> Organisations need to foster environments that promote cultural safety and recognise the ways that culture and connection can be protective and act to empower children and young people from Aboriginal and culturally and linguistically diverse backgrounds.[1036]

As noted in Chapter 9, for Aboriginal children and young people, connection to culture through family and community can increase protective factors against the risk of sexual abuse by helping to develop identity and a sense of belonging and by fostering high self-esteem, emotional strength and resilience.[1037]

Conversely, Aboriginal children and young people who are disconnected from their family, community and culture are 'at great risk of psychological, health, developmental and educational disadvantage' and 'suffer as children and later as adults from the grief and loneliness of not belonging'.[1038] This includes Aboriginal children who are disconnected from their families, communities and culture when they are remanded or sentenced to detention.

It is therefore essential that Tasmania's youth detention facilities support Aboriginal children and young people to maintain or build connections to family, community and culture while they are detained. For Aboriginal children and young people in youth detention who have previously been removed from their immediate families by the child protection system, connection to extended family, kin and Aboriginal community members is vital.

7.3.1 Identifying Aboriginality

For youth detention facilities to be culturally safe for Aboriginal children and young people, staff must accurately identify the Aboriginal status of those in detention.

As discussed in Chapter 9, in almost every meeting we had with Aboriginal communities, participants raised concerns about how Aboriginal status is determined in Tasmania and who is responsible for determining it. Ms Sculthorpe of the Tasmanian Aboriginal Centre also raised these issues in her evidence.[1039] In Chapter 9, we note that it is beyond the scope of our Inquiry to make recommendations on these questions.

However, it is within our terms of reference to address the increased risk of sexual abuse that Aboriginal children and young people face in youth detention due to their over-representation in the youth justice system. To provide adequate protection and support to Aboriginal children and young people in detention in relation to the risk of sexual abuse, it is important to ensure the Aboriginal status of children and young people in detention is accurately identified and recognised, so all Aboriginal children and young people in detention can be supported to stay connected to family, community and culture.

The Department's written procedure for admitting a child or young person into detention states that if the person is known to Community Youth Justice, their Aboriginal status must be collected from the Youth Justice Information System, and this information must be added to the 'Admissions Checklist'.[1040] The former Department of Health and Human Services had a department-wide procedure that required all staff of Children and Youth Services to determine a client's Aboriginal status every time the client 'commence[d] an involvement with' Children and Youth Services.[1041] This procedure continues to apply to children and young people being admitted to youth detention.[1042]

Secretary Pervan told us that the 'admission and induction process ask[s] direct questions concerning [A]boriginality'.[1043] He also told us that Aboriginal status is recorded at Ashley Youth Detention Centre through self-identification and 'may be updated throughout a young person's involvement with Youth Justice, which results in data that is changeable over time'.[1044]

The Commissioner for Children and Young People has previously observed about the out of home care system that children's Aboriginal status is not always consistently identified or recorded.[1045] Secretary Pervan told us that the former Department of Communities was 'improving collection and completion of Aboriginal status for children at the Advice and Referral Line and Child Safety Service'.[1046]

Nevertheless, we recommend in Chapter 9 that the Tasmanian Government ensures the Aboriginal status of all Aboriginal children in contact with Child Safety Services is accurately identified and recorded at the earliest opportunity (Recommendation 9.15). We anticipate that this would also result in better identifying Aboriginal status for children and young people entering youth detention.

Secretary Pervan told us that the induction assessment at Ashley Youth Detention Centre identifies a young person's:

> … background, physical and mental health, literacy, drug use, disability, indigenous status, familial and personal relationships and the young person's identified gender and sexuality (as identified by them). The assessment then allows for meaningful supports to be put into place that address their specific needs, and that they are stable and informed about their rights and routine before moving into a unit with other young people.[1047]

He also said that 'connection with community [E]lders' is sought for Aboriginal children and young people.[1048]

Where a child identifies as Aboriginal, the custodial case management guidelines require admissions staff to contact the Tasmanian Aboriginal Centre within 12 hours of the child's admission into detention.[1049] However, the guidelines do not specify what role the Tasmanian Aboriginal Centre is to perform in respect of case management for the child, nor do they contemplate the possibility of the child wanting to be supported by an Aboriginal organisation other than the Tasmanian Aboriginal Centre.

We understand that, in some cases, a worker from the Tasmanian Aboriginal Centre has been involved in case management meetings, conferencing and exit planning for Aboriginal children and young people at Ashley Youth Detention Centre, but we did not receive detailed evidence on this.[1050]

The admission procedure and custodial case management guidelines should be updated to require custodial staff to:

- ask children and young people who identify as Aboriginal whether they would like the support of an Aboriginal organisation (whether a recognised Aboriginal organisation or otherwise) or an Aboriginal community member while they are detained
- notify the relevant organisation or individual within 12 hours of the child or young person's admission
- facilitate the involvement of the child or young person's nominated representative in case planning, case management and exit planning in respect of the child or young person.

7.3.2 Cultural support and programs

Several of the children and young people interviewed for the *Take Notice, Believe Us and Act!* report indicated that they were Aboriginal, but none identified ways in which organisations were taking steps to ensure their cultural safety.[1051]

Victim-survivor Charlotte (a pseudonym), who is Aboriginal and was detained in the 2000s, told us she did not receive any cultural support when she was in Ashley Youth Detention Centre (refer to Chapter 11, Case study 1).[1052] Participants in our consultations with Aboriginal communities told us that the cultural needs of Aboriginal children and young people in Ashley Youth Detention Centre were not being met.[1053] One community member said:

> All the kids in jail are lost. They have lost their culture and community, and there is nothing for them to connect with when they are feeling low.[1054]

During our visit to Ashley Youth Detention Centre in August 2021 (discussed in Chapter 2), we observed only a few small signs or symbols to celebrate or recognise Aboriginal culture compared with the youth detention facilities we visited interstate, which had large, landscaped cultural outdoor areas and Aboriginal artwork and posters.

The Department provided us with a copy of its *Guidelines for Working with Young Aboriginal People and Other Young People from Culturally and Linguistically Diverse (CALD) Backgrounds*, dated August 2010.[1055] According to this document:

- case management staff will 'take responsibility for including any cultural needs in a young person's case plan and ensure that appropriate programs/practices are implemented and monitored'
- case management staff will 'seek and pay particular notice of cultural advice from family and the cultural community of the young person'
- a young person's cultural needs will be clearly conveyed to the unit staff responsible for day-to-day management and relayed to staff if the young person is transferred to another unit.[1056]

However, beyond a requirement to notify the Tasmanian Aboriginal Centre of the child's admission to custody, this document does not include any detail on how to meet the cultural needs of Aboriginal children in detention.[1057] In particular, it does not require staff to determine whether an Aboriginal child or young person already has a cultural support plan, nor does it provide any guidance on how to identify the cultural support needs of an Aboriginal child in detention.

Also, by including children and young people from culturally and linguistically diverse backgrounds and referring broadly to 'cultural needs', these guidelines fail to acknowledge or identify the unique experiences and needs of Aboriginal children and young people in detention.

Counsel Assisting our Inquiry asked Secretary Pervan to describe the extent to which there were programs at Ashley Youth Detention Centre to meet the needs of Aboriginal children and young people.[1058] In response, Secretary Pervan said:

> My understanding is that it actually depends on the child and which particular community they are from. The involvement and engagement of some community-controlled organisations is at a higher level and more direct, particularly for some young people; with others it's less so; it depends on the engagement and capability of the community organisation that's most representative of the young people in Ashley. It's something that we have invited, it's something that we're very keen to increase, and is part of our commitment through the Closing the Gap national agreements.[1059]

Secretary Pervan did not offer any more detail on the cultural support provided to Aboriginal children and young people in detention—for example, on specific cultural

programs that are being or have been run. We also note that the Custodial Inspector's 2019 *Equal Opportunity Inspection Report* on Ashley Youth Detention Centre failed to discuss this issue in any detail, finding that 'for the most part, young people at [Ashley Youth Detention Centre] are treated fairly and equitably'.[1060]

Dr Michael Guerzoni, Indigenous Fellow—Academic Development, University of Tasmania, told us that it is important for Aboriginal children and young people in detention to receive cultural immersion and cultural support, and for 'their Indigeneity [to be] encouraged and supported'.[1061]

Participants in our consultations with Aboriginal communities also told us that connection with culture for Aboriginal children and young people in detention is essential.[1062] Several Elders indicated that they used to visit Aboriginal children and young people in Ashley Youth Detention Centre as part of various programs, with one commenting:

> I loved seeing the kids at Ashleys. They could just be themselves, have a yarn. Your heart broke when you left.[1063]

The Department did not provide us with any information about these programs, although it did provide a copy of a 2021 Ashley Youth Detention Centre newsletter that refers to '[c]ultural story sharing with … an Aboriginal Elder', which would 'lead to the design of a yarning circle [and] bush tucker garden to be developed in the outdoor area'.[1064]

Cultural programs such as visiting Elders programs are an important way to support cultural connection for Aboriginal children and young people in detention. In our consultations with Aboriginal communities, we also heard that on-Country programs can help Aboriginal children and young people 'feel proud of themselves, release emotions and learn about themselves'.[1065] However, participants also referred to the absence of cultural programs, such as men's or women's 'sheds' in some areas, noting that some earlier programs had been discontinued.[1066]

Connection to culture for Aboriginal children and young people in detention could also be facilitated through a mentoring program. The Victorian Commission for Children and Young People has highlighted the benefits of cultural mentors for Aboriginal children and young people who are in contact with the youth justice system, particularly where programs use mentors with lived experience of the youth justice system, who can be 'credible messengers' in providing support to Aboriginal children and young people.[1067] Mentoring programs for children and young people in contact with the youth justice system have also been shown to reduce offending behaviour.[1068]

The Tasmanian Aboriginal Legal Service has referred to the potentially 'huge impact' of positive role models with lived experience of the youth justice system acting as mentors for Aboriginal children and young people in contact with the system.[1069]

Participants at one of our consultations with Aboriginal community members referred to the positive contributions of an Aboriginal worker based in an Aboriginal organisation who has lived experience of the youth justice system and has developed a strong rapport with Aboriginal children and young people in detention.[1070] Madeleine Gardiner, former Manager, Professional Services and Policy at Ashley Youth Detention Centre, also referred to this 'respected Aboriginal mentor' who performs positive work in Ashley Youth Detention Centre.[1071]

7.3.3 Visits, temporary leave and phone calls

Visits, temporary leave and phone calls are also important means of enabling Aboriginal children and young people in detention to stay connected to family, community and culture.

As discussed in Section 6.7, children and young people at Ashley Youth Detention Centre:

- have the right to regular contact with family members through personal visits, but management can refuse a visit if it believes that the 'security, safety or good order of the Centre or the health or well-being of the young person may be adversely affected by allowing the visit'[1072]
- can apply for temporary leave from the Centre—applications must undergo a thorough risk assessment, including consideration of the young person's 'behaviour and attitude at or near the time of the proposed leave', any history of threats or attempts to abscond, and the young person's 'recent and current colour status' under the Behaviour Development Program[1073]
- can make seven phone calls each week and are entitled to extra calls if they achieve 'yellow' or 'green' status in the Behaviour Development Program.[1074]

Ms Gardiner described two occasions where Aboriginal young people were denied visitation rights in circumstances where the visits were therapeutically important for these young people.[1075] The first occasion involved an Aboriginal young person being refused a visit from his brother in 2018, with no valid rationale apparent to Ms Gardiner.[1076] Ms Gardiner successfully appealed this decision.[1077]

In the second case, in 2019, Ms Gardiner's team had organised for a mentor from an Aboriginal organisation to visit Ashley Youth Detention Centre and sit with an Aboriginal young person while he viewed video footage from his father's funeral, which he had earlier been denied permission to attend.[1078] Although the mentor's visit was initially approved, Ms Gardiner later discovered that it had been cancelled by Ashley Youth Detention Centre management, without consultation, on the day it was scheduled to occur.[1079] The reason provided to Ms Gardiner for the cancellation was that there were not enough staff to supervise the visit.[1080] She described these decisions as 'not child-focused' and 'very insensitive'.[1081]

Were these situations to occur in future, we hope they would be approached with awareness of and sensitivity to the cultural needs of Aboriginal children and young people in detention on the part of Ashley Youth Detention Centre management and staff. Attendance at funerals can be an important way to maintain family connection and fulfil cultural obligations.[1082] Where this is not possible, every effort must be made to enable Aboriginal children and young people to take part in important cultural rituals in alternative ways.

We are also concerned that custodial policies allow the denial of an application for temporary leave to attend a family funeral based on a child or young person's recent behaviour and status in the Behaviour Development Program. The behaviour of a child or young person whose family member has recently died may be exacerbated by grief and trauma, and this should not be a reason to deny them access to their family.

We did not hear any evidence specifically about the ability of Aboriginal children and young people to make or receive phone calls from Ashley Youth Detention Centre. However, we consider that it is problematic to link a child's right to contact their family or community with the child's behaviour.

In Section 6.7.5, we recommend that the Department:

- develops and implements a policy on the importance to children and young people in detention of maintaining or building connections with their family and community that specifies ways to promote such connections and clearly states that entitlements to visits, temporary leave and phone or video calls cannot be denied on the basis of a child or young person's behaviour
- provides reasonable assistance (including financial help) to members of a child or young person's family or Aboriginal community to enable them to visit the child or young person frequently in detention (Recommendation 12.23).

7.3.4 Recruitment of Aboriginal staff

As noted, the National Royal Commission recommended that governments consider strategies for recruiting and developing Aboriginal staff to work at all levels of the youth justice system.[1083] Despite the substantial over-representation of Aboriginal children and young people in youth detention in Tasmania, the staffing structure for Ashley Youth Detention Centre provided to us by Secretary Pervan does not include any role(s) dedicated specifically to the wellbeing of Aboriginal children and young people in detention, such as an Aboriginal liaison officer.[1084]

Victim-survivor Charlotte (a pseudonym) told us that there was no one in Ashley Youth Detention Centre in the 2000s who helped her to feel culturally safe.[1085] She said that it would have made a difference while she was in the Centre if she had been supported by an Aboriginal worker to whom she could have disclosed the abuse she had experienced:

> There was none at that stage for anyone that was Aboriginal. I've been to [adult] jails in the past, like after that, and the Aboriginal support, like, the support workers that help, they do so much for people. Like, they need more of it and they definitely needed someone like that in [Ashley Youth Detention Centre], like, that you could go to tell stuff like that.[1086]

In its 2021 *Our Youth, Our Way* inquiry report, the Victorian Commission for Children and Young People found that Aboriginal liaison officers in Victoria's youth justice centres played an important role in supporting the cultural needs of Aboriginal children and young people in detention by contributing to the work of care teams, making sure Aboriginal children's voices are heard in decision making about them and generally supporting them.[1087] The *Our Youth, Our Way* report quotes the lead consultant forensic psychiatrist for Victoria's youth justice centres on the positive contribution that Aboriginal liaison officers make to therapeutic treatment for Aboriginal children and young people:

> Having [Aboriginal liaison officers] there completely changes the therapeutic results. The Aboriginal clients suddenly open up and the [Aboriginal liaison officers] do a ton of work explaining to the young person how it's going to work and that it's just a chat. If I was designing the perfect service, we would have one-on-one support for every Aboriginal young person.[1088]

However, the Victorian Commission for Children and Young People also found that, despite the value placed in Aboriginal liaison officers by the youth justice system, these roles were overloaded and experienced high turnover.[1089] It recommended that the Victorian Department of Justice and Community Safety review the Aboriginal liaison officer program to assess how it could best meet the competing needs and demands placed on it.[1090]

Participants in our consultations with Aboriginal communities similarly told us that Aboriginal liaison officers in schools were overloaded and not adequately resourced, and that more training and support was needed for people to take on these and similar roles.[1091]

We consider that there would be considerable benefit in establishing an Aboriginal liaison officer role or roles in Ashley Youth Detention Centre and any replacement detention facilities. The primary function of the Aboriginal liaison officer should be to support Aboriginal children and young people in detention. This should include involvement in case management and exit planning, and facilitating cultural support for Aboriginal children and young people. Aboriginal liaison officers should be identified positions.

In establishing these roles, the Tasmanian Government should ensure appointees are not overloaded and that they receive professional development, including training, in working with children and young people who have experienced trauma.

In Chapter 9 and Section 11.4 of this chapter, we recommend establishing an independent community visitor scheme for children and young people in out of home care and youth detention (Recommendations 9.34 and 12.36). This scheme would involve independent community visitors appointed by the new Commission for Children and Young People (Recommendation 18.6) undertaking weekly (or more frequent) visits to children and young people in detention, building trusting relationships with them, listening to any of their concerns about their treatment in detention and advocating on their behalf (this is discussed in Section 11.4). We recommend that, wherever possible, Aboriginal children and young people have access to an Aboriginal independent community visitor (Recommendation 12.36).

While Aboriginal liaison officers and independent community visitors would each be responsible for developing trusting relationships with Aboriginal children and young people in detention, we consider that their functions are different and that there is an important role for both. Aboriginal liaison officers would be employed by the Department and would be involved with Aboriginal children and young people on a day-to-day basis, providing them with cultural and other support. In contrast, independent community visitors would offer an external oversight mechanism for the safety and wellbeing of Aboriginal children and young people in detention and, where needed, advocate on their behalf to help to resolve their concerns.

7.3.5 Professional development for custodial staff

As noted, the National Royal Commission pointed to the need for culturally competent staff in custodial facilities who understand the needs and experiences of Aboriginal children in detention.[1092]

The Ashley Youth Detention Centre Learning and Development Framework (discussed in Section 4.7.1) indicates that staff undergo mandatory 'Aboriginal Cultural Awareness' training, and that '[c]ultural awareness will be embedded in all learning and development opportunities'.[1093] The evidence we heard (detailed in this section) indicates this training has not resulted in a culturally safe environment that responds to the specific experiences and needs of Aboriginal children and young people.

As discussed in Section 6.3, staff in detention facilities need to be equipped with the skills to undertake trauma-informed, evidence-based interventions with all children and young people in detention—many of whom have experienced significant trauma and may be engaging in challenging behaviours—without resorting to the use of force or isolation. However, to provide such interventions for Aboriginal children and young people, custodial staff also need to understand the nature and impacts of intergenerational trauma experienced by Aboriginal communities; the effects of dislocation from family, community and Country on Aboriginal children's wellbeing; and the need for Aboriginal children to be connected to culture while in detention.[1094] The training Ashley Youth Detention Centre staff receive does not appear to be equipping them with this knowledge or these skills.

Research indicates that, nationally, Aboriginal young people aged between 15 and 24 years are more than five times more likely to self-harm than non-Aboriginal young people and that the risk of self-harm is compounded for Aboriginal children and young people in detention, where there is also a high prevalence of self-harming behaviour.[1095]

The Ashley Youth Detention Centre *Suicide and Self-Harm Prevention Procedure* has only one reference to Aboriginal children and young people.[1096] This occurs in the context of discussion about the ongoing therapeutic management of a child or young person who has been the subject of a 'suicide and self-harm notification'.[1097] The procedure states that the 'risk intervention team' must discuss and agree on the type and level of interaction that the young person should have with parents, residents, staff members and other support people, noting that 'increased access to family may be an important protective factor' for Aboriginal children and young people.[1098]

In its *Our Youth, Our Way* inquiry report, the Victorian Commission for Children and Young People found that Aboriginal children and young people were substantially over-represented in incidents involving attempted suicide and self-harm in Victoria's youth justice centres, possibly indicating that Aboriginal children and young people were experiencing high levels of distress at being incarcerated.[1099] The Commission for Children and Young People recommended that the Victorian Department of Justice and Community Safety develop a strategy to provide consistent and therapeutic responses to children and young people at risk of suicide or self-harm in detention, including specific elements to ensure a culturally safe response to Aboriginal children and young people.[1100]

The Draft Youth Justice Blueprint refers to the need for the youth justice workforce to be:

> … culturally competent so it can support and respond to the needs of Aboriginal children and young people in the youth justice system and work with Aboriginal communities across the continuum to help them support their children and young people.[1101]

Also, as outlined in Section 6.3.3, the Keeping Kids Safe Plan states that the Australian Childhood Foundation Centre for Excellence in Therapeutic Care started a review of the Learning and Development Framework in September 2022.[1102] This review was due to be completed by 31 January 2023.[1103] In June 2023, the Department advised that the review was progressing and was anticipated to be completed by 30 June 2023.[1104] We have not been provided with the review's findings or recommendations.

In updating the Learning and Development Framework, the Tasmanian Government should ensure the framework is designed to equip staff with the knowledge and skills to provide a culturally safe environment for Aboriginal children and young people, including responding in trauma-informed and culturally safe ways to Aboriginal children and young people who are engaging in self-harm or other challenging behaviours.

Recommendation 12.29

The Tasmanian Government should take steps to ensure Ashley Youth Detention Centre and any replacement facilities are culturally safe for Aboriginal children and young people. These steps should include:

a. updating admission procedures and case management guidelines to require staff to

   i. ask children and young people who identify as Aboriginal whether they would like the support of an Aboriginal organisation or an Aboriginal community member while they are detained

   ii. notify the nominated organisation or individual within 12 hours of the child or young person's admission

   iii. facilitate the involvement of the child or young person's nominated representative in case planning, case management and exit planning in respect of the child or young person

b. updating relevant guidelines and procedures to require staff to consult with an Aboriginal child or young person's community to determine how best to provide individual cultural support to the child or young person while they are in detention

c. working with Aboriginal communities to establish ongoing cultural programs for Aboriginal children and young people in detention, such as visiting Elders programs, on-Country programs and cultural mentoring programs

d. ensuring the new policy on supporting children and young people in detention to maintain connections to their families and communities (Recommendation 12.23) emphasises the central importance of connection to family, community and culture for the wellbeing of Aboriginal children and young people in detention

e. establishing the role of Aboriginal liaison officer in youth detention to support Aboriginal children and young people, including by facilitating cultural support and becoming involved in case planning, case management and exit planning

f. ensuring the updated Ashley Youth Detention Centre Learning and Development Framework is designed to equip staff with the knowledge and skills to provide a culturally safe environment for Aboriginal children and young people, including providing trauma-informed and culturally safe responses to children and young people engaging in self-harm or other challenging behaviours.

7.4 Support for Aboriginal children leaving detention

As discussed in Section 6.8, we heard about a lack of effective support for children and young people leaving detention ('throughcare support') in Tasmania.[1105] Many participants in our consultations with Aboriginal communities commented on the absence of support for Aboriginal children and young people who are released from Ashley Youth Detention Centre.[1106] Some referred to the lack of safe and stable homes for Aboriginal children to return to:

> I remember one kid who couldn't go home afterwards because his dad and pop were on the drugs. There was nothing you could do.[1107]

Many participants commented that the absence of throughcare support for Aboriginal children and young people created a high risk that they would engage in further offending and return to detention:

> When our kids are in Ashleys, they've got nowhere to go, nothing to do, no follow up … that's a really big problem. They reoffend and go back in there again.[1108]

Another participant said:

> If they come out and go back to the same community, then what happens? They just go back to where they were before, and then end up back in Ashleys.[1109]

One Aboriginal community member suggested that, for some Aboriginal children and young people, the relative stability provided by Ashley Youth Detention Centre was preferable to their circumstances following release:

> … some kids would get themselves in trouble so they could go back there, because they don't have anywhere else to go, they just go home to drugs and abuse … for some of them it's a roof over their heads, it's meals three times a day.[1110]

These comments raise serious concerns about the Tasmanian youth justice system and related service systems, most notably the housing, child protection and out of home care systems. There is clearly an urgent need to address the lack of support for Aboriginal children and young people leaving detention in Tasmania.

Participants in our consultations with Aboriginal communities felt that support for Aboriginal children and young people following their release from youth detention should include housing, cultural support, drug and alcohol services and educational support.[1111]

As outlined in Section 6.8.2, the Draft Youth Justice Blueprint refers to the commencement of service planning at the earliest opportunity for a young person in contact with the youth justice system.[1112] This is welcome, but it is concerning that the Draft Youth Justice Blueprint does not refer to throughcare support specifically for Aboriginal children and young people, given the substantial over-representation of Aboriginal children and young people in detention.

We also welcome the Government's proposed supported residential facilities as temporary or transitional accommodation for children and young people released from detention (refer to Section 6.8.2). However, again, we note that the limited information provided about these facilities does not include any detail on how they will meet the particular needs of Aboriginal children and young people.[1113]

The North Australian Aboriginal Justice Agency provides a throughcare program for Aboriginal children and young people in youth detention in the Northern Territory.[1114] Case managers in this program support Aboriginal children and young people preparing to leave detention to 'help young people and their families develop strong and holistic post-release plans that address their goals, risks and transitional needs'.[1115] The program provides case management support following release for as long as the young person wants to remain involved, and there is an identified need.[1116]

The Victorian Aboriginal Child Care Agency manages the Youth Through Care program for Aboriginal children and young people aged 10 to 17 years in detention in Victoria. This program is funded by the National Indigenous Australians Agency.[1117] The program works to reduce reoffending by supporting Aboriginal children and young people through an 'intensive, holistic, client-centred, culturally appropriate and trauma-informed model with strong connection to family and Country'.[1118]

Youth Through Care program workers provide individual case management that starts from an Aboriginal child's or young person's entry into detention and continues for up to 24 months following their release.[1119] Post-release support can include helping children and young people attend Centrelink appointments, providing transport to and from drug and alcohol services, and visiting them in residential care or at home to provide social and emotional wellbeing support.[1120] Program workers may also provide outreach to the families of Aboriginal children and young people where the child or young person has not had recent contact with their family or if the worker has concerns about the welfare of a parent or carer of the child or young person.[1121]

We recognise the significant benefits of these programs but acknowledge that in a small jurisdiction such as Tasmania it may not be feasible to establish a separate throughcare support service for Aboriginal children and young people. In Section 6.8.3, we recommend that the Government establishes an integrated throughcare service for children and young people in detention that starts exit planning as soon as possible after a child or young person enters detention. This service should plan for safe and stable accommodation, access to physical and mental health support and help with education and employment after release to facilitate children and young people's reintegration into the community (Recommendation 12.24). This service must be culturally safe for Aboriginal children and young people, and responsive to their needs.

8 Harmful sexual behaviours in youth detention

Harmful sexual behaviours are highlighted as a concern in several chapters of our report. In Chapter 6 on education and Chapter 9 on out of home care, we explore the need for appropriate prevention and intervention responses for harmful sexual behaviours in those settings. In Chapter 21, we discuss the need for a statewide approach to therapeutic interventions for children who have engaged in harmful sexual behaviours.

As discussed in these other chapters, harmful sexual behaviours are generally considered to be:

> … sexual behaviours displayed by children and young people that fall outside what may be considered developmentally, socially, and culturally expected, may cause harm to themselves or others, and occur either face to face and/or via technology. When these behaviours involve another child or young person, they may include a lack of consent, reciprocity, mutuality, and involve the use of coercion, force, or a misuse of power.[1122]

Harmful sexual behaviours are a known risk in youth detention and there must be measures in place to address this risk.[1123] In this section, we consider the significant improvements that must be made for Ashley Youth Detention Centre and any future detention facilities to better prevent and respond to harmful sexual behaviours among children and young people in these facilities.

We recommend that the Department develops a clear policy for preventing and responding to harmful sexual behaviours in youth detention. This policy must consider the full range of harmful sexual behaviours that may occur in those settings, so all children and young people involved can receive assistance. While we focus on youth detention in this section, the policy should also apply to other residential youth justice facilities such as the Government's proposed assisted bail facilities (discussed in Section 5.4) and supported residential facilities (discussed in Section 6.8).

8.1 National Royal Commission

The National Royal Commission found that harmful sexual behaviours can often occur as a result of trauma, which many children in youth detention have experienced.[1124] The National Royal Commission also identified an increased risk of harmful sexual behaviours in youth detention, noting:

> The risk of children sexually abusing other children may be high in youth detention because children who have harmful sexual behaviours or have engaged in criminal or antisocial behaviour are disproportionately clustered in youth detention institutions, and placement decisions involving highly complex children with serious backgrounds of offending are challenging for administrators. Many children with harmful sexual behaviours may also model their behaviour on how they see adults or older children behave in institutions.

> Research also suggests that many children with harmful sexual behaviours act impulsively rather than in a premeditated manner. They may also be motivated by exerting power over or perpetrating violence towards other children.[1125]

The National Royal Commission made several recommendations relevant to harmful sexual behaviours in youth detention, including:

- Institutions need policies and procedures to understand, prevent and respond to harmful sexual behaviours.[1126]
- Children and young people should be assessed for risk for vulnerability to engaging in, or being subject to, harmful sexual behaviours before being placed in a detention centre. Placement decisions and supervision should be informed by these risk assessments to ensure the safest possible placements are provided for children.[1127]
- Children and young people who have displayed harmful sexual behaviours should have access to timely, expert assessment and a range of appropriate, coordinated interventions, including therapeutic interventions.[1128]
- Staff should receive training and ongoing professional development in trauma-informed care, including identifying and responding to harmful sexual behaviours and the needs of children and young people at risk of engaging in, or being subject to, harmful sexual behaviours.[1129]
- The facility should incorporate building and design features that reduce opportunities for harmful sexual behaviours to occur and monitor interactions between children and young people without infringing on children's privacy.[1130]
- Child-focused measures should exist to assist disclosure of harmful sexual behaviours such as children and young people having access to 'maximum contact' with trusted adults such as family, friends and community, and access to effective internal and external complaints-handling systems.[1131]

We discuss some of these issues—such as building design, increased access to trusted adults and effective complaints processes—in other sections of this chapter, as they relate to reducing the risk of all types of child sexual abuse in youth detention. In this section, we focus on recommendations specifically related to preventing and responding to harmful sexual behaviours in this setting.

We consider it useful to move beyond the National Royal Commission recommendations on risk assessments for harmful sexual behaviours to differentiate between screening assessments to accurately identify harmful sexual behaviours and clinical assessments for harmful sexual behaviours where risk is one component of the assessment. We elaborate on this approach in Section 8.4.2.

8.2 Harmful sexual behaviours at Ashley Youth Detention Centre

In her hearing evidence, the Director of Strategic Youth Services in the former Department of Communities acknowledged that Ashley Youth Detention Centre has had a longstanding problem with harmful sexual behaviours and has failed to address these behaviours through appropriate responses.[1132]

Since those hearings, the issue has remained a difficult one to address. In a submission to a parliamentary inquiry on adult imprisonment and youth detention, a staff member who worked at Ashley Youth Detention Centre between September and December 2022 stated that harmful sexual behaviours were commonplace and were directed at other young people as well as staff.[1133] The staff member described young people in the Centre as dismissing these incidents as 'just playing, joking around', with no complaints being made by the young people who experienced the behaviour.[1134]

In Chapter 11, Case study 2, we discuss several accounts of harmful sexual behaviours at Ashley Youth Detention Centre of which we were made aware. We identified systemic problems that contributed to the risk of harmful sexual behaviours among young people at the Centre, such as:

- a lack of assessment of the risk of harmful sexual behaviours for young people entering the Centre
- tensions between staff or teams within the Centre who held different views about how to manage the safety of young people
- staff lacking the knowledge to identify and respond appropriately to harmful sexual behaviours
- not always having a skilled investigative team available to the Centre when serious incidents occur.

Many of these problems are addressed by our recommendations in Section 8.5.

8.3 Clinical leadership

We consider that the therapeutic and wellbeing needs of the children and young people involved in harmful sexual behaviours are most likely to be given priority if professional staff with clinical expertise in harmful sexual behaviours are involved in assessing, monitoring and managing harmful sexual behaviours and in placement decisions.

This is a successful approach at Bimberi Youth Justice Centre in the Australian Capital Territory, where the Principal Practitioner, a clinical psychologist, oversees and is involved in decisions about risk, support needs and therapeutic interventions provided to children and young people at that centre.[1135]

Some progress has been made towards increasing clinical input at Ashley Youth Detention Centre. We heard that the Centre's Practice Manager had started meeting weekly, from 18 May 2022, with a Sexual Assault Support Service clinician to discuss any incidents or concerns about harmful sexual behaviours of children and young people in detention.[1136] The Practice Manager position has also been upgraded in pay classification in recognition of its specialised clinical role.[1137] The role includes 'clinical supervision' with operational staff to ensure they respond to disclosures of child sexual abuse in alignment with the advice provided by the Sexual Assault Support Service.[1138]

In its Keeping Kids Safe Plan, the Department stated that it had engaged a Senior Advisor from the Australian Childhood Foundation to provide a range of clinical review and support services for staff at Ashley Youth Detention Centre.[1139] We hope these services relate to harmful sexual behaviours as well as other risk and safety issues, and that this move precipitates a more cooperative relationship between those with clinical expertise and operational staff, as we recommend in Section 6.4.

To achieve greater clinical leadership on harmful sexual behaviours, staff in detention facilities and other residential youth justice facilities need to have ready access to harmful sexual behaviours specialists. In Chapter 9, we recommend establishing a Harmful Sexual Behaviours Support Unit in the new Office of the Chief Practitioner (refer to Recommendations 9.17 and 9.28).

The Harmful Sexual Behaviours Support Unit should support best practice responses in youth detention and other residential youth justice facilities through:

- tele-consults with staff at the facility to assist them in confirming the level of risk posed by behaviours and/or to assist the facility in developing a response plan for inappropriate or concerning sexual behaviours that can be addressed through a local area response without clinical intervention
- assistance in responding to critical incidents involving harmful sexual behaviours, including guidance on reporting, record keeping, clinical assessments and safety planning (including placement and supervision plans)
- support in accessing therapeutic treatment for children displaying harmful sexual behaviours, where this is clinically assessed as appropriate.

Given the unique characteristics of youth detention and the youth justice system, detailed youth justice-specific policies, protocols and practice guidance will be required.

The Harmful Sexual Behaviours Support Unit should support or lead development of these policies, protocols and guidance.

Allied health professionals working on site in youth detention and other residential youth justice facilities could support local clinical leadership in responding to harmful sexual behaviours. In Chapter 9, we recommend that more advanced professional development offerings be made available to relevant staff in the Child Safety Service, schools and youth justice (Recommendations 9.11 and 9.28).

8.4 Preventing harmful sexual behaviours

8.4.1 A proactive approach to sexual safety

Adolescence is a significant period in a child's sexual development. During puberty, adolescents are developing their sexual identity, which often involves consensual sexual exploration with peers. As noted, however, several factors increase the risk of inappropriate and harmful sexual behaviours in youth detention facilities.[1140] At the same time, children in detention are disproportionately likely to have experienced extensive school absenteeism or to have disengaged from education and are consequently less likely to have engaged in sexual health, respectful relationships and sexual safety education in schools.[1141]

These circumstances mean it is essential for youth detention to provide sex education tailored to the needs of a high-risk population. We heard that young people receive the 'Consent is a conversation' program through Ashley School, which promotes 'healthy, respectful intimate relationships'.[1142] We consider, however, that the National Royal Commission's observations indicate that sex education for children and young people in detention should go further. Similar to our recommendation for children and young people in out of home care (refer to Recommendation 9.28), sex education for children and young people in detention should be tailored to that setting and cover issues such as consent and what constitutes sexually abusive behaviours by adults and other children, as well as pornography and its impacts on children's views about relationships, sexuality and gender.[1143]

Further, we consider that a proactive approach for staff and young people in detention should form part of the Department's policy on harmful sexual behaviours in residential youth justice facilities.[1144] As discussed in our out of home care volume (Chapter 9), 'Power to Kids' is an example of a program designed for residential out of home care that could be adapted for use in detention and other residential youth justice facilities. Power to Kids is a multifaceted program proven to reduce the risk to children in residential care of sexual abuse in the form of harmful sexual behaviours, child sexual exploitation and dating violence.[1145] The Power to Kids model includes respectful relationships and sexuality education for the whole facility, including staff and young people, and guidance about responding appropriately to harmful sexual behaviours when they occur.[1146] Such strategies support a shared understanding of appropriate behaviours and a culture that reduces the likelihood that harmful sexual behaviours will occur.[1147]

8.4.2 Identification and assessment

The Government's Fifth Annual Progress Report and Action Plan on implementing the recommendations of the National Royal Commission ('Fifth Annual Report') describes 'new admission practices' whereby children and young people entering Ashley Youth Detention Centre 'undertake the admission induction program in their first week of

custody in which a full risk and needs assessment is carried out'.[1148] The Government stated that '[s]afety is ultimately the deciding factor for each individual unit and program placement' and that sexual and physical safety is taken into account during the risk assessment.[1149]

However, the Centre's current admission process does not include a screening assessment for harmful sexual behaviours.[1150] What is needed is a screening assessment based on an accepted contemporary model of harmful sexual behaviours that admission staff can use—in conjunction with proper training—to identify children and young people who may be likely to engage in harmful sexual behaviours. Those children and young people should immediately be referred to clinical staff for a clinical assessment to understand the child's risks and needs and inform placement decisions, safety planning and therapeutic interventions. The 'Assessment Intervention Moving on (AIM)' assessment framework currently used by the Sexual Assault Support Service is an example of a clinical assessment.[1151]

Also, given the heightened risks of harmful sexual behaviours in youth detention populations, policies and practices need to go beyond an initial assessment and instead provide a framework for recognising and responding to inappropriate and harmful sexual behaviours young people may display throughout their time in detention. The Hackett Harmful Sexual Behaviours Continuum, True Relationship Traffic Lights continuum or Paton and Bromfield Layered Continuum are examples used in Australia that provide a framework for understanding children's sexual behaviours and recognising where those behaviours have the potential to be harmful to the child displaying the behaviours or others.[1152]

8.4.3 Placement decisions

The National Royal Commission recommended that state and territory governments ensure placement decisions in youth detention are informed by an assessment that includes a child's vulnerability to sexual abuse or displaying harmful sexual behaviours.[1153] It identified that children and young people were more at risk from harmful sexual behaviours in youth detention when they were placed with older children and young people or when female children and young people were housed in a predominantly male environment.[1154]

The National Royal Commission acknowledged how challenging placement of children and young people in youth detention centres can be, particularly where there are limited accommodation options, such as having only one detention centre or one that is very small.[1155] We also acknowledge that staff shortages and high detainee-to-staff ratios can complicate placement decisions.

On 31 May 2022, the Department introduced a new *Unit Commissioning, De-Commissioning and Allocation to a Young Person Procedure* ('Unit Placement

Procedure').[1156] The Unit Placement Procedure acknowledges that decisions about unit placement are 'critical, as placement decisions can affect a young person's health and wellbeing by either increasing or decreasing the risk of immediate or future harm'.[1157] The following 'critical requirements' are identified in the Unit Placement Procedure 'in order to ensure the safety of young people':

> All new arrivals will be housed in the admission induction unit.
>
> Male and female detainees will be housed separately. Detainees that identify as transgender will guide their unit placement.
>
> If deemed safe, young people from Aboriginal and Torres Strait Islander backgrounds should room share.
>
> Placement decisions about young people must be made in the best interests of all young people at the Centre.[1158]

The Unit Placement Procedure describes the responsibility of the 'Risk Assessment Process Team' to consider 'the best interests of all affected young people' when determining placements for children and young people in the Centre.[1159] While the team must generally consider '[s]afety and security needs or risks', and gender and '[r]elationship dynamics in the Unit', the Unit Placement Procedure does not mention the risk of harmful sexual behaviours.[1160] We also consider that the Unit Placement Procedure lacks clarity on what 'operational considerations' may influence decisions about unit placement and who will make and review such decisions.

As acknowledged in the Fifth Annual Report, safety considerations should outweigh operational needs in making decisions about the placement of children and young people within detention facilities.[1161] As discussed, we consider that a screening and assessment process that informs the approach to unit and program assignments should occur at admission to minimise risk of the child experiencing or displaying harmful sexual behaviours.

8.4.4 Supervision

The National Royal Commission found that inadequate supervision in youth detention facilities provided more opportunity for harmful sexual behaviours.[1162] Poor supervision was a factor that contributed to a number of the incidents of harmful sexual behaviours in Ashley Youth Detention Centre described in our case studies, especially where other risk factors were present—such as younger children being left unsupervised with older children, or a girl being left unsupervised with boys.[1163]

Installing closed-circuit television cameras could be an alternative to in-person supervision. However, a number of the instances of harmful sexual behaviours described in the case studies occurred in the presence of closed-circuit television cameras, which may indicate that this form of supervision is less effective at deterring harmful sexual

behaviours and should not be relied on as a preventive practice in preference to in-person staff supervision. In Section 4.7, we discuss staffing shortages at Ashley Youth Detention Centre and make recommendations for staff recruitment.

8.5 Responding to harmful sexual behaviours

There must be a clear process for responding to incidents of harmful sexual behaviours when they occur in youth detention or other residential youth justice facilities.

The National Royal Commission stated that an institution's response to an incident of harmful sexual behaviour should involve:

- monitoring the safety and wellbeing of the children and young people involved as well as any children and young people who witnessed the incident
- complying with reporting obligations
- communicating with the children and young people involved and their carers
- documenting and sharing information where necessary.[1164]

We discuss each of these elements of a good response to harmful sexual behaviours in the following sections.

In its Fifth Annual Report, the Tasmanian Government said 'work has been undertaken to ensure that a risk sensible approach is applied to sexualised behaviours onsite with these behaviours not normalised' in Ashley Youth Detention Centre.[1165] It is not clear from that report what specific actions the Tasmanian Government has taken to ensure that outcome.

We note that sexualised behaviours occur on a continuum and, therefore, the response should be appropriate to the severity and chronicity of the behaviour.[1166] Lower-level behaviours such as sexualised talk and simulated masturbation in public settings can be managed by staff redirecting and reminding young people of what is appropriate behaviour. In so doing, staff support a norm for the culture of the facility that discourages young people from displaying more harmful sexualised behaviours.[1167] However, more serious behaviours require a more therapeutic response for the young people involved. The following principles should guide the response.

8.5.1 Child wellbeing

We heard that when Erin (a pseudonym) was sexually assaulted in Ashley Youth Detention Centre by a group of young people, she received no therapeutic response to the trauma.[1168] Children and young people who have been affected by harmful sexual behaviours—whether they engaged in, experienced or witnessed the behaviours—need to have timely, clinically supervised access to appropriate support for their wellbeing

following an incident.[1169] As discussed in Chapter 21, there are many benefits associated with sexual assault counselling and therapeutic interventions for harmful sexual behaviours being delivered to children in detention by community-based services. For example, with effective treatment, children's risk of continuing to display harmful sexual behaviours is significantly reduced.[1170]

Secretary Pervan told us that, following evidence from the Sexual Assault Support Service at our hearings in May 2022, senior staff from Ashley Youth Detention Centre established a formal arrangement for consulting with the Sexual Assault Support Service 'to provide recommendations for identifying, preventing and responding to harmful sexual behaviour, and child sexual abuse more generally'.[1171] He said that 'the Sexual Assault Support Service is now available to support young people who were victims or witnesses' of harmful sexual behaviours in the Centre and that a private psychology practice provides three hours per week of psychology services to those young people via a digital platform.[1172] He told us that a child who has experienced harmful sexual behaviours would receive therapeutic support from the private psychology practice, the Centre's nurse and the visiting doctor.[1173]

While this information is promising, we remain cautious. Renae Pepper, Senior Practitioner and Psychologist, Sexual Assault Support Service, expressed concern that the punitive approach at Ashley Youth Detention Centre (discussed in Section 4.2.2) was at odds with a therapeutic approach to responding to harmful sexual behaviours.[1174] This tension must be resolved if children and young people in detention are to receive appropriate interventions for harmful sexual behaviours.

Ideally, where longer-term sexual assault and harmful sexual behaviours clinical supports are required, they should be provided by clinical specialists outside the facility, who can continue to provide treatment following the young person's release from detention. This is important given the need to develop a therapeutic relationship for successful intervention and given that many young people are in detention for relatively short periods.[1175]

8.5.2 Communicating with children, young people and their carers

As discussed in Section 10, a child-focused complaints process involves the child and keeps them informed of the outcome.[1176] Furthermore, parents and guardians should also be kept informed of the wellbeing of their child in detention or another residential youth justice facility. The harmful sexual behaviours policy should outline how staff at such facilities will communicate with parents, carers or guardians of the children involved.[1177]

8.5.3 Reporting obligations

The current procedure for reporting incidents at Ashley Youth Detention Centre directs staff to record the incident and report it through the Centre Support Team and to the

Centre Manager for more serious incidents.[1178] The procedure instructs only the Centre Manager to 'make notifications to relevant parties', although it does not specify the parties involved.[1179] However, as discussed in Section 10.2.7, the Department's *Reporting Concerns* fact sheet advises staff of their mandatory obligations to report suspected child abuse or neglect to the Advice and Referral Line under the Children, Young Persons and Their Families Act.[1180] The fact sheet specifically includes harm that can occur 'between children and young people in any setting' as reportable to the Advice and Referral Line, and '[i]f the concerning behaviour is criminal in nature, then it must also be reported to Tasmania Police'.[1181]

To ensure incidents of harmful sexual behaviours are reported, the harmful sexual behaviours policy should include how mandatory reporting requirements are to be fulfilled. This should be aligned with the role and responsibilities of different agencies in responding to harmful sexual behaviours outlined in the statewide framework for preventing, identifying and responding to harmful sexual behaviours, which we recommend in Chapter 21 (Recommendation 21.8). These requirements should then be reinforced through staff training and professional development. However, as neither the Advice and Referral Line nor Tasmania Police are likely to have cause to respond in all situations of harmful sexual behaviours, a facility-led, clinically directed response is also required. The detailed policy, protocols and guidance on harmful sexual behaviours in youth detention and other residential youth justice facilities should describe this response.

Also, there should be appropriate departmental oversight of responses to harmful sexual behaviours in detention and other residential youth justice facilities. We recommend that management of the facility reports all incidents of harmful sexual behaviours to the Harmful Sexual Behaviours Support Unit to access advice, support and guidance from the unit and to enable data on harmful sexual behaviours in residential youth justice facilities to be included in the Department's monitoring and oversight of harmful sexual behaviours through the new Quality and Risk Committee (refer to Recommendation 9.5 in Chapter 9).

Given the history of inadequate responses by previous departments to such incidents, independent oversight is also required. In Chapter 18, we recommend establishing a new Commission for Children and Young People, which will oversee youth detention and the youth justice system. We consider that the Secretary of the Department for Education, Children and Young People should notify the new Commission for Children and Young People of incidents involving harmful sexual behaviours in detention and other residential youth justice facilities, and of the Department's responses. The new Commission for Children and Young People should have the power to compel the Department to provide information on its responses to such incidents.

8.5.4 Staff training and professional development

Staff in a residential youth justice facility need to understand trauma-informed care, how to identify and prevent harmful sexual behaviours, and how to respond to the needs of children and young people in that setting who have displayed or experienced inappropriate and harmful sexual behaviours.[1182]

We heard from former clinical staff that Ashley Youth Detention Centre staff lacked understanding of what constituted normal, inappropriate or harmful sexual behaviours among children and young people.[1183] We heard that staff relied on personal opinion to decide whether a behaviour was concerning, leading to an instance of harmful sexual behaviour being dismissed as 'locker room' behaviour and not serious.[1184] Consequently, children and young people at the Centre have not always received the help they needed in relation to harmful sexual behaviours, which increases the risk of future harmful sexual behaviours.[1185]

We were told that there had been no training for staff about harmful sexual behaviours until after the beginning of our Commission of Inquiry in late 2021, when the Sexual Assault Support Service provided some training sessions and consultations to Ashley Youth Detention Centre staff through its newly funded 'Prevention, Assessment, Support and Treatment' program.[1186] Feedback from staff at that time was that the training did not translate appropriately to a custodial environment.[1187]

We are pleased to hear that staff at Ashley Youth Detention Centre have now received training in harmful sexual behaviours. However, based on the feedback reported to the Sexual Assault Support Service, we remain concerned about how this training has been received or how effective it has been. We agree with Ashley Youth Detention Centre staff that training in harmful sexual behaviours needs to be tailored to the detention population and context. To be most effective, such training should be part of a wider strategy to create a child safe culture in youth detention, including transitioning to a therapeutic, child-focused youth detention system (refer to Section 6) and implementing measures to address staff culture and resistance to change (refer to Section 4.7).

8.5.5 Policy and procedures

A former Manager, Professional Services and Policy at Ashley Youth Detention Centre advised that during her time at Ashley Youth Detention Centre (2017 to 2019), the Centre did not have any policies or procedures to guide staff responses to harmful sexual behaviours.[1188] She told us that notifications of incidents to Tasmania Police or the Advice and Referral Line were not supported and she did not believe that 'officials in [Ashley Youth Detention Centre] were clear on [their mandatory reporting] obligations'.[1189]

Secretary Pervan told us that Ashley Youth Detention Centre 'does not have a policy specifically concerning child sexual abuse or harmful sexual behaviours' but that the 'existing practices and policies concerning incidents and reporting cover instances of

harmful sexual behaviour'.[1190] The Department told us that the Practice Framework and the Learning and Development Framework are the policies underpinning the Centre's approach to harmful sexual behaviours.[1191]

These documents indicate that trauma-informed care is to be provided to children and young people in Ashley Youth Detention Centre. However, they do not address understanding and responding to harmful sexual behaviours. As noted in Section 6.3.3, the Australian Childhood Foundation is reviewing the Practice Framework and the Learning and Development Framework.[1192]

As discussed in Section 10.2.4, the purpose of the *AYDC Incident Reporting Procedure* is to outline the steps that staff must take 'following an incident that has arisen from the behavior/s of a young person or multiple young people'.[1193] A central focus of this procedure is determining whether any young person involved in the incident has committed a 'detention offence' under the Youth Justice Act.[1194] We do not consider the *AYDC Incident Reporting Procedure* to be appropriate to guide responses to prevent and respond to harmful sexual behaviours.

Harmful sexual behaviours were a well-known risk for children and young people in institutional settings before the National Royal Commission and became even more clearly recognised after that Commission published its final report in 2017. It is concerning, however, that training for Ashley Youth Detention Centre staff on harmful sexual behaviours did not begin until August or September 2021 as discussed above, well after the start of our Commission of Inquiry. Children and young people in detention deserve protection from other children and young people who have displayed harmful sexual behaviours. Moreover, children and young people in detention who have displayed harmful sexual behaviours need and deserve access to interventions to help them change.

The absence of a clear policy on harmful sexual behaviours at Ashley Youth Detention Centre reflects the Tasmanian Government's general lack of a coordinated approach and response to harmful sexual behaviours (as discussed in Chapter 21 on therapeutic services). This omission needs to be rectified as a matter of priority to protect children and young people in detention and for children and young people who have displayed harmful sexual behaviours to receive appropriate treatment and support. In detention, attention must be paid to fundamentally shifting the culture from normalising and minimising harmful sexual behaviours to assuming responsibility for preventing and responding therapeutically to harmful sexual behaviours.

This changed culture should be supported by a comprehensive policy, protocols and practice guidance on addressing harmful sexual behaviours in youth detention that complements the child-focused, therapeutic model of care for detention that we recommend in Section 6.3.4.

Policies and procedures should include processes:

- for operational staff to screen young people for harmful sexual behaviours during their induction to the facility, identifying those young people who need further assessment and referring them for clinical assessment
- for clinical staff to assess young people identified during screening for their risks and needs in relation to harmful sexual behaviours, and develop a management plan that includes safety planning and therapeutic responses
- by which placement decisions and supervision requirements are informed by clinical assessment and safety planning in relation to harmful sexual behaviours.

Policies will need to balance the safety of young people in detention with the risks of imposing restrictive practices on the young person who has displayed harmful sexual behaviours (refer to Section 9 of this chapter for more information about restrictive practices).

Recommendation 12.30

1. The Harmful Sexual Behaviours Support Unit (Recommendation 9.28) should develop detailed youth justice-specific policies, protocols and practice guidelines to support best practice responses to harmful sexual behaviours in youth detention and other residential youth justice facilities.
2. All incidents of harmful sexual behaviours in youth detention or other residential youth justice facilities should be reported to:
    a. the Harmful Sexual Behaviours Support Unit to enable data on harmful sexual behaviours in youth detention and other residential youth justice facilities to be included in the Department for Education, Children and Young People's monitoring and oversight of harmful sexual behaviours through the new Quality and Risk Committee (Recommendation 9.5)
    b. the Commission for Children and Young People (Recommendation 18.6).
3. The Department should explore the potential to implement Power to Kids (or another program or approach with comparable components) in youth detention and other residential youth justice facilities as a supplementary strategy to address the heightened risk of harmful sexual behaviours in those settings and take a proactive approach to prevention.

4. The Tasmanian Government should ensure measures are in place to facilitate timely access to specialist therapeutic interventions for children in youth detention displaying or harmed by harmful sexual behaviours. Where treatment is likely to extend beyond their custodial sentence this should be provided by a clinician external to the detention centre who can continue the treatment after the child is released from detention.

9 Searches, isolation and use of force in youth detention

As highlighted throughout this volume, the National Royal Commission referred to the ways in which closed institutions such as youth detention facilities can become 'alternative moral universes', whereby norms and rules are established and maintained wholly within the institution.[1195] Where the institution fosters a culture of tolerance for humiliating and degrading children and young people, routinely using force or violence, or otherwise normalises aggression, acts of sexual abuse against children and young people are more common.[1196] Research also reveals that in institutions where the routine use of force or violence against children and young people is permitted, staff can become desensitised, making it easier for them to minimise or tolerate ongoing harm, including sexual harm, to children and young people.[1197]

As described in Chapter 11, Case studies 1, 3 and 4, it was apparent that the inappropriate and, possibly unlawful, use of searches, isolation and force at Ashley Youth Detention Centre occurred as part of a broader culture that enabled abuse, including sexual abuse, of children and young people in detention. We heard from victim-survivors that searches, isolation, use of force and child sexual abuse rarely occurred discretely; rather, two or more of these practices were often part of the same interaction with a child or young person. As identified in victim-survivor accounts outlined in the case studies:

- Strip searches described to us were, at times, a form of sexual abuse.
- Strip searches were often conducted prior to a child or young person being isolated and during their isolation.
- Force and restraints were used on children or young people when conducting strip searches and to isolate them.
- Force and restraints were used to disable a child or young person, so they could be sexually abused.
- Isolation and violence were threatened if a child or young person refused to comply with staff directions, including directions to submit to sexual abuse.

- Isolation and violence were threatened or used as punishment of a child or young person if they reported sexual or physical abuse.

These case studies suggest that the powers to search, isolate or use force against a child or young person in detention—which may be legitimately exercised in narrow and clearly defined circumstances—can be abused if the culture in detention enables it, staff do not have the necessary skills to avoid restrictive practices, oversight is impeded or lacking, children and young people feel unable to complain about mistreatment, and authorising laws and procedures do not include adequate safeguards.

Recommendations in other sections of this chapter are designed to achieve cultural change in youth detention (Section 4), ensure staff have the necessary skills to engage with children and young people constructively (Sections 4 and 6), improve complaints mechanisms and the Department's responses to incidents affecting children's safety in detention (Section 10) and strengthen external oversight of practices in detention (Section 11). In particular, we recommend changes to:

- ensure youth workers are appropriately qualified, trained and supported to deliver a therapeutic model of care to children and young people in detention, with enough staff to keep children and young people safe (Recommendation 12.9)
- ensure staff in youth detention facilities have the skills needed to undertake trauma-informed interventions with children and young people, including the skills to anticipate, de-escalate and respond effectively to challenging behaviours without resorting to force or other restrictive practices (Recommendation 12.18)
- establish an independent community visitor scheme for children and young people in detention (Recommendations 9.34 and 12.36)
- strengthen leadership in the youth detention system (Recommendation 12.6).

In addition, in Section 4.6.3, we recommend that the Department develops an empowerment and participation strategy for children and young people in detention that includes mechanisms to ensure children and young people in detention are aware of their rights (Recommendation 12.8). This should include awareness of their rights in relation to searches, isolation and use of force.

The regulatory framework for searches, isolation and use of force comprises the Youth Justice Act, the *Inspection Standards for Youth Custodial Centres in Tasmania* ('Inspection Standards') and custodial policies and procedures issued by the Department. In this section, we examine this framework, together with practices in relation to searches, isolation and the use of force in youth detention. We recommend measures to:

- clarify and strengthen relevant legislative provisions and custodial procedures
- improve reporting and oversight of searches, isolation and use of force

- ensure staff who use these practices and those who monitor and oversee their use have a strong understanding of relevant legislative, procedural and practice requirements.

As noted in the introduction to Volume 5, the Order establishing our Commission of Inquiry directed us to inquire into responses to allegations of child sexual abuse at Ashley Youth Detention Centre. However, we note that children and young people are also detained in adult custodial facilities that have been declared to be youth detention centres, including Hobart Reception Prison, Launceston Reception Prison and Risdon Prison.[1198] Children and young people can also be transferred from Ashley Youth Detention Centre to an adult prison facility or otherwise detained in an adult prison facility in certain circumstances (this is discussed in Section 6.9). We also note that the provisions of the Youth Justice Act in relation to searches of children and young people apply to prisons, reception prison watch-houses and police watch-houses, as well as detention centres.[1199]

Children and young people detained in custodial facilities other than Ashley Youth Detention Centre are subject to procedures and practices relating to searches, isolation and the use of force that may carry the same risk of abuse as in the Centre.[1200] While we have not inquired into the treatment of children and young people in adult custodial facilities, many of the issues raised in this section will also have implications for children and young people in those settings. We encourage the Government to consider our recommendations broadly and approach implementation consistently in relation to children and young people in all custodial settings in Tasmania.

We consider searches, isolation and use of force in turn.

9.1 Searches of children and young people

This section considers searches of children and young people in detention. It does not consider other searches carried out in detention, such as searches of children and young people's rooms.

As noted in Chapter 10, we sometimes use the term 'strip search' in this volume because this is the phrase victim-survivors commonly use when referring to a search involving any removal of clothing, whether partial or full. However, we note that in the Youth Justice Act and custodial standards and procedures, this practice is commonly referred to as an 'unclothed search', with a distinction drawn between partially clothed and fully unclothed searches. In this section, we refer to 'strip searches', 'fully unclothed searches' and 'partially clothed searches', depending on the context. We also refer more broadly to 'personal searches' in our discussion of current custodial procedures.

9.1.1 What we heard about strip searches in detention

As outlined in Chapter 11, Case study 1, victim-survivors told us about their experiences of strip searches at Ashley Youth Detention Centre. These experiences included:

- being routinely strip searched on admission to the Centre
- being strip searched while in isolation or while restrained
- being threatened with strip searches to ensure compliance with staff commands
- female detainees being strip searched by male staff
- staff inserting their fingers into the anus of young people during a strip search
- strip searches contributing to long-term adverse effects on a young person's mental health and wellbeing.

As noted in Chapter 11, Case study 1, many of these practices amount to child sexual abuse.

We received evidence from the Commissioner for Children and Young People, Leanne McLean, that, in the six-month period from 1 June 2018 to 30 November 2018, there were 203 strip searches conducted on children and young people detained at Ashley Youth Detention Centre.[1201] Despite this alarmingly high number of strip searches, no contraband was recovered from any of the searches.[1202]

The Custodial Inspector completed an inspection of youth custodial services in Tasmania in 2018.[1203] The Custodial Inspector's report recommended that the (former) Department of Communities:

- consider installing metal detectors and x-ray machines at the Admissions Unit to prevent contraband entering Ashley Youth Detention Centre and to minimise the need for personal searches
- carry out unclothed searches of children and young people on the basis of a rigorous risk assessment rather than on a routine basis.[1204]

9.1.2 Youth Justice Act

As outlined in Chapter 10, the Youth Justice Act contains provisions relevant to searches of children and young people in detention.

Before December 2022, the Youth Justice Act allowed a detention centre manager to submit a child or young person to a search for prohibited items as soon as possible after admission or return after a temporary leave of absence from the detention facility, and at any other time when there were reasonable grounds to believe that the child or young person may have had contraband in their possession, or in the manager's opinion, it was necessary to conduct the search in the interests of security.[1205] As a result of

December 2022 amendments to the Youth Justice Act, references to searches being conducted on admission or after temporary leave have been removed.[1206]

Under the new provisions, a 'search officer' (a person authorised to conduct a search) must not conduct a search of a child or young person unless the search officer believes on reasonable grounds that the search is 'necessary for a relevant search purpose' and the type and manner of search are proportionate to the circumstances.[1207]

The Youth Justice Act defines a 'relevant search purpose' as follows:

- to ensure the safety of the child or young person or another person
- to obtain evidence relating to the commission of an offence or to prevent the loss or destruction of evidence relating to an offence
- to ascertain whether the child or young person has possession of a concealed weapon, or another article capable of being used as a weapon, to inflict injury or to aid in escape from custody
- to ascertain whether the child or young person has possession of drugs or prohibited items, or
- for a clothed search, to remove into safe keeping any articles in the possession of the child or young person.[1208]

The Youth Justice Act now includes the following 'hierarchy' of searches, from the least to the most intrusive:

- a search (which may be a search by way of a scanning device) that involves no touching of a child or young person or of clothing they are wearing
- a search that includes 'minimal touching' of the child or young person or their clothing
- a search that includes removing some clothing
- a search that includes more than minimal touching of the child or young person or their clothing
- an 'unclothed search', which is defined as a search that requires the child or young person's torso or genitals to be exposed to view, or their torso or genitals, clothed only in underwear, to be exposed to view.[1209]

A 'body cavity search' is not permitted.[1210]

The Youth Justice Act provides that a search officer must not conduct an unclothed search of a child or young person unless the 'relevant authorising officer' (the Secretary

or the detention centre manager) has authorised the search.[1211] A relevant authorising officer must not authorise an unclothed search unless they believe on reasonable grounds that:

- the search is necessary for a relevant search purpose
- the type of search, and the manner of search, are proportionate to the circumstances
- despite being the most intrusive type of search, an unclothed search is necessary and reasonable to achieve a relevant search purpose
- the search is to be conducted in the least intrusive manner that is necessary and reasonable to achieve a relevant search purpose.[1212]

The Youth Justice Act also includes principles for carrying out searches. Among other matters, the search officer must ensure:

- the search is conducted in a manner that is consistent with retaining the child or young person's dignity and self-respect, and that minimises any trauma, distress or harm
- the search is the least intrusive type of search and is conducted in the least intrusive manner necessary and reasonable to achieve a relevant search purpose for which the search is conducted
- the search is completed as quickly as is reasonably possible
- the search is conducted in circumstances that allow reasonable privacy for the child or young person
- they do not remove, or require the child or young person to remove, more clothing than is necessary and reasonable.[1213]

The Youth Justice Act now also requires that a search involving touching or the removal of any clothing be conducted by a search officer of the same gender as the young person, or if the youth is transsexual, transgender or intersex, a person of the gender requested.[1214] For unclothed searches conducted in the presence of another person (an observer), the same gender requirements apply to that observer.[1215] The only exception to these requirements is where it is 'not reasonable or practicable' for them to apply 'because of the urgency with which the search is required in order to address the risk of harm or trauma to the youth or another person'.[1216]

The Youth Justice Act permits a search officer to use force to conduct the search, but only where this is 'the only means, in the circumstances, by which the search can reasonably be conducted'.[1217] The officer must ensure that, if force is used, it is the least amount of force that is reasonable and necessary to enable the search to be conducted.[1218]

Under the 2022 amendments to the Youth Justice Act, a record of each search must be kept in a search register established and maintained by the Secretary, with details including the degree of the intrusiveness of the search and any force used to conduct the search.[1219] The register must be made available for inspection by the Ombudsman, the Custodial Inspector and any approved or prescribed person or body (of which there are none currently).[1220]

9.1.3 Inspection standards on searches

Following the 2022 amendments, the Youth Justice Act now more closely reflects the Inspection Standards on searches. According to these standards:

- Searches of a young person must be conducted safely and 'only when reasonable and necessary', and they must be proportionate to the situation.[1221]
- Pat searches and searches using metal detectors should be undertaken first. Unclothed searches should be a last resort, and cavity searches should never be conducted.[1222]
- Unclothed searches should not be routinely conducted on entry and exit to a detention facility where a young person has been in a secure vehicle while off the premises.[1223]
- Staff should be appropriately trained to conduct unclothed searches.[1224]
- The staff member conducting the unclothed search should be the same sex as the young person unless the young person identifies as transgender, in which case the young person should nominate the gender of the person they want to conduct the search.[1225]

9.1.4 Custodial procedures on searches

The Department's *Personal Searches of Young People Detained at AYDC Procedure* ('Search Procedure'), effective from February 2023, sets out requirements for 'personal searches' of children and young people in detention.[1226] This procedure replaced an earlier procedure on searches dated September 2019, which in turn replaced a procedure introduced in 2012.[1227] We acknowledge that there have been several significant changes to search procedures since 2012, many of which occurred in 2019—these included introducing the requirement for 'reasonable grounds' for a search, prohibiting fully unclothed searches and requiring modesty gowns for children and young people if they are asked to remove clothing.[1228] Nevertheless, here we focus on the current procedure.

One of the purposes of the Search Procedure is to ensure that, 'when required, searches of young people are conducted in a safe and least intrusive manner, while maintaining the privacy, dignity and rights of the young person'.[1229] The Search Procedure recognises

that '[a] search is an infringement on a person's right to privacy' and that a search that does not comply with legal and procedural requirements 'has the potential to be considered trespass and/or assault'.[1230]

The Search Procedure defines a 'personal search' as:

- a metal detector search, which involves a child or young person walking through a large metal detector while fully clothed and does not require them to be touched[1231]
- a wand search, which involves using an approved hand-held metal detector on a fully clothed child or young person and does not require them to be touched[1232]
- a pat search, which involves 'the careful patting down of a young person's clothed body after the removal of outer garments (such as a coat or jacket) and shoes and socks' to feel for any hidden items[1233]
- a partially clothed search, which involves 'visual examination of the upper body after removal and searching of upper garments, followed by visual examination of the lower body after return of the upper garments and the removal of lower garments'.[1234]

The Search Procedure:

- prohibits '[f]ully [u]nclothed' searches, defined as asking a child or young person to remove all their clothing at the same time[1235]
- prohibits cavity searches, defined as 'a visual, manual or instrument inspection of a young person's body cavities including mouth, ears, vaginal, or anal orifices'[1236]
- prohibits any personal search being undertaken 'automatically', instead requiring all personal searches to be based on 'reasonable grounds'[1237]
- specifies that the type of search undertaken 'must be the least intrusive in accordance with the risk posed'[1238]
- states that partially clothed searches 'must only be undertaken as a last resort, in circumstances where all reasonable grounds indicate that the young person is carrying a prohibited and/or unauthorised item' and can only occur with approval from the Director, Custodial Youth Justice[1239]
- enables force to be used to undertake a search, but only as a last resort, where 'all other strategies, such as negotiation, have failed', and subject to 'prior approval of the Director with sufficient intelligence to support the request'.[1240]

The Search Procedure requires operational staff to take the following steps:

- Assess whether reasonable grounds exist for a personal search—in undertaking this assessment, staff must consider 'the history, behaviour and situational factors associated with the young person', including their age and gender, their behaviour or demeanour on admission and whether they have a history of drug or alcohol use.[1241]
- '[C]onsider the level of risk' associated with the search—this is 'a matter of professional judgement made on a case-by-case basis' and involves using a 'hierarchy of risk assessment tool' (we were not provided with this tool).[1242]
- Determine the most appropriate type of search to be conducted based on the risk—as noted, this must be 'the least intrusive that is necessary and reasonable in the circumstances'.[1243]
- Seek approval for the search from the 'relevant Delegate'—for partially clothed searches, this is the Director, Custodial Youth Justice, and for other personal searches this is the 'Youth Worker, Operations Coordinator'.[1244]
- Inform the young person of the intent to conduct a search and the reasons for the search, explain how the search will be undertaken and offer an opportunity for the young person to ask questions.[1245]
- Carry out the search 'in a location and manner that maintains the young person's dignity' and meets specified requirements—for example, two staff must be present for all searches.[1246]
- Record information about the search, including the grounds for the search, the type of search based on the risk assessment, and approval for the search in 'the Search Register located in each unit folder on O: Drive', which is presumably a shared drive.[1247]

The requirements in the Search Procedure about the gender of the staff members carrying out or observing a search do not entirely reflect the requirements in the Youth Justice Act. For example, for partially clothed searches, the Search Procedure provides that:

> Every effort should be made to ensure that two staff of the same gender [as the young person] are available. In exceptional circumstances, the Observer may be of the opposite sex if two same-sex officers are not available.[1248]

The Search Procedure does not define 'exceptional circumstances'.

In contrast, as noted in Section 9.1.2, the Youth Justice Act requires an observer to be of the same gender as the young person (or of the gender requested if the young person is transsexual, transgender or intersex), subject only to a limited exception based on the urgency of the need for the search 'in order to address the risk of harm or trauma' to the young person or another person.

According to the Department's Keeping Kids Safe Plan, Ashley Youth Detention Centre provides the search register to the Commissioner for Children and Young People and the Custodial Inspector on a monthly basis.[1249]

The Keeping Kids Safe Plan also states that, once updated, the Search Procedure would be implemented with staff.[1250]

9.1.5 Understanding and implementation of search procedures in detention

We asked managers and staff at Ashley Youth Detention Centre about their understanding of procedures and practices in relation to searches of children and young people at the Centre, noting that the procedures have changed over time.

Former Centre Manager Patrick Ryan told us that when he first started working at Ashley Youth Detention Centre in 2017, the policy on strip searches was 'prescriptive' and required children and young people to be strip searched 'when they're coming in from Police custody, they'd had a visitor, when they'd been off site'.[1251] Mr Ryan commented that 'the policy was too rigid'; that is, staff 'were strip searching residents too often'.[1252]

We asked the Assistant Manager at Ashley Youth Detention Centre, Fiona Atkins, about the changes introduced in 2019 for strip searches at Ashley Youth Detention Centre (outlined in Section 9.1.4). She responded:

> One major change was in relation to requiring reasonable cause to perform a search of young people instead of automatically searching young people. For example, in respect of a new admission, you would have to provide a reason for the search such as a history of contraband. The other major change was the introduction of the vanity gown for searches and ensuring that young people were asked if they wanted to use it if a search was required.[1253]

Consistent with this, Centre Manager Stuart Watson, who started in the role in 2020, told us that 'searching is something that is evidence-based or information-based, or there's got to be a reason. Searching is not mandatory, it's something that is not routine'.[1254]

When queried about the safeguards in place at Ashley Youth Detention Centre to protect young people from being subjected to searches that were not authorised, Mr Watson told us that if a child or young person at the Centre was subjected to an unauthorised search, '[t]hey can pick up the phone pretty much at any time and ring the Commissioner [for Children and Young People] directly'.[1255] He explained that a young person can also complain to the staff members conducting the search, the Operations Coordinator or other members of Ashley Youth Detention Centre staff.[1256] Mr Watson told us that '[e]nsuring that a young person has multiple avenues for complaining about an inappropriate or unauthorised search is an important part of a system of checks and balances on searches'.[1257]

Mr Watson also said that 'if staff see something that's not appropriate, they can complain'.[1258]

We also received evidence from current and former Ashley Youth Detention Centre staff about their understanding of strip searches. A staff member told us that although reference to modesty gowns was included in the procedure introduced in 2019, the gowns were not available to children and young people until 2021.[1259]

A Department of Communities issues briefing to the then Minister for Children and Youth, unsigned but noted as 'cleared' by Secretary Pervan in December 2021, referred to the following allegation raised by the then Leader of the Tasmanian Greens Party, Cassy O'Connor, in December 2020 regarding strip searches at Ashley Youth Detention Centre:

> A PIN [Provisional Improvement Notice] should go to WorkSafe, when breaches occur. Policy is when children are searched, modesty gown must be used (re Children's Commissioner recommendation). Workers lodged a PIN because there are no gowns (in last 12 months).[1260]

The briefing stated that, in January 2020, an Ashley Youth Detention Centre Health and Safety Representative had lodged a Provisional Improvement Notice about concerns that the security of the Centre and the safety of staff were 'potentially at great risk as a new search procedure [had] allegedly [been] implemented without adequate consultation or training'.[1261] According to the briefing, the Health and Safety Representative withdrew the notice following a meeting with Mr Watson 'where additional strategies were agreed to address any training concerns'.[1262]

In his statement to our Commission of Inquiry, Mr Watson told us that modesty gowns were not being used when he started working at the Centre in January 2020 but that he later ensured staff were trained and the gowns were used.[1263] In May 2022, a staff member told us she had 'only recently' been informed by the 'legal team in Hobart' that her interpretation of the procedure introduced in 2019 was not correct and that a modesty gown was to be given to a young person to put on, so they could undress and dress again under it. This staff member stated that '[u]ntil then scrutiny from the legal department had been amiss'.[1264]

In October 2022, Secretary Pervan confirmed that routine strip searching of children and young people in detention had ceased and referred to funding for new technology to conduct searches:

> Searches are sometimes required for safety and security reasons to prevent harmful items such as drugs and weapons from entering custodial facilities. The practice of routine strip searches of youth has already ceased in all custodial facilities in Tasmania. Changes to the Youth Justice Amendment (Searches in Custody) Bill 2022 formalises reform on searches of children. The Government is also investing in alternative security strategies such as body scanners that will minimise the reliance on more invasive search types. $1.3 million was allocated in the 2022–23 State Budget to implement this technology in Tasmanian correctional facilities, including Ashley Youth Detention Centre.[1265]

9.1.6 Improving search practices in detention

We welcome the 2022 amendments to the Youth Justice Act and the recent changes to the custodial procedure on searches of children and young people in detention. We note that the Search Procedure includes some safeguards that are not contained in the Youth Justice Act—in particular, the requirement for authorisation for a partially clothed search to be sought from the Director, Custodial Youth Justice, rather than from the Centre Manager. While we consider that the higher level of approval is appropriate at this time, it may be that as the culture of Ashley Youth Detention Centre changes, it would be appropriate for authorisation for partially clothed searches to be provided by the Centre Manager. In Section 4.4.2, we recommend that the Centre Manager role be reclassified to at least a Senior Executive Service Level 1 (Director level) in the Tasmanian State Service (Recommendation 12.6). For these reasons, we do not recommend that the Youth Justice Act be amended to require the higher level of approval required by the Search Procedure.

The Search Procedure also includes a prohibition on fully unclothed searches, which we recommend be included in the Youth Justice Act.

We consider that the Search Procedure should be strengthened by: defining fully unclothed searches as a form of child sexual abuse; explicitly outlining a hierarchy of search options; aligning gender requirements for staff who conduct or observe searches with requirements in the Youth Justice Act; and specifying reporting requirements for searches (discussed below). The Search Procedure should also be made publicly accessible on the Department's website.

We welcome the Government's investment in body scanner technology to facilitate less intrusive searches of children and young people in detention. In implementing this technology at Ashley Youth Detention Centre or any future detention facility, the Government should ensure its use is balanced against respect for children and young people's privacy and dignity.

We also welcome the use of a 'hierarchy of risk assessment tool' to help operational staff assess the level of risk associated with a proposed search and to determine the least intrusive type of search necessary and reasonable in the circumstances. Staff must be properly trained in how to use this tool and it should be included in the Department's Practice Manual.

We are concerned about the lack of understanding of search procedures among staff, particularly in view of significant changes to procedures in and since 2019. It was not clear to us that staff had been properly trained on earlier updates to the procedure to ensure consistent understanding and practice for searches. We also note that, despite references to providing modesty gowns in the 2019 updates to the procedure, in practice, these were not provided until concerns were raised. In Section 9.4, we recommend joint training on searches for Ashley Youth Detention Centre staff, staff at

any new detention facility and relevant staff of the Youth Justice Services directorate of the Department for Education, Children and Young People, to ensure a shared understanding across detention facilities and the broader Department of laws, policies and procedures.

We consider that care should be taken not to place the onus on young people to complain after an unlawful or inappropriate search (although this option should always be available to them—refer to Section 10); rather, the onus must be on the Department and facility management to ensure searches are carried out lawfully and in line with custodial procedures, and to take prompt action if they are not.

Departmental and independent oversight of searches of children and young people in detention is essential. In Section 4.5.1, we discuss the previous lack of transparency in Ashley Youth Detention Centre's operations, which limited the Department's ability to monitor the safety of children and young people in detention.

We recommend that Ashley Youth Detention Centre (and any future detention facility) provides a monthly report to the Secretary on searches of children and young people in detention.

In Chapter 9, we recommend that the Department establishes a Quality and Risk Committee that is chaired by the Secretary and has monitoring functions for the out of home care system (Recommendation 9.5). We consider that this committee should also have some monitoring functions for youth detention and should receive quarterly reports on searches. These reports should include enough information to enable the Quality and Risk Committee to analyse and monitor trends in searches and identify any concerns in the treatment of children and young people. This should include the number of searches carried out, the type and purpose of each search, the grounds for each search, the risk assessment associated with each search, information on search authorisations and identification of any items recovered from the search.

We welcome the legislative requirement to maintain a search register that must be made available to oversight bodies. As noted, the Department provides the search register on a monthly basis to the Commissioner for Children and Young People and the Custodial Inspector. In Chapter 18, we recommend establishing a new Commission for Children and Young People, with monitoring and oversight functions for youth detention—we discuss these functions in Section 11.6 of this chapter. We recommend that the search register be provided to the Commission for Children and Young People, at a minimum, on a monthly basis to enable it to monitor searches of children and young people in detention.

Recommendation 12.31

1. The Tasmanian Government should introduce legislation to amend the *Youth Justice Act 1997* to ensure the Act expressly prohibits fully unclothed searches of children and young people in detention.
2. The Department for Education, Children and Young People should:
    a. introduce body scanner technology at Ashley Youth Detention Centre and include such technology in any facility designed to replace the Centre
    b. update the Department's *Personal Searches of Young People Detained at AYDC* procedure to
        i. define a fully unclothed search as a form of child sexual abuse
        ii. explicitly outline the hierarchy of search options, from the least to the most intrusive
        iii. align gender requirements for staff who conduct or observe searches with requirements in the *Youth Justice Act 1997*
        iv. specify internal and external reporting requirements in relation to searches
    c. publish the personal searches procedure on the Department's website
    d. consider what search policies and procedures, if any, should apply in the proposed new assisted bail and supported residential facilities
    e. ensure Ashley Youth Detention Centre (and any future detention facility) provides
        i. monthly reports on searches of children and young people in detention to the Secretary
        ii. quarterly reports on searches of children and young people in detention to the Quality and Risk Committee (Recommendation 9.5) to enable it to monitor trends and identify any areas of concern
        iii. the search register and all relevant supporting documentation to the Commission for Children and Young People (Recommendation 18.6) on a monthly basis or more frequently, as agreed with the Commission for Children and Young People.

9.2 Isolation

'Isolation' of children and young people in detention is defined in different ways and can cover a range of situations involving confining, secluding, separating or segregating a child or young person from other children and young people. In a 2016 report on human rights standards in youth detention facilities in Australia, the Australian Children's Commissioners and Guardians distinguished between the following practices:

- 'Seclusion', 'isolation', 'confinement' or 'separation'—this involves the involuntary placement of a child or young person in a room from which they are not able to leave.[1266]
- 'Segregation'—this involves limiting a child or young person's contact with certain peers in the facility (for example, by changing the child or young person's education and recreation times, so they do not encounter another child or young person) but does not necessarily involve placing added restrictions on their movements.[1267]
- 'Lockdown'—this involves keeping large groups of children in their rooms for periods of time, which is frequently used as part of a detention facility's safety and security management regime.[1268]

According to the Australian Children's Commissioners and Guardians, seclusion and segregation 'should not be used in any form on children with known psychosocial issues, indicators of self-harm, mental illness or other related vulnerabilities'.[1269]

As outlined in Chapter 10, under the Youth Justice Act, isolation is defined as 'locking a detainee in a room separate from others and from the normal routine of the detention centre'.[1270] We discuss this definition in Section 9.2.4.

According to international human rights standards:

- The solitary confinement of a child in detention and any other punishment that may compromise the physical or mental health of a child are strictly prohibited.[1271] The United Nations has defined solitary confinement as confinement for 22 hours or more a day without meaningful human contact.[1272]
- Any separation of a child in detention from others must be 'for the shortest possible time and used only as a measure of last resort for the protection of the child or others'.[1273]
- Any disciplinary measures and procedures in detention should be consistent with upholding the inherent dignity of the child and 'the fundamental objective of institutional care, namely, instilling a sense of justice, self-respect and respect for the basic rights of every person'.[1274]

9.2.1 What we heard about isolation practices in detention

As discussed in Chapter 11, Case study 3, we heard a range of evidence about isolation practices at Ashley Youth Detention Centre from victim-survivors and their families. They described various experiences, including recollections of:

- different degrees or kinds of isolation, ranging from being held in a room alone to being confined to a unit with only staff
- at times, lengthy periods of isolation, including for a number of weeks
- inappropriate isolation being used for a range of reasons, including as part of the induction process, as a form of punishment for bad behaviour or self-harm, against victims of assault, or as retribution for making complaints
- poor isolation conditions, often with limited or no access to therapeutic programs, education, health care or enough food or bedding
- handcuffs and physical restraint being used to place a child or young person in isolation, or while they were in isolation
- isolation that traumatised and confused children and young people, including contributing to long-term negative effects on their mental health and wellbeing.

In Chapter 11, Case study 3, we also describe evidence of several practices used at Ashley Youth Detention Centre that involved separating children and young people from others, but which were not formally labelled as isolation or treated in line with legal requirements for the use of isolation. Labels used to describe such practices included 'unit bound', 'individualised programs', 'separate routine' and the 'Blue Program'.

In that case study, we find that the use of isolation as a form of behaviour management, punishment or cruelty and contrary to the Youth Justice Act has been a regular and persistent practice at Ashley Youth Detention Centre since at least the early 2000s, and the conditions that enabled this practice still exist today. We also find that:

- Isolation practices often involved segregating children and young people from other detainees and denying them the right to take part in the usual educational programming offered through Ashley School.
- The Department, and sometimes the Tasmanian Government, have been on notice about potentially unlawful isolation practices at Ashley Youth Detention Centre since at least 2013, and have not taken sufficient action.
- The Department demonstrated, at best, naivety in repeatedly addressing poor and potentially unlawful isolation through training and policy change, and accepting lack of staff knowledge as an explanation, despite many staff, including operational leaders, having long employment histories at the Centre.

As noted in Section 4.7.2, in July 2023, Commissioner McLean informed us that, since August 2022, there had been a deterioration of conditions for children and young people in detention, and that isolation practices continued to be used at the Centre.[1275] She advised that, over the previous six months, her office had observed (among other practices):

- Individual young people being referred to as 'unit bound' by staff during conversations, on office noticeboards, and in Weekly Review Meeting … minutes;
- The extended use of unit-specific lockdowns … and the extended isolation of individual young people, with one young person likening these practices to the 'Blue Program';
- Moving or threatening to move young people to units that experience more frequent lockdowns as a means of responding to and/or managing behaviour;
- The reintroduction of 'quiet time,' which sees young people restricted to their rooms every day between 12:30pm – 1:15pm, sometimes without staff being present in the unit …[1276]

This is extremely concerning.

In response to Commissioner McLean's comments, the Government acknowledged that restrictive practices continued at Ashley Youth Detention Centre due to staff shortages (discussed in Section 9.2.2).[1277] Secretary Bullard also stated:

> The [Commissioner for Children and Young People] has expressed concern that young people at [Ashley Youth Detention Centre], particularly those in the Franklin Unit, have been locked down in response to their behaviour. I am advised that young people in the Franklin Unit have been subject to the same restrictive practices as other young people at [the Centre]. I understand that some residents may perceive that they are being treated differently if they are in their rooms while others are out of theirs. This is not the case, as restrictive practice means that young people are out of their rooms at different times of the day, depending on the number and experience of staff present in [the Centre] and the need to accommodate any association issues between young people.[1278]

We note that the Government's response did not address Commissioner McLean's observations:

- that staff were referring to individual children as 'unit bound'
- of extended isolation of individual young people
- that daily 45-minute 'quiet time' had been reinstated.

As such, the Government's response did not address all our grave concerns about the continuing use of isolation at Ashley Youth Detention Centre. As we only became aware of these concerns in July 2023, we were unable to continue to explore these specific matters.

Given the focus on isolation practices as human rights violations within our hearings—including a specific focus on 'unit bound' and the Blue Program—we find it astounding that these practices would persist or be reinstated during our Commission of Inquiry. Commissioner McLean's observations suggest a culture that has continued to be punitive and has remained impervious to change. We remain gravely concerned that human rights abuses of children have occurred at Ashley Youth Detention Centre during our Inquiry and persist at the time of writing.

9.2.2 Lockdowns related to staff shortages

As discussed in Section 4.7, we also heard evidence about lockdowns involving children and young people being kept in their rooms for extended periods and unable to take part in normal programs, such as school, as a result of not enough staff being available to safely cover the normal operations of the Centre.[1279] We heard that, to ensure the Centre's minimum staff-to-detainee ratios were maintained during staff shortages, only one child or young person per unit could be out of their room at a time, usually on an hourly rotation.[1280]

In November 2021, a young person detained at Ashley Youth Detention Centre made a complaint to the Ombudsman alleging they had been unable to attend school programs due to staff shortages.[1281] The Ombudsman's investigating officer noted that it was concerning that a young person could not attend school programs for about a week due to the inability of staff to provide the necessary coverage, and the issue had not been proactively identified or addressed.[1282] We discuss restricted access to education during lockdowns in Section 6.6.2.

Commissioner McLean informed us that, between February and August 2022, her office had received 45 requests for advocacy about restrictive practices and lockdowns, making such practices the most common concern in the requests received during that time.[1283]

We also received concerning evidence from Vincenzo Caltabiano, former Director of Tasmania Legal Aid, and Hannah Phillips, a lawyer with experience working with youth in the Tasmanian justice and child safety systems, that restrictive practices at Ashley Youth Detention Centre have had the effect of limiting children and young people's access to legal representation.[1284]

Lucas Digney, Assistant State Secretary, Health and Community Services Union (Tasmania Branch), told us that the restrictive practices flowing from understaffing resulted in isolation of children and young people at Ashley Youth Detention Centre:

> … they are being kept in their rooms for extended periods of time, and if one of our members wanted to place a young person in their room and they did it without authority, well, they would be disciplined for that because that young person is being isolated. And, I'm sure that most people would agree that that's

> an intolerable situation, that we are detaining young people and we're placing them in a regime of restrictive practice simply because we can't resource the facility where we're housing them.[1285]

Mark Morrissey, former Commissioner for Children and Young People, told us that isolation and lockdowns at Ashley Youth Detention Centre could be construed as constituting torture in the context of the United Nations' Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment ('OPCAT'):

> So, I understand within the OPCAT context … the use of isolation to some people's minds would actually be a form of torture … and we've heard evidence, I think, when I've been listening, of young people being locked in their cells for a week or two or longer alone, often on weekends due to staffing, short staffing, whatever reasons they were locked in their rooms as well. For a young person to be locked in a room, in my view, that does constitute a form of torture …[1286]

In December 2022, the United Nations Committee against Torture (responsible for monitoring the implementation of the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment) stated that it was 'seriously concerned' about 'solitary confinement' practices at Ashley Youth Detention Centre and two other youth detention centres in Australia.[1287] The committee also stated that it considered current practices contravened the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment and the associated United Nations Standard Minimum Rules for the Treatment of Prisoners (also known as the Nelson Mandela Rules).[1288]

In July 2023, the Commissioner for Children and Young People told us that 'rolling lockdowns' continued to occur at Ashley Youth Detention Centre.[1289]

9.2.3 The Department's views on lockdowns

In August 2022, Pamela Honan, Director, Strategic Youth Services in the Department, told us that the increased use of 'restrictive practices' was not satisfactory and that efforts had been made to communicate the context surrounding these restrictions to children and young people in detention:

> I am not happy with staff having to implement restrictive practices, however, it has been explained to detainees that this is not their fault, and it is not a punishment. Staff on site are working with youth workers to ensure young people are rotated out of their rooms and units as much as possible to engage in educational learning, recreation activities and exercise. This occurs for several hours a day on most days but requires a number of staff to work significant overtime.[1290]

Secretary Pervan was asked whether he was aware of the opinion expressed by Mr Morrissey, and with which the Ombudsman agreed, that confining children to their rooms for prolonged periods could constitute torture.[1291] Secretary Pervan responded:

> Without wanting to go to a specific case, only because I don't have the detail in front of me, as I understand—and it's a superficial understanding—the definition of 'torture' in that document goes to intent, and there was, I believe, looking at the past, a use of restrictive practice to—it would be argued by the staff involved it was used as a disciplinary measure, but yet the intent was to cause people to feel bad, it wasn't for their safety, it wasn't for any other purpose but to punish them.[1292]

Secretary Pervan distinguished between lockdowns caused by staff shortages and using isolation as torture:

> There are two profound differences between isolation or restrictive practice being used as torture and what we've seen recently. One is that cognisance that it's damaging to the wellbeing of people to have them in isolation, and that in this instance when we haven't been able to get the young people out for the time that they've been required, the staff there, up to and including Ms Honan, have explained to them what the context is, why it's happening and what we're doing to try and fix it. So they haven't just been locked in their rooms and not told anything; it's been explained to them that its only because we're short of staff and we're doing everything we can to get them out of their rooms, and as soon as we've had more staff on deck they've been back to normal programs and access to services and activities.[1293]

Confining children and young people to their rooms for prolonged periods has serious detrimental effects on their health and wellbeing, regardless of the reason or justification for the confinement. Mr Watson told us that he is:

> … very concerned when young people are restricted to their rooms due to staff shortages. I am concerned that their access to face-to-face schooling is reduced. I am concerned that their access to outside areas is reduced as well as their access to exercise, each other and their families is reduced. I am concerned that young people may have their mental health impacted.[1294]

9.2.4 The Youth Justice Act and inspection standards

As noted, isolation is defined in the Youth Justice Act as 'locking a detainee in a room separate from others and from the normal routine of the detention centre'.[1295] The Youth Justice Act does not define 'normal routine' or 'separate from others'. As discussed in Chapter 11, Case study 3, Ashley Youth Detention Centre and the Department distinguished some practices, such as 'unit bound', from isolation under the Youth Justice Act on the basis that these practices were part of the normal routine of the Centre. We do not agree with this interpretation of the legislation.

Also as discussed in Chapter 11, Case study 3, Ashley Youth Detention Centre and the Department suggested that practices involving locking a young person in a unit with a youth worker did not constitute isolation under the Youth Justice Act on the basis that this is not separation 'from others'.[1296] We consider that the relevant question should be whether a child or young person has been separated from other children and young people, rather than from staff.[1297]

As outlined in Chapter 10, section 133 of the Youth Justice Act gives the detention centre manager the power to authorise the isolation of a child or young person:

- if their behaviour presents an immediate threat to their own safety or the safety of any other person or to property, and all other reasonable steps have been taken to prevent the child or young person from harming themselves, any other person or damaging property, but have been unsuccessful, or[1298]
- 'in the interests of the security of the centre' (this would appear to be the power generally relied on to authorise lockdowns of Ashley Youth Detention Centre).[1299]

The Youth Justice Act also provides that:

- If necessary, reasonable force may be used to place a child or young person in isolation.[1300]
- A child or young person in isolation must be 'closely supervised and observed' at intervals of no longer than 15 minutes.[1301]
- The detention centre manager must ensure the particulars of every use of isolation are recorded in an isolation register.[1302]
- Using isolation as a punishment is prohibited, 'except as provided' in section 133 of the Act.[1303]

The Inspection Standards refer to 'separation, segregation or isolation' but state that 'isolation' is 'the term generally used by Ashley Youth Detention Centre and Children and Youth Services for instances of separation and segregation of young people'.[1304]

According to Standard 8.9:

- A young person should only be separated or segregated in response to an 'unacceptable risk to themselves or others and only when all other means of control have been exhausted' (although this standard contemplates that separation, segregation or isolation may also be necessary 'for the good order of the detention centre').[1305]
- Separation, segregation and isolation should never be used as a sanction or to obtain compliance with staff instructions.[1306]
- Separation, segregation or isolation should be for the minimum time necessary.[1307]
- Staff should closely supervise a child or young person in separation or segregation, who should not be left for long periods with nothing to occupy them.[1308]
- The conditions of separation or segregation should 'provide no less amenity than normal accommodation', except where a child or young person is separated due to a serious risk of suicide or self-harm.[1309]

- A register recording details of the separation and the young person's routine while in separation should be maintained.[1310]

9.2.5 Custodial isolation procedures

The key policy and procedure document currently in place to guide the isolation of children and young people at Ashley Youth Detention Centre is the *Use of Isolation Procedure* dated 1 July 2017 ('Isolation Procedure').[1311] The Isolation Procedure defines 'isolation' in the same way as the Youth Justice Act, but specifies considerably more detailed requirements for using isolation than the Youth Justice Act and the Inspection Standards.[1312] As discussed in Chapter 11, Case study 3, staff at Ashley Youth Detention Centre do not appear to have applied the Isolation Procedure to some practices that involved the isolation of children and young people, such as 'unit bound'.

According to the Isolation Procedure:

> Isolation is a prohibited action, except for in very specific circumstances. All other reasonable steps must be taken before its use is considered. Where it is authorised it must be kept to the minimum time necessary to ensure the safety of individuals or property. The goal is to help the young person reintegrate into the group as safely and as quickly as possible.[1313]

The Isolation Procedure:

- requires youth workers to 'make every effort' to help a young person whose behaviour is escalating to regain control of their behaviour before resorting to isolation[1314]
- includes a (non-exhaustive) list of actions youth workers can take in response to a young person's escalating behaviour—these include identifying and removing the trigger for the behaviour, redirecting the young person's attention, offering a task such as exercising or listening to music, and asking another youth worker to take over supervision of the situation[1315]
- states that authorisation of isolation under the Youth Justice Act 'in the interests of the security of the centre' might include isolation 'to prevent or control a security breach' such as a riot, power failure, breach of the perimeter, or an escape, or 'to allow order or control to be restored to the Centre (or to prevent its anticipated loss)'[1316]
- requires isolation to be authorised by the Centre Manager or their delegate (discussed below) in person, by phone or in writing[1317]
- states that, to authorise isolation, the Centre Manager (or their delegate) must be satisfied that 'isolation is a reasonable intervention under the circumstances and is in accordance with the legislation and this procedure'[1318]
- prohibits the commencement of isolation until authorisation is obtained.[1319]

Before or as soon as possible after isolation has been authorised, the Centre Manager (or their delegate) must undertake an assessment to determine the conditions for the care and treatment of the young person while in isolation, in consultation with health services staff and members of Ashley Youth Detention Centre's Multi-Disciplinary Team (discussed in Section 6.4.1) who are on site at the time.[1320] The assessment must consider matters such as the needs of the young person, any trauma history, their response to previous isolations, the risk of suicide or self-harm and their relationships with particular staff and other children and young people.[1321]

The Centre Manager (or their delegate) sets the conditions of isolation, which must be recorded on the authorisation form, in relation to:

- the period of isolation—this must be the shortest period that is appropriate in the circumstances and can involve an initial period of 30 minutes, an extension of the initial period to three hours and further extensions subject to an approval process (outlined below), but the total time in isolation cannot exceed 12 hours[1322]
- supervision and observation requirements—an observation must occur at least every 15 minutes and more often where there are concerns for the young person's wellbeing, and observations must be recorded and signed by the observer[1323]
- medical reviews—a young person in isolation must be checked by the Correctional Primary Health Services nurse every three hours and by a medical practitioner after seven hours (or earlier on the advice of the nurse)[1324]
- 'other conditions'—this may include specifying safe and therapeutic items to be left with the young person (such as playing cards or drawing materials) or access to a support person, cultural advisor or youth worker[1325]
- arrangements following the young person's release from isolation—for example, whether they should be referred to 'an appropriate health service'.[1326]

To extend isolation beyond a three-hour period, the Centre Manager (or their delegate) must:

- review the observation records prepared during the period of isolation
- consult with the Correctional Primary Health Services nurse or medical practitioner and available members of the Multi-Disciplinary Team
- consult with the Director, Strategic Youth Services on the outcome of these consultations
- complete the 'Authorisation for Extension of Isolation' form, noting any new conditions of the isolation or change to conditions.[1327]

As discussed in Chapter 11, Case study 3, in December 2021, the instrument dealing with delegation of authorities and powers at Ashley Youth Detention Centre was revised. The 2021 delegation instrument provides as follows:

- The Assistant Manager of the Centre may exercise the power to isolate a young person under the Youth Justice Act.[1328]
- The Director, Strategic Youth Services or the Operations Manager may exercise the power to isolate a young person under the Youth Justice Act if the Centre Manager and the Assistant Manager are 'on leave, uncontactable, or unable for any other reason to perform the relevant function'.[1329]
- An Operations Coordinator may authorise isolation for a period of 30 minutes.[1330]
- A youth worker may exercise the power to isolate a young person under the Youth Justice Act, only for an initial period of 30 minutes and only if the youth worker is performing the duties of the Operations Coordinator.[1331]

The Centre Manager (or their delegate) must ensure 'the particulars of every use of isolation' are recorded in the isolation register.[1332] Since 2017, the isolation register has been recorded electronically.[1333] Each month, a report that includes the isolation register 'and associated documents' is sent to the Commissioner for Children and Young People and the Custodial Inspector.[1334] Commissioner McLean told us that:

> … the quality and reliability of the [Ashley Youth Detention Centre isolation] data is questionable and there can be inconsistencies between the reports we receive from children and young people about the use of such practices, and the data.[1335]

In response to this comment, the Department told us that it was continuing 'to look at the collection and reporting of data sets that relate to youth justice, with a view to improving both the integrity and timeliness of that data being reported'.[1336]

The Isolation Procedure requires the Centre Support Team (now known as 'Weekly Review Meetings'—refer to the discussion in Section 6.4.1) to conduct monthly reviews of the use of isolation. These reviews must focus on any patterns of use, any strategies that have been useful in reducing isolation use or reducing the length of time someone is in isolation, and how that information can be used to inform staff training, supervision and program scheduling.[1337] The Centre Support Team must forward this information to the Centre Manager (if they were not at the meeting) and the Director, Strategic Youth Services.[1338]

Secretary Pervan told us that isolations data is analysed monthly for the Director and that 'if a pattern is identified' for a particular young person or staff member, 'the Director will ask the Manager, Custodial Youth Justice for more information to determine whether there is an issue with the young person or staff member'.[1339] Secretary Pervan also told us that the Commissioner for Children and Young People is provided with copies of minutes from Weekly Review Meetings and with monthly isolation summaries.[1340]

The Isolation Procedure states that the Quality Improvement and Workforce Development Team randomly selects incidents that involved isolation to assess whether isolation was appropriately authorised, observations were carried out appropriately, the period of isolation was appropriate, and if isolation use was accurately recorded in the isolation register.[1341] This team no longer exists, so this safeguard is now missing.

Secretary Pervan also told us that, following an isolation, an evaluation of the isolation episode is conducted at the next meeting of the Multi-Disciplinary Team.[1342]

9.2.6 Our recommendations on isolation and lockdowns

Definition of isolation and amendments to the Youth Justice Act

We consider that any practice involving a child or young person in detention being confined to their room or unit and prevented from having contact with other children and young people (outside the normal overnight routine) constitutes isolation and should be managed in accordance with the law, standards and procedural requirements for isolation, regardless of the label used to refer to the practice. In particular, a practice should be considered isolation even if a child or young person is confined to a unit with a member of staff. This should be made clear in the Youth Justice Act. This change should ensure all isolation practices (broadly defined) are authorised and recorded according to the appropriate procedure.

Isolation must not be used as punishment for perceived poor behaviour. As discussed in Chapter 11, Case study 3, many instances of isolation of children and young people at Ashley Youth Detention Centre were connected to the Behaviour Development System (later renamed the Behaviour Development Program) and were, ultimately, used as a form of punishment for perceived inappropriate or poor behaviour. In Section 6.3.4, we recommend that the Behaviour Development Program be discontinued.

The list of 'prohibited actions' in the Youth Justice Act refers to 'the use of isolation, within the meaning of section 133, as a punishment except as provided in that section'.[1343] In our view, as currently worded, this provision can be read as allowing isolation as a punishment where it is carried out in line with section 133. This can be contrasted with the equivalent Victorian provision in the *Children, Youth and Families Act 2005* (Vic), which simply lists as a prohibited action 'the use of isolation (within the meaning of section 488) as a punishment'.[1344] We recommend that the Youth Justice Act be amended to state more clearly that isolation must not be used to punish a child or young person.

We note that, in New South Wales, the *Children (Detention Centre) Act 1987* (NSW) makes it a criminal offence for a person to punish a detainee or cause a detainee to be punished by 'segregating' them in contravention of section 19 of that Act.[1345] We recommend that the use of isolation as a punishment be made a criminal offence in Tasmania.

We also recommend that the Youth Justice Act explicitly refers to the principle that isolation should only be used as a measure of last resort and for the minimum time necessary.

Changes to the Isolation Procedure

We recommend that the Department clarifies delegations for the purposes of authorising isolation and extensions of isolation, and that these delegations be specified in the Isolation Procedure. In particular, the circumstances in which the Centre Manager or Assistant Manager are 'uncontactable, or unable for any other reason to perform the relevant function' should be clarified, so all staff and managers of detention facilities and others in the Department have a clear understanding of authorisation processes for isolation. As described in Chapter 11, Case study 3, the need to clarify this was highlighted by the independent investigation of an incident that occurred at Ashley Youth Detention Centre in December 2019 involving the isolation of children and young people at the Centre.

We also recommend that the Department alters the Isolation Procedure to require authorisation to extend a period of isolation beyond three hours to be provided by a senior departmental official, rather than by the Centre Manager. We consider such oversight to be necessary given the serious and detrimental effects of extended isolation on children and young people's mental health and wellbeing.

We also recommend that the Department publishes the Isolation Procedure on its website.

Staff understanding and implementation of isolation procedures

As discussed in Chapter 11, Case study 3, we are concerned about inconsistencies in Ashley Youth Detention Centre staff and managers' understanding of isolation procedures, particularly in relation to which circumstances amounted to isolation and the authorisation processes when the practice was identified as isolation.

It is vital that departmental and detention centre managers and staff understand what practices amount to isolation and the procedures for authorising and implementing lawful and appropriate isolation of children and young people.

It is also important to ensure isolation is not being used as a primary or default response to children and young people who display difficult, challenging or complex behaviour, or as a punishment for negative behaviour. The Draft Youth Justice Blueprint refers to the fact that the best-performing youth justice systems achieve safety and security 'primarily through relationships' rather than isolation.[1346] This requires, at a minimum, comprehensive, ongoing training and professional development for operational staff in de-escalation techniques and the appropriate use of isolation. Our recommendation for training on the use of isolation is discussed in Section 9.4.

However, we also consider that cultural change may be required to ensure staff comply with isolation laws and procedures in detention. As discussed in Chapter 11, Case study 3, we hold concerns that a punitive culture may have been supported and applied by some staff at Ashley Youth Detention Centre, who may have taken opportunities, whenever they arose, to nullify reforms to isolation procedures and return to more punitive isolation practices.

In Section 4.2, we discuss resistance to change among some staff at Ashley Youth Detention Centre. To address this issue and achieve meaningful cultural change in youth detention, in Section 4, we recommend significant reforms in the areas of staffing, leadership, governance and children's participation.

Changes to reporting and oversight

We consider that there needs to be greater Department oversight of isolation in detention. As discussed in Chapter 11, Case study 3, it is not clear that the Centre Manager routinely reported all uses of isolation to the Department, as opposed to doing so only in instances where isolation formed part of a response to a critical incident on site. Secretary Pervan told us that '[t]he Director is informed contemporaneously with any periods of isolation that extend beyond three hours', but this is not reflected in the Isolation Procedure.[1347] Updating the Isolation Procedure to require authorisation for isolation longer than three hours from a senior departmental official (as recommended) will improve departmental oversight of isolation.

The Isolation Procedure refers to monthly reviews of isolations at Ashley Youth Detention Centre being provided to the Director, and regular audits of isolations being undertaken by the Department's Quality Improvement and Workforce Development Team. As mentioned in Section 9.2.5, this team no longer exists and we are not aware that its functions for monitoring isolations are currently performed by any other team in the Department.[1348]

The Department should provide monthly reports on isolation to the Secretary. This is important for effective internal oversight of youth detention, particularly given the previous lack of transparent reporting from Ashley Youth Detention Centre to senior officials in the Department.

The Department should not rely solely on Ashley Youth Detention Centre's analysis of isolations data. As with searches, we recommend quarterly reporting on isolations to the new Quality and Risk Committee, which should monitor trends and patterns in isolation use and identify any areas of concern.

We also recommend, at a minimum, monthly reporting of isolation data—including the register and all relevant supporting documentation—to the new Commission for Children and Young People (Recommendation 18.6). In response to a draft of this chapter, Commissioner McLean proposed that the Department be required to report isolations

to the Commission for Children and Young People within 24 or 48 hours of each isolation incident.[1349] We have not tested the feasibility of this proposal with the Government. The Government should work with the Commission for Children and Young People to determine an appropriate regime for the reporting of isolation data that prioritises the safety of children and young people.

In addition, to acknowledge the importance of these issues and to strengthen transparency and accountability, we recommend that the Department publishes quarterly data about isolation in youth detention.

Changes to address lockdowns

We acknowledge that, even in a well-run detention facility, occasional lockdowns may be unavoidable. However, we are deeply concerned about the prolonged, rolling lockdowns that have occurred at Ashley Youth Detention Centre in recent years due to chronic understaffing and the seriously detrimental impact of these lockdowns on the mental and physical wellbeing of children and young people in detention. We understand that, as recently as July 2023, lockdowns brought on by staff shortages continued at the Centre, with children and young people locked in their rooms or units for up to 23 hours a day.[1350]

We acknowledge that there was no suggestion made to us by the Department or Ashley Youth Detention Centre management or staff that lockdowns were beneficial or did not present a significant cause for concern. We also acknowledge that, to some degree, especially in relation to the COVID-19 pandemic, understaffing has been beyond the direct control of the Centre's management and the Department. However, as discussed in Section 4.7.2, while sometimes framed by management and departmental officials as a recent phenomenon, staff shortages have been a longstanding issue at Ashley Youth Detention Centre.

As discussed in Section 4.2.2, understaffing damages staff morale, increases workloads and creates risks to staff safety. Lockdowns imposed when there are not enough staff can make children and young people 'agitated and more difficult to engage with' when they are released from their rooms, which 'leads to frustration and confrontation between staff and detainees'.[1351] This can, in turn, lead to further reductions in staff numbers, creating a cycle that is difficult to break.

The persistent nature of staff shortages at Ashley Youth Detention Centre requires the Department to take steps to ensure the Centre is appropriately staffed to provide therapeutic responses to children and young people and avoid the need for lockdowns. We make recommendations to improve staff recruitment and retention in Section 4.7.3. We anticipate that implementation of these recommendations will reduce the need for lockdowns.

We understand that the power to authorise a lockdown of a youth detention facility arises from the power in the Youth Justice Act to authorise isolation of a child or young person 'in the interests of the security of the centre'.[1352] Isolation under this provision is covered by the Isolation Procedure, although the relevant part of the procedure does not refer to lockdowns.

We made a number of requests for information about the policies and processes under which children and young people in detention are isolated and how the use of isolation is monitored.[1353] Although we did not receive evidence on the process for authorising lockdowns at Ashley Youth Detention Centre, it was not clear to us that the Isolation Procedure was followed. That procedure would require individual assessments to be undertaken for every child or young person to be subjected to a lockdown before it could be authorised, with individual plans for how each child or young person's isolation during the lockdown should be managed. It would also require the isolation of each child and young person as part of a lockdown to be entered on the isolation register.

While we acknowledge that the Isolation Procedure focuses primarily on 'behavioural' isolations, and does not appear to contemplate facility-wide lockdowns, it is concerning if proper procedures are not being followed for the isolation of children and young people through lockdowns. In recognition of the serious impact of lockdowns on children and young people in detention, we recommend that Ashley Youth Detention Centre (and any future detention facility) records information about lockdowns, including unit-specific lockdowns, separately from isolations occurring in response to behaviour. This should include the reason for the lockdown, the number of children and young people subjected to the lockdown, the duration of the lockdown and the measures taken to meet children's and young people's needs, and support their health and wellbeing during the lockdown.

Lockdown data should be provided to the new Commission for Children and Young People (Recommendation 18.6), monthly or more frequently, and be published regularly on the Department's website. We note that, in Victoria, the Department of Justice and Community Safety publishes quarterly data on 'behavioural based' isolations and 'isolations based on the security of the centre concerns' (lockdowns) in youth justice centres.[1354]

Recommendation 12.32

1. The Tasmanian Government should introduce legislation to amend the *Youth Justice Act 1997* to ensure the Act:
    a. makes clear that confining a detainee in their room or unit and preventing them from having contact with other detainees (other than overnight) constitutes isolation, regardless of the label used to refer to the practice
    b. clarifies that the use of isolation as a punishment is a prohibited action and makes it a criminal offence for a person to punish a detainee by isolating them or causing them to be isolated
    c. refers expressly to the principle that isolation should only be used as a measure of last resort and for the minimum time necessary.
2. The Department for Education, Children and Young People should:
    a. update the Department's *Use of Isolation* procedure to
        i. make clear that confining a detainee in their room or unit and preventing them from having contact with other detainees (other than overnight) constitutes isolation, regardless of the label used to refer to the practice
        ii. specify clearly who is a delegate of the Secretary or the detention centre manager for the purpose of authorising isolation and extensions of isolation
        iii. require isolation beyond three hours to be authorised by a senior departmental official such as a Director
        iv. specify internal and external reporting requirements in relation to isolation
    b. publish the updated *Use of Isolation* procedure on the Department's website
    c. ensure Ashley Youth Detention Centre (and any future detention facility) records information on lockdowns, including the reason for the lockdown, details of authorisation processes, the duration of the lockdown, the number of children and young people isolated during the lockdown, measures adopted during the lockdown to meet the needs of children and young people and support their health and wellbeing, and steps taken after the lockdown to address its effects on children and young people

d. ensure Ashley Youth Detention Centre (and any future detention facility) provides

   i. monthly reports on isolation and lockdowns in detention to the Secretary

   ii. quarterly reports on the isolation of children and young people in detention and lockdowns to the Quality and Risk Committee (Recommendation 9.5) to enable it to monitor trends and identify any areas of concern

   iii. the isolation register (with all relevant supporting documentation) and separate data on lockdowns to the Commission for Children and Young People (Recommendation 18.6) on a monthly basis or more frequently, as agreed with the Commission for Children and Young People

e. publish quarterly data on isolation and lockdowns in youth detention.

9.3 Use of force

As outlined in Chapter 10, according to international legal instruments, the use of force in detention is only permitted when it is strictly necessary—that is, where the child poses an imminent threat of injury to themselves or others—and where other methods of control have been exhausted.[1355] When force is deemed necessary, it must be used: by properly trained staff; for the shortest possible time or a limited time; without causing humiliation and degradation; and only in self-defence, in response to attempted escape or in response to active or passive physical resistance.[1356]

9.3.1 What we heard about the use of force in detention

As discussed in Chapter 11, Case studies 1 and 4, we heard evidence about some staff regularly using force against children and young people at Ashley Youth Detention Centre. Some of the experiences shared by victim-survivors about the use of force included:

- force and restraints being used to effect strip searches
- children and young people being restrained as part of isolation practices
- force, restraints and violence being used to punish children and young people for not following orders or for reporting abuse
- staff using violence against children and young people, and encouraging violence amongst them, as a form of humiliation
- force, restraints and violence being used to facilitate staff members' sexual abuse of children or young people, or in connection with sexual abuse.

As detailed in Chapter 11, Case studies 1 and 4, we heard allegations that children and young people detained at Ashley Youth Detention Centre had been pinned down by staff members for relatively minor infractions, had their heads deliberately slammed against furniture and walls, been handcuffed for hours at a time, been dragged while handcuffed, had bones broken by staff, and had staff target them for physical violence. We discuss the punitive culture at Ashley Youth Detention Centre in Section 4.2.

In Chapter 11, Case study 4, we find that:

- Most, if not all, the accounts we heard describe an excessive, unreasonable or likely illegal use of force by some staff at Ashley Youth Detention Centre.
- Victim-survivors' accounts, viewed as a whole, suggested a pattern of some staff using force instead of de-escalation techniques to manage young people's behaviour.
- Various reviews of inappropriate uses of force at Ashley Youth Detention Centre from 2016 to 2017 identified that force was used other than as a last resort or when there were no obvious threats to staff or others.
- The excessive use of force has been a longstanding method of abusing children and young people by some staff at Ashley Youth Detention Centre, and the Department and Tasmanian Government have not always responded appropriately.

Commissioner McLean told us that children and young people in custody consistently raise concerns with her regarding the excessive use of force and that:

> use of force incidents against children and placing the child in isolation are closely interrelated, often causally and cyclically: an isolation event leading to behaviour of a child where force is used, causing further isolation, and so on.[1357]

At our hearings in August 2022, Mr Watson indicated that he believed that the use of force had decreased recently due to increased closed-circuit television camera coverage and hard drive capacity to store the footage, but conceded that force was still used too often:

> My Director's Executive Assistant has been in her role for 25 years and I can recall her saying to me on two months in a row, this is the first time in her 25 years that she can recollect no use of force and no isolation for the centre … That's something that, you know, when I first started, use of force and isolation were reasonably common and it's something that I'm—I believe is far less common today; however, it's still too high. We're still working to reduce it further.[1358]

We discuss the limited coverage of closed-circuit television cameras at Ashley Youth Detention Centre in Section 6.2.

9.3.2 The Youth Justice Act and inspection standards

As outlined in Chapter 10, the Youth Justice Act prohibits the use of physical force against a child or young person unless it is reasonable and:

- necessary to prevent the child or young person from harming themselves or anyone else, or from damaging property
- necessary for the security of the centre, or
- otherwise authorised under the Youth Justice Act or at common law—reasonable force may be used to carry out a search or to place a child or young person in isolation.[1359]

The Youth Justice Act also prohibits any action that inflicts, or is intended to inflict, physical pain or discomfort on a child or young person in detention as a punishment.[1360]

If force is used in the context of a search, this must be reported to the person in charge of the facility.[1361]

The Inspection Standards set a higher standard than the Youth Justice Act for when force can be used and the conditions of its use. The standards state that force must only be used 'when it is necessary to prevent an imminent and serious threat of self-harm or injury to others, and only when all other means of control have been exhausted'.[1362] The Inspection Standards also state that:

- force must only be used for 'the shortest time required'[1363]
- force should never be used as a sanction or to obtain a young person's compliance with staff instructions[1364]
- the use of force should not cause humiliation or degradation[1365]
- all instances of force should be recorded, investigated and reported[1366]
- a young person who has been subjected to force should be provided with health care following the incident and offered the opportunity to discuss the incident with a staff member who was not involved[1367]
- parents and carers are notified of incidents of restraint or force where appropriate.[1368]

9.3.3 Custodial procedures on the use of force

The key policies and procedures on the use of force at Ashley Youth Detention Centre are the:

- *Use of Physical Force Procedure* dated 10 December 2018 ('Use of Force Procedure')[1369]

- *Minimising the Use of Physical Force and Restraint Practice Advice* dated 1 July 2017 ('Use of Force Practice Advice')[1370]
- *Use of Mechanical Restraints (Handcuffs) Procedure* dated 21 October 2019[1371]
- *Use of Mechanical Restraints Practice Advice* dated 21 October 2019.[1372]

Together, these documents prohibit:

- using 'excessive force', which is defined to include 'any force when none is needed', 'more force than is needed', 'any force or level of force continuing after the necessity for it has ended', and 'knowingly wrongful use of force'[1373]
- using a technique or hold 'that is not proportionate to the level of risk present' or for longer than required, use of positions that make it difficult for the young person to breathe, and use of body weight to sit or lie across a young person's back or stomach[1374]
- applying direct pressure to the neck, thorax, abdomen, back or pelvic area[1375]
- using handcuffs except where 'it is reasonable and necessary to prevent harm to a person, property or for the security of the Centre and all other means of control have been exhausted and failed' (handcuffs 'must never be used as a punishment')[1376]
- using any type of mechanical restraint other than handcuffs[1377]
- using force against a young person to facilitate compliance with an order or direction from a staff member.[1378]

The Use of Force Procedure advises staff that, where excessive use of force is suspected, they may be subject to 'internal and/or external investigation' and 'disciplinary and/or criminal proceedings'.[1379]

According to the Use of Force Practice Advice, '[t]he use of force is considered a severe measure that should only be carried out as a last resort'.[1380] If a young person appears unsettled or anxious, or if an incident is escalating, the Use of Force Procedure requires staff to 'alert the Operations Coordinator and other relevant staff' to discuss and assess the level of risk, and strategies to reduce the chance of an incident occurring or escalating.[1381] When undertaking a risk assessment, staff are encouraged to consider matters such as what is going on in the young person's life as well as the young person's developmental age, mental or physical traits, substance use, history of incidents and previous reactions to the use of force.[1382]

The Use of Force Practice Advice emphasises the importance of communicating with the young person, using non-threatening body language, listening, asking open-ended questions, guiding them towards making positive behaviour choices and being 'specific and gentle, but firmly directive' about the desired behaviour.[1383]

To assess whether force is an appropriate response, staff must consider whether it is 'proportionate', 'lawful', 'accountable' (staff must be able to justify using force and explain why other options were not used), 'necessary' (the force must be required to fulfil a staff member's duty of care), and 'ethical' (the use of force must 'reflect human rights principles').[1384]

When force is required, staff must:

- 'apply the minimum amount of physical force necessary using an approved technique to gain control of the young person's behaviour'[1385]
- continuously monitor the young person for signs of distress and continue talking to the young person throughout the incident, making it clear that the use of force will stop when it is no longer necessary to protect the young person or others[1386]
- 'discontinue the use of force as soon as the young person has become compliant'.[1387]

Following a use of force, the Operations Manager must review closed-circuit television camera footage of the incident as soon as practicable and the Operations Coordinator must:[1388]

- report the use of force to the Centre Manager[1389]
- put in place a plan to debrief the young person if required, review the young person's 'behaviour goals and strategies' and address the need for any 'post incident intervention'[1390]
- ensure any injured staff have been attended to and 'conduct a debrief for all staff involved in the incident to ensure they are safe and well before they go home'.[1391]

The Correctional Primary Health Services nurse must 'sight every young person who has been restrained, assess for possible injury and treat as required'.[1392]

Relevant staff must record the details of the use of force on the 'Use of Force Register' and 'follow the Incident Reporting procedure'.[1393] We understand this to be a reference to the *AYDC Incident Reporting Procedure* dated 1 July 2018 ('Incident Reporting Procedure').[1394] The purpose of that procedure is to 'outline the steps that staff at Ashley Youth Detention Centre must take following an incident that has arisen from the behavior/s of a young person or multiple young people'.[1395] The Incident Reporting Procedure does not define 'incident'.

According to the Incident Reporting Procedure:

- Staff must report information about the incident and the young person—this includes identifying 'whether restrictive practices were used and what type (use of force, mechanical restraints, isolation)' and recommending 'a level of seriousness (recorded incident, minor incident or detention offence)' for the incident.[1396]

- The Centre Support Team (now known as 'Weekly Review Meetings') must review the circumstances of the incident.[1397]
- The Centre Manager must review the incident, decide on further actions required and advise the Director, Strategic Youth Services 'as appropriate'—if notified, the Director must decide whether an independent investigation is called for and the type of investigation.[1398]

Ms Honan told us that incident reporting is escalated to her 'if there is a significant event such as sexual/physical assault, damage to property, disturbance, self harm, [or] escape' and that she is notified of '[a]ll incidents of injury or harm to a young person'.[1399] This list would not cover all uses of force. Ms Honan also told us that, in 2020, the 'Ashley Incident Management System'—a centralised system for electronic recording of incidents—was implemented and all staff were trained in using this system.[1400]

The Use of Force Procedure requires the Centre Support Team to conduct monthly reviews on the use of force and to forward this information to the Centre Manager and the Department.[1401] Ms Honan told us she receives monthly reports on the use of force.[1402]

The Use of Force Procedure also contemplates the review of an agreed number of randomly selected incident reports involving the use of force to establish whether force was appropriate and accurately recorded in the use of force register, but does not specify who should conduct these reviews or how often they should be conducted.[1403]

9.3.4 Recent reforms

The Keeping Kids Safe Plan refers to the Department establishing an 'Incident Review Committee' at Ashley Youth Detention Centre, in September 2022, to 'review incidents on a weekly basis for compliance with policy and procedure, follow up actions based on review findings and to identify learning areas to support staff'.[1404] This committee is chaired by the Director, Custodial Operations, and its members include the Director, Strategic Youth Services and the Centre Manager.[1405] The committee reports to the Executive Director, Services for Youth Justice.[1406]

According to the Incident Review Committee's terms of reference, its functions are to review 'all serious/major incidents that occurred over the last 7 calendar days' and 'agree actions to be undertaken or make recommendations arising from the serious/major incident'.[1407] The terms of reference anticipate that 'relevant footage will be downloaded, reviewed and discussed by the committee members during the meeting'.[1408]

We are unsure how the work of the Incident Review Committee intersects with or complements the work of the Risk Assessment Process Team, which also reviews serious incidents (refer to Chapter 10).

Further, the division of responsibility between the Incident Review Committee and the Weekly Review Meetings in reviewing incidents weekly at Ashley Youth Detention Centre is unclear to us. It may be that the Incident Review Committee is responsible for reviewing only 'serious/major' incidents, while all other incidents are considered at the Weekly Review Meetings. It would be beneficial to clarify this in the Incident Reporting Procedure.

The Keeping Kids Safe Plan also states that Ashley Youth Detention Centre 'reports all critical incidents and follow up actions to both the [Commissioner for Children and Young People] and Custodial Inspector on a real time basis'.[1409] However, Commissioner McLean told us that she does 'not receive reports of all critical incidents' at Ashley Youth Detention Centre and that, when she is notified of incidents, it is 'certainly … not in "real time"'.[1410] She also stated that she is 'not generally provided with sufficient detail to understand what has occurred and what has been done in response to the incident'.[1411]

9.3.5 Minimising the use of force in detention

The Inspection Standards impose a more stringent standard than the Youth Justice Act for the use of force in detention by not permitting force solely to prevent damage to property or where 'necessary for the security of the centre'.[1412]

We recommend amendments to the Youth Justice Act to more closely reflect the Inspection Standards. In particular, the Youth Justice Act should provide that force should only be used against a child or young person in detention when reasonable and necessary to prevent an imminent and serious threat of harm to the child or young person or to others, or to prevent an imminent escape, and when all other means of control have been exhausted. Force should be used for the shortest time necessary and should never be used to punish a child or young person or to secure their compliance with an instruction or direction. We consider that these changes would enable the use of force to prevent an assault, harmful sexual behaviours or the destruction of property that involves an imminent threat of serious harm to a person.

We do not recommend any changes to the existing provisions of the Youth Justice Act in relation to the use of force to carry out a search or to place a child or young person in isolation, noting we make recommendations in Section 9.2.6 directed at minimising the use of isolation.

We also recommend that the Youth Justice Act makes it a criminal offence for a person to use force against a child or young person in detention in contravention of the Act. We note that section 22 of the *Children (Detention Centres) Act 1987* (NSW) makes it a criminal offence to subject a detainee to a range of punishments, including striking them or subjecting them to any other form of physical violence, or to handcuff or forcibly restrain a detainee without reasonable excuse.[1413]

The Use of Force Procedure is considerably more comprehensive than the Youth Justice Act in terms of controls, checks and balances on the use of force. However, we consider that it could be strengthened to reflect extra safeguards in the Inspection Standards, namely:

- the requirement to provide every child or young person who has been subjected to force with health care (as opposed to the current requirement for the nurse to 'sight every young person who has been restrained')[1414]
- the requirement to offer every child or young person who has been subjected to force the opportunity to discuss it with a staff member who was not involved (as opposed to the current requirement to '[d]ebrief the young person … if required')[1415]
- the requirement to notify parents and carers of incidents of force or restraint where appropriate.

We also recommend that the Use of Force Procedure be updated to require all uses of force to be reported immediately to a senior departmental official such as a Director.

Consistent with our recommended approach to reporting on searches, isolation and lockdowns, we recommend monthly reporting on the use of force to the Secretary, and quarterly reporting to the Quality and Risk Committee to monitor trends and patterns in the use of force.

Data on the use of force should also be reported to the new Commission for Children and Young People (Recommendation 18.6). The Commissioner for Children and Young People proposed that such reporting occur within 24 or 48 hours of each use of force incident.[1416] However, we have not tested the feasibility of this proposal with the Government. We recommend monthly reporting, at a minimum, on the use of force to the new Commission. The Government should work with the Commission for Children and Young People to determine an appropriate frequency for the reporting of data on the use of force in youth detention.

Finally, we are concerned that incidents examined in Chapter 11, Case study 4, reveal that staff did not follow procedure. We address this in the next section.

Recommendation 12.33

1. The Tasmanian Government should introduce legislation to amend the *Youth Justice Act 1997* to provide that:
    a. subject to sections 25E and 133, force may only be used when reasonable and necessary to prevent an imminent and serious threat of harm to a person or to prevent an imminent escape, and when all other means of control have been exhausted
    b. force must be used for the minimum time necessary
    c. force must never be used to punish a child or young person, or solely to secure their compliance with an instruction or direction
    d. using force in contravention of the Act is a criminal offence.
2. The Department for Education, Children and Young People should:
    a. update the Department's *Use of Force* procedure to
        i. require all uses of force to be immediately reported to a senior departmental official, such as a Director, in addition to identifying the use of force as part of an incident report
        ii. require every child or young person who has been subjected to the use of force to be provided with health care and offered the opportunity to discuss the incident with a staff member who was not involved
        iii. require parents and carers of a child or young person who has been subjected to the use of force to be notified
        iv. specify internal and external reporting requirements in relation to the use of force
    b. publish the updated *Use of Force* procedure on the Department's website
    c. ensure Ashley Youth Detention Centre (and any future detention facility) provides
        i. monthly reports on the use of force in detention to the Secretary
        ii. quarterly reports on the use of force in detention to the Quality and Risk Committee (Recommendation 9.5) to enable it to monitor trends and identify any areas of concern
        iii. the use of force register and all relevant supporting documentation to the Commission for Children and Young People (Recommendation 18.6) on a monthly basis or more frequently, as agreed with the Commission for Children and Young People.

9.4 Training on searches, isolation and use of force

In Section 4.7.3, we recommend continuing professional development for youth workers on: expected standards of behaviour in interacting with children and young people; the human rights of children and young people in detention; approaches to setting fair, clear and firm boundaries for children and young people's behaviour within a therapeutic, trauma-informed framework; and training in all custodial policies and procedures.

As noted throughout this section, there is a particular need for ongoing training and professional development for youth detention centre staff in laws, policies and procedures on searches, isolation and the use of force. We consider that it is also important for staff of the Department's Youth Justice Services directorate (including leadership) who are not based at Ashley Youth Detention Centre to be familiar with the laws, policies and procedures for these practices. This would ensure consistency of understanding across the Department, strengthen internal oversight of restrictive practices in detention and improve those practices.

Accordingly, we recommend joint training for staff of youth detention facilities and other relevant youth justice staff in the Department on the laws, standards, policies and procedures on isolation, the use of force and personal searches of children and young people in detention. While we consider that such training will help change practices at Ashley Youth Detention Centre, training alone is not enough. In Section 4, we make recommendations designed to achieve broader cultural change in youth detention and ensure past harmful practices do not continue.

There is also a need to ensure police understand legislative and procedural requirements for restrictive practices in youth detention. In Chapter 11, Case study 7, we find that Tasmania Police should improve its responses to allegations of child sexual abuse made by current and former detainees at Ashley Youth Detention Centre. Our suggestions for improvement include ensuring police have ready access to guidance on Tasmanian law in relation to personal searches, isolation and the use of force so they can readily identify when alleged conduct falls outside the parameters of acceptable professional conduct and may indicate that a crime has occurred. We make a recommendation to this effect here. We consider that this guidance will also assist police who carry out searches of children and young people in police custody.

Recommendation 12.34

1. The Department for Education, Children and Young People should provide regular joint training and professional development for staff who have contact with children and young people in youth detention facilities and relevant staff of the Youth Justice Services directorate on laws, standards, policies and procedures regarding the use of isolation, the use of force and searches of children and young people in detention to ensure consistency in understanding and application. This training should be mandatory.
2. Tasmania Police should ensure its members receive regular training and guidance on laws and procedures on the use of isolation, the use of force and searches of children and young people in detention to enable police to readily identify conduct that falls outside the parameters of acceptable professional conduct among staff and may constitute a criminal offence.

10 Responding to concerns, complaints and critical incidents in youth detention

Effective complaints processes are critical to creating a safe detention environment. Children and young people in detention who have a concern—for example, about the services they have received or not received while in detention, or about the behaviour of staff or other children and young people, including child sexual abuse—need a clear, safe and accessible process to raise the concern and make a complaint, and to have confidence that it will be taken seriously and responded to appropriately. Effective processes are also required for the family members of children and young people in detention or detention facility staff who want to raise a concern about the treatment or safety of a child or young person in detention.

Complaints from or about a child or young person in detention can be responded to 'internally' (by the detention facility or by the Department) or 'externally' (by an independent oversight body). In Section 11, we discuss the role of external oversight bodies in supporting children and young people in detention to raise concerns about their treatment (including making a formal complaint about the Department to the Ombudsman) and advocating to resolve their concerns.

In this section, we examine the internal processes of Ashley Youth Detention Centre and the Department for identifying and responding to concerns and complaints from or about children and young people in detention, including those involving child sexual abuse and other serious allegations.

The case studies in this volume indicate serious problems with the Department's responses to concerns, complaints and critical incidents in detention involving risks to the safety of children and young people in detention. In Chapter 11, Case study 2, we find that Ashley Youth Detention Centre has been aware of harmful sexual behaviours at the Centre and has not taken steps to protect children and young people from these behaviours. As discussed in that case study, when harmful sexual behaviours occurred, staff or Centre management often failed to respond appropriately—whether by not removing the risks, not supporting the victim-survivor, or punishing them for making a complaint.

In Chapter 11, Case study 6, we find that Ashley Youth Detention Centre and the Department did not respond appropriately to a serious allegation from Max (a pseudonym) of misconduct against a staff member. As discussed in that case study, we consider that the response to Max's allegation suggests systemic problems in how Ashley Youth Detention Centre and the Department respond to serious allegations, including by children and young people against staff members. We observed similar problems in the Department's response to allegations of child sexual abuse against staff (discussed in Chapter 11, Case study 7) and in a complaint from Alysha (a pseudonym), a former staff member at Ashley Youth Detention Centre, about the safety of children (discussed in Chapter 11, Case study 5).

Overall, the evidence detailed in our case studies indicates shortcomings in the Department's responses to complaints, including not:

- creating a culture where complaints by staff or children and young people are encouraged
- recognising complaints involving child sexual abuse or harmful sexual behaviours
- appropriately escalating and formalising complaints
- adequately and appropriately investigating complaints
- responding to complaints in a way that maintained safety and confidentiality and managed fear of reprisal for the complainant
- addressing safety risks raised by complaints.

The National Royal Commission recommended that institutions have 'a clear, accessible and child-focused complaints handling policy and procedure that sets out how the institution should respond to complaints of child sexual abuse'.[1417] The National Royal Commission's final report set out a list of actions that should form part of an effective institutional response to a complaint of child sexual abuse. These were: identifying a complaint; assessing risk; reporting to police, child protection and other bodies; investigating the complaint; communicating and providing support to those affected

by the complaint; maintaining records; completing a 'root cause analysis' to identify systemic factors that may have contributed to the complaint; and monitoring and reviewing outcomes.[1418]

The National Royal Commission also recommended that state and territory governments review internal and external complaints-handling systems concerning youth detention to ensure they are capable of effectively dealing with complaints of child sexual abuse.[1419] According to this recommendation, the review should ensure (among other matters) that children can easily access child-appropriate information about complaints processes, complaints-handling systems are accessible for children with literacy difficulties or who speak English as a second language, and children are regularly consulted about the effectiveness of complaints-handling systems, so systems are continually improved.[1420]

In our view, the Department's processes for identifying and responding to complaints and serious incidents in youth detention, including those relating to child sexual abuse, require significant reform. In this section, we recommend that the Department implements measures to:

- address structural barriers in complaints systems and create a culture in which complaints and critical feedback from staff, children and young people in detention and family members are encouraged (broader cultural change in youth detention is discussed in Section 4)
- provide for concerns and complaints about child sexual abuse and related conduct by staff to be referred to and investigated by a new Child-Related Incident Management Directorate, recommended in Chapter 6 (Recommendation 6.6)
- ensure concerns and complaints related to harmful sexual behaviours are reported to the Department's new Harmful Sexual Behaviours Support Unit and managed in line with a separate policy recommended in Section 8.5 of this chapter (Recommendation 12.30)
- ensure children and young people in detention feel safe to raise concerns, are aware of their rights to make a complaint and understand complaints processes
- ensure staff are aware of their role in responding to concerns raised by children and young people in detention and have clear processes for raising concerns about other staff
- update and strengthen custodial policies and procedures for complaints processes.

10.1 What we heard about complaints processes in detention

Victim-survivors told us about their experiences in making, or attempting to make, complaints at Ashley Youth Detention Centre. They reported significant barriers to making complaints. Some said that they did not complain for fear of repercussions from staff or other detainees; others told us they tried to complain but felt discouraged from going further because of the responses they received.[1421] We acknowledge that the complaints policies and procedures in place at the time of these experiences differed from those currently in place (described in Section 10.2); however, we consider that this evidence is still highly relevant to reforming complaints handling for children and young people in detention.

One victim-survivor, Fred (a pseudonym), said he received no feedback at all after making a complaint:

> So, I wrote down my experience on a piece of paper and put it in an envelope with – I believe I was told to put 'complaints' on it – and slipped it under my door; it was picked up by passing officers, like, as all mail would go out, and I never heard anything. I put two complaints in in my time at Ashley and I never heard anything about either of them.[1422]

Victim-survivor Warren (a pseudonym) described never making a complaint due to fear of the repercussions:

> I never made a complaint about anything that happened while I was in Ashley. The process of making a complaint was to write it down and give it to the workers. If someone ever complained about something it would always get back to the workers and they would tell each other about it. They would make your life hell and you suffered more. Because of this, no-one really made any complaints.[1423]

Some victim-survivors spoke of feeling complaining was futile because they would not be believed. Max said:

> Yeah, even if me and my mate had've made a complaint, still, that's only two criminals against, like, four or five or, like, five or six staff members that have all got good records and that, and they're youth workers, they're not—the way we seen it as, there's nothing we can do, no-one's gonna believe us.[1424]

These experiences are reflected in the *Take Notice, Believe Us and Act!* report, which found that some children and young people (with experiences in detention, out of home care, education and health systems) felt unsafe raising concerns or making a complaint. Young people in detention described a culture 'where "snitches" were frowned upon or where their adult and peer harassers retaliated when their behaviours were raised'.[1425]

When asked what they would do if they were unsafe or had been harmed, most children and young people interviewed for the *Take Notice, Believe Us and Act!* report

said they would turn to someone outside the institution to raise their concern or make a complaint.[1426] In Section 11.4, we recommend establishing an independent community visitor scheme to enable every child or young person in detention to have regular, frequent access to a trusted adult who is independent of the Department and who can advocate on their behalf.

In her submission to our Inquiry, Angela Sdrinis, a lawyer who specialises in institutional abuse claims, outlined multiple barriers to children and young people reporting child sexual abuse at Ashley Youth Detention Centre.[1427] These included children and young people: being unaware of complaints procedures; having an 'ingrained distrust of authorities'; fearing being ridiculed, accused of lying or not being believed; being denied access to or avoiding external supports such as family visits; being intimidated by staff; and fearing being known as someone who reports.[1428] Ms Sdrinis also referred to children's illiteracy, poor communication skills, lack of self-esteem and disempowerment due to intergenerational trauma as barriers to reporting.[1429]

Mark Morrissey, former Commissioner for Children and Young People, also referred to children and young people being reluctant to complain:

> One thing I observed: often the culture that existed in an adult prison would reach back into the young people at Ashley. So, some of these children came from the generational situation where other family members had been in jail and they learnt the culture and the rules of a prison … which meant not being a dog or speaking up …[1430]

Mr Morrisey also highlighted the problems he observed with complaints processes at Ashley Youth Detention Centre after starting in his role in 2014. He explained that, at that time, a child or young person wishing to make a complaint had to put the complaint in writing and place it in a brightly coloured public complaints box that was in a prominent position in the Centre's dining room.[1431]

Mr Morrissey stated that this was problematic because many of the children in detention were illiterate and because, in an environment where the dominant ethos was 'don't dob', the public location of the complaints box was a major disincentive to making a complaint.[1432] As he outlined in his statement:

> The chances of a young person placing a complaint or concern in the box were close to zero. Interestingly I was advised by [Ashley Youth Detention Centre] management that 'the young people rarely if ever make complaints so I was not to expect very much'… I was not made aware of any complaints going into the complaint box between 2014 and 2017.[1433]

We note that, according to the *Feedback, Concern & Complaints Info Sheet* given to children and young people in detention, there are now multiple 'post boxes' for feedback and complaints located throughout Ashley Youth Detention Centre, rather than a single complaints box (this is discussed in Section 10.2).[1434]

10.2 Complaints processes at Ashley Youth Detention Centre

10.2.1 Youth Justice Act

The Youth Justice Act gives children and young people in detention the right to complain about their treatment in detention. Section 129 of the Youth Justice Act provides that a child in detention can complain to the Secretary of the Department (or the Ombudsman) about the standard of care, accommodation or treatment they are receiving in a detention centre.[1435]

More broadly, section 137 of the Youth Justice Act provides that a child in detention, a member of the child's family or a guardian can complain to the Secretary about any matter affecting or connected with a child in detention. Section 138 states that, on receiving a complaint, the Secretary must provide the complainant and child with written notice detailing the complaint and how the complaint will be dealt with.[1436] The Secretary does not have to deal with a complaint reasonably believed to be 'trivial' or 'made only to cause annoyance'.[1437]

10.2.2 Ashley Youth Detention Centre policies and procedures

We asked the Tasmanian Government to provide the policies and procedures applied to complaints made by or on behalf of children at Ashley Youth Detention Centre.[1438] In June 2022, we received three Ashley Youth Detention Centre complaints policies and procedures, each of which was undated:

- *Responding to Feedback, Concerns and Complaints Procedure* ('Complaints Procedure')
- *Feedback and Complaints Practice Advice* ('Complaints Practice Advice')
- a *Make a Complaint* form for children and young people.[1439]

The Complaints Procedure and Complaints Practice Advice were updated with effect from October 2022 and we refer to these updated versions in our discussion.[1440] The Department's Practice Manual now also includes a new *Feedback, Concern & Complaints Info Sheet* ('Information Sheet') for children and young people at Ashley Youth Detention Centre (effective from October 2022) and a new *Help Form* for children and young people in detention to seek help or provide feedback (effective from September 2022) ('Help Form'), which we also discuss in Section 10.2.3.[1441]

In addition, there are custodial policies and procedures that guide staff who have concerns about the safety of a child or young person in detention, including concerns about the behaviour of a colleague. These are discussed separately in Section 10.2.7.

We also note that the Department's website includes a page called 'Complaints—Child Safety and Youth Justice Services', which states that a person can make a complaint about a youth justice service if they are: a client of the service; a 'friend, relative or guardian of a client'; a service provider; or 'anyone who has a valid interest in an issue'.[1442] Complaints can be made to any staff member or emailed or mailed to the Department.[1443] The website indicates that the Department will treat complaints confidentially and try to resolve any formal complaint within four weeks of receiving it.[1444]

10.2.3 Information provided to children and young people about the complaints process

On admission to Ashley Youth Detention Centre, children and young people are given a booklet called *Information for Young People and Families*.[1445] This booklet advises children and young people that:

- they can complain about services at Ashley Youth Detention Centre or about the behaviour or conduct of a staff member or another young person
- they can complain to any staff member, who 'can start the process to deal with your complaint'
- they 'should not feel scared about making a complaint' and can choose to 'have a support person who can provide emotional and administrative support, make sure the complaint is dealt with fairly and promptly, and help you understand the process and the outcome'
- they have a choice as to whether their complaint is dealt with by Ashley Youth Detention Centre (in which case staff will refer the complaint to the Centre Manager) or by the Secretary of the Department (in which case staff can provide contact information, but the young person must contact the Secretary themselves)
- the Centre Manager may decide not to investigate if they believe the complaint is 'trivial or made to cause annoyance'
- complaints referred to the Centre Manager will usually be investigated within 21 days and the young person will receive a letter telling them the outcome of their complaint
- they can ask for a review by the Secretary or the Ombudsman of a decision made about a complaint if they are not happy with it.[1446]

Custodial procedures also require staff to explain this information verbally to children and young people on admission.[1447]

The Information Sheet (also provided on admission) advises children and young people that if they want to provide feedback to Ashley Youth Detention Centre management or make a complaint they can:

- fill out a Help Form, which can be found in each unit, at Ashley School and in the 'Health Corridor' (discussed in Chapter 10)—once completed the form can be placed in one of several 'post boxes' located in the young person's unit, at Ashley School or in the corridor near the health services
- join the 'Resident Advisory Group', which is a fortnightly forum designed to give children and young people detained at Ashley Youth Detention Centre 'a say about the things that affect them', including their views on the 'physical amenity of the site, detention processes, standard of care, treatment and program options and how safe they feel' (the Resident Advisory Group is discussed in detail in Section 4.6.2)
- contact the Ombudsman or the Commissioner for Children and Young People by using the phone in their unit or writing to them.[1448]

The Help Form is a relatively simple, two-page form that invites children and young people to write their 'issues, problems, feedback or suggestions' in relation to a range of areas, including safety, phone calls, food and clothing, and to tick a box indicating whether they would like the form to go the Centre Manager, the Secretary or the Ombudsman.[1449]

The Complaints Procedure requires Ashley Youth Detention Centre managers to ensure each unit's meeting area displays 'promotional feedback and complaints resources'.[1450]

10.2.4 Process for responding to complaints from children about sexual abuse

According to the Complaints Practice Advice, where a child or young person discloses harm by a staff member, this is to be addressed by a different process—'not the complaints process'—and staff who receive such a disclosure 'must immediately report that to an Operations Coordinator or Manager for follow up'.[1451] Staff must also 'ensure that the young person is kept safe from further harm and follow procedures regarding the notification of harm'.[1452]

The different process to be followed where a child or young person discloses harm is not clear to us. The Complaints Procedure refers to a separate procedure called *When a Young Person Discloses Harm*, but this document was not provided to us and we could not find it in the Department's Practice Manual.[1453]

According to the Complaints Procedure:

> If the young person discloses abuse (verbal, physical or sexual) by another resident or staff member, an incident report must be raised (see incident procedure).[1454]

This would appear to be a reference to the *AYDC Incident Reporting Procedure* ('Incident Reporting Procedure'), although this procedure does not address harm by staff.[1455] The purpose of this procedure is to outline the steps that staff must take 'following

an incident that has arisen from the behavior/s of a young person or multiple young people'.[1456] A central focus of the procedure is determining whether any young person involved in the incident has committed a 'detention offence' under the Youth Justice Act, rather than responding to the needs of young people affected by the incident.[1457]

Secretary Pervan's view was that any allegation of harmful sexual behaviours at Ashley Youth Detention Centre fell within the definition of an 'incident' for the purposes of the Incident Reporting Procedure.[1458] While the Incident Reporting Procedure may apply to concerns involving harmful sexual behaviours (because these could be described as constituting an incident 'arising from the behaviour' of a young person), we do not consider this procedure to be suitable to guide responses to such concerns. Viewing harmful sexual behaviours solely through the lens of 'detention offences' is inconsistent with a contemporary understanding of such behaviours (refer to Chapter 21 for a discussion of these issues). We discuss the Department's response to harmful sexual behaviours in detention in Section 8 and recommend developing a separate departmental policy to prevent and respond to such behaviours in detention (Recommendation 12.30).

As noted, the Incident Reporting Procedure does not refer to or contemplate reports or allegations of child sexual abuse or other allegations of abuse or human rights violations by staff. In her August 2022 statement to our Inquiry, Pamela Honan, Director, Strategic Youth Services, told us that she was not aware of any policy governing the Department's response to allegations of child sexual abuse as these matters are 'managed by People and Culture'.[1459]

In his June 2022 statement, Secretary Pervan told us that if a complaint is made about the sexual abuse of a child or young person in detention by a current staff member, 'it may be referred to the Department's People and Culture Division', which notifies Tasmania Police and the Registrar of the Registration to Work with Vulnerable People Scheme; undertakes an initial risk assessment (also referred to in this volume as a 'preliminary assessment') that may result in action to remove the staff member from the workplace; and prepares advice for the Secretary about whether a breach of the State Service Code of Conduct may have occurred.[1460]

The Secretary may then appoint an investigator to investigate the allegation in line with the procedure in Employment Direction No. 5—Breach of Code of Conduct.[1461] The Secretary considers the investigation report prepared by the investigator and the staff member's response to the report, and makes a determination as to any breaches of the Code of Conduct and sanctions, which may include terminating the staff member's employment.[1462]

Secretary Pervan said that the governance process of the People and Culture Division ensured that 'the safety of a child or young person [was] the primary consideration when responding to an allegation' and that support was made available to the complainant.[1463]

However, former Acting Executive Director of People and Culture, Jacqueline Allen, told us that the Department's People and Culture team:

> … [did] not have documented or approved Communities Tasmania policies and procedures, relating to supporting complainants and victims; assessing and taking steps to ensure the safety of detainees; notifying other agencies of allegations; conducting investigations; decision making regarding outcomes and disciplinary processes; informing affected parties of outcomes; and record keeping.[1464]

Ms Allen explained that this was because the People and Culture team was not directly in contact with complainants and victim-survivors because contact was typically made through the Department of Justice (for claimants through the National Redress Scheme) or the Office of the Solicitor-General (for civil litigation complainants).[1465]

Ms Allen told us that, despite this, there were many informal policies and procedures that People and Culture adopted in relation to the notification process.[1466] For example, Employment Direction No. 5 specifically outlined how People and Culture were to conduct investigations, including how to involve a young person.[1467] Ms Allen also told us that, from around November 2020 onwards, once the People and Culture team was made aware of an allegation, it would inform other agencies of allegations associated with an employee.[1468]

Ms Allen also stated that 'People and Culture provided advice and guidance around employee related matters in the department, not resident, children or youth related matters'.[1469] She told us that while she had responsibility for managing parts of the complaints process, such as collecting and organising information that forms part of a preliminary assessment, neither she nor the People and Culture team had decision-making authority for Ashley Youth Detention Centre.[1470] Instead, Ms Allen said that the Centre's management was responsible for 'receiving and acting on complaints, allegations, and concerns regarding conduct of [Centre] officials'.[1471] She indicated that the People and Culture team was not directly responsible for the safety of children and young people because this responsibility sat with Ashley Youth Detention Centre management.[1472]

Ms Honan stated that her role was to report these matters to People and Culture.[1473] A discussion would occur with People and Culture about who was best to handle the complaint or allegation depending on the nature of it.[1474] She said that any allegations about harm of a young person by an official were referred to and managed by People and Culture.[1475] Ms Honan added that she did not hold an investigative role; rather, her role was to support the investigation by providing any information or documentation available to assist enquiries.[1476]

As illustrated here and in Chapter 11, Case study 7, the lack of clarity about the process for responding to complaints involving child sexual abuse in detention is highly problematic and places children and young people in detention at increased risk of child sexual abuse.

10.2.5 Process for responding to other complaints from children

In summary, the Complaints Procedure provides that the process for responding to complaints (other than those involving the disclosure of harm or abuse) is as follows:

- The Ashley Youth Detention Centre Senior Management Team discusses the complaint and appoints an 'Investigator' (presumably a member of staff, although this is not specified) to 'follow up on the complaint and manage the response process', although 'sensitive matters (such as staff misconduct) [are] handled separately by the Director and Executive Director', while complaints about Ashley School or the health service are referred to the manager of the relevant service.[1477]
- The Investigator (or their delegate) reads the complaint and speaks to the complainant 'for further clarity', then speaks to other 'parties' and 'gathers relevant details in order to make an informed decision'.[1478]
- If the complaint is 'complex', the Investigator can 'table it at the next [Senior Management Team] morning meeting for further consultation'.[1479]
- The Senior Management Team discusses the 'final recommendation' and determines the outcome, and the young person is informed of the outcome verbally and in writing.[1480]
- The outcome is recorded in the 'complaints register'.[1481]

According to the Complaints Procedure, a child or young person who has made a complaint must receive an acknowledgment letter within 72 hours of lodging the complaint and a follow-up letter every 10 days until the complaint is resolved. They should also be offered support in relation to the complaint.[1482]

10.2.6 Strengths and limitations of complaints processes for children and their families

There are some positive features of the complaints processes, policies and procedures described in the preceding sections. In particular, we commend the requirement in the Complaints Procedure to provide support to a child or young person making a complaint, and to keep them informed of the investigation process.

However, we note the following structural limitations of current complaints processes and barriers to making complaints:

- Many children and young people in detention have low literacy levels. This severely limits the effectiveness of detailed written information provided to them about how to make a complaint. We are not convinced that children and young people read the information booklet given to them on admission to detention.

- While staff are also required to verbally explain complaints processes to children and young people when they are admitted to detention, admission can be an overwhelming experience and there is a risk that the child or young person will not understand or retain a verbal explanation of how to make a complaint.
- The Help Form, while simple, relies on a child or young person being able to express their concern or complaint in writing, which they may be unable or unwilling to do.
- While there are now several 'post boxes' throughout Ashley Youth Detention Centre for receiving written complaints, they appear to still be located in shared spaces, which may make some children and young people reluctant to use them, for fear of being perceived as a 'snitch'.
- As noted in Section 11.4, while children and young people in detention can make phone calls to the Commissioner for Children and Young People or the Ombudsman to raise concerns or make complaints, it is not clear that such calls can always be made in private.

In an environment where there has previously been a strong culture of non-disclosure, strategies are required to overcome these structural barriers to children and young people raising concerns or making complaints.

We also note the following concerns with the current Complaints Procedure and Complaints Practice Advice:

- They do not define child sexual abuse and related conduct, including harmful sexual behaviours.
- As noted, they do not clearly explain the procedure to be followed where a child or young person discloses a safety concern (such as sexual abuse by staff or harmful sexual behaviours by another child or young person), nor do they refer to another procedure that does so.
- They do not define or provide guidance on what might constitute a 'sensitive matter', other than 'staff misconduct' (noting that, in any event, the Complaints Procedure and Complaints Practice Advice do not apply to complaints about abuse of a child or young person by a staff member).
- They do not refer to the procedure for notifying Tasmania Police, Child Safety Services or the Registrar of the Registration to Work with Vulnerable People Scheme of relevant concerns (refer to Section 10.2.7).
- They do not include mechanisms to conduct a risk assessment or undertake a root cause analysis to enable systemic improvements to be implemented following the investigation of a complaint.

- While the Complaints Procedure directs staff to record complaints in the complaints register, Secretary Pervan did not refer to this register when explaining the Centre's complaints process.[1483] Secretary Pervan said that staff have recorded 'incidents' in the 'Ashley Incident Monitoring System' since January 2021.[1484]
- They are not publicly accessible. As noted, the Department's website explains that complaints can be made by any person who has a 'valid interest in an issue' relating to a decision, a service provided or the behaviour of Child Safety and Youth Justice Services staff.[1485] However, aside from a short explanation of 'what you can expect when making a complaint', the website does not provide any policy or procedure outlining how the Department handles complaints, concerns or allegations involving children and young people in detention.[1486]

10.2.7 Complaints from staff

The Complaints Procedure and the Complaints Practice Advice are concerned with responding to complaints from children and young people rather than from staff. The Department's Practice Manual includes the following documents to guide staff who have concerns about the safety of children and young people in detention:

- The *Contacting the SFSK Advice and Referral Line Procedure* requires staff to contact the Advice and Referral Line where they believe, suspect or know that a child or young person is at risk of, or is experiencing, abuse or neglect.[1487] This procedure advises staff who become aware of historical or current concerns about the conduct of another employee 'as it relates to the safety of children and young people' to immediately report those concerns to their supervisor and contact the Advice and Referral Line.[1488]
- The *Reporting Concerns* fact sheet advises staff 'to report any conduct or behaviour which is of concern to you, and that could compromise the safety and wellbeing of a child'.[1489] Concerns about the conduct of another staff member must be reported to the Department's People and Culture team, to the Advice and Referral Line and, '[i]f the concerning behaviour is criminal in nature', to Tasmania Police.[1490] Staff should also discuss their concerns with their supervisor or manager as soon as practicable.[1491] The fact sheet acknowledges that 'these matters can cause significant distress for employees and can be confronting and disturbing' and indicates that '[e]xtensive support is available to all employees', including support from the employee's manager and from 'Health and Wellbeing Officers'.[1492]
- More broadly, the *Transparency and Accountability* policy requires staff to comply with the State Service Code of Conduct, to '[c]ommunicate when things go wrong so that matters can be addressed at the earliest possible moment' and to '[f]oster a no blame culture to promote practice improvement'.[1493]

None of these documents defines or explains child sexual abuse, harmful sexual behaviours, grooming or professional boundary breaches.

Even where there are clear policies and procedures requiring staff to report concerning behaviour on the part of colleagues, staff may be unlikely to report where the culture does not enable or encourage this—for example, where staff feel that they may be labelled 'difficult' or 'hysterical', their concerns may be minimised by management, or they may experience reprisals. In Section 4, we make a series of recommendations aimed at creating a child safe culture in youth detention. We also consider that there are opportunities to encourage and empower staff in youth detention to report concerning conduct on the part of their colleagues. These are discussed in Section 10.3.1.

10.2.8 Planned reforms

The Keeping Kids Safe Plan, released in October 2022, indicated that the Department was '[d]eveloping and implementing a robust internal complaint system (for both children and young people and staff)' at Ashley Youth Detention Centre.[1494]

In February 2023, Secretary Bullard advised us that the Department had begun a 'complaints management review project' with a view to aligning its approach with other government agencies such as the Department of Health.[1495] The Department for Education, Children and Young People's *Project Initiation Plan – Complaints Management Review* states that a review of complaints functions has occurred in the Children and Families and the Education portfolios, but has yet to be undertaken for 'functions within Youth Justice'.[1496]

We also note that the Department's *Safeguarding Framework* describes broadly how the Department will implement Standard 6 of the Child Safe Standards—'Processes to respond to complaints and concerns are child-focused'—including ways for people and children to report concerns, for providing trauma-informed support following disclosure, for record keeping and for transparent communication.[1497] However, it is not clear how this will be applied to children and young people in detention.

10.3 Improving complaints processes

The *Take Notice, Believe Us and Act!* report found that, for children and young people to feel able to raise a concern or disclose abuse or mistreatment, they needed:

- to know what complaints processes were in place and how to access them[1498]
- to have at least one trusted adult they could turn to[1499]
- to have confidence that they would be believed[1500]
- to know that adults and organisations would take their concerns seriously and respond quickly and effectively, so things would change for the better[1501]
- to know they would be protected from any consequences or repercussions.[1502]

As noted in Section 11.4, we recommend establishing an independent community visitor scheme for children and young people in detention. This would give each child and young person a trusted adult to speak to regularly and frequently, who would be independent of the Department and would have the power to advocate on the child or young person's behalf. The other features identified by children and young people in the *Take Notice, Believe Us and Act!* report are addressed in the following discussion.

10.3.1 Encouraging complaints and critical feedback

The Department needs to take active steps to create a culture in which complaints and critical feedback are encouraged. This is essential to overcome children's and young people's mistrust of and lack of confidence in complaints processes and the dominant culture of not 'dobbing'.

It is important to ensure children and young people in detention understand the complaints process and feel safe making a complaint. This requires them to know what to expect when making a complaint, what steps the Department or the facility will take in response to a complaint and how complainants will be protected against repercussions.

As outlined in Section 10.2.6, there are several structural barriers to children and young people in detention making complaints, including low literacy levels and a heavy reliance on information provided to children and young people during admission. The Department should ensure its complaints processes address these barriers.

In our view, children and young people in detention should be regularly, actively reminded about feedback and complaints processes throughout their time in detention, using a variety of developmentally appropriate mechanisms. These could include visual materials displayed in every unit and regular information sessions on how to make a complaint. Implementation of the independent community visitor scheme recommended in Section 11.4 will also provide a regular reminder to children of their right to make a complaint.

Children and young people also need to be empowered and feel confident to make complaints. We acknowledge that such confidence may only develop once children and young people begin to use the complaints process and see quick, decisive, effective action taken in response to their complaints, without negative repercussions for them. Building this confidence may take time.

Nevertheless, as Mr Morrissey stated, it is important as part of a therapeutic environment to give children and young people the 'skills and permission to have a voice'.[1503] In Section 4.6, we make recommendations aimed at promoting the voices of children and young people in detention and empowering them to have input into detention centre operations and processes. In particular, we recommend that the Department reviews and strengthens the Ashley Youth Detention Centre Resident Advisory Group.

The families and guardians of children and young people in detention also need to be made aware of, and have confidence in, departmental complaints processes. In the Australian Capital Territory, the complaints management policy for responding to a complaint about youth detention is publicly available.[1504] We recommend that the Department develops and publishes a guide to making a complaint about youth detention, so anyone with a concern about a child or young person in detention has an easily accessible complaint pathway.

Staff in detention facilities also need to be encouraged to report concerns about their colleagues, make complaints and provide feedback without fear of reprisal. In Chapter 15, we discuss programs used in the health sector to improve organisational culture and encourage staff to speak up if they observe concerning actions or behaviour—in particular, the 'Speaking up for Safety' program, which is being implemented at Royal Hobart Hospital.[1505]

In Chapter 15, we also discuss the Ethos Program, which is a peer-based early intervention program designed to recognise staff who demonstrate positive behaviours, remove barriers from speaking up about concerns that affect patient or staff safety, and allow for a quick, fair and transparent response to all staff, including those making a complaint and those with concerning behaviours.[1506] Under the Ethos Program:

- staff are trained on how to 'speak up' effectively and can use an online messaging system to submit feedback for recognition (to acknowledge positive behaviour) or reflection (to offer feedback for improvement)[1507]
- feedback is delivered by a trained 'Ethos Messenger', who is generally a peer of the staff member, via an informal conversation[1508]
- trained staff triage reports received through the Ethos messaging system across four levels, depending on the seriousness of the incident.[1509]

In Chapter 15, we recommend that the Department of Health considers integrating features of the Ethos Program into its cultural improvement program (Recommendation 15.4). A similar reporting system that applies to all staff could also be a valuable initiative for creating a culture that enables the giving and receiving of feedback in youth detention.

10.3.2 Responding to complaints—the role of the Child-Related Incident Management Directorate and the Harmful Sexual Behaviours Support Unit

In Chapter 6, we recommend establishing a Child-Related Incident Management Directorate to receive, assess, investigate, coordinate and oversee the Department's responses to allegations of child sexual abuse and related conduct (including grooming and professional boundary breaches), and other harms to children and young people by staff (Recommendation 6.6).

The Child-Related Incident Management Directorate would have three functions:

- an incident report management function, which would be responsible for assisting child-facing services in the Department (such as Ashley Youth Detention Centre) with managing incidents or allegations against staff, including being the point of contact for these services—this function should be responsible for ensuring the relevant government institution takes appropriate actions in relation to matters referred to the Directorate
- an investigations function, comprising appropriately trained and skilled investigators who would undertake preliminary assessments, investigate incidents of alleged misconduct (including allegations of child sexual abuse) and prepare reports for misconduct adjudicators to consider
- a misconduct disciplinary advice function that involves misconduct adjudicators examining reports prepared by investigators on incidents of alleged misconduct, assessing whether misconduct has been established and, where there may have been a breach of departmental policies, preparing a report recommending a course of action for the Secretary.

The recommended approach is based on the South Australian Department for Education's system for responding to and investigating complaints of child sexual abuse.[1510] In our view, the South Australian model embodies many of the features that the National Royal Commission recognised as being instrumental to an institution's ability to respond to concerns or complaints of child sexual abuse in a way that is sensitive and child-focused. These include:

- investigations being conducted by impartial, objective, trained investigators[1511]
- children being interviewed by people with relevant specialist skills (for example, knowledge of child development, trauma-related behaviours, indicators of abuse and investigative techniques)[1512]
- responding to complainants in a sensitive, supportive and protective way and ensuring affected parties (including the subject of the complaint) have access to support, therapeutic treatment services and advocacy.[1513]

The Child-Related Incident Management Directorate would be responsible for leading the response to allegations of child sexual abuse by staff across all portfolios of the Department, namely education, out of home care and youth justice.

In relation to youth detention, we recommend the following:

- All concerns and complaints involving allegations of child sexual abuse and related conduct (including grooming and boundary breaches) or other harms to children (including the inappropriate use of force, isolation or searches) by staff should be referred immediately to the Child-Related Incident Management Directorate.

- The incident report management function of the Child-Related Incident Management Directorate should be responsible for ensuring detention centre management communicates appropriately with children and young people affected by an allegation against a staff member, as well as their parents or carers.
- The incident report management function and the investigations function of the Child-Related Incident Management Directorate should be performed by staff with knowledge and understanding of the youth justice system, and an understanding of the characteristics of abuse and mistreatment of children and young people in detention. This is particularly important in view of the widespread and systematic abuse experienced by some children and young people at Ashley Youth Detention Centre, as illustrated in Chapter 11, Case study 1.

In the case of concerns or complaints about harmful sexual behaviours, in Chapter 9 we recommend that the Department establishes a Harmful Sexual Behaviours Support Unit (Recommendation 9.28) in the new Office of the Chief Practitioner (Recommendation 9.17). We recommend that this unit supports all child-facing services in the Department, including youth justice services, to manage harmful sexual behaviours through the provision of advice, guidance and support. The Harmful Sexual Behaviours Support Unit should work closely with the new Quality and Risk Committee (Recommendation 9.5) to ensure systemic risks, practice issues and opportunities for improvement are identified.

In Section 8.5 of this chapter, we recommend (in Recommendation 12.30) that:

- the Harmful Sexual Behaviours Support Unit develops detailed policies, protocols and guidelines to support best practice responses to harmful sexual behaviours displayed in youth detention or other residential youth justice facilities
- all complaints about harmful sexual behaviours in youth detention or other residential youth justice facilities be reported to the Harmful Sexual Behaviours Support Unit and to the new Commission for Children and Young People.

The question then arises as to whether other, non-serious concerns and complaints about youth detention should also be automatically escalated within the Department. We note that in the Australian Capital Territory, the complaints management policy for children and young people in detention aims to 'resolve complaints quickly and effectively and at the lowest level of formality possible', stating that:

> In many cases, concerns and complaints can be resolved quickly and effectively through informal communication with young people, their family members or significant others. In some cases a young person may simply want to have the reasons for a decision clearly explained to them, or may want an opportunity to have their views and concerns listened to and taken seriously.[1514]

Alison Grace, Deputy Centre Manager, Bimberi Youth Justice Centre, in the Australian Capital Territory, told us that '[a]s much as possible young people are encouraged to speak with their supervising Youth Worker, Team Leader and/or Unit Manager to address their concerns'.[1515]

The Australian Capital Territory's complaints management policy places clear obligations on staff to 'take the time to stop, listen and respond' to any concerns raised by children and young people in a supportive and consistent manner because this may 'reduce the need for complainants to escalate their concerns into formal complaints'.[1516] However, the policy also states that '[u]nder no circumstances should staff try to talk a child or young person out of making a complaint'.[1517] If the child or young person wants to make a complaint, staff should help them to do so.[1518] Unit Managers will typically investigate complaints, but serious matters must be escalated to the Manager and the Director, Child and Youth Protection Services Operations.[1519]

We are mindful of the voices of victim-survivors who spoke of feeling there was no point in making a complaint to Ashley Youth Detention Centre because they felt they would not be believed or would suffer reprisals. We note that most of the matters about which victim-survivors remained silent would constitute serious complaints that would be escalated to the new Child-Related Incident Management Directorate under our recommended complaints-handling system.

We are also mindful that it may be impractical and not in a child's or young person's best interests for all minor concerns or complaints about youth detention to be escalated within the Department for investigation; for example, it may delay resolving the complaint. On this basis, we recommend that the primary responsibility for responding to non-serious concerns and complaints remains with management and staff of the detention facility.

10.3.3 Other recommended improvements to complaints processes

The Complaints Procedure and Complaints Practice Advice should be updated to reflect the changes recommended in Sections 10.3.1 and 10.3.2 and to:

- demonstrate the ways in which specific barriers to making complaints in detention settings have been addressed
- clearly define child sexual abuse and related conduct, including sexual misconduct, (consistent with the Child and Youth Safe Organisations Act—discussed in Chapter 18), grooming and boundary breaches
- set timeframes for responding to complaints
- specify any voluntary or mandatory reporting obligations
- specify requirements for communicating with and providing support to complainants and other affected people

- include procedures for formalising complaints received verbally, via email or other means where it is clear that the intent of the person is to make a complaint
- clarify requirements for recording complaints and investigation outcomes
- ensure complaints processes apply to any new detention facility designed to replace Ashley Youth Detention Centre, as well as other residential youth justice facilities, including the proposed assisted bail facilities and supported residential facilities (discussed in Sections 5.4.5 and 6.8.2 respectively).

The role of detention centre staff in complaints processes should be to respond supportively and proactively to concerns raised by children and young people, explain complaints processes to them and support them to make a complaint. They should understand which concerns and complaints must be referred immediately to the Child-Related Incident Management Directorate, and their mandatory and voluntary reporting obligations.

Staff receiving a complaint need to consider the intent of the person raising the issue—if it is clear they are making a complaint or reporting a serious incident, it needs to be treated as such, regardless of whether it is raised verbally, via email or using another mechanism, and regardless of whether it is made using the right form.

In Section 4.7.3, we recommend that professional development for staff includes training on all departmental policies and procedures (Recommendation 12.9). This should include training on complaints processes. In Section 4.8, we recommend that the Department develops a professional conduct policy that sets out the standards of behaviour expected of those who work in youth detention and other youth justice facilities, including contractors and volunteers (Recommendation 12.10).

Recommendation 12.35

The Department for Education, Children and Young People should:

a. update its complaints procedure and practice advice for youth detention to

   i. address structural barriers to making complaints in detention and include developmentally appropriate communication methods at all stages

   ii. require concerns, regardless of the form in which they are raised, to be recognised, recorded and actioned as a complaint where the person raising the concern wants to make a complaint

   iii. define child sexual abuse (including sexual misconduct, grooming and harmful sexual behaviours) and boundary breaches

iv. require all complaints and concerns involving allegations of child sexual abuse and related conduct or other harms to children (including the inappropriate use of force, isolation or searches) by staff, breaches of the State Service Code of Conduct or the professional conduct policy for youth detention (Recommendation 12.10) and reportable conduct as defined by the *Child and Youth Safe Organisations Act 2023* to be referred immediately to the new Child-Related Incident Management Directorate for response (Recommendation 6.6)

v. require all incidents involving harmful sexual behaviours to be reported to the Harmful Sexual Behaviours Support Unit (Recommendation 9.28)

vi. clearly specify mandatory and voluntary reporting obligations for staff in relation to Tasmania Police, Child Safety Services, the Registrar of the Registration to Work with Vulnerable People Scheme and the Independent Regulator under the *Child and Youth Safe Organisations Act 2023*

vii. set timeframes for responding to complaints

viii. specify requirements for communicating with and providing support to complainants and other affected parties, including parents or carers of affected children and young people

ix. clarify the requirements for recording complaints and outcomes of complaint investigations to enable the monitoring of trends for quality, safety and governance purposes

x. include procedures for making and responding to complaints in relation to other residential youth justice facilities, including the proposed assisted bail and supported residential facilities

b. ensure staff in detention and other residential youth justice facilities understand and comply with their role in responding to complaints, including complaints about child sexual abuse, and have a clear process for raising safety concerns about other staff

c. use a range of child-friendly tools to ensure children and young people in detention and other residential youth justice facilities are aware of complaints processes and understand the steps facility staff and the Department will take in response to a complaint, including a complaint about child sexual abuse

d. ensure a child-friendly guide to making a complaint and explaining complaints procedures, including the circumstances under which complaints made to oversight bodies may be referred to the Department, is readily accessible on the Department's website, as well as a guide for adults wishing to make a complaint on behalf of a child in detention or another residential youth justice facility

e. ensure there are staff in the Child-Related Incident Management Directorate with expertise in youth justice, including an understanding of the risks of child sexual abuse in detention and the characteristics of mistreatment and abuse in detention environments.

11 Independent oversight of youth detention

Independent external oversight is a vital component of safeguarding children and young people held in a closed facility such as Ashley Youth Detention Centre, where contact with people outside the facility is heavily controlled, regulated and limited.

To help identify and minimise the risks of child sexual abuse, children and young people in detention must have access to regular visits from the staff of an independent oversight body who have the interpersonal skills, cultural competency and professional background to build rapport and trust with them.[1520]

Children must also be empowered to engage with and participate in complaints and monitoring mechanisms while in detention.[1521] They should feel confident to raise concerns with an oversight body and to make a formal complaint where necessary. This requires oversight bodies to be reliable, trustworthy and adequately resourced, and to communicate effectively with each other so children and young people in detention get useful responses to complaints, without negative repercussions.[1522]

Youth detention oversight bodies must also be proactive, particularly where children and young people may be reluctant to raise concerns or make complaints.[1523] According to Stephen Kinmond OAM, former New South Wales Deputy Ombudsman (Human Services) and current New South Wales Children's Guardian with responsibility for overseeing reportable conduct:

> … if a particular agency or sector has demonstrated low reporting rates, it is important for the oversight body to take timely action. Indeed, for the [New South Wales reportable conduct scheme], the Ombudsman's ability to undertake auditing activities was a critical function in assisting an agency to improve its systems and practices for providing safe environments for children in its care.[1524]

As the National Royal Commission noted, oversight bodies such as inspectors of custodial services, visitor schemes, children's commissioners and guardians, and ombudsman offices can mitigate the heightened risks of child sexual abuse associated with a secure, locked youth detention facility and ensure greater transparency and accountability.[1525]

The National Royal Commission recommended that:

> State and territory governments should ensure they have an independent oversight body with the appropriate visitation, complaint handling and reporting powers to provide oversight of youth detention. This could include an appropriately funded and independent Inspector of Custodial Services or similar body. New and existing bodies should have expertise in child-trauma, and the prevention and identification of child sexual abuse.[1526]

As mentioned in Section 10, the National Royal Commission also recommended that state and territory governments review existing external complaints-handling systems concerning youth detention centres to ensure they are capable of effectively dealing with complaints of child sexual abuse, so:

- children can easily access child-appropriate information about external oversight
- children have confidential and unrestricted access to external oversight bodies
- staff involved in managing complaints internally and externally include Aboriginal people and professionals qualified to give trauma-informed care
- complaints-handling systems are accessible for children with literacy difficulties or who speak English as a second language
- children are regularly consulted about the effectiveness of complaints-handling systems and systems are continually improved.[1527]

The *Take Notice, Believe Us and Act!* report confirmed the importance of all children and young people in detention having access to external advocates who could proactively seek their views and respond when they had safety concerns.[1528] However, as outlined in Section 10.1 and described in Section 11.2, some victim-survivors who were or had been in detention told us that they did not know who to contact to make a complaint, they did not feel safe making a complaint and, when they did complain, there was no action or response.

As noted, it is essential for children and young people in detention to feel safe to disclose sexual abuse or other mistreatment to an independent oversight body. However, it is not enough for an oversight body to rely solely on disclosures or complaints from children and young people in detention for the proper performance of its functions. An effective oversight body in the youth detention context is one that understands that youth detention exposes children and young people to a higher risk of sexual abuse and is cautious if there are low rates of complaints.[1529]

We note that the youth justice reforms outlined in the Keeping Kids Safe Plan, Draft Youth Justice Blueprint and Draft First Action Plan do not indicate any intention to reform current youth justice oversight mechanisms.[1530]

In this section, we recommend:

- establishing an independent community visitor scheme for children and young people in detention, to give them an independent, trusted adult to whom they can speak regularly, with whom they can safely and confidently raise concerns, and who will advocate on their behalf
- improving the Ombudsman's processes for handling complaints containing allegations of sexual abuse involving children and young people in detention
- strengthening and improving systemic monitoring of Tasmania's youth detention facilities.

11.1 Tasmania's system of oversight for youth detention

Several bodies in Tasmania are responsible for independently monitoring the safety and wellbeing of children and young people in youth detention. Collectively, the Commissioner for Children and Young People, Ombudsman and Custodial Inspector provide independent, external oversight for children and young people held in Ashley Youth Detention Centre.[1531] Their roles are described in the following sections.

Also, in February 2022, the Tasmanian Government announced that it had appointed Richard Connock as a Tasmanian National Preventive Mechanism following the enactment of the *OPCAT Implementation Act 2021* in November 2021.[1532] Mr Connock is also the Ombudsman, Custodial Inspector, Tasmanian Health Complaints Commissioner, Energy Ombudsman and de facto Information and Privacy Commissioner.[1533] The National Preventive Mechanism, established in line with OPCAT, is an independent body tasked with preventing torture. Its key function is:

> … to regularly examine the treatment of persons deprived of their liberty in places of detention with a view to strengthening, if necessary, their protection against torture and other cruel, inhuman or degrading treatment or punishment.[1534]

The role does not investigate complaints.[1535] The Tasmanian National Preventive Mechanism is discussed in Section 11.7.

In this section, we discuss oversight functions exercised over individual children and young people in youth detention and the youth detention system itself. For individuals, we distinguish between advocacy on behalf of an individual child—including visiting a child in detention, helping them to raise any concerns about their experience in detention and seeking resolution of those concerns—and the formal investigation of a complaint about detention made by a child or young person.

As discussed in Chapter 18, the current oversight arrangements for institutions responsible for children and young people are complex and fragmented. This is true of youth detention. Table 12.1 summarises the functions of the Commissioner for Children and Young People, the Ombudsman and the Custodial Inspector in respect of youth detention. These functions are then discussed in the following sections.

Table 12.1: Overview of current youth detention oversight system

Function	Commissioner for Children and Young People	Ombudsman	Custodial Inspector
Visiting an individual child in detention and listening to their concerns	●		
Advocating on behalf of an individual child in detention (including assisting the child to make a formal complaint)	●		
Investigating a complaint from a child about detention		●	
Inspecting detention facilities			●
Monitoring the wellbeing of children in detention	● (as part of general function of monitoring the wellbeing of all Tasmanian children)		● (as part of inspection function)
Making recommendations to government about children in detention or the detention system	●	●	●

11.1.1 Commissioner for Children and Young People

The Commissioner for Children and Young People is an independent statutory officer appointed by the Governor on the advice of the Minister for Education, Children and Youth under the *Commissioner for Children and Young People Act 2016* ('Commissioner for Children and Young People Act').[1536] As mentioned earlier, the Commissioner for Children and Young People is Leanne McLean, who was appointed in November 2018.[1537]

The general functions of the Commissioner for Children and Young People are described in Chapter 18. These functions are broad and include advocating for all children and young people, as well as promoting, monitoring and reviewing the wellbeing of children and young people in Tasmania.[1538]

The statutory functions of the Commissioner for Children and Young People do not specifically refer to monitoring the wellbeing of children and young people in youth detention or monitoring the operation of the youth justice system more broadly. However, the Commissioner for Children and Young People Act specifies that it must be administered in line with several principles, including that the interests and needs of 'vulnerable' children and young people—defined to include detainees and former detainees—should be given special regard and serious consideration.[1539]

The Act also requires the Commissioner for Children and Young People to act 'as advocate for a detainee under the *Youth Justice Act 1997*'.[1540] This entails:

a. listening to, and giving voice to, the concerns and grievances of the detainee and facilitating the resolution of those concerns and grievances

b. seeking information about, and facilitating access by the detainee to, support services appropriate to the needs of the detainee

c. assessing whether the detainee has been provided with adequate information about his or her rights

d. assessing, in the Commissioner's opinion, the physical and emotional wellbeing of the detainee.[1541]

The Commissioner for Children and Young People is a 'prescribed officer' for the purposes of section 135A of the Youth Justice Act.[1542] This entitles the Commissioner to access, at any reasonable time, any detention centre for the purposes of performing functions under the Commissioner for Children and Young People Act, and to visit any detainee at a centre for the purposes of performing functions under the Youth Justice Act in relation to the detainee.[1543] The detention centre staff and manager must allow the Commissioner for Children and Young People to conduct an interview with a detainee 'out of the hearing of any other person' and must not, without the approval of the detainee, open, copy, remove or read any correspondence between the detainee and the Commissioner.[1544]

The Commissioner for Children and Young People does not have the power to investigate or review decisions made about individuals. An exception applies where the Minister for Education, Children and Youth requests that the Commissioner investigates or reviews a decision or recommendation made, or an act or omission, under any Act.[1545] In these circumstances, the Commissioner can undertake an investigation or review that is outside of their general jurisdiction.[1546] Commissioner McLean told us that she had not been asked to undertake such an investigation during her term as Commissioner for Children and Young People.[1547]

The Commissioner for Children and Young People can: provide a child, or the child's family, with information about relevant government and non-government programs or services; refer a child to such programs or services; or investigate or otherwise deal with any matter affecting the wellbeing of children generally when it is raised through a matter relating to a specific child.[1548] This general power in relation to all children applies equally to children in detention. The Commissioner for Children and Young People can also refer any matter to the Ombudsman or Custodial Inspector if the Commissioner considers it appropriate.[1549]

Commissioner McLean indicated that she visits Ashley Youth Detention Centre every three weeks and that during 2020–21 she visited 15 times.[1550] She said she meets with

children and young people in a quiet space if they request this, and with or without a youth worker present.[1551] She also advised that she participates in programs, visits young people in their units and can move through the Centre unaccompanied.[1552]

Commissioner McLean explained that she can assist children and young people to make a complaint to relevant authorities, which most commonly involves raising a complaint directly with Ashley Youth Detention Centre management, the Secretary of the Department, the Ombudsman or Tasmania Police.[1553]

In February 2022, an Advocate for Young People in Detention was appointed to assist Commissioner McLean to perform her youth detainee advocacy functions and meet the demand for help with making a complaint:[1554]

> … we now have a full-time advocate for young people in detention who lives in the North West of the state, who's present on site very regularly and has a mobile phone whose number is available to all detainees from admission. So, since the instigation of that additional resource we have seen a dramatic increase in the call on our advocacy and also an increase in the call upon us to facilitate a complaint.[1555]

However, despite her regular visits to Ashley Youth Detention Centre, Commissioner McLean told us that, as at 12 April 2022, no child or young person detained there had raised with her allegations of child sexual abuse perpetrated by staff.[1556]

In her statement to our Commission of Inquiry, Commissioner McLean identified four instances where she had been made aware (from a source other than a child) of child sexual abuse allegations involving children and young people at Ashley Youth Detention Centre.[1557] These instances largely related to potential harmful sexual behaviours displayed by young people or historical allegations of abuse.[1558] Commissioner McLean told us that she generally responded by referring the matters to other relevant authorities, discussing issues with the (former) Department of Communities, monitoring progress and outcomes of any reviews and, in one case, providing advocacy for a young person.[1559]

We acknowledge that the Commissioner for Children and Young People currently has no statutory power to investigate such incidents on her own motion, or to investigate departmental responses to such allegations. Nevertheless, the handling of these incidents highlights the limitations of, and weaknesses in, Tasmania's current system of oversight of youth detention, where the Commissioner for Children and Young People is reliant on the assurances of the Department and lacks the power to inquire into the accuracy of those assurances.

We note that if these or similar incidents occurred in future, those involving allegations against staff would be subject to the Reportable Conduct Scheme under the Child and Youth Safe Organisations Act (discussed in Chapter 18). Under this scheme, an allegation that a 'worker' at Ashley Youth Detention Centre engaged in 'reportable conduct' (such as sexual offences, sexual misconduct or grooming) against a child or young person

in detention would need to be notified to the Independent Regulator and investigated by the head of the detention facility (as the 'relevant entity').[1560] This is the Secretary of the Department, or their delegate.

Under the Child and Youth Safe Organisations Act, the Independent Regulator of the Reportable Conduct Scheme would be responsible for monitoring the investigation. It would receive: a copy of investigation findings, with reasons for the findings; details of any disciplinary or other action taken by management against the worker; and, where no action was proposed, the reasons for this decision.[1561] The Independent Regulator would also have the power to investigate an allegation of reportable conduct on the Independent Regulator's own motion, if it considered that this was in the public interest.[1562]

We strongly support the introduction of a reportable conduct scheme in Tasmania. In Chapter 18, we recommend establishing a new Commission for Children and Young People (Recommendation 18.6), which should assume the functions of the Independent Regulator of the Reportable Conduct Scheme. We discuss the new Commission for Children and Young People in Section 11.3.

We note that concerns about children and young people in detention who have engaged in harmful sexual behaviours against other children and young people in detention would not be subject to the Reportable Conduct Scheme because that scheme does not extend beyond reportable conduct by a 'worker' (defined as a person aged 18 years or older). In Section 8.5, we recommend that the Department be required to notify the new Commission for Children and Young People of incidents involving harmful sexual behaviours in youth detention, so the Commission has a complete picture of what is occurring in youth detention (Recommendation 12.30).

As discussed in Chapter 18, despite the statutory requirement that the Commissioner for Children and Young People acts 'independently, impartially and in the public interest', we heard evidence that cast doubt on the operational independence of the role.[1563] In particular, former Commissioner for Children and Young People Mark Morrissey recounted several experiences where he felt the independence of his office had been undermined by the Government (these are described in Chapter 18). Mr Morrissey referred to:

> … an apparent attempt to undermine the raison d'etre of the [Commissioner for Children and Young People]—namely as an independent voice legitimately advocating for children and young people, particularly vulnerable and at-risk children.[1564]

Mr Morrissey said that, following these experiences, he found it increasingly difficult to have his message accepted about child protection reform work and decided to retire.[1565] He also indicated that his two predecessors had not continued in their roles for the full intended duration of their appointments, but did not specify or speculate as to why.[1566]

As discussed in Chapter 18, lack of control over resourcing can also impede the independence of an oversight body. Commissioner McLean noted that, in contrast to the Ombudsman, who has control of his own budget and has a separate appropriation, the budget for the Commissioner for Children and Young People is an output item from the (former) Department of Communities budget.[1567] Commissioner McLean also told us that resourcing for her office 'has remained a constant challenge' and resourcing constraints have limited her ability to fulfil her functions.[1568] The funding allocated to the Commissioner for Children and Young People was $1,386,000 in 2021–22.[1569] In Chapter 18, we discuss independent resourcing of the new Commission for Children and Young People.

11.1.2 Ombudsman

The Ombudsman is an independent statutory officer appointed under the *Ombudsman Act 1978*.[1570] The Ombudsman has a role both in relation to individuals and the youth detention system (refer to Table 12.1). As noted, the position is currently held by Richard Connock.[1571]

The primary role of the Ombudsman is to investigate the administrative actions of public authorities to ensure they are lawful, reasonable and fair.[1572] The Ombudsman may receive complaints from people who are aggrieved by the administrative actions of public authorities if they have not been successful in resolving their complaint directly with the authority.[1573] This includes complaints from children and young people in detention about their treatment in Ashley Youth Detention Centre.[1574]

Under the Youth Justice Act, a child or young person detained at a youth detention centre is entitled to complain to the Ombudsman about the standard of care, accommodation or treatment they are receiving in the detention centre.[1575] Where a child or young person in detention wants to make a complaint to the Ombudsman, staff of the detention centre must take all steps necessary to facilitate the complaint and must send the Ombudsman an unopened, sealed envelope containing the complaint.[1576]

The Ombudsman's 2021–22 annual report indicates that most complaints across all public authorities are resolved by way of 'preliminary inquiries'—this involves a 'co-operative approach' where authorities provide information and work with the Ombudsman to address complaints and improve processes.[1577] However, where appropriate, the Ombudsman may conduct an investigation on the basis of a complaint or on the Ombudsman's own motion.[1578] Following an investigation, a report is prepared for the public authority and this may contain recommendations to remedy actions.[1579] The report may also be provided to the relevant Minister and to Parliament.[1580] The Ombudsman does not have the power to compel a public authority to adopt any recommendations, although these 'are ordinarily accepted and acted upon'.[1581]

The Ombudsman advised us that his office receives 'very few, if any' complaints about child sexual abuse.[1582] The Ombudsman's most recent annual report indicates that the Ombudsman received two complaints about Ashley Youth Detention Centre in 2021–22, up from one complaint in 2020–21.[1583] The annual report provides no more information on the nature of these complaints.

Case studies 1 and 7 in Chapter 11 examine the former Ombudsman's response to a complaint made by Erin (a pseudonym) in 2012 about the sexually inappropriate behaviour of a male youth worker at Ashley Youth Detention Centre. The then Ombudsman referred the allegations to Ashley Youth Detention Centre management and finalised the complaint.[1584]

We are aware of other complaints about the behaviour of staff at Ashley Youth Detention Centre that the then Ombudsman classified as 'minor' and referred in error to Centre management for internal review between 2009 and 2013.[1585] In our view, the allegations in these complaints were not minor in nature. In Chapter 11, Case study 7, we observe that this historical arrangement between the Office of the Ombudsman and the Department, at least on occasion, resulted in serious matters being erroneously referred back to the Centre in and around 2012. In that case study, we also express our concern about the integrity of the processes which were in place in the Office of the Ombudsman at the time to ensure inappropriate referrals were not made.

The current Ombudsman advised us that this arrangement is no longer in place.[1586] Mr Connock said that the Ombudsman's Office now conducts preliminary enquiries for 'any complaint' it receives.[1587] We have not been advised about how this process has been formalised.

We also understand that Ashley Youth Detention Centre management has, in the past, advised staff that they should not have direct contact with the Offices of the Ombudsman or Custodial Inspector, and that all enquiries from those offices must be escalated to senior management.[1588]

11.1.3 The Custodial Inspector

The Office of the Custodial Inspector was established by the *Custodial Inspector Act 2016* ('Custodial Inspector Act') and commenced operation in November 2016.[1589] The purpose of the office is to 'provide independent, proactive, preventive and systemic oversight of custodial centres', including Ashley Youth Detention Centre.[1590] The Custodial Inspector must act independently, impartially and in the public interest.[1591]

As noted, the current Custodial Inspector is Mr Connock, who also holds several other appointments.[1592]

The Custodial Inspector's functions include:

- preparing and publishing guidelines and standards for conducting inspections[1593]
- carrying out a mandatory inspection of each custodial centre against all inspection standards at least once every three years, and any occasional inspections of the Custodial Inspector's own accord or as requested by the Minister for Corrections and Rehabilitation[1594]
- reporting to the Minister or Parliament on the inspections, and any particular issue or general matter relating to the functions of the Custodial Inspector, if it is in the public interest to do so, or if requested by either House of Parliament or a Committee of either House of Parliament[1595]
- providing an annual report to Parliament[1596]
- providing advice or making recommendations that the Custodial Inspector thinks appropriate, including advice or recommendations relating to the safety, custody, care, wellbeing and rehabilitation of prisoners and detainees.[1597]

The Custodial Inspector has published *Inspection Standards for Youth Custodial Centres in Tasmania,* comprising standards under nine themes: governance and procedural fairness; informed advice; service delivery; family and community; partnerships; infrastructure; workforce; security; and health and wellbeing.[1598]

The Custodial Inspector does not respond to individual complaints.[1599] However, if the Custodial Inspector considers that a matter raised by, or during, a mandatory or occasional inspection should be investigated, the Custodial Inspector may refer the matter to the Ombudsman or any other such person or body for investigation.[1600]

The Custodial Inspector is also entitled to visit or speak to a detainee at all reasonable times.[1601] The person in charge of a custodial centre, each member of staff of the custodial centre and any person providing services in a custodial centre must allow the Custodial Inspector (like the Commissioner for Children and Young People) to conduct an interview with a detainee out of the hearing of any other person, and must not, without approval of the detainee, copy, remove or read any correspondence between the detainee and the Custodial Inspector.[1602] These requirements are reflected in the Youth Justice Act.[1603]

The Custodial Inspector's 2020–21 annual report indicated that the Custodial Inspector held 'few concerns about the operations at [Ashley Youth Detention Centre]'.[1604]

Mr Connock told us that his many other responsibilities limited his ability to visit Ashley Youth Detention Centre.[1605] Mr Connock also indicated that the Office of the Custodial Inspector was 'not well enough resourced to do a full omnibus inspection most of the time', so it undertook themed inspections instead.[1606] The permanent staffing of the

Office of the Custodial Inspector is the Inspector, one Principal Inspection Officer, one Senior Inspection Officer and one Administration and Research Officer.[1607] Given the other demands on his time, the current Custodial Inspector has formally delegated all of his functions and powers under the Custodial Inspector Act to his staff.[1608]

In the Custodial Inspector's 2021–22 annual report, the Custodial Inspector noted that, despite receiving extra funding for the Administration and Research Officer position, the Inspectorate's resources were 'still limited'.[1609] He noted that, due to the departure of two staff members in late 2021 and difficulties in recruiting staff, there was a backlog of inspections.[1610] He also indicated that the Inspectorate was unlikely to meet its three-year legislative timeframe for inspecting all custodial centres against all standards.[1611]

The Custodial Inspector has prepared eight reports into Ashley Youth Detention Centre, covering the themes of health and wellbeing; education and programs; custody; families, communities and partnerships; equal opportunity; food and nutrition; resources and systems; and environmental health and hygiene.[1612] These reports were published between October 2018 and February 2022. They relate to inspections undertaken between May 2017 and February 2021.

There is only one reference to child sexual abuse in the Custodial Inspector's reports on Ashley Youth Detention Centre—in the 2019 *Custody Inspection Report*.[1613] That report referred to the National Royal Commission's recommendation that state and territory governments review legislation, policies and procedures to ensure best practice for personal searches. The Custodial Inspector's report recommended that the (former) Department of Communities consider 'best practice processes for conducting personal searches of young people including providing clear information, including illustrations, about how the search will be performed'.[1614] As discussed in Section 9.1.4, the Department updated its procedure for personal searches of children and young people in detention in February 2023.[1615]

In oral evidence, Mr Connock indicated that the standards related to safety, security and health would be particularly important for managing allegations of child sexual abuse.[1616]

The security standards refer to 'the importance of ensuring that the environments in which young people are lawfully detained are safe, secure, and developmentally appropriate'.[1617] They specify (among other matters) that:

- detention centres are to be adequately staffed at all times[1618]
- the use of force, including any form of restraints, should not cause humiliation or degradation and should be used for the shortest possible time (refer to Section 9.3)[1619]

- behaviour management schemes should have incentives to promote effort and good behaviour and use fair sanctions for poor behaviour (these schemes are discussed in Section 6.3)[1620]
- young people should be separated or segregated only in response to an unacceptable risk to themselves or others, and only when all other means of control have been exhausted (isolation is discussed in Section 9.2)[1621]
- young people, staff and visitors should understand that bullying and intimidating behaviour are not acceptable and be aware of the consequences of such behaviour.[1622]

The health and wellbeing standards 'provide guidance to youth justice services about ways that optimise the health and wellbeing of young people'.[1623] They state that young people in custody should have their health needs addressed by appropriate health and ancillary services, and they should have a minimum of 10 hours out of their rooms each day.[1624]

We agree that these standards are relevant to ensuring an environment that protects children and young people from the risks of child sexual abuse. However, we consider that other standards are also relevant to minimising the risks of child sexual abuse in youth detention, such as the service delivery standard, which states that 'young people in detention centres have the right to be safe and free from abuse'.[1625]

In oral evidence, Mr Connock told us that his office received 'all sorts of internal documentation now' about Ashley Youth Detention Centre, including 'numbers about residents, where they're housed [and] various incidents'.[1626] According to the Tasmanian Government's most recent progress report on implementing the recommendations of the National Royal Commission, Ashley Youth Detention Centre has 'implemented changes to ensure that the Custodial Inspector is notified of all significant incidents' at the Centre.[1627] This is a positive development. However, it is not clear that the Custodial Inspector is resourced well enough to analyse or act on these reports.

Further, while we acknowledge the Custodial Inspector's resourcing constraints, we consider that thematic inspections are less likely to identify abuse or mistreatment of children and young people in detention than full, open-ended inspections that take a broad view of children's safety, health and wellbeing.

Chapter 11, Case study 1 reveals recollections of victim-survivors who said they had been sexually abused at Ashley Youth Detention Centre from the early 2000s to as recently as the early 2020s.[1628] In that case study, we find that, for decades, some children and young people detained at Ashley Youth Detention Centre experienced systematic harm and abuse. In Chapter 11, Case study 3, we find that the use of isolation as a form of behaviour management, punishment or cruelty and contrary to the Youth Justice Act has been a regular and persistent practice at Ashley Youth Detention Centre since at least the early 2000s, and the conditions that enabled this practice still exist today. While

the Custodial Inspector's 2019 *Custody Inspection Report* commented on the use of isolation, that report did not identify any abusive practices in relation to this issue.[1629]

In oral evidence, Mr Connock conceded he was unaware of the extent of the abusive practices at Ashley Youth Detention Centre and accepted that more needed to be done to empower children and young people experiencing sexual or other abuse to make complaints.[1630]

We acknowledge that, as outlined in Sections 10.1 and 11.2, many children and young people felt it was unsafe to raise concerns with oversight bodies about child sexual abuse at Ashley Youth Detention Centre for fear of reprisals or punishment from staff or other young people in detention. Nevertheless, we consider that a proactive oversight body should understand the risks of child sexual abuse in the institution it is overseeing and not accept the absence of reports of abuse as an indication that abuse is not occurring. Rather, as noted, an effective oversight body should treat low reporting rates in a high-risk institution as grounds for further action and investigation.

11.2 Experiences of children and young people

We heard evidence from children and young people in detention and former detainees that suggests that external oversight of youth detention has not been effective. We acknowledge that some of these experiences predate the creation of the statutory Commissioner for Children and Young People and the Custodial Inspector.

Some children and young people in detention or formerly in detention were unaware that they could ask an external entity for help. For example, Warren (a pseudonym), a victim-survivor who was first admitted to Ashley Youth Detention Centre in the mid-2000s when he was 13 years old, told us:

> I didn't know if there was anyone outside Ashley we could make a complaint to. Now I know I can make a complaint to the Ombudsman but I didn't know that when I was at Ashley.[1631]

We also heard that where young people in detention did make a complaint, they did not receive effective responses from the oversight body in question, or faced negative repercussions from Ashley Youth Detention Centre staff for doing so. Erin, whose experiences we describe in Chapter 11, Case study 1, told us that the complaint she made to the Ombudsman about highly concerning sexual behaviour towards her from a male youth worker in 2012 was referred to the Centre and that the Ombudsman's Office did not contact her again.[1632] Erin said she was not notified of any outcome by the Department or the Ombudsman and said other staff were 'pissed off' at her for speaking up. Subsequently, she felt it was pointless to make a complaint.[1633]

As discussed in Chapter 11, Case study 6, when Counsel Assisting asked Max (a pseudonym), a victim-survivor who was detained at Ashley Youth Detention Centre, how he was treated by staff after speaking to the Commissioner for Children and Young People in the late 2010s, he said:

> They treated me like shit. They weren't giving me any, like, toasties, they'd only give me drinks when I was allocated drinks. Like, before that they'd give us drinks sort of whenever, like toasties whenever, and then they just started just restricting everything. They tried to do it all by the rules, but like, they were just being real—they were just being real, like, real strict about everything, when they hadn't been like that, then after that they just started doing it.[1634]

When Counsel Assisting asked Max if he felt like he was being punished because he had spoken to the Commissioner for Children and Young People, he replied 'Yeah, yeah, it was obvious what they were doing'.[1635]

We did not ask the Tasmanian Government or the Commissioner for Children and Young People to give extensive evidence to reject or support Max's evidence. However, the Ashley Youth Detention Centre staff member against whom the allegation was made denied the allegation during hearings.[1636]

Children and young people consulted for the *Take Notice, Believe Us and Act!* report said they were aware that the Commissioner for Children and Young People could help them make complaints.[1637] However, some children and young people reported that they were not always allowed or encouraged to contact independent entities, while others noted that there were repercussions for doing so:[1638]

> That's another thing that Ashley [Youth Detention Centre] hates as well. They put all these posters up and that, but deep down they hate it. If you say, 'I want to call the Commissioner,' they're just like, 'Oh, you're going to do that, are you?' Because most times people do it to complain about a certain staff member. And then that staff member doesn't do shit for you. They say, 'Well, if you call the Commissioner, then I'm not doing shit for you.' They're like, 'I'll give you what I have to, I'll give you your food and that, but only because I have to by law, but I'm not going to sit there and like you. If you do that, you're just a scumbag.' The amount of times I've had that said to me, then like, 'No, I'm only joking'.[1639]

In Section 4, we make recommendations aimed at transforming the culture in youth detention, including ensuring children and young people are aware of their rights, empowering them to speak up and ensuring staff in detention facilities comply with a professional conduct policy that specifies standards of acceptable behaviour. In Section 10.3, we recommend measures to encourage complaints and critical feedback in youth detention from children and young people, and staff.

We also consider that there is scope to strengthen Tasmania's system of external oversight for youth detention.

11.3 A new Commission for Children and Young People

In Chapter 18, we set out our recommendations to establish a new, independent Commission for Children and Young People that would subsume the functions of the current Commissioner for Children and Young People and have additional functions (Recommendation 18.6). These would include regulatory functions under the Child and Youth Safe Organisations Act in relation to the Child and Youth Safe Standards and the Reportable Conduct Scheme.

The new Commission for Children and Young People would have three statutory officeholders, each appointed by the Governor for a term not exceeding five years:

- a Commissioner for Children and Young People, who would also be the Independent Regulator under the Child and Youth Safe Organisations Act
- a Commissioner for Aboriginal Children and Young People (discussed in Chapter 9)
- a Child Advocate (Deputy Commissioner) (discussed in Chapter 9).

To be effective, a youth detention oversight body should have expertise in relation to children and be independent—in its composition, resources, legal status and powers—of the institutions or agencies it is responsible for overseeing.[1640] As discussed in Section 11.1.1, we heard evidence that cast doubt on the ability of the role of Commissioner for Children and Young People to be performed independently and effectively.

To maximise the independence of the new Commission for Children and Young People, we recommend in Chapter 18 that:

- Commissioners for Children and Young People and Deputy Commissioners be appointed following an externally advertised merit-based selection process to ensure they have relevant professional qualifications and substantive experience in matters affecting children (Recommendation 18.7)
- before making a recommendation to the Governor for an appointment to the Commission for Children and Young People, the Minister be required to consult with the leader of any political party that has at least two members in either house of Parliament (Recommendation 18.7)
- the Commission for Children and Young People be separately and directly funded, like the Ombudsman, rather than through the Department for Education, Children and Young People (Recommendation 18.8)
- the performance of the functions of the Commission for Children and Young People be monitored by a joint standing committee of the Tasmanian Parliament (Recommendation 18.9).

The new Commission for Children and Young People would not be a general complaints-handling or investigation body but would have a new individual advocacy function for children in out of home care and youth detention through a new independent community visitor scheme, and functions and powers to monitor the out of home care and youth justice systems (refer to Chapter 9 and the discussion in Sections 11.4 and 11.6 of this chapter).

11.4 Strengthening individual advocacy for children in detention

It is vital that children and young people in youth detention are supported to express any concerns about their treatment and that those concerns are treated confidentially.[1641] It is also essential that such support remains in place until those concerns are resolved. The South Australian Guardian for Children and Young People, Penny Wright, told us that, despite not having a direct complaints-handling function for children in youth detention, her office's most important mechanisms for protecting children in detention against the risk of sexual abuse were regular visits to detention facilities, regular sighting of all children in detention and the opportunity for children to speak to advocates confidentially.[1642]

As noted, the Commissioner for Children and Young People also has an individual advocacy function for children and young people in detention, which involves the Commissioner regularly engaging with children in detention and providing them with an opportunity to speak with advocates confidentially. While we consider that this function could be strengthened, we acknowledge that the performance of the Commissioner's advocacy role has been enhanced since the appointment of a fixed-term dedicated Advocate for Young People in Detention in the office of the Commissioner for Children and Young People (noted in Section 11.1.1).[1643]

We heard evidence about the operation of independent community visitor schemes in Queensland and Victoria.[1644] The Queensland scheme applies to children in out of home care and youth detention, while the Victorian scheme only applies to children in youth detention centres.[1645] We also heard from Ms Wright about her role as Training Centre Visitor.[1646] We were impressed by the capacity of these mechanisms to identify issues of concern to children and young people in detention—including concerns about child sexual abuse—and to effectively advocate on behalf of children and young people in detention for the resolution of their concerns.

In Chapter 9, we recommend that the Tasmanian Government introduces legislation to establish an independent community visitor scheme for children in out of home care, youth detention and other residential youth justice facilities, based on the Queensland Community Visitor Program (Recommendation 9.34). The key features of that program, which is administered by the Queensland Public Guardian, are:

- Community visitors are appointed for up to three years by the Public Guardian.[1647] They must have the 'knowledge, experience or skills needed' to perform the functions of the role.[1648] They are not volunteers and are not employees of the public service.[1649]
- Community visitors have a range of statutory functions, including developing a trusting and supportive relationship with each child they visit, advocating on behalf of the child, inspecting detention centres, and ensuring the child's needs are being met.[1650]
- Community visitors must visit children in detention 'regularly'.[1651] One Queensland youth detention centre is visited twice a week, while the remaining two are visited weekly.[1652] A child in detention can also request a visit from a community visitor.[1653]
- Community visitors have various statutory powers, including the power to enter a detention centre without notice, inspect the centre, talk to a child in private and require a staff member to answer questions and produce documents.[1654]

In Chapter 9, we also recommend that the independent community visitor scheme be administered by the new Commission for Children and Young People and led by the new Child Advocate. The Child Advocate should be responsible for appointing community visitors based on their skills, knowledge and expertise, including in the areas of child development, working with vulnerable children and young people, and the experiences and needs of Aboriginal children and young people. The Child Advocate should appoint at least one independent community visitor who is Aboriginal.

In relation to youth detention, we consider that community visitors should be responsible for:

- developing trusting and supportive relationships with children and young people in detention and assisting them to understand their rights
- advocating on behalf of children and young people in detention by listening to, giving voice to and helping to resolve their concerns and grievances
- facilitating access to support services for children and young people in detention
- inquiring into and reporting on the physical and emotional wellbeing of children and young people in detention
- inquiring into whether the needs of children and young people in detention are being met
- conducting exit interviews with children and young people leaving detention.

The independent community visitor scheme should be funded to enable every child and young person in detention to be visited weekly or whenever a child requests a visit. Ideally, a child would be visited by the same visitor each week, to build a relationship of trust. Children and young people in other residential youth justice facilities, such as the proposed assisted bail facilities (discussed in Section 5.4.5) and supported residential facilities (discussed in Section 6.8.2), should also receive regular visits.

Aboriginal children in detention should have access, wherever possible, to an independent community visitor who is Aboriginal. Alternatively, an Aboriginal child or young person in detention may request the involvement or assistance of the Commissioner for Aboriginal Children and Young People. Where such a request is made, the Child Advocate should work closely with the Commissioner for Aboriginal Children and Young People to arrange this.

We also consider that a child or young person who is transferred from youth detention to adult prison before they turn 18 should continue to receive visits from an independent community visitor until they turn 21. This will ensure continuity of the relationship between the visitor and the child or young person and recognise the increased vulnerability to sexual abuse of children and young people in prison.

Interviews between independent community visitors and young people in detention should be conducted in a safe environment, and out of the hearing and sight of detention centre staff and other young people to ensure privacy and confidentiality.[1655] We heard evidence that, occasionally, the environment at Ashley Youth Detention Centre was not always safe for discussions with oversight bodies. Commissioner McLean told us that, during periods when the Centre was under restrictive practices or lockdowns (discussed in Sections 4.7.2 and 9.2.2), she had to conduct advocacy through the door of children and young people's rooms:

> My understanding today is that we have moved back to restrictive practices, that young people may be cycling in and out of their rooms on an hourly basis … When you visit the facility to speak to young people and advocate for them through a small window hole in the door, it is really awful … I don't think it would meet the safety requirements of the centre for a worker, because they're so thin on the ground, to come off the floor to supervise a young person out of their room to engage with the Commissioner or the Advocate.[1656]

We also heard that phone calls at Ashley Youth Detention Centre are monitored and are within a sight line of a youth worker.[1657] We heard that a phone with prerecorded numbers had been installed at Ashley Youth Detention Centre, but these did not include the numbers of all oversight bodies.[1658]

In 2019, the Custodial Inspector observed that, for a phone call to be made from Ashley Youth Detention Centre, a child or young person needed to ask a staff member to provide a phone, which would then be plugged into a connection point on the wall.[1659]

In some units, such points were available in rooms separate from the common area; however, the Custodial Inspector noted that sound travelled around these rooms and 'little privacy [was] afforded for the young person making the call'.[1660] In other units, the only phone connection point was in the common area, which provided 'no privacy whatsoever'.[1661] The Custodial Inspector recommended that the then Department of Communities consider:

> … options for installing private spaces with appropriate confidential settings in each unit at [Ashley Youth Detention Centre] for young people to make professional and personal telephone calls.[1662]

The Tasmanian Government's most recent annual Action Plan in response to the recommendations of the National Royal Commission states that:

> … all children and young people detained at [Ashley Youth Detention Centre] can contact the [Commissioner for Children and Young People] by telephone at any time, in a physical location that offers the detainees increased privacy.[1663]

As noted in Section 6.7.4, in June 2023, the Department informed us that it had 'recently procured mobile phones for young people within Ashley Youth Detention Centre', which would give them 'the ability to make personal and professional calls from the privacy of their bedrooms or the Centre's outside spaces or meeting rooms, outside of school hours'.[1664] The mobile phones were expected to be provided to children and young people in July 2023.[1665] We welcome this initiative because it is essential that children and young people be able to make private phone calls, including to oversight bodies.

In Chapter 9, we recommend that the independent community visitor scheme includes funding for a small number of legally trained child advocacy officers—also appointed by the Child Advocate—to help children and young people in out of home care and youth detention with more complex concerns. These officers could assist children and young people in detention to make a formal complaint to the Ombudsman, where the concern cannot not be resolved informally. The Ombudsman's processes are discussed in Section 11.5.

Recommendation 12.36

The Tasmanian Government, in establishing and resourcing the new independent community visitor scheme (Recommendation 9.34), should ensure:

a. independent community visitors visit children and young people in detention facilities weekly, at a minimum

b. Aboriginal children and young people in detention or other residential youth justice facilities have access, wherever possible, to visits from an Aboriginal independent community visitor or from the Commissioner for Aboriginal Children and Young People, depending on the child's preference

c. independent community visitors have the necessary statutory powers to perform their functions, including the power to enter the facility, have access to children and young people in the facility and inspect the facility

d. each facility where children and young people are detained or reside has a safe, dedicated space where independent community visitors can meet with children and young people and discuss concerns without being observed or overheard by staff or other children and young people.

11.5 Complaints to the Ombudsman about children's experiences in detention

From 1 January 2024, under the Child and Youth Safe Organisations Act, complaints about child sexual abuse and related matters against staff in youth detention will constitute a 'reportable allegation' and fall within the scope of the Reportable Conduct Scheme. If the Ombudsman's Office received such a complaint, it should be able to share this information with the Independent Regulator of the scheme, so a reportable conduct investigation can be undertaken (refer to Chapter 18 for a discussion of information sharing between oversight bodies).

For complaints about administrative actions or departmental decisions, such as the placement of a child or young person in a particular unit in a detention facility, we consider that the Ombudsman is the appropriate body to continue to receive such complaints, rather than the new Commission for Children and Young People. However, there is scope to improve the Ombudsman's processes.

Currently, a complaint to the Ombudsman must be made by the person who is 'personally aggrieved' by the administrative action, unless that person has died or cannot act for themselves, in which case the complaint may be made by a personal representative suitable to represent them.[1666] We heard from Mr Connock that if a child or young person has the capacity and wants to make a complaint, then 'it should probably come from the young person, but we would treat everything on a case-by-case [basis]'.[1667]

In Chapter 9, we recommend that the new Child Advocate be given the power to make a complaint to the Ombudsman on behalf of a child in out of home care, youth detention or another residential youth justice facility (Recommendation 9.35). In that chapter, we also propose that the Office of the Ombudsman works with the new Commission for Children and Young People to establish an accessible, child-friendly complaints process and develop specialisation among investigators in managing complaints from or involving children in out of home care, youth detention or other residential youth justice facilities.

In Chapter 18, we recommend that the Ombudsman, the Commission for Children and Young People, the Integrity Commission and the Registrar of the Registration to Work with Vulnerable People Scheme develop a memorandum of understanding relating to the management of reports, complaints and concerns about child sexual abuse (Recommendation 18.15). This memorandum of understanding should provide for permissive information-sharing practices that prioritise the safety of children. We discuss this recommendation in Section 11.8 of this chapter.

In Chapter 18, we also recommend that the Ombudsman, the Commission for Children and Young People, the Integrity Commission and the Registrar of the Registration to Work with Vulnerable People Scheme work jointly to develop a user-friendly guide for the general public that describes (among other matters):

- how each of these agencies can assist with complaints and concerns about how organisations respond to child sexual abuse
- the process they will adopt to respond to reports, complaints and concerns
- how information provided by a person lodging a report, complaint or concern will be shared and managed
- how agencies are committed to a 'no wrong door' approach to complaints, so people are reassured that all reports, complaints and concerns will receive a response from an agency (Recommendation 18.14).

We also recommend that a child-friendly version of this guide be developed and publicised widely in youth justice, out of home care and health settings and schools. Both guides should be available on the agencies' websites and form part of their child safety community education and engagement activities.

To improve the Ombudsman's internal processes, we recommend that it develops guidelines for its staff on managing complaints involving child sexual abuse in youth detention, other residential youth justice facilities or out of home care.

Recommendation 12.37

The Ombudsman should develop written guidelines for its staff on managing complaints it receives containing allegations of child sexual abuse involving children in youth detention, other residential youth justice facilities or out of home care. Among other matters, these guidelines should include:

a. the definition of child sexual abuse and related conduct, including sexual misconduct, grooming, harmful sexual behaviours and boundary breaches

b. the process for reporting relevant allegations to Tasmania Police, Child Safety Services, the Registrar of the Registration to Work with Vulnerable People Scheme and the Independent Regulator under the *Child and Youth Safe Organisations Act 2023*

c. guidance on referring an allegation or complaint to an agency named in the complaint

d. guidance on communicating with child complainants on the referral of their complaints to other entities and the progress of investigations into their complaints

e. processes for sharing information with other oversight bodies regarding the management of complaints (Recommendation 18.15).

11.6 Systemic monitoring of youth detention

The Custodial Inspector is responsible for inspecting and monitoring Tasmania's custodial centres. As such, the Custodial Inspector is not focused solely on youth detention and does not have specialist expertise in children or the youth justice system. To date, the Custodial Inspector has not identified any specific risks of child sexual abuse in Ashley Youth Detention Centre, even though such risks have clearly existed.

Mr Connock, the current Custodial Inspector, holds six other statutory roles and has limited capacity to devote to inspecting Ashley Youth Detention Centre. We received evidence that the Office of the Custodial Inspector is under-resourced.[1668] We are concerned that the current system for monitoring youth detention is ill-equipped to identify or prevent risks of child sexual abuse to children and young people in detention.

In our view, the oversight body responsible for systemic monitoring of youth detention should be child-focused and should specialise in working with children and young people. It should have expertise in child trauma and in preventing and identifying child sexual abuse.[1669] It should be resourced to engage in regular and frequent monitoring of youth detention facilities.

In Victoria, the Commission for Children and Young People has functions in relation to 'vulnerable children and young persons'.[1670] These include children and young people detained in a youth justice centre or a youth residential centre under the *Children, Youth and Families Act 2005* (Vic) and children involved in the youth justice system more broadly.[1671] One of these functions is to 'monitor and report to Ministers on the implementation and effectiveness of strategies relating to the safety or wellbeing of vulnerable children and young persons'.[1672]

According to its 2021–22 annual report, the Victorian Commission for Children and Young People monitors the safety and wellbeing of children and young people in Victoria's two youth justice centres. It does this by reviewing all serious incidents (such as assaults or self-harm) that occur in those centres, by conducting onsite inspections and by monitoring custodial population data and incident trends. It also tracks the use of isolation, force and restraints.[1673] The Victorian Commission for Children and Young People operates an independent visitor program for children and young people in youth justice centres and conducts exit interviews with children and young people leaving youth justice centres.[1674]

The Victorian Commission for Children and Young People also has specific inquiry powers in relation to children in youth detention. For example, it has a systemic inquiry power that enables it to conduct an inquiry into the provision of youth justice services to vulnerable children if it identifies a persistent or recurring systemic issue in the provision of those services and considers that a review will improve those services.[1675] In 2021, the Victorian Commission for Children and Young People published its *Our Youth, Our Way* inquiry report on the over-representation of Aboriginal children and young people in Victoria's youth justice system (discussed in Section 7).[1676] That inquiry was conducted using the Commission for Children and Young People's systemic inquiry power.[1677]

The Victorian Commission for Children and Young People can also conduct an inquiry into the safety and wellbeing of a vulnerable child or group of vulnerable children, where the inquiry relates to the services provided or omitted to be provided to that child or group of children.[1678]

Similarly, the Northern Territory Children's Commissioner has the power to undertake investigations into systemic issues in youth detention under Part 5 of the *Children's Commissioner Act 2013* (NT).[1679] In 2021–22, the Children's Commissioner used its own-motion investigation powers to conduct preliminary inquiries into the detention of children under the age of 14 years in the Alice Springs Youth Detention Centre and Don Dale Youth Detention Centre.[1680] The Children's Commissioner also has the power to inquire into the services provided to an individual child in youth detention.[1681]

In Tasmania, Commissioner McLean told us that she is provided with data about children and young people held at Ashley Youth Detention Centre, including the daily roll, minutes of Weekly Review Meetings and monthly reports of incidents, isolation, use of force and searches.[1682] She conceded that her office is constrained in its ability to analyse this data in significant detail due to a lack of resources.[1683] Commissioner McLean also referred to her role in advocating for a therapeutic approach to youth justice and noted that she had observed a strong emphasis on a shift to a therapeutic model since she started in the role.[1684]

We consider that the new Commission for Children and Young People, as an oversight body dedicated exclusively to issues relating to children and young people, should be

given functions and powers to monitor the wellbeing of children and young people in detention and the youth justice system more broadly. The Commission for Children and Young People should have expertise in working with vulnerable children and a deep understanding of the many challenges faced by children and young people in detention.

Giving the new Commission for Children and Young People systemic monitoring functions for youth detention would be complemented by the proposed independent community visitor scheme (refer to Recommendation 12.36). Through this scheme, the concerns expressed to visitors by children and young people in detention during regular visits would provide early and valuable insight into any systemic problems arising in youth detention centres.[1685]

This recommendation would also be consistent with our recommendation in Chapter 9 to give the Commission for Children and Young People expanded powers and resources to oversee and monitor the out of home care system. As noted in that chapter and in Section 5.5.3 of this chapter, many children in detention are also involved in the out of home care system—we consider it logical and appropriate for a single oversight body to monitor the experiences of these vulnerable children.

The Commission for Children and Young People should also have the power to enter adult prisons to monitor the safety and wellbeing of children and young people in those facilities. This is essential because of the increased vulnerability of children and young people to sexual abuse in prison.

We acknowledge that implementing these recommendations will require additional resourcing for the new Commission for Children and Young People. However, we consider that this is essential to ensure that a body with the necessary specialisation and expertise is responsible for systemic monitoring of youth detention.

Systemic monitoring by the Commission for Children and Young People should replace the inspection and monitoring of youth detention centres currently undertaken by the Custodial Inspector. However, the Tasmanian Government should consider whether the Commission for Children and Young People should assume responsibility for maintaining and reviewing the *Inspection Standards for Youth Custodial Centres in Tasmania* or whether they should remain the responsibility of the Custodial Inspector, given the Custodial Inspector will continue to be responsible for the standards for adult custodial facilities. If the Custodial Inspector retains responsibility for the youth detention standards, the Office of the Custodial Inspector should liaise with the new Commission for Children and Young People in updating and maintaining the standards.

Recommendation 12.38

The Tasmanian Government should ensure the Commission for Children and Young People (Recommendation 18.6):

a. has functions and powers to monitor the operation of youth detention centres and other residential youth justice facilities, and the safety and wellbeing of, and the provision of services to, children and young people in detention, and in the youth justice system more broadly, by

   i. regularly monitoring and reviewing custodial population data and information on serious or adverse incidents (such as child sexual abuse, assaults, attempted suicide, self-harm, riots, escapes and property damage) and the use of isolation, force, restraints and searches

   ii. conducting regular onsite inspections of youth detention and other residential youth justice facilities

   iii. conducting own-motion systemic inquiries into issues that are identified through monitoring

   iv. conducting own-motion inquiries into the youth justice services received by an individual child or group of children

b. has the power to enter adult prison facilities to visit children and young people in those facilities to monitor their safety and wellbeing

c. is adequately resourced on an ongoing basis to fulfil its systemic monitoring functions.

11.7 Appointing a child-specific National Preventive Mechanism

As noted in Chapter 10, Australia is a party to the United Nations Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment ('OPCAT'), which it ratified in 2017.[1686]

Article 3 of OPCAT contains an obligation on States Parties to set up, designate or maintain, at the domestic level, one or several visiting bodies for preventing torture and other cruel, inhuman or degrading treatment or punishment, known as the National Preventive Mechanism.[1687] The key functions of the National Preventive Mechanism are to visit and inspect places of detention, and to provide advice and make recommendations to the State to prevent torture and cruel, inhuman or degrading treatment.[1688]

Article 17 of OPCAT requires States Parties to maintain, designate or establish the National Preventive Mechanism no later than one year after ratification of the protocol.[1689] Australia sought to delay its obligation to establish a National Preventive Mechanism, with 20 January 2023 set as the date for compliance.[1690]

OPCAT also requires States Parties to facilitate visits by the United Nations Subcommittee on the Prevention of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment ('Subcommittee on Prevention').[1691] The Subcommittee on Prevention comprises 25 independent human rights experts who serve in their personal capacity and monitor States Parties' adherence to OPCAT.[1692]

The National Royal Commission recommended that the National Preventive Mechanism(s) be provided with:

> ... the expertise to consider and make recommendations relating to preventing and responding to child sexual abuse as part of regularly examining the treatment of persons deprived of their liberty in places of detention.[1693]

In October 2022, the Australian Human Rights Commission published a 'road map' to compliance with OPCAT.[1694] This followed a national symposium in September 2022 that brought together relevant stakeholders from the Australian, state and territory governments.[1695] That document recommended that governments ensure National Preventive Mechanisms are designed and operate in a way that reflect the needs of vulnerable cohorts who are disproportionately represented in places of detention.[1696]

The Tasmanian Parliament passed the *OPCAT Implementation Act 2021* in November 2021. The purpose of the Act is to enable the National Preventive Mechanism to be appointed and maintained, and for the Subcommittee on Prevention to fulfil its mandate as set out in OPCAT.[1697] Significantly, the Act provides for the appointment of 'a person, or more than one person' as a Tasmanian National Preventive Mechanism.[1698]

The functions of the Tasmanian National Preventive Mechanism include:

- regularly examining the treatment of people deprived of their liberty in places of detention, with a view to strengthening, if necessary, their protection against torture and other cruel, inhuman or degrading treatment or punishment
- requiring the provision of, or access to, information held by any person concerning detainees, including the number and treatment of detainees
- accessing, inspecting and reviewing places of detention
- interviewing detainees
- making recommendations and providing advice to the relevant authorities, to improve the treatment and conditions of people deprived of their liberty and prevent torture and other cruel, inhuman or degrading treatment or punishment
- developing and publishing guidelines and standards in respect of detainees or places of detention.[1699]

In February 2022, the Tasmanian Government announced that Richard Connock had been appointed to the position of a Tasmanian National Preventive Mechanism for two years.[1700]

In the Ombudsman's 2021–22 annual report, Mr Connock referred to his appointment as a Tasmanian National Preventive Mechanism and indicated that he was not required to report publicly on the performance of these functions.[1701] He also stated that 'little work' has been undertaken by the Australian, state and territory governments to progress implementation of OPCAT—for example, to establish monitoring standards—which 'renders the making of [a National Preventive Mechanism] office Budget Submission impossible at present'.[1702]

The Ombudsman's annual report also observed that implementing the National Preventive Mechanism would require 'significant resourcing and funding'.[1703] Mr Connock reiterated during our hearings that this additional appointment constituted a further stretching of his capacity, explaining that 'with OPCAT I've now got seven jurisdictions, and it's becoming increasingly difficult to keep track of everything'.[1704]

The Subcommittee on Prevention suspended a visit to Australia in October 2022 after it was unable to gain unrestricted access to all places of deprivation of liberty in Queensland and New South Wales.[1705] Subsequently, it announced that it had decided to terminate its suspended visit to Australia.[1706] However, before the visit to Australia was suspended, the Subcommittee on Prevention visited Ashley Youth Detention Centre.[1707] In February 2023, the Subcommittee on Prevention indicated that it would share a report with the Australian Government on what was observed during its October visit 'as soon as possible'.[1708] The Australian Government has not disclosed whether it will release the report publicly.

We note that other jurisdictions have appointed multiple National Preventive Mechanisms for different detention contexts.[1709] In the Northern Territory, the Office of the Children's Commissioner has been proposed (though not yet appointed) as a child-specific National Preventive Mechanism, alongside the Northern Territory Ombudsman.[1710]

Given Mr Connock's many statutory roles, we consider that there would be considerable benefit in the Tasmanian Government appointing another National Preventive Mechanism with expertise in children and young people to focus on examining facilities where children and young people are detained. Given our recommendation to transfer systemic monitoring functions for youth detention from the Custodial Inspector to the new Commission for Children and Young People (Recommendation 12.38), we also recommend appointing this body as a Tasmanian National Preventive Mechanism for children and young people. The two National Preventive Mechanisms should work together closely.

We acknowledge that a small number of children may be sentenced to adult imprisonment, or may be transferred from youth detention to adult prison, and that the Commission for Children and Young People will not be a body with general expertise in the adult correctional system. Despite this, we consider that the significant number of children in youth detention who are also involved in the out of home care system makes the new Commission—a body with responsibility for monitoring the out of home care and youth justice systems—an appropriate National Preventive Mechanism for children and young people.

According to Article 18 of OPCAT, States Parties must 'guarantee the functional independence of the national preventive mechanisms as well as the independence of their personnel'. To achieve this, the Commission for Children and Young People's National Preventive Mechanism function should be funded and resourced separately from its other functions.

Recommendation 12.39

The Tasmanian Government should:

a. appoint the Commission for Children and Young People (Recommendation 18.6) as an additional National Preventive Mechanism under the United Nations Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT), with expertise in child rights, child trauma, the prevention and identification of child abuse, the needs of Aboriginal children and young people and the needs of children and young people with disability, and with power to inspect places where children and young people are detained

b. resource Tasmanian National Preventive Mechanisms sufficiently to allow them to effectively fulfil their functions under OPCAT.

11.8 Collaboration among oversight bodies

As discussed in Chapter 18, effective information sharing is a crucial part of any child-centred system to ensure oversight bodies are clear about their respective roles and responsibilities in responding to any concerns about child safety. A child (or their advocate) should be able to make a complaint to, or raise a concern with, any of these oversight bodies and have it actioned or redirected appropriately without the child or young person needing to understand which type of complaint or concern should be raised with which body.

In Chapter 18, we describe the evidence we heard from Commissioner McLean, Mr Connock and Michael Easton, Chief Executive Officer, Integrity Commission, about the way the Commissioner for Children and Young People, Ombudsman and Integrity Commission work together on matters concerning children and young people. We heard that there are no consistent formal arrangements for information sharing or clear roles and responsibilities between these entities, with the determination of who is best placed to deal with a complaint often managed on a case-by-case basis.[1711]

In discussing the information-sharing relationship between these entities, Mr Connock said:

> So, while there's no protocol or memorandum of understanding, we all have a high level of understanding of our various functions … As the Commissioner has said, she doesn't have the individual complaint-handling thing, but our two offices have a really good relationship, I think, and a good understanding, and we will take the complaint if it's within our jurisdiction.[1712]

Commissioner McLean noted that if a child or young person wanted to make a complaint, she would assist them to make that complaint to the Ombudsman.[1713] However, she indicated that there had been times when she had been unclear about whether a particular complaint would constitute a matter over which the Ombudsman had jurisdiction:

> And it's those good relations that we have with [Mr Connock] and his office that clear that up. I largely agree with what [Mr Connock] has said in that regard; there are no formal arrangements.[1714]

Commissioner McLean also indicated that there were no formal arrangements for sharing outcomes of individual cases referred to the Ombudsman:

> So, we don't have a formal record-keeping system in that regard, but we do check in with young people very regularly, including whether or not they have heard about the progress of their complaint.[1715]

Subsequently, in August 2022, Commissioner McLean told us that her office had negotiated an information-sharing arrangement with the Ombudsman's Office, noting that it can be confusing for children and young people to determine the responsible oversight body:

> … I acknowledge that it can be a bit confusing for young people and we often find ourselves in that explanatory position and saying, 'Look, we're not going to handle this complaint but we will make sure that the Ombudsman gets the complaint'. And just recently between the Ombudsman's Office and our office we have negotiated an information-sharing arrangement that, with the use of a consent form, enables information about the outcome of the complaint to also come through my office so that we can help to communicate the outcome of the complaint to the young person.[1716]

We do not consider that relying on goodwill between oversight bodies is sufficient to protect the rights of vulnerable children and young people. We commend the information-sharing arrangement that has been agreed between the Commissioner for Children and Young People and the Ombudsman.

No child or young person should be turned away from an oversight body; rather, an oversight body that is approached by a child or young person should determine where they will receive the most appropriate assistance.

We consider that establishing the independent community visitor scheme for children and young people in detention (refer to Recommendation 12.36) will go a considerable way to ensuring children and young people feel confident to raise concerns about their treatment in detention, are aware of their rights, and understand the roles of the various oversight bodies and the process for making a formal complaint. As outlined in Section 11.4, independent community visitors would be responsible for assisting children and young people in detention to raise concerns and make complaints, and would keep children and young people informed of the progress of these matters.

Also, as noted in Chapter 18, we consider that there would be benefit in oversight bodies developing clear and formalised information-sharing agreements to underpin their practices. This is particularly important considering the new Commission for Children and Young People's recommended oversight functions and powers in relation to Child and Youth Safe Standards and the Reportable Conduct Scheme.

In that chapter, we recommend that the Commission for Children and Young People, the Integrity Commission, the Ombudsman and the Registrar of the Registration to Work with Vulnerable People Scheme develop a formal memorandum of understanding for managing and overseeing reports, complaints and concerns relating to child sexual abuse that:

- defines the roles, responsibilities, functions and limitations of each agency and describes where these overlap or intersect
- requires consultation prior to the initiation of systemic reviews or inquiries where the subject of that inquiry relates to areas of common interest or intersecting functions
- provides for permissive and enabling information-sharing practices that prioritise the safety and welfare of children for individual matters and ensure each party receives from others de-identified trend data necessary to perform its functions (Recommendation 18.15).

12 Conclusion

We remain gravely concerned about the culture at Ashley Youth Detention Centre and the safety and wellbeing of the children and young people detained there.

Children in detention are among the most vulnerable children in the community. Many have experienced violence, abuse, neglect and trauma, and have been failed by multiple service systems—education, health, housing and child protection—before coming into contact with the criminal justice system. The detention system must not harm them further. It must keep them safe from sexual abuse. It must also provide the children in its care with the support they need to turn their lives around.

In this chapter, we have described the extensive reforms needed to divert children from detention wherever possible and to create a child safe culture in youth detention—a culture where children are aware of their rights, they are listened to, their views are taken into account, and their rights are respected. Implementing these reforms will require strong leadership, a long-term commitment to change from all involved, and staff who have the right attributes and skills to build constructive and therapeutic relationships with children in detention. Resistance to change among staff must be overcome to achieve meaningful reform.

Implementation of our recommendations will also require a genuine commitment to listening to the voices of children in detention and those with experience of detention and, in particular, to the voices of victim-survivors of child sexual abuse in detention.

We acknowledge that reform of youth detention and the youth justice system is a monumental task. Those responsible for implementation will face challenges and setbacks. We agree with the Northern Territory Royal Commission that:

> Progress is not always linear, especially during a process of major reform and when dealing with a vexed social issue such as young people who have offended. Critics of the system may seize on these moments to discredit it, but they are both normal and inevitable. They are not a reason to abandon the change. The leaders of the reform should acknowledge the possibility that missteps will occur … The test for those administering the system and their leaders is how they respond to challenges when they arise.[1717]

We urge the Tasmanian Government and future governments to maintain the commitment to implementing our recommendations to ensure the safety of Tasmanian children in youth detention and the youth justice system.

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1268 Australian Children's Commissioners and Guardians, *Human Rights Standards in Youth Detention Facilities in Australia: The Use of Restraint, Disciplinary Regimes and Other Specified Practices* (Report, April 2016) 60–61.

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1334 Statement of Michael Pervan, 27 July 2022, 72 [242].

1335 Commissioner for Children and Young People, *Procedural Fairness Response*, 12 July 2023, 3.

1336 Letter from Timothy Bullard to Commission of Inquiry, 3 August 2023, 2.

1337 Children and Youth Services, 'Procedure: Use of Isolation', 1 July 2017, 6–7, produced by the Tasmanian Government in response to a Commission notice to produce.

1338 Children and Youth Services, 'Procedure: Use of Isolation', 1 July 2017, 7, produced by the Tasmanian Government in response to a Commission notice to produce.

1339 Statement of Michael Pervan, 27 July 2022, 72 [246].

1340 Statement of Michael Pervan, 27 July 2022, 48 [94].

1341 Children and Youth Services, 'Procedure: Use of Isolation', 1 July 2017, 7, produced by the Tasmanian Government in response to a Commission notice to produce.

1342 Statement of Michael Pervan, 27 July 2022, 61 [177].

1343 *Youth Justice Act* 1997 s 132(a).

1344 *Children, Youth and Families Act 2005* (Vic) s 487(a).

1345 *Children (Detention Centres) Act 1987* (NSW) ss 19, 22(1)(h), 22(3). The maximum penalty for this offence is 10 penalty units or imprisonment for a period not exceeding 12 months or both (s 22(3)).

1346 Department for Education, *Draft Youth Justice Blueprint 2022–2032: Keeping Children and Young People out of the Youth Justice System* (Draft Report, 3 February 2023) 31.

1347 Statement of Michael Pervan, 27 July 2022, 72 [242].

1348 Statement of Michael Pervan, 6 June 2022, 52 [232].

1349 Commissioner for Children and Young People, *Procedural Fairness Response*, 4 August 2023, 6.

1350 Isabel Bird, 'Locked Down at Ashley for up to 23 Hours "Every Day"', *The Examiner* (Launceston, 8 July 2023); Commissioner for Children and Young People, *ABC Radio – Lockdowns at AYDC for up to 23 Hours a Day* (Web Page, 6 July 2023) <https://childcomm.tas.gov.au/abc-radio-lockdowns-at-aydc-for-up-to-23-hours-a-day/>.

1351 Statement of Lucas Digney, 9 August 2022, 10 [30].

1352 *Youth Justice Act 1997* s 133(2)(b).

1353 Request for statement served on Michael Pervan, 25 May 2022, 9 [20], [21], 15 [54(d)], 16 [54(e)]; Request for statement served on Michael Pervan, 2 August 2022, 26 [78]; Request for statement served on Stuart Watson, 22 July 2022, 11 [53(d)], [60(a) and (b)]; Request for statement served on Pamela Honan, 25 July, 6 [13(a) and (b)], 10 [37(e)].

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1355 *United Nations Rules for the Protection of Juveniles Deprived of Their Liberty*, GA Res 45/113, UN Doc A/RES/45/113 (4 April 1991) annex I, 208 [63–64]; Juan E Méndez, *Report of the Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*, UN Doc A/HRC/28/68 (5 March 2015), 21 [86(f)].

1356 *United Nations Standard Minimum Rules for the Treatment of Prisoners (the Nelson Mandela Rules)*, GA Res 70/175, UN Doc A/RES/70/175 (8 January 2016) r 82; *United Nations Rules for the Protection of Juveniles Deprived of Their Liberty*, GA Res 45/113, UN Doc A/RES/45/113 (4 April 1991) annex, 208 [63–64]; Juan E Méndez, *Report of the Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*, UN Doc A/HRC/28/68 (5 March 2015), 21 [86(f)].

1357 Commissioner for Children and Young People, *Procedural Fairness Response*, 4 August 2023, 8.

1358 Transcript of Stuart Watson, 23 August 2022, 3154 [35–44].

1359 *Youth Justice Act 1997* ss 131(5), 132(b), 133(4).

1360 *Youth Justice Act 1997* s 132(c).

1361 *Youth Justice Act 1997* s 25J.

1362 Office of the Custodial Inspector, *Inspection Standards for Youth Custodial Centres in Tasmania* (July 2018) 37 [8.3.1].

1363 Office of the Custodial Inspector, *Inspection Standards for Youth Custodial Centres in Tasmania* (July 2018) 37 [8.3].

1364 Office of the Custodial Inspector, *Inspection Standards for Youth Custodial Centres in Tasmania* (July 2018) 37 [8.3.5].

1365 Office of the Custodial Inspector, *Inspection Standards for Youth Custodial Centres in Tasmania* (July 2018) 37 [8.3.2].

1366 Office of the Custodial Inspector, *Inspection Standards for Youth Custodial Centres in Tasmania* (July 2018) 37 [8.3.8], [8.3.9].

1367 Office of the Custodial Inspector, *Inspection Standards for Youth Custodial Centres in Tasmania* (July 2018) 37 [8.3.11], [8.3.12].

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1369 Children and Youth Services, 'Procedure: Use of Physical Force', 10 December 2018, produced by the Tasmanian Government in response to a Commission notice to produce.

1370 Children and Youth Services, 'Practice Advice: Minimising the Use of Physical Force and Restraint', 1 July 2017, produced by the Tasmanian Government in response to a Commission notice to produce.

1371 Custodial Youth Justice, 'Procedure: Use of Mechanical Restraints (Handcuffs)', 21 October 2019, produced by the Tasmanian Government in response to a Commission notice to produce.

1372 Children and Youth Services, 'Practice Advice: Use of Mechanical Restraints', 21 October 2019, produced by the Tasmanian Government in response to a Commission notice to produce.

1373 Children and Youth Services, 'Procedure: Use of Physical Force', 10 December 2018, 4, produced by the Tasmanian Government in response to a Commission notice to produce.

1374 Children and Youth Services, 'Procedure: Use of Physical Force', 10 December 2018, 4, produced by the Tasmanian Government in response to a Commission notice to produce.

1375 Children and Youth Services, 'Practice Advice: Minimising the Use of Physical Force and Restraint', 1 July 2017, 4, produced by the Tasmanian Government in response to a Commission notice to produce.

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1377 Custodial Youth Justice, 'Procedure: Use of Mechanical Restraints (Handcuffs)', 21 October 2019, 1, produced by the Tasmanian Government in response to a Commission notice to produce.

1378 Children and Youth Services, 'Procedure: Use of Physical Force', 10 December 2018, 2, produced by the Tasmanian Government in response to a Commission notice to produce. In addition, Ashley Youth Detention Centre staff are prohibited from deploying any form of chemical agent designed to cause temporary incapacitation or sensory irritation, such as oleoresin capsicum spray: Statement of Michael Pervan, 20 December 2022, Annexure 80 ('Use of Chemical Agents and Restraints', Procedure, Custodial Youth Justice, 21 October 2019) 1.

1379 Children and Youth Services, 'Procedure: Use of Physical Force', 10 December 2018, 4, produced by the Tasmanian Government in response to a Commission notice to produce.

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1392 Children and Youth Services, 'Procedure: Use of Physical Force', 10 December 2018, 4, produced by the Tasmanian Government in response to a Commission notice to produce.

1393 Children and Youth Services, 'Procedure: Use of Physical Force', 10 December 2018, 5, produced by the Tasmanian Government in response to a Commission notice to produce. The *Report on Use of Physical Force* form dated 1 July 2017 requires reasons for the use of force and details of the circumstances around the use of force, injuries to the young person, whether handcuffs were applied, the staff member(s) involved and injuries to staff. An authorisation section requires sign-off by the 'Supervisor', 'Operations Manager' and 'Manager': Children and Youth Services, *Report on Use of Physical Force* (Form, 1 July 2017).

1394 Children and Youth Services, 'Procedure: AYDC Incident Reporting', 1 July 2018, produced by the Tasmanian Government in response to a Commission notice to produce.

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1396 Children and Youth Services, 'Procedure: AYDC Incident Reporting', 1 July 2018, 3, produced by the Tasmanian Government in response to a Commission notice to produce.

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1398 Children and Youth Services, 'Procedure: AYDC Incident Reporting', 1 July 2018, 4–5, produced by the Tasmanian Government in response to a Commission notice to produce.

1399 Statement of Pamela Honan, 18 August 2022, 11 [9.1–9.2].

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1401 Children and Youth Services, 'Procedure: Use of Physical Force', 10 December 2018, 5, produced by the Tasmanian Government in response to a Commission notice to produce.

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1405 Statement of Chris Simcock, 28 October 2022, Attachment 3 ('Ashley Youth Detention Centre Incident Review Committee Terms of Reference', Department for Education, Children and Young People, undated) 1.

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1407 Statement of Chris Simcock, 28 October 2022, Attachment 3 ('Ashley Youth Detention Centre Incident Review Committee Terms of Reference', Department for Education, Children and Young People, undated) 1.

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1410 Commissioner for Children and Young People, *Procedural Fairness Response*, 4 August 2023, 9.

1411 Commissioner for Children and Young People, *Procedural Fairness Response*, 4 August 2023, 9.

1412 *Youth Justice Act 1997* s 132(b)(ii), (iii).

1413 *Children (Detention Centres) Act 1987* (NSW) s 22(1)(a), (2), (3).

1414 Children and Youth Services, 'Procedure: Use of Physical Force', 10 December 2018, 4, produced by the Tasmanian Government in response to a Commission notice to produce.

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1416 Commissioner for Children and Young People, *Procedural Fairness Response*, 4 August 2023, 9.

1417 *Royal Commission into Institutional Responses to Child Sexual Abuse* (Final Report, December 2017) vol 7, 217.

1418 *Royal Commission into Institutional Responses to Child Sexual Abuse* (Final Report, December 2017) vol 7, 33.

1419 *Royal Commission into Institutional Responses to Child Sexual Abuse* (Final Report, December 2017) vol 15, 17, Recommendation 15.9.

1420 *Royal Commission into Institutional Responses to Child Sexual Abuse* (Final Report, December 2017) vol 15, 17, Recommendation 15.9.

1421 Transcript of 'Simon', 18 August 2022, 2758 [27–31], 2759 [15–18]; Transcript of 'Max', 23 August 2022, 3118 [5–13], 3122 [42–43]; Transcript of 'Fred', 25 August 2022, 3344 [15–42].

1422 Transcript of 'Fred', 25 August 2022, 3344 [15–21].

1423 Transcript of 'Warren', 18 August 2022, 2769 [6–15].

1424 Transcript of 'Max', 23 August 2022, 3118 [8–13].

1425 Tim Moore and Morag McArthur, *Take notice, believe us and act! Exploring the safety of children and young people in government run organisations* (Research Report prepared for the Commission of Inquiry into the Tasmanian Government's Responses to Child Sexual Abuse in Institutional Settings, February 2023) 73.

1426 Tim Moore and Morag McArthur, *Take notice, believe us and act! Exploring the safety of children and young people in government run organisations* (Research Report prepared for the Commission of Inquiry into the Tasmanian Government's Responses to Child Sexual Abuse in Institutional Settings, February 2023) 69.

1427 Statement of Angela Sdrinis, 5 May 2022, 68.

1428 Statement of Angela Sdrinis, 5 May 2022, 68.

1429 Statement of Angela Sdrinis, 5 May 2022, 68.

1430 Transcript of Mark Morrissey, 18 August 2022, 2775 [39–46].

1431 Statement of Mark Morrissey, 9 August 2022, 14 [87–88].

1432 Transcript of Mark Morrissey, 18 August 2022, 2774 [38–44]; Statement of Mark Morrissey, 9 August 2022, 14 [87]–15 [88].

1433 Statement of Mark Morrissey, 9 August 2022, 15 [88–89].

1434 Ashley Youth Detention Centre, *Feedback, Concerns & Complaints Info Sheet* (Information Sheet, 28 October 2022).

1435 *Youth Justice Act 1997* s 129(1)(d).

1436 *Youth Justice Act 1997* s 138(1).

1437 *Youth Justice Act 1997* s 138(2).

1438 Notice to produce served on the State of Tasmania, 9 March 2022, 5–6 [12].

1439 Statement of Michael Pervan, 7 June 2022, Annexures 27–29 ('Responding to Feedback, Concerns and Complaints', Procedure, Custodial Youth Justice Services, undated; 'Feedback and Complaints', Practice Advice, Custodial Youth Justice Services, undated; 'Make a Complaint', Form, undated).

1440 Custodial Youth Justice Services, *Responding to Feedback, Concerns and Complaints* (Procedure, 28 October 2022); Custodial Youth Justice Services, *Feedback and Complaints* (Practice Advice, 28 October 2022).

1441 Ashley Youth Detention Centre, *Feedback, Concerns & Complaints Info Sheet* (Information Sheet, 28 October 2022); Ashley Youth Detention Centre, *Help Form* (Form, 13 September 2022).

1442 Department for Education, Children and Young People, *Complaints – Child Safety and Youth Justice Services* (Web Page) <https://www.decyp.tas.gov.au/about-us/complaints-child-safety-service/>.

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1448 Department for Education, Children and Young People, *Feedback, Concerns & Complaints Info Sheet* (Information Sheet, 28 October 2022) 1.

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1450 Custodial Youth Justice Services, *Responding to Feedback, Concerns and Complaints* (Procedure, 28 October 2022) 2.

1451 Custodial Youth Justice Services, *Feedback and Complaints* (Practice Advice, 28 October 2022) 1.

1452 Custodial Youth Justice Services, *Feedback and Complaints* (Practice Advice, 28 October 2022) 3.

1453 Custodial Youth Justice Services, *Responding to Feedback, Concerns and Complaints* (Procedure, 28 October 2022) 5.

1454 Custodial Youth Justice Services, *Responding to Feedback, Concerns and Complaints* (Procedure, 28 October 2022) 3.

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1456 Children and Youth Services, 'Procedure: AYDC Incident Reporting', 1 July 2018, 1, produced by the Tasmanian Government in response to a Commission notice to produce.

1457 Children and Youth Services, 'Procedure: AYDC Incident Reporting', 1 July 2018, 1, 3–4, produced by the Tasmanian Government in response to a Commission notice to produce.

1458 Statement of Michael Pervan, 23 August 2022, 54 [221].

1459 Statement of Pamela Honan, 18 August 2022, 17 [16–17]. The list of delegations under sections 137 and 138 of the *Youth Justice Act 1997* states that responsibility for complaints sits with Children and Youth Services: at 6–7 [3].

1460 Statement of Michael Pervan, 7 June 2022, 20 [128], 21 [133–136].

1461 Statement of Michael Pervan, 7 June 2022, 21 [136].

1462 Statement of Michael Pervan, 7 June 2022, 21–22 [137].

1463 Statement of Michael Pervan, 7 June 2022, 20 [128].

1464 Statement of Jacqueline Allen, 15 August 2022, 43 [247].

1465 Jacqueline Allen, *Procedural Fairness Response*, 31 July 2023, 1–2 [1].

1466 Jacqueline Allen, *Procedural Fairness Response*, 31 July 2023, 1–2 [1].

1467 Jacqueline Allen, *Procedural Fairness Response*, 31 July 2023, 1–2 [1].

1468 Jacqueline Allen, *Procedural Fairness Response*, 31 July 2023, 1–2 [1].

1469 Jacqueline Allen, *Procedural Fairness Response*, 31 July 2023, 2–3 [2].

1470 Statement of Jacqueline Allen, 15 August 2022, 32 [180].

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1472 Statement of Jacqueline Allen, 15 August 2022, 37 [201].

1473 Statement of Pamela Honan, 18 August 2022, 17 [16.1].

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1477 Custodial Youth Justice Services, *Responding to Feedback, Concerns and Complaints* (Procedure, 28 October 2022) 4–5. The earlier version of the Complaints Procedure assigned responsibility to the Centre Manager for delegating complaints to staff members to investigate: Statement of Michael Pervan, 7 June 2022, Annexure 27 ('Responding to Feedback, Concerns and Complaints', Procedure, Custodial Youth Justice Services, undated) 4–5.

1478 Custodial Youth Justice Services, *Responding to Feedback, Concerns and Complaints* (Procedure, 28 October 2022) 5.

1479 Custodial Youth Justice Services, *Responding to Feedback, Concerns and Complaints* (Procedure, 28 October 2022) 5.

1480 Custodial Youth Justice Services, *Responding to Feedback, Concerns and Complaints* (Procedure, 28 October 2022) 5.

1481 Custodial Youth Justice Services, *Responding to Feedback, Concerns and Complaints* (Procedure, 28 October 2022) 5.

1482 Custodial Youth Justice Services, *Responding to Feedback, Concerns and Complaints* (Procedure, 28 October 2022) 5.

1483 Custodial Youth Justice Services, *Responding to Feedback, Concerns and Complaints* (Procedure, 28 October 2022) 5.

1484 Statement of Michael Pervan, 7 June 2022, 20 [130]–21 [132].

1485 Department for Education, Children and Young People, *Complaints – Child Safety and Youth Justice Services* (Web Page) <https://www.decyp.tas.gov.au/about-us/complaints-child-safety-service/>.

1486 Department for Education, Children and Young People, *Complaints – Child Safety and Youth Justice Services* (Web Page) <https://www.decyp.tas.gov.au/about-us/complaints-child-safety-service/>.

1487 Custodial Youth Justice Services, 'Procedure: Contacting the SFSK Advice and Referral Line', 26 August 2021, 1, produced by the Tasmanian Government in response to a Commission notice to produce.

1488 Custodial Youth Justice Services, 'Procedure: Contacting the SFSK Advice and Referral Line', 26 August 2021, 2, produced by the Tasmanian Government in response to a Commission notice to produce.

1489 Children, Youth and Families, 'Fact Sheet: Reporting Concerns', 26 August 2021, 1, produced by the Tasmanian Government in response to a Commission notice to produce.

1490 Children, Youth and Families, 'Fact Sheet: Reporting Concerns', 26 August 2021, 1, produced by the Tasmanian Government in response to a Commission notice to produce.

1491 Children, Youth and Families, 'Fact Sheet: Reporting Concerns', 26 August 2021, 2, produced by the Tasmanian Government in response to a Commission notice to produce.

1492 Children, Youth and Families, 'Fact Sheet: Reporting Concerns', 26 August 2021, 2, produced by the Tasmanian Government in response to a Commission notice to produce.

1493 Children and Youth Services, *Transparency and Accountability* (Policy, 1 July 2015) 1.

1494 Department for Education, Children and Young People, *Keeping Kids Safe: A Plan for Ashley Youth Detention Centre until Its Intended Closure* (Report to the Commission of Inquiry into the Tasmanian Government's Responses to Child Sexual Abuse in Institutional Settings, October 2022) 12.

1495 Letter from Timothy Bullard to Commission of Inquiry, 9 February 2023, 10.

1496 Letter from Timothy Bullard to Commission of Inquiry, 9 February 2023, Annexure 10.1 ('Project Initiation Plan – Complaints Management Review', Plan, Version 1.0, Department for Education, Children and Young People, 31 January 2023) 3.

1497 Department for Education, Children and Young People, *Safe. Secure. Supported. Our Safeguarding Framework* (April 2023) 35–40.

1498 Tim Moore and Morag McArthur, *Take notice, believe us and act! Exploring the safety of children and young people in government run organisations* (Research Report prepared for the Commission of Inquiry into the Tasmanian Government's Responses to Child Sexual Abuse in Institutional Settings, February 2023) 69–70.

1499 Tim Moore and Morag McArthur, *Take notice, believe us and act! Exploring the safety of children and young people in government run organisations* (Research Report prepared for the Commission of Inquiry into the Tasmanian Government's Responses to Child Sexual Abuse in Institutional Settings, February 2023) 70.

1500 Tim Moore and Morag McArthur, *Take notice, believe us and act! Exploring the safety of children and young people in government run organisations* (Research Report prepared for the Commission of Inquiry into the Tasmanian Government's Responses to Child Sexual Abuse in Institutional Settings, February 2023) 71.

1501 Tim Moore and Morag McArthur, *Take notice, believe us and act! Exploring the safety of children and young people in government run organisations* (Research Report prepared for the Commission of Inquiry into the Tasmanian Government's Responses to Child Sexual Abuse in Institutional Settings, February 2023) 71–72.

1502 Tim Moore and Morag McArthur, *Take notice, believe us and act! Exploring the safety of children and young people in government run organisations* (Research Report prepared for the Commission of Inquiry into the Tasmanian Government's Responses to Child Sexual Abuse in Institutional Settings, February 2023) 73.

1503 Transcript of Mark Morrissey, 18 August 2022, 2775 [32–46].

1504 ACT Government, 'Children and Young People (Complaints Management) Policy and Procedures 2018 (No. 1)', *ACT Legislation Register* (Web Page) <https://www.legislation.act.gov.au/ni/2018-437/>.

1505 Statement of Kathrine Morgan-Wicks, 24 May 2022, 17 [147].

1506 Statement of Erwin Loh, 24 June 2022, 4 [18].

1507 Statement of Erwin Loh, 24 June 2022, 4 [19].

1508 Statement of Erwin Loh, 24 June 2022, 4 [20].

1509 Statement of Erwin Loh, 24 June 2022, 5 [28–29].

1510 Department for Education, *Managing Allegations of Sexual Misconduct in SA Education and Care Settings* (March 2019).

1511 *Royal Commission into Institutional Responses to Child Sexual Abuse* (Final Report, December 2017) vol 7, 206.

1512 *Royal Commission into Institutional Responses to Child Sexual Abuse* (Final Report, December 2017) vol 7, 206.

1513 *Royal Commission into Institutional Responses to Child Sexual Abuse* (Final Report, December 2017) vol 7, 211–213.

1514 ACT Government, *Children and Young People (Complaints Management) Policy and Procedures 2018 (No.1)* (Notifiable Instrument NI2018–437, 7 August 2018) 1.

1515 Statement of Alison Grace, 29 July 2022, 12–13 [65].

1516 ACT Government, *Children and Young People (Complaints Management) Policy and Procedures 2018 (No.1)* (Notifiable Instrument NI2018–437, 7 August 2018) 9.

1517 ACT Government, *Children and Young People (Complaints Management) Policy and Procedures 2018 (No.1)* (Notifiable Instrument NI2018–437, 7 August 2018) 9.

1518 ACT Government, *Children and Young People (Complaints Management) Policy and Procedures 2018 (No.1)* (Notifiable Instrument NI2018–437, 7 August 2018) 10.

1519 ACT Government, *Children and Young People (Complaints Management) Policy and Procedures 2018 (No.1)* (Notifiable Instrument NI2018–437, 7 August 2018) 9–10.

1520 Manfred Nowak, *Report of the Independent Expert Leading the United Nations Global Study on Children Deprived of Liberty* (Report, July 2019) 19 [104]; Lisa Ewenson and Bronwyn Naylor, 'Protecting Human Rights in Youth Detention: Listening to the Voices of Children and Young People in Detention' (2021) 27(1) *Australian Journal of Human Rights* 110.

1521 Lisa Ewenson and Bronwyn Naylor, 'Protecting Human Rights in Youth Detention: Listening to the Voices of Children and Young People in Detention' (2021) 27(1) *Australian Journal of Human Rights* 97, 109.

1522 Lisa Ewenson and Bronwyn Naylor, 'Protecting Human Rights in Youth Detention: Listening to the Voices of Children and Young People in Detention' (2021) 27(1) *Australian Journal of Human Rights* 97, 106–107, 112.

1523 Statement of Stephen Kinmond, 29 March 2022, 7 [33].

1524 Statement of Stephen Kinmond, 29 March 2022, 8 [34].

1525 *Royal Commission into Institutional Responses to Child Sexual Abuse* (Final Report, 2017) vol 15, 75-77, 141, Recommendation 15.10.

1526 *Royal Commission into Institutional Responses to Child Sexual Abuse* (Final Report, 2017) vol 15, 135, Recommendation 15.9.

1527 *Royal Commission into Institutional Responses to Child Sexual Abuse* (Final Report, 2017) vol 15, 135, Recommendation 15.9.

1528 Tim Moore and Morag McArthur, *Take notice, believe us and act! Exploring the safety of children and young people in government run organisations* (Research Report prepared for the Commission of Inquiry into the Tasmanian Government's Responses to Child Sexual Abuse in Institutional Settings, February 2023) 82–83.

1529 Refer to Chapter 10 for a discussion of the risks of child sexual abuse in youth detention.

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Commission of Inquiry into the Tasmanian Government's Responses to Child Sexual Abuse in Institutional Settings

Who was looking after me? Prioritising the safety of Tasmanian children

Volume 6: Children in health services
Book 1

August 2023

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Volume 6
Children in health services (Book 1)

The Honourable Marcia Neave AO
President and Commissioner

Professor Leah Bromfield
Commissioner

The Honourable Robert Benjamin AM SC
Commissioner

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Introduction to Volume 6

This volume—Volume 6—focuses on children in Tasmania's health system and how the Department of Health prevents and responds to child sexual abuse. The terms of reference for our Commission of Inquiry specifically require us to have regard to:

> The adequacy and appropriateness of the responses of the Tasmanian Health Service and the Department of Health to allegations of child sexual abuse, particularly in the matter of James Geoffrey Griffin (deceased 18 October 2020).[1]

Health services, particularly hospitals, are often assumed to be inherently safe places for children and young people. They are imagined as busy places, humming with staff who have been professionally trained and rigorously screened by oversight bodies to confirm their suitability to work with children and young people. The public naturally assumes that those working in health services will place the best interests of patients at the centre of what they do.

There has been limited research to test the assumption that hospitals are inherently safe for children and young people, and there is little evidence available about the risks of child sexual abuse in health services. However, based on the available research and the limited evidence we heard, there *are* inherent risks posed to children and young people in health services.

Health workers can have intimate contact with children, sometimes without supervision. Children and young people who seek treatment often feel unwell or may have disabilities or mental health concerns that create a dependency on health workers for their care. Children and young people often have less social power than adults and are therefore less able to advocate for themselves. Parents and carers typically take for granted that they can safely leave their children unsupervised in the care of a health worker and that any intimate procedures are warranted or necessary.

The overwhelming majority of health workers do an outstanding job in providing safe, empathetic and high-quality care to children and young people. We met many such health workers across Tasmania during our Commission of Inquiry. We consider the trust and goodwill extended to health workers to be well founded. However, a significant reason that our Commission of Inquiry was established was the shocking and devastating revelations that James Griffin, who was a paediatric nurse on Ward 4K at Launceston General Hospital for nearly 20 years, perpetrated child sexual abuse inside and outside the hospital. Sadly, these revelations were not so shocking to those who knew of Mr Griffin's abuses first-hand or had tried, with little success, to raise the alarm about his concerning behaviour over the years.

While it may be tempting to view Mr Griffin's abuses as an anomaly, they are not. The risk of child sexual abuse in health services must be recognised and addressed. We heard from several people who had reported allegations of abuse within, or connected to, health services across Tasmania, including at Royal Hobart Hospital.[2]

However, our Commission of Inquiry received a substantial amount of evidence about allegations of child sexual abuse connected to Launceston General Hospital. For this reason, we focus primarily on Launceston General Hospital in this volume.

As part of our examination of Launceston General Hospital, we focused on three case studies—those of Mr Griffin and two other individuals who were accused of child sexual abuse at Launceston General Hospital prior to Mr Griffin's employment there or before there were complaints about his conduct. Launceston General Hospital's failure to identify and respond to the red flags raised about Mr Griffin over his long tenure at the hospital are indicative of an institution that did not learn from its previous experience in responding to allegations of child sexual abuse.

We do not discuss the first case study in our report because it is subject to a restricted publication order, which means it will not be made available to the public or media. We are committed to being open and transparent and have sought to examine the prevention, identification, reporting of and responses to child sexual abuse. During our Inquiry, we heard evidence that, too often, people, including victim-survivors, have felt silenced or unable to come forward and be heard. At the same time, we have sought to avoid prejudicing any current investigation or proceedings. Not only was this required by our terms of reference, but we are acutely aware of ensuring we did not prejudice the ability of victim-survivors to seek justice and ongoing attempts to keep children safe. It is in this context that we made a restricted publication order in relation to the first case study. We made this order because we were satisfied that the public interest in the publishing of evidence contained in the first case study is outweighed by relevant legal considerations, including avoiding prejudicing current investigations and proceedings.

Zoe Duncan (now deceased) alleged that she was sexually abused by Dr Tim (a pseudonym) as an 11-year-old in 2001.[3] Her incremental disclosures were met with scepticism and disbelief from the hospital, which set in train a sequence of wrongful assumptions that neither she nor her parents could overturn, despite their best efforts. Zoe remains deeply loved and missed by her family, who were generous in giving us an insight into her life and the abuse she suffered, as well as the disbelieving responses to her allegations by the hospital and other investigatory agencies. The agreement of Zoe's parents to allow us to consider her experience in more detail reflects their desire for Zoe's legacy to be one of protecting other children and young people from abuse and ensuring they are believed when they report concerns. We document the case study relating to Dr Tim in Chapter 14.

Because previous matters, such as Dr Tim, did not act as 'wake-up calls' to the hospital and broader Department of Health, Mr Griffin tested and overstepped boundaries early in his tenure at the hospital and continued to do so until a victim-survivor eventually reported him to police in 2019.

We were overwhelmed by the extent of Mr Griffin's abuse. In line with our terms of reference, we considered in detail the history of complaints and concerns raised about this nurse at Launceston General Hospital. The length of the case study about Mr Griffin reflects the volume of material we received and evidence we heard, much of which was already available to the hospital and other agencies and had been for some time. The amount of information about Mr Griffin's offending points to numerous missed opportunities—by Launceston General Hospital, Tasmania Police and Child Safety Services—to intervene earlier.

We heard from many victim-survivors, former patients and current and former hospital staff, some of whom shared their anguish and frustration that their reports and concerns about Mr Griffin had been ignored. We are indebted to all the victim-survivors, former patients and current and former staff who shared information with us. Without the public participation of some of these witnesses, particularly victim-survivors Kylee Pearn and Tiffany Skeggs and whistleblower Will Gordon, we would not have been able to make the findings we have. These witnesses went to extraordinary lengths to draw attention to systemic failures to protect children and young people from Mr Griffin. We were humbled by their actions, their generous assistance to our Inquiry and their unwavering commitment to children's safety.

We document the case study of Mr Griffin in Chapter 14.

Some of the witnesses who gave evidence to us were wary of doing so. The Tasmanian Government encouraged witnesses to provide information to our Commission of Inquiry. In particular, the Premier, the Honourable Jeremy Rockliff MP, stated that the Government sought to 'reassure all Tasmanians that we absolutely encourage people to come forward'.[4]

In August 2022, the Tasmanian Government also recognised the contribution of victim-survivors and state servants who had provided information to our Commission of Inquiry. The Premier stated:

> I want to once again thank victims and survivors for having the courage to share their experiences, along with State Servants who have come forward in an effort to make things better for children and young people in Tasmania. I want to again reiterate today that all State Servants have my full support to come forward and shine a light on these matters.[5]

The *Commissions of Inquiry Act 1995* also reflects the importance of protecting those who provide information to a commission.

We note the statement of Kathrine Morgan-Wicks PSM, Secretary, Department of Health, in our hearings, who welcomed the courage of some current and former staff in giving evidence to our Commission of Inquiry:

> To our employees, to Will Gordon, to Maria Unwin and Stewart Millar, to Annette Whitemore, and may I also include Amanda Duncan as an employee that has spoken out for her sister: thank you for your bravery in coming forward as whistleblowers and for your continued efforts to try to alert the department to serious misconduct by other Health employees.
>
> I am sorry that it has taken a Commission of Inquiry for you to be believed or for your complaints and our lack of action to be publicly known.[6]

We consider the commitment of these individuals, who were vulnerable in their own reflections about their past actions (some of which were described with some regret), should be viewed within the context of their broader actions at the time and subsequently. We agree with the Premier and the Secretary that they should be commended for coming forward and sharing their experiences.

Taken together, the case studies show a fundamental failure of leadership at Launceston General Hospital to respond to potential risks to child safety over more than three decades, contributed to by the associated failures of Tasmania Police and Child Safety Services. The accounts in these case studies cannot be categorised as 'one-off' or 'rare instances' of inappropriate responses by the hospital to allegations of unprofessional behaviour.

We heard about the absence of effective protocols to protect children and young people at the hospital, the poor attitudes of managers to complainants and the inadequate responses of the hospital to disclosures.

These systemic failures at Launceston General Hospital have existed for decades and are likely endemic to the Tasmanian health system. Our recommendations—which we summarise below—are therefore relevant to all health services.

This volume comprises three chapters; Chapter 13—Background and context: Children in health services, Chapter 14—Case studies: Children in health services, and Chapter 15—The way forward: Children in health services.

In Chapter 13 we provide the context for our case studies. We outline Tasmania's health system (particularly as it relates to child safety) and summarise previous reviews of the health system that identified some of the same problems we discovered through our Commission of Inquiry. As previously noted, Chapter 14 focuses on our case studies—those of Dr Tim and Mr Griffin. In these case studies we identify systemic and individual failings within Launceston General Hospital relevant to the hospital's response to these allegations.

In holding individuals to account, we have tried to be fair and balanced, recognising that none of us are immune from imperfect responses and that we hold the benefit of knowledge that was not available to some at that time. We are also mindful that people operated in a broader context and that it was, in part, the hospital's lack of leadership and protocols, as described in the case studies, that enabled the unsatisfactory response of some to concerns and complaints about misconduct.

We are also conscious that some people were subject to greater scrutiny than others because of their roles in responding to complaints about Dr Tim and Mr Griffin, or because these people were more prominent in the information we received. We acknowledge that we may have not identified the relevant conduct of others because we were not made aware of it or did not have enough evidence to substantiate it. In considering the actions of individuals, we carefully considered their relative roles and responsibilities, and whether we considered their conduct justified our particular focus.

In these case studies we identify individual and systemic failings. These inform our understanding of the broader problems that need to be addressed in health services to protect children and young people from sexual abuse in the future, and to ensure health services respond better when abuse does occur.

In Chapter 15 we make recommendations for reform.

We recommend that the Department of Health develops and publicly communicates a policy framework and implementation plan for reforms to improve responses to child sexual abuse in health services. This policy and plan should explain the purpose and need for the reforms; the role, responsibilities and interactions of bodies established by the Department of Health as part of the reforms; how the reforms will work together to provide a system-wide response to child sexual abuse in health services; how the reforms are being prioritised for implementation; who is responsible for their implementation; and the expected timeframes for implementation.

Of national significance, recognising the risks we have identified of child sexual abuse in health settings, we recommend that the National Principles for Child Safe Organisations should be a mandatory requirement for accrediting health services against the National Safety and Quality Health Service Standards under the Australian Health Service Safety and Quality Accreditation Scheme, and the Tasmanian Government should advocate for this reform at the national level.

We recommend that the Department of Health's cultural improvement strategy ensures clear organisational values, has strong governance, and ensures accountability of senior managers and executives. We recommend the Department of Health establishes processes and forums to facilitate the participation of children and young people in decisions affecting the delivery of health services, including a health services advisory group. The advisory group should comprise young people of varying ages and backgrounds, but who share significant experience with health services. Through the advisory group young people should have a say in departmental strategies, policies, procedures and protocols that affect them.

We recommend that the Department of Health develops a professional conduct policy for staff who have contact with children and young people in health services. The policy should provide examples of behaviour that is inappropriate in clinical and non-clinical contexts, such as engaging with children through online social networks and having unnecessary contact with children outside the professional relationship. It should also reference existing professional and ethical obligations held by registered health practitioners.

The development and implementation of a clear complaints management, escalation and investigation process is critical. Noting the specialised context in which health workers operate, the Department of Health may choose to establish a standalone Health Services Child-Related Incident Management Directorate or to partner with the Child-Related Incident Management Directorate we recommend in Volume 6 (Recommendation 6.6).

The Department of Health, Launceston General Hospital and Tasmania Police must ensure ongoing assistance to known and as yet unknown victim-survivors of child sexual abuse by Mr Griffin. The Department of Health should also develop and implement a critical incident response plan to ensure that measures are in place to communicate with clarity and consistency, and to support the affected members of the community, in the event of a future critical incident, such as a serious breach to children's safety within the public health system. The plan should identify who is responsible for leading the response to the critical incident, facilitate psychological first aid, support and critical incident debriefing and provide for a review of how the Department of Health responded to the critical incident.

Further, the Tasmanian Government should ensure a review of the *Health Complaints Act 1995* is completed and considers the role of the Health Complaints Commissioner in relation to addressing systemic issues within health services related to child safety.

Although the case studies in Chapter 14 focus on conduct that occurred at Launceston General Hospital, the aim of our report and recommendations is to prompt and facilitate change across the broader Tasmanian Health Service, the Department and agencies that work alongside those services, such as Tasmania Police and Child Safety Services.

Although most health services are places of healing and safety for children, our Commission of Inquiry has identified the high cost of complacency about the risks of child sexual abuse in these settings. The issues at Launceston General Hospital can and doubtlessly do occur within other health services. Services beyond the immediate remit of our Inquiry are encouraged to reflect on their own understanding and decision making about child safety and to take steps to make their organisation safe for children and young people. We trust the evidence presented in this volume of our report provides compelling reasons to do so.

13 Background and context: Children in health services

1 Introduction

In this chapter we summarise what is known about child sexual abuse in international and Australian health services, including through the Royal Commission into Institutional Responses to Child Sexual Abuse ('National Royal Commission') and our own research into children and young people's perceptions of safety in government health institutions in Tasmania. We briefly describe the Tasmanian health system and the key regulatory bodies that play a role in overseeing health services and the people who work within them. We also summarise four key reviews that have examined aspects of the Tasmanian health system relevant to our Commission of Inquiry, including organisational culture, governance arrangements and the reporting and management of misconduct.
We conclude the chapter by highlighting what we heard about the organisational culture at Launceston General Hospital, which as noted earlier is the primary focus of the remainder of this volume, including our case studies in Chapter 14.

2 Understanding the health context

Health services and health workers have a duty of care to patients, including children and young people, that extends to keeping them safe from harm while they are under their care.

Because people often assume health services are highly controlled, supervised and public environments, the risk of sexual abuse to children in these settings can be underestimated. People rightly expect that health workers will act in the best interests of patients and according to their professional obligations.

We reviewed a key report examining child sexual abuse in healthcare contexts published in the United Kingdom (discussed in Section 2.1.1), as well as research we commissioned into the experiences of Tasmanian children (discussed in Section 2.1.2), to learn more about the vulnerability of children and young people in health services. We also learned from the lived experience of victim-survivors and people working in these settings about the specific factors that can increase the risks of abuse to children in health services.

2.1 Research into child sexual abuse in health services

Unlike other government or government funded institutions of interest to our Commission of Inquiry, child sexual abuse within health services has not been the subject of significant research. There is limited data on the prevalence and incidence of child sexual abuse perpetrated within health services.[7] Consequently, the extent and nature of child sexual abuse that occurs in these institutions is not well understood.

Although the National Royal Commission heard evidence from some people who had experienced child sexual abuse in health services, child sexual abuse in health institutions was not a specific focus of the National Royal Commission.[8] Nonetheless, the National Royal Commission made the following general observations about child sexual abuse in health contexts:

> Medical practitioners, health professionals and hospitals are responsible for improving and maintaining the health of their patients. Patients, who are in a vulnerable state of illness, place their trust in health care providers. Patients, and the parents of child patients, place such trust in medical practitioners that they permit those medical practitioners to view and touch intimate parts of the patient's anatomy. Patients permit these acts because of the close nature of the health practitioner–patient relationship and because they believe that a health practitioner is acting in pursuit of a higher purpose of assisting the patient with his or her illness or injury and not out of personal sexual gratification.
>
> Children often follow instructions from health care providers without question and the private one-on-one nature of therapy places children in a vulnerable position.[9]

This observation extends beyond medical practitioners—it applies to all health workers within the health system, some of whom will use their position to abuse or manipulate children and young people.[10]

2.1.1 Truth Project thematic report into child sexual abuse in healthcare contexts

In 2020, as part of the Independent Inquiry into Child Sexual Abuse in the United Kingdom, the Truth Project published a thematic report that included findings about the experiences of victim-survivors of child sexual abuse in healthcare contexts.[11] The report described the research into health workers as sexual abusers of children as 'dated and sparse'.[12] The report also stated that it is difficult to estimate the prevalence of health workers breaching sexual boundaries, particularly in relation to children, because most child sexual abuse is hidden.[13]

The Truth Project report considered power dynamics that exist between health workers and patients, including the power dynamics between children and the health workers upon whom they rely to treat them.[14] The report described health services (particularly mental health facilities) as 'strong institutions'; that is, the power imbalance between patients and staff, coupled with the depersonalisation of patients that can occur in such institutions, creates an environment that enables abuse to occur.[15] This can be exacerbated when there is a workplace culture that prevents people from speaking up about wrongdoing.[16] We found similar problems through our Inquiry.

Key qualitative findings from the Truth Project report included:

- The vulnerability of patients in health settings was heightened because of patients being alone and without chaperones, and due to the 'unique nature of the position of trust and authority' held by health practitioners.[17]
- Although there were examples of children, their parents and staff being manipulated by abusers, overall, there was little evidence of grooming from health workers, which was attributed to the fact that such workers often did not need 'special' explanations to perpetrate their abuse.[18]
- Abusers were most commonly men with routine access to children, with many abusing children under the guise of medical procedures or examinations, sometimes involving medication.[19]
- Many (but not all) abused children had experienced abuse and neglect at the hands of family members and had experienced other difficulties (for example, bullying) that contributed to their health problems and made them particularly vulnerable to abuse within health services.[20]
- Only a quarter of the children who were abused felt they could disclose their abuse. Those who did disclose were often not believed, particularly if they were experiencing mental health problems at the time of their treatment. There were also limited processes or pathways for young people to disclose sexual abuse, particularly if they were inpatients.[21]
- For victim-survivors, abuse in a health setting sometimes contributed to a lifelong fear and mistrust of health workers.[22]

2.1.2 Commission of Inquiry's research into children and young people's perceptions of safety in government health institutions in Tasmania

As part of our Commission of Inquiry, we commissioned research that explored children and young people's perceptions of safety in government organisations in Tasmania, including hospitals.[23] This research enabled us to learn directly from the views and experiences of children and young people.

As part of this research, children and young people described two factors that contributed to making a health institution or hospital feel safe. The first was the presence of an adult who was 'friendly and kind', who 'showed interest' and who asked children and young people what they needed.[24] The second was the protective role parents or carers play in a child or young person's home life and engagement with institutions. For example, one young person reported feeling a lot more at ease in hospital knowing that his parents were there to make sure he was getting the care he needed, as well as to help him raise concerns and to advocate on his behalf.[25] Other children and young people who had spent time in hospital held a similar view:

> When there were issues, my mother had to go to the front counter, the main hub desk of the paediatric unit, and voice her frustration on behalf of not only my parents, but also me.[26]

Another participant in the research said:

> It does help to have someone to talk to. They said parents could sleep on a couch in the room. If I needed something I would ask my mum to ask them because I was too scared to talk to nurses. I was a real timid little kid. I just felt really little and [I would] just get Mum to do it.[27]

Several young people who had experienced a stay in hospital reported not feeling safe due to the physical characteristics of the hospital environment. They talked about how hospitals could feel 'creepy' and 'sterile'. One young person described the hospital environment in the following way:

> My room was dark. I didn't have access to a window. It felt like solitary confinement. It was quite horrible: that situation, I didn't feel safe. I didn't feel like I could flourish in an area like that. I didn't feel like I could get better in an area like that. It really wasn't useful until I was moved into a room where there were three windows and where I had different nurses, where I felt like, 'okay, I'm starting to get better. I can do this. I can get out of here'.[28]

Another young person talked about how having their own space in hospital was important:

> I've had a few surgeries and sometimes I am in a room by myself, sometimes I am in a room with someone else and that doesn't feel comfortable being in a room with someone you don't know. It's being in a room with strangers.[29]

One young person discussed the experience of being Aboriginal and having contact with a health institution. This person said the hospital made no attempts to acknowledge their culture or to support them to stay connected to their culture while they were in hospital:

> I didn't really feel represented or supported in terms of my cultural identity. I wasn't even asked if this was something I wanted, or if this was something that I valued about myself. It wasn't until I had been mentioning parts of my culture to nurses that that was a topic of conversation.
>
> [Question (from researcher): So, you would've been able to tell if it was culturally safe for you. In what way? How would it have been culturally safe for you?]
>
> If I had an Aboriginal youth worker come over. I didn't feel support in that aspect. And also, even whether there was access to national indigenous TV on the television, whether there was an Aboriginal mural in the hospital or things like that.[30]

These views from children and young people show how hospitals can feel unsafe and unwelcoming for many and how difficult it can be to raise concerns with staff, particularly if a young person does not have protective family or carers to advocate for them. The views referenced above reinforced for us the importance of hearing directly from children and young people about what is needed to facilitate and enhance their safety.[31] We discuss empowering children and young people in health services in Chapter 15.

2.2 Evidence of the risk factors for child sexual abuse in hospitals

Catherine Turnbull, Chief Child Protection Officer, SA Health, Department for Health and Wellbeing, told us that children and young people can be at risk of abuse or neglect perpetrated by adult patients, visitors, health workers or other children and young people in hospital settings.[32] She identified several risk factors that can make children and young people more vulnerable to abuse and neglect in hospital settings. These risk factors include:

- children and young people recovering in rooms that are not closely monitored by staff and/or closed-circuit television[33]
- placing children and young people in group rooms without enough regard for their suitability to be placed together[34]
- inpatient services that have a mix of child and adult patients[35]
- health workers treating children and young people without other people present (such as a parent/carer or other staff member)[36]
- failure to offer a chaperone where treatment is provided by a staff member of a different gender[37]

- the length and regularity of children and young people's attendance at hospital, and the degree of familiarity between children and young people and their treating health workers[38]
- feelings of disempowerment and dependency that arise in children and young people who have been hospitalised for long periods (or who have been hospitalised repeatedly), which can affect their ability to disclose concerns.[39]

Kathryn Fordyce, Chief Executive Officer, Laurel House, also described the vulnerability of young people in health services, stating that, '[u]nfortunately, there are social norms that mean we condition children, especially those with disabilities and health conditions, to be compliant and submissive'.[40] She described that trying to empower children to speak up when they are harmed is:

> … even more complicated for a child with a disability or a health condition who has been poked and prodded their whole life, and had their personal space invaded many times for legitimate medical or care reasons. All too often adults ignore a child's attempt to maintain their bodily autonomy, and then those same adults are surprised when children are abused and do not report it.[41]

3 Tasmania's health system

The Tasmanian Government provides a range of healthcare and health support services to the community. These services are delivered through major hospitals, district hospitals and community health services across three service areas—North, North West and South.[42]

The four major government hospitals that service the Tasmanian community are Launceston General Hospital, Mersey Community Hospital, North West Regional Hospital and Royal Hobart Hospital. Launceston General Hospital, North West Regional Hospital and Royal Hobart Hospital each have a paediatric unit and offer outpatient services to children and young people.[43] The smaller Mersey Community Hospital provides emergency paediatric services. District hospitals and community health services also provide healthcare and support services to children and young people.

3.1 Department of Health

The Department of Health is the system-wide administrator of the public health system and its attendant organisations in Tasmania. The Department is one of the largest public sector agencies in Tasmania, employing around 15,500 people who work across approximately 330 sites statewide.[44] The Department's workforce includes medical practitioners and specialists, allied health professionals, dental practitioners, paramedics, nurses and midwives, facilities officers, administration and support staff and contracted locum and agency staff.[45] A large base of volunteers also contribute their time and efforts across health services.[46]

The Department of Health has undergone several 'machinery of government' changes since the late 1990s.[47] These have resulted in substantial modifications to the Department's organisational structure and governance arrangements.[48] The recent *Independent Child Safe Governance Review of the Launceston General Hospital and Human Resources* (discussed in Chapter 15) found that this restructuring has contributed to 'some confusion around management roles, responsibilities and accountabilities' and a level of 'restructuring "fatigue"'.[49]

As noted, Secretary Morgan-Wicks leads the Department of Health. Secretary Morgan-Wicks started in the role on 2 September 2019.[50] The Secretary has a range of duties including planning health services and overseeing the performance of executive and senior staff.[51] The Secretary is also responsible for the performance of the Tasmanian Health Service and the Health Executive.[52]

A note on language

Unless otherwise stated, further references to 'the Department' in this volume are to the Tasmanian government department responsible for 'hospitals, ambulances, community health, and related areas such as primary healthcare'.[53] During the period under examination by our Commission of Inquiry (that is, responses to reports of child sexual abuse since 1 January 2000) this Department has been called the Department of Health and Human Services and the Department of Health.

3.2 Tasmanian Health Service

In line with the *Tasmanian Health Service Act 2018*, the Tasmanian Health Service is a statutory entity responsible for delivering health services to the community. Its functions are:

- to manage the operations of health services, including at public hospitals
- service planning
- budget management
- ensuring the Minister for Health's policies are implemented.[54]

3.3 Health Executive

The purpose of the Health Executive is to 'lead the strategic direction and provide oversight of the Department's key responsibilities'.[55] It includes the Secretary as well as a range of other senior roles, including the chief executives of Tasmania's hospitals, the Chief People Officer, the Chief Medical Officer and the Chief Nurse and Midwife.[56]

The functions of the Health Executive are to:

- administer and manage the Tasmanian Health Service
- perform and exercise the functions and powers of the Tasmanian Health Service
- ensure the services the Tasmanian Health Service provides are delivered in line with Tasmanian Health Service standards and within budget
- manage and monitor, and report to the Secretary on, the administration and financial performance of the Tasmanian Health Service
- monitor and report to the Secretary on the outcomes, for people, of providing health services to those people
- set up appropriate management and administrative structures for the Tasmanian Health Service
- perform any other functions specified by the Secretary.[57]

Various subcommittees and local health service managers across the State support the Health Executive.[58]

Some of the members of the Health Executive also serve on the Tasmanian Health Service Executive, which is responsible to the Secretary for administering and managing the Tasmanian Health Service.[59]

4 Oversight of the Tasmanian health system

As in other states and territories, external agencies oversee aspects of Tasmania's health system. These agencies are:

- the Office of the Health Complaints Commissioner Tasmania, which responds to systemic complaints about Tasmanian health services
- the Australian Health Practitioner Regulation Agency ('Ahpra') and the National Health Practitioner Boards, which respond to notifications about registered health practitioners, including those in Tasmania
- the Australian Commission on Safety and Quality in Health Care ('Safety and Quality Commission'), which accredits Tasmanian health service organisations against the National Safety and Quality Health Service Standards.

A core function of these oversight bodies is ensuring the safety of patients, including children and young people, who receive healthcare or health support services.

We briefly outline below the role of these bodies in overseeing aspects of Tasmania's health system.

4.1 Office of the Health Complaints Commissioner Tasmania

The Office of the Health Complaints Commissioner Tasmania was established in 1997 under the *Health Complaints Act 1995*. The Health Complaints Commissioner (at the time of writing) is Richard Connock, who was appointed to the role in July 2014.[60]

The functions of the Health Complaints Commissioner include to receive, assess and resolve complaints and to enquire into and report on matters relating to health services, at their discretion or as directed by the Minister for Health.[61]

The Health Complaints Commissioner performs their functions independently, impartially and in the public interest.[62] The Commissioner is not subject to the direction of any person about the way their functions are performed.[63]

4.2 Australian Health Practitioner Regulation Agency and National Health Practitioner Boards

In 2008, Australian states and territories agreed to develop a National Registration and Accreditation Scheme for health practitioners. This scheme replaced individual practitioner regulation in each jurisdiction.[64] The *Health Practitioner Regulation National Law Act 2009* ('National Law') began in all states and territories in 2010. Tasmania adopted the National Law through the *Health Practitioner Regulation National Law (Tasmania) Act 2010*.[65] The National Law established Ahpra and 15 National Health Practitioner Boards ('National Boards') for 16 health professions.[66] The National Law applies to all health practitioners who are registered in any one of these 16 health professions.[67]

Ahpra is the national organisation responsible for administering the National Registration and Accreditation Scheme.[68] Ahpra has a range of functions, but it primarily provides administrative support to the National Boards in performing their functions under the National Law.[69] Ahpra also establishes procedures for receiving and assessing applications for registration and notifications about registered health practitioners and maintains the national register of registered health practitioners.[70] This register, which can be searched on Ahpra's website, contains information about registered health practitioners, including information about current restrictions that apply to their registration.[71] An Agency Management Committee oversees Ahpra's work.[72]

The National Boards for the 16 health professions have a range of functions including:

- determining requirements for registration within the health professions
- approving accredited programs of study for registration in the health professions
- registering suitably qualified people in the health professions

- working with Ahpra to ensure the national register of health practitioners is up to date
- developing standards, codes and guidelines for the health professions
- overseeing notifications about people who are or were registered in the health professions
- overseeing the management of health practitioners registered in the health professions
- referring matters about people who were or are registered in the health professions to a relevant tribunal.[73]

In Tasmania, the relevant tribunal is the Tasmanian Civil and Administrative Tribunal.[74]

4.3 Australian Commission on Safety and Quality in Health Care

The Safety and Quality Commission was established by the former Council of Australian Governments in 2006 and is jointly funded by the Commonwealth and states and territories.[75] It started as an independent statutory authority on 1 July 2011.[76] The objectives of the Safety and Quality Commission are to 'contribute to better health outcomes and experiences for all patients and consumers and improve value and sustainability in the health system by leading and coordinating national improvements in the safety and quality of health care'.[77]

The Safety and Quality Commission has a range of functions in relation to healthcare safety and quality, which are set out in the *National Health Reform Act 2011* (Cth).[78] As part of its role, the Safety and Quality Commission develops the National Safety and Quality Health Service Standards ('National Standards').[79] The National Standards 'provide a nationally consistent statement on the level of care that consumers can expect to receive from health service organisations'.[80]

There are eight National Standards, including a Clinical Governance Standard, a Partnering with Consumers Standard and a Communicating for Safety Standard.[81] The primary aims of the National Standards are to protect the public from harm and to improve the quality of health service delivery.[82] We consider how the National Standards should relate to child safety (including the National Principles for Child Safe Organisations) in Chapter 15.

5 Previous reviews examining the Tasmanian health system

Over the past two decades the Tasmanian health system has been the subject of several reviews and investigations. These reviews and investigations have considered issues of performance, efficiency, organisational culture and misconduct committed by State Service employees. Although none of the reviews have specifically examined child sexual abuse in health services, many have identified some of the same problems that we found through our Commission of Inquiry as exacerbating the risks of child sexual abuse.

These problems include:

- ineffective governance arrangements and a lack of clarity about roles and responsibilities among staff in health services
- an absence of scrutiny over staff conduct and decision making and a lack of accountability for senior managers and executives
- organisational cultures characterised by poor leadership and toxic behaviour, including misconduct by State Service employees in relation to conflicts of interest, underperformance and mistreatment of staff
- failures to report misconduct due to fear of retribution
- instability because of changes in organisational and governance structures.

These reviews are relevant to our Inquiry because the available research into the risks of child sexual abuse in health services shows that workplaces with dysfunctional cultures—particularly those that allow poor conduct to go unaddressed—contribute to, or at least hinder, the identification of child sexual abuse.[83] These reviews also show that problems with governance, culture and misconduct within the Tasmanian health system are longstanding.

5.1 Report of an Investigation into Ward 1E and Mental Health Services in Northern Tasmania (March 2005)

In March 2004, the then Minister for Health and Human Services directed the then Health Complaints Commissioner to investigate Ward 1E at Launceston General Hospital and its associated Oldaker and Spencer clinics. At the time of the investigation, Ward 1E and its associated clinics were managed by Mental Health Services as part of the Community, Population and Rural Health Division of the Department of Health and Human Services and was not managed through the Launceston General Hospital.[84]

The investigation was prompted by several complaints to the Health Complaints Commissioner and Nursing Board of Tasmania about the treatment of patients in these units.[85] The complaints raised serious concerns about the standard of care and treatment provided to patients and alleged sexual misconduct by two nurses and a ward attendant against highly vulnerable adult patients.[86]

The Health Complaints Commissioner was tasked with examining the incidents and the Department's response to these complaints.[87] The Health Complaints Commissioner was also tasked with making recommendations for improvement, including in relation to complaints management, governance and risk management, performance oversight and the protection of patients.[88]

Two investigations addressed the terms of reference—one into the specific complaints about the behaviour of individual staff (which included sensitive information about patients) and the other into the broader systemic issues highlighted in the complaints.[89] We summarise the findings of the latter investigation below, noting that many of the problems identified are similar to those we heard about nearly 20 years later through our Commission of Inquiry.

5.1.1 Investigation into systemic issues

The Health Complaints Commissioner's investigation explored how reported incidents were managed, whether the individual performance of staff members was monitored, whether standards set by regulatory bodies were complied with, and whether systemic problems were identified and addressed.[90]

The report found that Ward 1E and its associated clinics did not, in many respects, provide an appropriate model of care for mental health patients nor foster an environment consistent with best practice.[91] The report also described serious sexual misconduct by staff at the facilities.[92]

The Health Complaints Commissioner made 26 recommendations, all aimed at improving the standard of care at the facilities.[93] These recommendations related to nursing practice, governance and incident reporting within a safety and quality framework, and the importance of spelling out appropriate professional conduct and accountability.[94]

Key recommendations included:

> **1. Ethical and appropriate workplace conduct**
>
> That Area Management, HR [Human Resources] and non-nursing personnel receive education and training in relation to the State Service Code of Conduct and its operation, with particular reference to the sort of conduct that could constitute a breach of its terms.

2. Appropriate professional conduct

That guidelines, educational units and protocols be developed and implemented in relation to professional boundaries for MHS [Mental Health Service] health professionals, and operate in conjunction with a governance and professional mentorship model.

3. Training — incident reporting, complaints and grievances

That all ward staff and area management officers receive education and training in relation to the procedures for the reporting of incidents, concerns and complaints and their investigation and resolution; with particular reference to the need to have regard to any clinical and clinical risk management issues raised by incidents, concerns or complaints.

4. Clinical supervision and mentorship

4.1 That if feasible, clinical supervision be delivered by both internal and external supervisors.

4.2 That the model of care formulated clearly articulate[s] the governance arrangements for the service. These governance arrangements need to incorporate both the unit specific governance and the broader hospital or health service governance arrangements. Clear lines of accountability and minimal duplication should be established.

4.3 Clinical leadership should be reflected in the governance arrangements and the role of clinical leaders determined by the model of care implemented.

4.4 Any amendments to clinical leadership should be implemented as an interim measure until a model of care is agreed.

4.5 That a Ward Management committee be part of the governance model.

...

20. Complaints

20.1 Implementation of policy and procedures for a continuum that addresses information notification of complaints through to sentinel events. The policy should cover resources required, governance arrangements, legislative requirements, staff development, timeframes and quality improvement cycles.

20.2 Any complaints [about] sentinel events and associated investigations or responses should be recorded on a database to allow trend analysis to occur and corrective action implemented.

20.3 That the skills base of managers and HR staff in relation to complaint handling be strengthened through the provision of additional training, with a focus on the importance of timeliness in responding to these types of matters.[95]

The Health Complaints Commissioner concluded that systemic failures can create a workplace culture that is conducive to misconduct or unprofessional conduct. This in turn has the potential to have an adverse effect on clinical practice and professional workplace relationships.[96]

5.1.2 Implementation

In April 2005, the then Minister for Health and Human Services established a taskforce to oversee implementation of the 26 recommendations.[97] The taskforce submitted a final report to the Minister in November 2006, which stated that 22 of the 26 recommendations had been implemented.[98] The report noted that the four outstanding recommendations were to be implemented over the following year by senior mental health service staff on Ward 1E as part of the broader *Mental Health Services Strategic Plan 2006–2011*.[99]

In June 2007, following more allegations about staff behaviour on Ward 1E, an external reviewer was engaged to undertake an audit. The purpose of the audit was to assess whether the Health Complaints Commissioner's 26 recommendations had, in fact, been implemented.[100] The external reviewer found that the recommendations had been implemented and that actions beyond the recommendations were taken.[101] However, the external reviewer identified that a persistent negative culture within the service and failures to adequately change this culture were having an ongoing adverse impact on practice.[102]

The external reviewer made a further 38 recommendations with respect to leadership, clinical governance, practice development, human resources management, partnership development, mental health promotion and information management.[103] The Department of Health and Human Services undertook a range of actions in response to the external reviewer's report.[104]

In December 2008, the external reviewer was invited to evaluate the progress the Department had made in implementing the 38 recommendations.[105] A final report, which was not publicly released, noted significant progress. However, the external reviewer also made another seven recommendations, some of which were addressed as part of a workforce review of Mental Health Services in 2009.[106]

5.1.3 Parallels between the 2005 investigation and evidence before our Commission of Inquiry

At our hearings, Mr Connock, current Health Complaints Commissioner, told us it was 'concerning' that very similar issues to those identified in the investigation of Ward 1E had emerged before our Inquiry.[107] He said there were 'very strong parallels' between the circumstances giving rise to the investigation into Ward 1E and the evidence that had emerged at our hearings, particularly about the nature of the misconduct, inadequate record keeping of complaints, poor communications about what had occurred, and inadequate support for those affected.[108]

5.2 Report to the Australian Government and Tasmanian Government Health Ministers, Commission on Delivery of Health Services in Tasmania (April 2014)

In September 2012, the Australian and Tasmanian governments set up the Commission on Delivery of Health Services in Tasmania ('Delivery of Health Services Commission'). The purpose of the Delivery of Health Services Commission was 'to investigate health service delivery in Tasmania, identify inefficiencies, and make recommendations on opportunities for lasting improvements in quality, efficacy, and system sustainability'.[109]

The Delivery of Health Services Commission's report documented far-reaching problems and called for a 'fundamental reform and redesign' of the Tasmanian health system.[110] The report noted that the health system had been the subject of several previous reviews, including *Tasmania's Health Plan 2007* and *The Tasmanian Hospital System: Reforms for the 21st Century* (2004), and that many of the issues identified in these previous reviews had not been rectified.[111]

The report also documented deficiencies in the clarity of roles and responsibilities between the Department of Health and Human Services (as it was then) and the former Tasmanian Health Organisations, finding that these deficiencies had negatively affected performance management, clinical governance, safety and quality, service planning, integration, engagement with the community and leadership and culture.[112]

Comments in the report on the culture of the health system were particularly concerning. The report described a 'deeply engrained culture of resistance to change, evidenced by the system's inertia in the face of several reviews recommending reform'.[113] The culture, as described, was characterised by varying degrees of denial about the problems within the health system and cynicism about the ability to implement initiatives designed to improve efficiency and sustainability.[114] The report stated that decisions made by some health practitioners or administrators appeared to be based on political convenience and self-interest rather than what was in the best interests of patients.[115]

Further, the report expressed serious concerns about the conduct of some staff within the health system:

> We have observed a lack of respect amongst key stakeholders, competition and a lack of cooperation, and resistance to routine performance measures. While there are capable and committed individuals within the health system, there are administrators and clinicians in leadership positions who behave in an unduly territorial manner. Personal animosities appear to override professional considerations and what should be universally accepted codes of conduct.[116]

We are particularly concerned about the reference to territorial disputes because such disputes can lead to problems being concealed to protect the reputation of a division or staff contingent.

The Delivery of Health Services Commission further noted in its report that the lack of leadership and accountability mechanisms within the Tasmanian Health Organisations had created 'a culture where behaviour that falls far outside acceptable professional conduct' was tolerated without consequence and was therefore allowed to thrive.[117] The Delivery of Health Services Commission also found that the Tasmanian Health Organisation model, whereby staff misconduct was the responsibility of local governing councils, shielded misconduct and the response to it from broader scrutiny by the then Department of Health and Human Services.[118]

The report concluded that 'poor leadership and bad behaviour [was] at the heart of Tasmania's inability to achieve both effective governance and sustainable change in its health system'.[119] The report stated that cultural problems needed to be addressed before any system reform or clinical redesign could be effectively undertaken.[120]

The Delivery of Health Services Commission made six recommendations, focusing on:

- governance arrangements, including positive leadership and collaboration
- requiring leadership roles to be performed according to a code of conduct
- making cultural change and leadership a top priority
- delivering whole of system leadership training to managers within the health system
- requiring leaders within the Tasmanian Health Organisations to take part in performance management
- implementing a change management process informed through staff consultation.[121]

The website that housed the Delivery of Health Services Commission's report has been decommissioned. The extent to which the Tasmanian Government accepted the Delivery of Health Services Commission's recommendations is unclear because no formal response to the recommendations is publicly available.

Subsequent reforms to the health system appear to have at least partially responded to the Delivery of Health Services Commission's report and prior reports. However, we note that the culture of leaving unprofessional conduct unaddressed and unscrutinised was evident in all our case studies, in particular our case study of Mr Griffin, which we discuss in Chapter 14.

5.3 An Investigation into Allegations of Nepotism and Conflict of Interest by Senior Health Managers (2014)

The Integrity Commission investigated senior health managers in 2014 following a complaint from a member of the public. The complaint alleged that two senior officers at the North West Area Health Service (as it was then) had used their positions to employ family members and associates.[122]

The Board of the Integrity Commission found that the two officers had not disclosed significant conflicts of interest and had failed to comply with the applicable policies for employment.[123] Significant gaps were also found in record keeping relevant to the recruitment of these roles.[124]

A key issue the Board of the Integrity Commission considered was how the organisational culture at North West Area Health Service had influenced attitudes and responses to inappropriate behaviour. The Board commented that:

> A good workplace culture which promotes the values, code of conduct and principles of the State Service can improve morale, boost productivity, and improve an organisation's reputation with the community, suppliers and its own employees. Equally, an organisation whose leaders consistently breach the principles, code of conduct and applicable policies, and who demonstrate inappropriate and improper conduct, risks producing a workplace culture that fails to implement or even understand the principles.[125]

The Integrity Commission observed that the improper conduct had been instigated by senior officers, who should have known that such conduct was improper and contributed to an unhealthy culture that discouraged staff from raising concerns.[126] The Integrity Commission noted it was significant that a member of the public had to complain about the conduct before any action was taken.[127]

The Integrity Commission's report, which had 11 recommendations to prevent future misconduct, was referred to the then Premier and Auditor-General for action. Broadly, these recommendations were about keeping health service staff accountable for their recruitment practices.[128]

The Integrity Commission also noted that as part of a 2013 investigation into allegations of misconduct in recruitment within the Department of Health and Human Services, it had recommended to the Department of Premier and Cabinet that a mandated process of declaration of knowledge or association be established in State Service selection processes.[129]

In a media release issued in response to the 2014 Integrity Commission report, the Premier stated that the Government had acted on the recommendations.[130] In 2020, the Integrity Commission again inquired into the misconduct of public officers in the Tasmanian Health Service, North West Region.[131] The report noted that management

can dictate culture. It highlighted that a similar culture existed in 2020 to that which it had identified in its 2014 report, noting that employees failed to report conduct even though they had significant concerns about the integrity of management's actions.[132]

5.4 Performance of Tasmania's Four Major Hospitals in the Delivery of Emergency Department Services (May 2019)

In 2019, the Tasmanian Auditor-General reported on the findings of an assessment of the efficacy of emergency departments in Tasmania's four major hospitals, from the perspective of patients.[133] These four hospitals were the Launceston General Hospital, Mersey Community Hospital, North West Regional Hospital and Royal Hobart Hospital.[134]

In his report, the Auditor-General concluded that the Tasmanian hospital system was not working effectively to meet the growing demand for emergency department care, inpatient beds and performance obligations in relation to emergency department access and patient flow, as required by the *Tasmanian Health Service Plan*.[135] This failure was found to be due to capacity constraints and longstanding cultural and process weaknesses within the hospitals, which impeded effective discharge planning, bed management and coordination between emergency departments and inpatient areas.[136] The Auditor-General made 10 recommendations.

Although most of the Auditor-General's report concerned service delivery within emergency departments, it also referenced the culture within the Tasmanian Health Service. The report acknowledged that:

> Successive reviews by the Tasmanian and Australian governments over the last decade have highlighted dysfunctional silos, behaviours, process barriers and resistance to change from some clinicians and administrators within hospitals as major drivers of inefficiencies.[137]

The Auditor-General further observed, while conducting the assessment, that hospital staff had described longstanding cultural and governance challenges as factors contributing to poor coordination between emergency departments and inpatient wards. These challenges included:

- the ongoing presence of dysfunctional operational 'silos'
- the lack of effective whole of hospital leadership and action to drive change
- the effects of disruptive governance role 'churn' at the senior executive level
- perceived inadequate planning, governance and resourcing to implement past reforms
- lack of accountability among staff.[138]

Reference was again made to the findings of the Delivery of Health Services Commission in its 2014 report.[139]

To address the cultural issues raised, the Auditor-General recommended that:

> [The] Tasmanian Health Service and [the Department of Health and Human Services] urgently implement a culture improvement program and initiatives with clearly defined goals, accountabilities and timeframes to:
>
> - eliminate the longstanding dysfunctional silos, attitudes and behaviours within the health system preventing sustained improvements to hospital admission, bed management and discharge practices
> - ensure that all Tasmanian Health Service departments and staff work collaboratively to prioritise the interests of patients by diligently supporting initiatives that seek to optimise patient flow.[140]

A media release from the then Minister for Health indicated that the Tasmanian Government had noted the recommendations and was considering opportunities for reform.[141]

6 Poor culture at Launceston General Hospital

Just as previous reviews have identified a dysfunctional culture across some of Tasmania's health services, we heard from several current and former staff members about a longstanding dysfunctional culture at Launceston General Hospital. Staff members told us of their concerns about entrenched cultural problems at the hospital, including practices of favouritism in recruitment and the manipulation of recruitment processes, and deliberate attempts to suppress or conceal complaints of misconduct.[142] A sample of the evidence we heard in relation to the dysfunctional culture at Launceston General Hospital is summarised below.

One former staff member, who worked at Launceston General Hospital in the late 1990s, described the hospital's culture during their time of employment as 'grotesque' and 'distorted'.[143] They said the culture was:

> Grotesque in that it prioritised reputations and institutional interests over staff and patient safety. Distorted in that it punished those who sought to protect staff, patients and children. I believe that patients are not safe if staff don't feel safe.[144]

Maria Unwin told us of learning about an incident of alleged abuse from her colleagues when she started working at Launceston General Hospital in the 1990s. She said that, in the period she worked in Ward 4K, the response of hospital management to this incident left a clear message for staff:

> I was always shocked that even when someone was caught in the act of child sexual abuse they would only be moved on and that would be covered up.[145]

Ms Unwin also stated that those who spoke up about issues at Launceston General Hospital were considered by management to be 'trouble-makers'.[146]

Another nurse who had worked at Launceston General Hospital since the early 1990s told us she believed Ward 4K had a 'culture of fear and insecurity' that 'allowed staff concerns about Jim Griffin's behaviour to be ignored'.[147]

A current employee of the hospital told us she thought there was a 'distinct cultural lack of regard for clinical governance', resistance to change and narrow-mindedness.[148] This employee also noted what she understood to be a resistance from management to receiving and acting on feedback, and that management had promoted 'a culture of dismissing complaints'.[149]

At our consultation in Launceston, several former and current staff members independently raised concerns about the culture at Launceston General Hospital. These concerns included:

- a poor complaints process that lacked transparency
- management minimising staff concerns when reporting those concerns to senior management or the executive
- preferential treatment for some staff, including disclosing the identity of staff members who had complained about them
- victimising complainants
- managers not responding to complaints causing people to stop raising concerns
- a hierarchical, chauvinistic culture that normalised sexualised bullying of staff
- some staff members bullying, ostracising and intimidating colleagues so they would not make complaints against them
- staff being so fearful of management that they had physical traumatic reactions when management was nearby
- the hospital silencing dissent by 'weaponising the legal system' such that people were scared to speak up for fear that a defamation or breach of confidentiality action, or reprimands for failing to personally make a mandatory report, would be the consequence
- staff feeling as though they could not report poor conduct because they owed their jobs to those people exhibiting the conduct, or the allies of those people
- staff not making complaints due to fear of reprisal

- management being motivated by a desire to protect the reputation of the institution over the needs of children
- rumours that destroying incriminating records was a regular practice within the hospital.[150]

While we have not established that each of these concerns are true, when considered as a whole they paint a picture of a culture that discourages complaints and fails to respond to complaints when they are made and may allow poor conduct to go unaddressed. Such a culture increases the risk of child sexual abuse occurring or being ignored.

The cultural issues described above give context to what we heard about the ways in which Launceston General Hospital, its executive and senior managers responded to complaints about, and the alleged conduct of, staff at the hospital such as Dr Tim and Mr Griffin. We make a range of findings about the collective leadership of Launceston General Hospital in its response to Mr Griffin's abuses within that case study.

In the next chapter—Chapter 14—we present our case studies.

Notes

Introduction to Volume 6

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Chapter 13 — Background and context: Children in health services

7 Tim Moore and Morag McArthur, *Take notice, believe us and act! Exploring the safety of children and young people in government run organisations* (Research Report prepared for the Commission of Inquiry into the Tasmanian Government's Responses to Child Sexual Abuse in Institutional Settings, February 2023) 16.

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24 Tim Moore and Morag McArthur, *Take notice, believe us and act! Exploring the safety of children and young people in government run organisations* (Research Report prepared for the Commission of Inquiry into the Tasmanian Government's Responses to Child Sexual Abuse in Institutional Settings, February 2023) 26.

25 Tim Moore and Morag McArthur, *Take notice, believe us and act! Exploring the safety of children and young people in government run organisations* (Research Report prepared for the Commission of Inquiry into the Tasmanian Government's Responses to Child Sexual Abuse in Institutional Settings, February 2023) 43.

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14 Case studies: Children in health services

Content warning

Please be aware that the content in this report includes descriptions of child sexual abuse and may be distressing or raise issues of concern for some readers.

We encourage readers to exercise discretion in their engagement with this content and to seek support and care if required.

1 Introduction

In this chapter, we present three case studies relating to allegations against staff in health settings. Our terms of reference specifically required us to have regard to allegations of child sexual abuse against James Griffin.[1] We received evidence about other allegations in health settings and examined some of these more closely. We did this to acknowledge the efforts of the victim-survivors involved and their families to improve the safety of other children and young people, and to bring to light that Mr Griffin's abuse, and the hospital's failures to respond to it appropriately, were not an anomaly.

Case study 1 examines a complaint made by an individual in respect of receiving a health service. We make findings in relation to this case study, but it is subject to a restricted publication order.

Case study 2 examines a 2001 complaint by 11-year-old Zoe Duncan (now deceased) and her parents alleging sexual abuse by Dr Tim (a pseudonym), a former doctor at Launceston General Hospital. It outlines a series of wrongful assumptions and inadequate investigations, each infecting the next. We make several findings in relation to this case study.

Case study 3 examines at length the evidence we received about Mr Griffin's abuse throughout his tenure at the hospital. Over the course of Mr Griffin's offending, there were numerous and consequential missed opportunities—by Launceston General Hospital, Tasmania Police and Child Safety Services—to intervene earlier. The number and scale of findings we make in this case study is reflective of the magnitude of the failures to keep children and young people safe from Mr Griffin for almost twenty years, until he was finally suspended from his employment in mid-2019 after losing his registration to work with vulnerable people following a police report. They also reflect a series of response failures—in the systems and processes, and in the conduct of individuals, once Mr Griffin's offending was known. We carefully considered the responsibilities of individuals at the hospital relative to their roles in addressing Mr Griffin's behaviour, and in the context of the dysfunctional environment in which they were operating. In some cases, the conduct and omissions of individuals in response to known risks and incidents of abuse by Mr Griffin were not justified and we make findings accordingly.

In accordance with the Restricted Publication Order of the Commission of Inquiry dated 30 August 2023 and section 10(3) of the *Commissions of Inquiry Act 1995* (Tas), the Governor has omitted Volume 6, Chapter 14, Case Study 1 because the public interest in the disclosure of that part of the report is significantly outweighed by other relevant considerations, namely the right of any person to a fair trial.

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Case study 2: Response to complaint about Dr Tim (a pseudonym)

1 Overview

In a written statement and at our hearings, Anne and Craig Duncan told our Commission of Inquiry about the experiences of their daughter Zoe at Launceston General Hospital. While we refer to Mr Duncan for much of this case study, because the statement is written in his voice, we acknowledge that this was a task Mr and Mrs Duncan undertook together with great care and dignity. We also acknowledge that Zoe's sister, Amanda Duncan, contributed to our understanding of Zoe and her experiences.

Zoe Duncan experienced many health issues as a child, including epilepsy, chronic asthma and juvenile arthritis.[137] Although she was resilient and considered these issues 'just a part of life', they did result in regular visits to Launceston General Hospital.[138]

In 2001, when Zoe was 11 years old, she made allegations about sexual abuse perpetrated against her at Launceston General Hospital by an emergency department doctor who we will refer to as Dr Tim (a pseudonym).[139] Mr Duncan said that these events changed Zoe, describing his daughter prior to her admission to Launceston General Hospital in the following way:

> Prior to May 2001, Zoe was a carefree child. She had a well-developed sense of humour and laughed often. Zoe could see the funny side of life, even when unwell. She enjoyed sport and played hockey, basketball and football. Zoe was a prolific reader and loved writing. She enjoyed jazz and national dancing as well as learning to play the piano. Zoe deeply appreciated and often expressed awe at the beauty of nature. Annual camping holidays at the Mersey Bluff, Devonport were always eagerly anticipated and provided Zoe with many happy and relaxed occasions with family and friends. From a young age Zoe had a deep insight into people and could generally read others extremely well. She was loving and loyal to her family and friends. Zoe was extremely honest, bright, well-mannered and delightful company. A gentle, kind and caring person, who was grateful for, and content with, life's smallest pleasures. We would describe Zoe as an easy child to parent.[140]

This description contrasts significantly with how Mr Duncan described Zoe after she was discharged from Launceston General Hospital in May 2001:

> Following her abuse at [Launceston General Hospital], Anne and I didn't have the same daughter anymore, nor Amanda her sister. The girl who went into hospital was not the same girl who returned home. Zoe withdrew from me for many months. She had been hurt by a man and found it difficult to be around men and boys. She would

> stay in her bedroom crying. She was withdrawn, angry, had a lack of energy and interest in life. I would describe Zoe as having a complete change in personality. She started having suicidal thoughts and suffering from insomnia. Zoe began to wet the bed which had not occurred prior to her admission to [Launceston General Hospital]. She began having periods lasting in excess of 20 days, which her [general practitioner] stated was due to stress. Zoe was prescribed Xanax to help her manage the overwhelming anxiety she experienced. The experience at [Launceston General Hospital] caused significant emotional dulling and stress. In addition to Zoe, every member of the family was in incredible emotional pain.[141]

In 2002, Zoe wrote a letter that described what she said happened at the hospital and how it had affected her:

> The hospital experience with the man, [Dr Tim], has changed me in ways I don't want it to. My thoughts, my dreams and the way I feel about things. I find this all too much and what people might think about me. I feel so terrible but it keeps getting worse. People say I'll get over it but I don't feel I will. I'm falling apart and I'm struggling to keep my head above the water. I'm trapped, scared, nowhere to go. I can't go on like this. I'm trying to do my best but I'm being held down and I just want to wither away.[142]

2 Zoe's admission to Launceston General Hospital in 2001

On 18 May 2001, Zoe was taken to the Launceston General Hospital emergency department after an asthma attack.[143] Mr Duncan told our Commission of Inquiry that at the hospital he and Mrs Duncan met Dr Tim, who said they 'had a very beautiful daughter'.[144]

On 19 May 2001, Zoe was again taken to the emergency department after another asthma attack.[145] This time, Dr Tim was assigned as Zoe's treating doctor.[146] Late that afternoon, Dr Tim told Mr and Mrs Duncan that Zoe would need to remain under observation in the emergency department for a few hours and then stay overnight in the paediatric ward, Ward 4K.[147] Mr Duncan recalled that Dr Tim commented that Zoe's younger sister, Amanda, looked tired and suggested the family go home and collect some personal items for Zoe's stay.[148] Mr Duncan also recalled that before leaving the hospital Dr Tim asked how far away they lived and how long it would take for them to drive home to collect the items.[149]

While Mr Duncan was driving back to the hospital with the items, he got a phone call from Dr Tim, who said Zoe was upset and wanted to speak with her dad.[150] The call disconnected before Mr Duncan could speak with Zoe so he contacted Mrs Duncan and asked her to find out what was going on before he continued the drive to the hospital.[151]

When Mr Duncan arrived at the emergency department, he saw Dr Tim emerging from behind the curtains of Zoe's cubicle.[152] Mr Duncan recalled that Dr Tim reiterated that he had called because Zoe was upset.[153] On entering the cubicle, Mr Duncan saw Zoe 'curled up on the bed in the foetal position'.[154] Mr Duncan told us that Zoe said: 'Dad, Dad get that man away from me, he's dangerous, he's a madman'.[155] Zoe told him that Dr Tim had said he loved her, wanted to marry her and had been touching her all over.[156] Mr Duncan told us Zoe also said Dr Tim had squeezed her breast, tugged her ears and put his fingers in her mouth.[157] He said Zoe also reported fearing Dr Tim would follow her to Ward 4K.[158]

Mr Duncan told us that he reported what Zoe had said to a nurse on duty. Not wanting to falsely accuse Dr Tim of wrongdoing, and hoping that there had been a misunderstanding, Mr Duncan indicated at that stage he did not want to take things further.[159] Despite his reservations, Mr Duncan said the nurse reported Zoe's allegations and set up a meeting between Mr Duncan and four members of staff, including the after-hours nurse coordinator and the registrar on duty.[160] Mr Duncan said he was told that Zoe would be transferred to Ward 4K and Dr Tim would be instructed not to see her.[161] Shortly after this meeting Zoe was moved to Ward 4K.[162]

Later that night, the after-hours nurse coordinator notified the former Executive Director of Medical Services, Dr Peter Renshaw, of Zoe's allegations.[163] Dr Renshaw was Dr Tim's line manager at the hospital.[164]

Dr Renshaw's file note of matters relating to Zoe ('the Zoe Duncan file note') records that the initial allegations made by Zoe on 19 May 2001 were that Dr Tim had given Zoe a hug, kissed her hand, said she was a pretty girl and that if she were older, he would marry her.[165] The Zoe Duncan file note is generally consistent with the incident report made by the nurse on duty, which records Zoe's allegations as: 'the doctor kissed my hand, cuddled me and said if I was older he would marry me. Please don't tell anyone'.[166] Neither the Zoe Duncan file note nor the nurse's incident report refer to Dr Tim touching Zoe's left breast, tugging her ears or putting his fingers in her mouth.

The Zoe Duncan file note states that staff indicated to Dr Renshaw that these events were 'a highly unusual situation' and that 'no one was certain how it was to be handled'.[167] The Zoe Duncan file note also states that Mr Duncan wanted the complaint to be dealt with 'quietly', that he was concerned for Dr Tim's reputation and that he had asked that no formal complaint be documented. According to the Zoe Duncan file note, nursing staff were not to approach Dr Tim until the Duncans had spoken to Dr Renshaw.[168]

Dr Renshaw gave evidence to us that when he was notified of Zoe's initial allegations on 19 May 2001 he did not perceive them to involve an assault but rather a 'professional boundary violation which could be, but may not have been, child sexual abuse'.[169] Dr Renshaw also said he did not consider that the behaviour reported was at a level that required Dr Tim to be prevented from continuing to work in the emergency department.[170] Dr Renshaw said there was 'no necessity for sudden knee-jerk actions'

on this night.[171] Dr Renshaw confirmed that he did not speak with Dr Tim about Zoe's allegations or take any other steps at that time.[172]

In his evidence to us, Dr Renshaw said that 'Dr Tim was actually told by the after-hours nurse manager' on the night of 19 May 2001 to not visit Zoe.[173] The documentary evidence is unclear as to what time Dr Tim was given this instruction. A Medical Council of Tasmania investigation report (discussed in Section 5.2) notes that the nurse manager 'left instructions' sometime after 9.00 pm that Dr Tim was not to see Zoe.[174]

Mr Duncan said that later that night, while Zoe was on Ward 4K, he retrieved some items from his car.[175] When he returned, Zoe told him that Dr Tim had been to see her.[176] Mr Duncan recalled that Zoe said Dr Tim had been there for 'about 30 seconds' and had said he hoped she was okay and to remember 'this is our little secret'.[177]

Mr Duncan told us that, on the morning of 20 May 2001, he reported Dr Tim's visit to the after-hours nurse coordinator, who suggested he speak with Dr Renshaw.[178] An appointment with Dr Renshaw was arranged for the next day.[179] Mr Duncan recalled encountering the registrar from the previous night, who asked him how Zoe was before saying they had been at Dr Tim's house the night before.[180] Mr Duncan told us that the registrar said to him: 'The doctor is a very nice man, and you better hurry up and decide what you are going to do. I don't think the doctor will take it any further and see his lawyer as he is not that sort of person'.[181] Mr Duncan perceived this as a 'thinly veiled threat' and believed that the registrar was attempting to protect a friend and colleague.[182]

We did not seek or receive evidence from the registrar or the after-hours nurse coordinator who were on shift the night Zoe made her allegations.

Later that day, Mrs Duncan arrived at Launceston General Hospital and Mr Duncan returned home.[183] Mr Duncan told us that, while washing some of Zoe's clothing from the hospital, he noticed blood on Zoe's underpants.[184] Zoe did not have her period.[185]

Later that night, Zoe told Mrs Duncan that Dr Tim had 'put his front bottom on her front bottom'.[186] At the time, Mrs Duncan thought this meant Dr Tim had leant across Zoe.[187]

3 Launceston General Hospital's response to Zoe's allegations

On 21 May 2001, the Duncans met with Dr Renshaw.[188] Mr Duncan recalled telling Dr Renshaw what Zoe had disclosed and who was involved.[189]

The Zoe Duncan file note states that, at the meeting, the Duncans 'thanked me for the way the hospital had dealt with the matter thus far' and indicated that Zoe had raised a further concern about Dr Tim that involved 'touching'.[190] The Zoe Duncan file note records that the Duncans believed 'something unusual had gone on' but were not sure

what it was.[191] The file note also records that Dr Renshaw asked the Duncans whether they thought Zoe would be willing to speak to him directly, in the presence of a family member, so he could 'assess' her story.[192]

The Zoe Duncan file note states that Dr Renshaw told the Duncans that the hospital had 'absolutely no previous problems with [Dr Tim]' but that he would, 'as a matter of urgency', reinforce the hospital's chaperone policy and that the hospital would continue to 'closely but discretely' monitor Dr Tim.[193] At our hearings, Dr Renshaw conceded that there was no suggestion at this point that he would preclude Dr Tim from treating children.[194] When asked at the hearings whether he should have prevented Dr Tim's access to children while he considered the issue, Dr Renshaw said that it would have been 'premature' but conceded that it 'should have been considered'.[195] Dr Renshaw also conceded that he should have reported the incident to Child Safety Services at this time.[196] He agreed that one of the factors that influenced his decision not to report was the reluctance of the Duncans to report, but later conceded that their views should not have influenced his decision.[197]

The Zoe Duncan file note further states that, later that afternoon (at about 4.00 pm), Dr Renshaw spoke with Zoe in the presence of Mr Duncan, a resident medical staff coordinator and a nurse on Ward 4K.[198] According to Mr Duncan, Zoe told Dr Renshaw exactly what she had told Mr Duncan the night before.[199] Mr Duncan recalled that Zoe explained and demonstrated that Dr Tim had tugged at her ears, put his finger in her mouth and touched her like 'this' while flicking her hands down her chest and legs. Mr Duncan also recalled that Zoe told Dr Renshaw about the comments Dr Tim made about her being beautiful and wanting to marry her, as well as Dr Tim telling her: 'This is our little secret'.[200]

Dr Renshaw told us it was during this meeting that Zoe disclosed Dr Tim had touched her left breast during an examination and that it felt 'different' to other examinations.[201] Dr Renshaw told us at our hearings that at the time he accepted what Zoe had told him was true, including that Dr Tim had touched Zoe's breast, kissed her hand, hugged her, spoken about her appearance and said he wanted to marry her.[202] We note that these allegations, taken together, are an allegation of child sexual abuse. Despite Dr Renshaw accepting these allegations as a truthful account, they were not treated as an allegation of child sexual abuse. Dr Renshaw did not report Zoe's allegations to Tasmania Police or Child Safety Services at that time. Instead, Dr Renshaw told Zoe that it was important for her to feel safe and that she had a right to have another person present when she was being examined.[203] Dr Renshaw told us he did not see any difficulty in asking an 11-year-old child under the hospital's care to take steps for her own protection.[204]

Dr Renshaw told us that Zoe also revealed at this meeting that Dr Tim had visited her on Ward 4K in the evening of 19 May 2001.[205] Dr Renshaw told us he explained to Zoe that doctors sometimes follow their patients to check on them after they have been

admitted, but that he also 'agreed' at the meeting that Dr Tim's behaviour constituted a 'further professional boundary issue'.[206]

At our hearings, Counsel Assisting asked Dr Renshaw whether he should have stood Dr Tim down after this discussion with Zoe. Dr Renshaw responded:

> I don't know. I actually don't know that I actually would have had the power to stand him down, but regardless of the [human resources] processes that are required, at that time I don't think it was appropriate to do that, but yes, today I would do that.[207]

When Dr Renshaw was asked if he saw this as an error of judgment at the time, he conceded that it was an error of judgment that arose because he was inexperienced in his role.[208]

Mr Duncan told us that after the meeting he asked Dr Renshaw what he thought about Zoe's allegations. Mr Duncan recalled that Dr Renshaw responded that 'Zoe wasn't upset enough to have experienced sexual misconduct of any kind'.[209] The Zoe Duncan file note records that during this meeting Zoe's 'affect did not seem to reflect the degree of awkwardness or distress that she was describing'.[210] When Counsel Assisting asked Dr Renshaw about this observation in the Zoe Duncan file note, he said he was making a clinical observation.[211] We note that Dr Renshaw's clinical observation and his evidence outlined above that he accepted Zoe's allegations as being true are somewhat contradictory.

Dr Renshaw told us in his statement that, after he spoke with Zoe, he 'deemed that there had been a breach of professional boundaries' but that he 'was not clear that the nature of the breach was sufficient to justify immediate notification to [Child Safety Services]'.[212] Dr Renshaw later told us that, although he discussed the option of reporting with Zoe's family, he did not consider it was necessary to report the matter to Child Safety Services.[213] Dr Renshaw said he did not accept that the allegation Dr Tim touched Zoe's breast, without more, amounted to assault or child sexual abuse.[214] Dr Renshaw also told us he considered a mandatory report was unnecessary for several reasons, including that there was no sexual assault reported.[215]

Claire Lovell, Executive Director, Children and Family Services within the former Department of Communities, gave evidence that it is best practice to report boundary breaches, inappropriate behaviour and sexual abuse as soon as they are observed or reported.[216]

Dr Renshaw conceded at our hearings that, at the time he became aware of the further disclosure that Dr Tim had touched Zoe's left breast, he should have escalated the complaint as a matter of child safety, and taken steps to ensure Dr Tim did not have access to children.[217] These concessions are the subject of findings we make later in this case study.

Mr Duncan told us that on 22 May 2001, he spoke with Dr Renshaw to again put aspects of Zoe's disclosures to him for a response.[218] Mr Duncan recalled that in response to Zoe's disclosure that Dr Tim had touched her breast, Dr Renshaw said that Dr Tim could have been trying to locate the heart.[219] In response to Zoe's disclosure that Dr Tim had put his fingers in her mouth, Mr Duncan recalled that Dr Renshaw said that Dr Tim may have been feeling for ulcers.[220] In response to Zoe's disclosures that Dr Tim had visited her on Ward 4K, Mr Duncan recalled that Dr Renshaw said he encouraged doctors to follow up with admitted patients as good practice.[221] In response to the disclosure that Dr Tim had told Zoe 'this is our little secret', Mr Duncan recalled that Dr Renshaw said this was a silly thing to say and that the standard of English among foreign doctors needed to be addressed.[222] Mr Duncan recalled telling Dr Renshaw that 'one of the parties concerned here has been tragically aggrieved but nevertheless I'm troubled by the nature of Zoe's allegations and the tenuous responses to them'.[223]

The Zoe Duncan file note makes no reference to this exchange. Instead, it states that Mr Duncan 'thanked me for the way the matter had been handled' and records that Mr Duncan asked Dr Renshaw to convey to Dr Tim the Duncans' apologies for having to raise the matter.[224] The file note also states that Mr Duncan 'appeared satisfied with the monitoring plan', although this monitoring plan is not outlined in the Zoe Duncan file note.[225] At our hearings, Dr Renshaw maintained that this file note was an accurate record of the meeting with Mr Duncan.[226] It is apparent to us that Dr Renshaw does not accept Mr Duncan's account of events. It is not necessary to resolve this for the purpose of our Inquiry and we make no finding in this regard.

In his statement to us, Dr Renshaw said that he also met with Dr Tim on 22 May 2001 and 'spoke with him about professional boundaries and the need to observe the hospital's guidance on chaperones'.[227] On one account in Dr Renshaw's statement, he indicated that he counselled Dr Tim about the complaint, provided him with a copy of the hospital's chaperone procedure and told Dr Tim that further complaints would need to be referred to Child Safety Services or to the police.[228] In another account in the same statement, Dr Renshaw said that he mentioned the possibility of police involvement but not the involvement of Child Safety Services.[229] In oral evidence at our hearings, Dr Renshaw told us that at the time of Zoe's allegations he had assumed there was a chaperone policy in place at Launceston General Hospital, but when he went looking for one to explain it to Dr Tim, he discovered the hospital only had an informal policy in place.[230] As a result, he wrote a new chaperone policy (which we discuss in Section 4.1).[231] Dr Renshaw's varying accounts of this meeting are internally inconsistent and consequently impeach the reliability of his account of this meeting.

At our hearings, Dr Renshaw gave evidence that Dr Tim 'was off duty earlier that week' and that he 'didn't get around to actually talking to [Dr Tim] until the week after' Zoe's disclosures.[232] Dr Renshaw told us that the first meeting with Dr Tim occurred on 29 May 2001. Dr Renshaw made a file note of this meeting ('the Dr Tim file note'), which records:

'I explained to [Dr Tim] that a complaint had been made against him from the Duncans' and '[Dr Tim] was immediately distressed and vehemently denied any wrong doing'.[233] Due to the varying accounts across Dr Renshaw's statement and the evidence he gave at our hearings, we cannot be certain that a meeting with Dr Tim took place prior to 29 May 2001 and we make no finding in this regard.

4 Reporting, incremental disclosures and investigations

4.1 Multiple contacts about making a report

On 24 May 2001, after Zoe had been discharged from Launceston General Hospital, Zoe's general practitioner contacted Dr Renshaw. Zoe's general practitioner asked whether a report had been made to Child Safety Services about her allegations.[234] Dr Renshaw told us that he had mentioned the possibility of a report to the Duncans, but they had been reluctant to proceed.[235]

Dr Renshaw stated that Zoe's general practitioner told him Zoe had since made additional allegations against Dr Tim.[236] Dr Renshaw gave evidence that because Zoe's general practitioner was not forthcoming about what the allegations were, he asked them to write to him formally about the concern and that he would confirm 'current actions' about any notifications in writing.[237]

On 25 May 2001, Zoe's general practitioner wrote a letter to Dr Renshaw seeking confirmation that he was 'acting on this matter including reporting, if appropriate to relevant authorities'.[238] It is not clear to us whether Dr Renshaw responded to this letter.

Mrs Duncan also contacted Dr Renshaw on 25 May 2001 to ask if he had reported Zoe's disclosures because Zoe's psychologist needed the matter to be reported before speaking with Zoe.[239]

The Zoe Duncan file note records the conversation with Mrs Duncan on 25 May 2001. It states that Mrs Duncan was 'concerned by Zoe's behaviour, and mentioned crying in school and problems sleeping', that Mrs Duncan had told Zoe's teachers about the 'problem at the hospital', that Mrs Duncan was trying to arrange counselling for Zoe, and that she had contacted Laurel House but:

> ... had not provided full details to Laurel House, because they had told her that they would have to report the matter to [Child Safety Services]. The family was not sure that was the way they wanted it handled.[240]

Further, the Zoe Duncan file note states that Dr Renshaw told Mrs Duncan that 'the hospital would be willing to proceed with the report to [Child Safety Services] if she so desired'.[241]

The Zoe Duncan file note indicates that four days later, on 29 May 2001, Laurel House contacted Dr Renshaw 'to check as to how the reporting process was going'.[242] The Zoe Duncan file note states that Laurel House indicated Mrs Duncan had been reluctant to provide information to them because of the need to advise Child Safety Services.[243] The Zoe Duncan file note also records that Dr Renshaw told Laurel House he would immediately make a report to Child Safety Services given the matter 'had already been mentioned to at least four professionals outside the hospital'.[244] This was the third time that Dr Renshaw had been contacted about reporting Zoe's allegations.

In his statement to us Dr Renshaw wrote that, until 1 September 2021:

> … I had no knowledge, nor had I received any information from Mr and Mrs Duncan, the GP or Laurel House that the investigated complaint against [Dr Tim] extended to physical sexual assault (i.e. well beyond a professional boundary transgression).[245]

Dr Renshaw's evidence suggests a lack of understanding and insight in relation to allegations of child sexual abuse. We note that although it was not apparent to Dr Renshaw at the time, it was apparent to Zoe's general practitioner and Laurel House that the nature of Zoe's allegations about Dr Tim were serious and warranted reporting to Child Safety Services.

On 29 May 2001, before making a report to Child Safety Services, Dr Renshaw met with Dr Tim. The Dr Tim file note states that Dr Renshaw explained to Dr Tim that the Duncans had made a complaint.[246] Dr Renshaw told Dr Tim that further details about the complaint had been provided to others, but that as far as Dr Renshaw was aware, they concerned an allegation that Dr Tim had 'spoken improperly to Zoe and touched her unnecessarily'.[247] The Dr Tim file note records that Dr Tim denied any wrongdoing and stated he would 'cooperate fully with any investigation'.[248]

Dr Renshaw also recorded in the Dr Tim file note that he indicated to Dr Tim that 'the hospital did not have, and had not been provided with, any evidence to support the allegations'.[249] When asked about this by Counsel Assisting our Inquiry, Dr Renshaw said he was not quite sure how telling Dr Tim this could potentially compromise subsequent investigations.[250]

On the same day, after meeting with Dr Tim, Dr Renshaw said that he made a verbal report to Child Safety Services about Zoe's allegations.[251] When speaking with the intake officer at Child Safety Services, Dr Renshaw elaborated on his observation that Zoe's 'affect did not seem to reflect the degree of awkwardness she was describing'.[252] The investigation report from Child Safety Services (discussed in Section 4.3) records that Dr Renshaw told the intake officer that Zoe could not remember whether Dr Tim had a stethoscope when he examined her and that she was smiling when talking about being touched on the chest.[253] It is further recorded that when the intake officer asked Dr Renshaw whether Zoe may have been embarrassed, he said he 'didn't think so', and that Zoe was 'giving very mixed messages' and was 'not as upset as the parents claimed'.[254]

The Zoe Duncan file note states that, after making the report to Child Safety Services, Dr Renshaw phoned Mrs Duncan to advise her that the report had been made. The file note further states that Mrs Duncan 'expressed mixed emotions about this' but 'thanked me once again for our help'.[255]

Dr Renshaw told us that he had 'no further direct involvement' in the investigation of Dr Tim after he made the verbal report to Child Safety Services on 29 May 2001.[256]

The protocol that applied at the time of Zoe's allegations was the *Protocol for Hospital-Based Medical and Nursing Staff for the Reporting and Management of Cases of Suspected Child Abuse or Neglect* ('Protocol').[257]

The Protocol contained 'Essential practice guidelines' ('Guidelines'). Under the heading 'consultation', the Guidelines state:

> No decisions or actions in respect of suspected actual or potential child abuse or neglect are to be made by any health worker in isolation unless there is a concern for the immediate safety of the child.
>
> Whenever child abuse is suspected or identified the matter must be given top priority. The most senior medical officer on duty in the unit should be advised at once and the Paediatric Registrar must be contacted immediately ...[258]

We understand that Dr Renshaw was the most senior medical officer on duty at the time.

Under the heading 'Response to Disclosure', the Guidelines state:

> Information volunteered by the child should be fully and accurately recorded. However, no in depth interview of a child, especially regarding sexual abuse should be attempted.
>
> Authorised officers in the Department of Community and Health Services (DC&HS) located in Intake and Assessment units (formerly known as Child Protection Units), and the police, have statutory responsibility for the investigation of child abuse.[259]

Under the heading 'Notification to DCHS Intake & Assessment/Child Protection Unit or the Police', the Guidelines state:

> DCHS Intake & Assessment/Child Protection Units are located in all regions with "after hours" telephone numbers and should be contacted in all cases of suspected child abuse or neglect. However, not all situations will require immediate action by child protection staff. In some cases where there is concern about the child's situation but the child has not been abused, effective preventative interventions supportive to a family environment may be provided after full investigation and assessment.
>
> Decisions about whether to refer, and where, must not be made in isolation. Discuss concerns you may have with an immediate senior colleague and follow the procedure in 6 below.
>
> If you believe a child is in immediate danger do not hesitate to call the Intake & Assessment/Child Protection Unit and a decision can then be made in consultation as to whether it is necessary to call the police.

The procedure in 6, titled 'A general approach for child abuse', states:

- In all cases where child abuse is suspected or identified, make an initial brief assessment and discuss concerns with an immediate senior colleague.
- In all cases of suspected child abuse the Paediatric Registrar must be notified and this person must notify the paediatric consultant on call.
- Standard hospital procedures for medical examination will follow with compilation of history, physical examination, conduct of investigation if necessary, provision of appropriate health care and admission, if required.
- The paediatric team should in all such cases ensure contact is made (if it has not been already) with the 'on call' Intake & Assessment/Child Protection Unit duty officer.[260]

At our hearings, Dr Renshaw told us that contact with the paediatric registrar was not clinically required at the time.[261] He gave evidence that he did not consider it 'clinically appropriate' that Zoe be seen by a paediatric doctor because she had already been examined by the paediatric registrar on admission to the hospital and was already under the care of a paediatric doctor.[262] He said that no examination was undertaken in response to Zoe's allegations because the alleged abuse occurred 'in the context of a normal clinical examination' and 'a touch does not leave a mark'.[263] Elizabeth Stackhouse, former Chief Executive Officer, Launceston General Hospital, told us the requirement to contact the paediatric registrar was included in the Protocol 'because you're dealing with a child'.[264] She indicated it is important to have a doctor with familiarity in paediatrics assist children in cases of potential abuse.[265]

Finding—Dr Peter Renshaw failed to comply with Launceston General Hospital's protocol for reporting and management of cases of suspected child abuse

On 19 May 2001, Zoe's allegations were that Dr Tim had given her a hug, kissed her hand, said she was a pretty girl and that, if she were older, he would marry her.[266] We note that Dr Renshaw gave evidence that when he was notified of Zoe's initial allegations on 19 May 2001, he understood them to be 'a professional boundary violation which could be, but may not have been, child sexual abuse'.[267] On his own evidence, this was an allegation of potential child sexual abuse, which should have activated the Protocol and Guidelines in place at the time.

Dr Renshaw failed to comply with the Protocol and Guidelines in several respects. First, he did not contact the paediatric registrar about Zoe's allegations. This was a missed opportunity to receive assistance from specialist staff.

Second, Dr Renshaw failed to comply with the Protocol because, contrary to what its Guidelines required, he spoke to Zoe about her allegations in circumstances where he did not have the statutory responsibility or authority for investigating whether abuse had occurred. Dr Renshaw's file note indicates that he spoke with Zoe to 'assess her story'. Dr Renshaw later described this as a brief assessment.[268] In our view, however, Dr Renshaw's meeting with Zoe constituted an 'in depth' interview under the Protocol because it extended beyond merely accurately recording 'information volunteered by the child' and involved Dr Renshaw assessing Zoe's 'affect'. The Protocol specifically recommended against undertaking an 'in depth' interview. By this stage, the Duncans had told Dr Renshaw that Zoe had raised further allegations about Dr Tim touching her.

Although our view is that Dr Renshaw's interview with Zoe should not have taken place at all, we also highlight that Dr Renshaw did not have any training in child abuse or experience in interviewing children.

Third, Dr Renshaw failed to consult a senior colleague and consider making a report to Child Safety Services. The Protocol says: 'Decisions about whether to refer, and where, must not be made in isolation. Discuss concerns you may have with an immediate senior colleague and follow the procedure … below'. Having such a discussion may have resulted in a mandatory report being made to Child Safety Services earlier.

We consider that Dr Renshaw's failure to comply with the Protocol—by failing to immediately alert the paediatric registrar of Zoe's allegations, his failure to discuss reporting to Child Safety Services with a senior colleague, and his subsequent interview of Zoe—may have contributed to delaying Zoe's disclosure of more serious allegations against Dr Tim, including that he had raped her. Furthermore, the failure to comply with the Protocol meant that a forensic examination was never entertained as an option. Dr Renshaw told us that he considered 'a forensic examination or detailed interview was simply not required'.[269] This was a missed opportunity to collect forensic evidence that may have been relevant to Zoe's allegations.

Finding—Dr Peter Renshaw failed to comply with his mandatory reporting obligations in a timely manner, which impacted on the ability to gather evidence and future investigations

Ten days passed between Zoe's initial disclosures on 19 May 2001 and Dr Renshaw's verbal report to Child Safety Services on 29 May 2001. During this time, Dr Renshaw received more information about Zoe's disclosures. On 21 May 2001, Zoe told Dr Renshaw that Dr Tim had touched her on the breast, inserted a finger in her mouth, made comments about her appearance and expressed a desire to marry her. Taken together, this was an allegation of child sexual abuse.

At the time of Zoe's allegations, Dr Renshaw had mandatory reporting obligations (as a medical practitioner) under the *Children, Young Persons and Their Families Act 1997*. Specifically, under section 14 of the Act, he was required to report to Child Safety Services as soon as practicable if he knew or believed or suspected on reasonable grounds that a child had been abused.[270] We are of the view that in the circumstances we have outlined, any professional would, on reasonable grounds, form a suspicion that child sexual abuse had occurred and make a mandatory report as required under the Act.

Dr Renshaw could have reported the matter to Tasmania Police and Child Safety Services when he first became aware of it on 19 May 2001, but he should have reported it to these authorities after the Duncans raised the concern about Dr Tim touching Zoe on 21 May 2001. Compounding this, Dr Renshaw did not report the matter after speaking to Zoe in the afternoon of 21 May 2001 when she told him directly that Dr Tim had touched her on the breast, inserted a finger in her mouth, had made comments about her appearance and expressed a desire to marry her.

Dr Renshaw conceded that on 21 May 2001 he should have made a report to Child Safety Services.[271]

Dr Renshaw was also contacted individually, after the initial allegations, by three separate parties (Zoe's general practitioner, Mrs Duncan and Laurel House) before he made a report to Child Safety Services. It is significant that two professional parties and Mrs Duncan were expressing serious concerns about Zoe and her contact with Dr Tim.

Dr Renshaw's inaction had an adverse impact on later investigations. As discussed later in this case study, subsequent investigation reports from Child Safety Services and the Medical Council of Tasmania refer to Dr Renshaw's delay in reporting. They suggest that a more timely report and advice from Child Safety Services may have resulted in a clearer picture of what occurred while also preventing the potential contamination of Zoe's story and reducing the emotional trauma for Zoe.[272]

Finding—Launceston General Hospital failed to consider and take active steps to stand down Dr Tim while Zoe Duncan's allegations were investigated

At no time after Zoe's allegations were made or while subsequent investigations by Child Safety Services or Tasmania Police were underway was Dr Tim stood down from his employment at Launceston General Hospital.

Dr Renshaw gave evidence that he took no steps to limit Dr Tim's access to children. He stated that he believed this step would have been 'premature' and 'an overreaction'.[273] Dr Renshaw also said that standing down a doctor would be

'very hard to do' in a general hospital emergency department, and that he did not know whether he would have had the power to stand Dr Tim down at the time.[274] He conceded that if a similar complaint was made today, this would be a step he would take.[275] As indicated, during examination by Counsel Assisting our Inquiry, Dr Renshaw ultimately conceded that his failure to consider whether to stand down Dr Tim was an error of judgment, which arose because he was in a role where he was inexperienced.[276]

Ms Stackhouse told us that she was not aware of any steps taken against Dr Tim while Zoe's allegations were being investigated.[277] She said that 'upon reflection' Dr Tim should have been 'stood aside while the allegation was investigated by an independent party, not a member of [Launceston General Hospital] staff'.[278]

The failure of Launceston General Hospital to take steps to stand down Dr Tim while the matter was investigated meant that Dr Tim continued to work in the emergency department with no restriction on his ability to treat children. Launceston General Hospital failed to consider this risk and then failed to take steps to mitigate the risk. We received no evidence to suggest that consideration was given to this course of action. The failure to consider and take steps to stand down Dr Tim while Zoe's allegations were investigated also represents a poorer pattern of practice than occurred when immediate steps were taken several years earlier to remove a health professional after an allegation of child sexual abuse was made against them.

As noted, at our hearings Dr Renshaw also told us that at the time of Zoe's allegations he had assumed there was a chaperone policy in place at Launceston General Hospital. However, when he went looking for one to explain it to Dr Tim, he discovered the hospital only had an informal policy in place.[279] As a result, he wrote a new chaperone policy.[280]

This evidence is consistent with evidence given by Ms Stackhouse, who told us that while it was accepted professional practice at the time that patients be offered a chaperone during clinical examinations, the hospital's chaperone policy 'was largely implied' and only appeared in some of the hospital's guidelines for surgical medical staff.[281] Ms Stackhouse said that because of investigations into Zoe's allegations, the hospital drafted a chaperone policy, along with a revised protocol for reporting and managing suspected cases of child abuse and neglect. Ms Stackhouse said that the hospital adopted these documents in 2002.[282]

The relevant draft chaperone policy (drafted by Dr Renshaw) stated:

> It is hospital policy that clinical examinations of children shall not occur, except in circumstances of extreme urgency, without the presence of a chaperone. This will generally be a member of the child's family or a health professional.[283]

The Launceston General Hospital Executive approved and implemented the policy in June 2002.[284]

Finding—Launceston General Hospital should have formalised, implemented and enforced a chaperone policy as soon as practicable after Zoe Duncan's May 2001 disclosure and not waited until June 2002

Launceston General Hospital's failure to formalise, implement and enforce a chaperone policy at the time of Zoe's disclosure affected Zoe's safety and the safety of other patients in the hospital's care. It also meant there was no formal policy against which Dr Tim could have been sanctioned had this been pursued.

The hospital should have formalised, implemented and enforced a chaperone policy as soon as practicable after Zoe's May 2001 disclosures and not waited until June 2002 to do so.

4.2 Zoe's continuing distress

In mid-2001, Zoe, aged 11, wrote:

> I'm also having problems with a man that I was uncomfortable with. He was telling me he loved me and wanted to marry. He kissed my hand, smothered me and felt me all around the top half. He whispered to me, stuck his fingers in my mouth and felt my tongue, tugged my ears and kept squeezing my hand. And he kept saying sick things. There's more but it's just horrible![285]

Zoe would go on to make further incremental and more serious allegations about Dr Tim, which we describe later in this case study.

4.3 Child Safety Services investigation

On 13 June 2001, Child Safety Services wrote to Mrs Duncan and to Dr Renshaw, advising that Zoe's matter would be investigated.[286] It was stated in that letter that the investigator 'will be following the policy re allegations against an employee of the agency' and that 'this policy is in draft but in use'.[287]

At the time, the relevant policy was the Department of Community and Health Services' *Procedure to be Followed where there is an Allegation of Maltreatment of a Client (who is a Child) by an Employee of the Agency* (June 1997). The procedure stated that any incident of maltreatment, including sexual maltreatment, by a staff member in the performance of their duties was to be investigated and actioned under the *Tasmanian State Service Act 1984*.[288] The procedure also stated that an initial inquiry was to be undertaken by an agency nominee with the assistance of a child protection officer.[289]

According to the procedure:

> 3.4.1 The purpose of this initial inquiry is to determine whether there is 'reason to believe' that maltreatment may have taken place, and that proper arrangements are made for the care and protection of the child.

> This investigation should not be lengthy nor should it involve the gathering of evidence needed to satisfy either a police inquiry or a State Service inquiry. It should provide enough information only to ensure that the agency nominee can write a report for the Secretary.
>
> This inquiry will normally include:
>
> 1. An interview with the child
> 2. An interview with the employee against whom the allegation has been made
> 3. Consideration of the manager's report
> 4. Any other investigation that the Agency nominee or the Intake and Assessment Officer/Child Protection Officer believe to be necessary in order to make an assessment of the allegation.[290]

The procedure further provided that 'on receipt of the report from the Agency nominee and the Child Protection Unit, the Director, Child Youth and Family Support is to determine future action'.[291] Recommended actions were outlined in relation to the following circumstances:

- where there is no case to answer
- where a criminal offence may have been committed
- where action under provisions of the Tasmanian State Service Act is required
- where no action is to be taken under the Criminal Code or the State Service Act
- where the case cannot proceed to any action beyond interviewing the client.[292]

On 20 June 2001, Dr Renshaw made an addition to the Zoe Duncan file note stating that an investigator from Child Safety Services had contacted him about the Zoe Duncan case. Dr Renshaw recorded that the investigator told him Zoe had made 'fresh allegations' the week before that may require police investigation.[293] It is not clear to us what allegations are being referred to here.

According to Dr Renshaw's file note, the investigator asked Dr Renshaw whether he was aware of the policy on investigations involving departmental employees, to which he replied that he was not.[294] The investigator then faxed a draft copy of the policy dated 1997 (noting it was now June 2001), before supplying a final version and asking the hospital to nominate a person to assist Child Safety Services with its investigation.[295]

Dr Renshaw recorded in the Zoe Duncan file note that, after liaising with Ms Stackhouse, he notified Child Safety Services of the hospital's nominee, who was a different employee of the hospital.[296]

In a request for statement, Michael Pervan, former Secretary, Department of Communities, was asked why Child Safety Services was tasked with the initial investigation and

assessment of Zoe's allegations instead of Tasmania Police.[297] Secretary Pervan responded that according to the Child Safety Services investigation report (discussed below), protocols at the time (and prior to his tenure) 'did not provide instruction for referring matters of a possible criminal nature to Police prior to the Department establishing the facts of a case and interviewing the involved parties'.[298]

At our hearings, representatives from Tasmania Police and Child Safety Services agreed that Zoe's allegations should have been investigated by Tasmania Police. Darren Hine AO APM, former Commissioner, Tasmania Police, told us that Zoe's allegations should have been referred to Tasmania Police, which has primary authority over investigations of this nature.[299] Ms Lovell also told us that where allegations are made, Tasmania Police should be notified straight away to determine who has responsibility for particular aspects of the investigation and the sequence in which aspects of an investigation are to be carried out.[300]

Ms Lovell described Child Safety Services' procedure for investigating the allegations against Dr Tim in 2001 as 'unusual', noting she had not seen a procedure (since beginning work with child safety in 2004) that required Child Safety Services to complete an investigation and be satisfied that there is sufficient evidence before referring a matter to Tasmania Police.[301] Ms Lovell said that she was 'really struggling to imagine a scenario where a child safety officer is leading an investigation like this rather than police'.[302] She described the investigation, including the interviewing of witnesses (discussed below), as forming part of the role of police and as being 'far out of scope for the role of a child safety officer'.[303] She was also of the view that the Child Safety Services procedure did not enhance child safety and would instead delay a police investigation and require victim-survivors to unnecessarily repeat their story to police.[304]

Finding—The procedure used by Child Safety Services to investigate Zoe Duncan's allegations against Dr Tim was inappropriate and not consistent with best practice at the time

We agree with the comments made by former Commissioner Hine and Ms Lovell that it is not an appropriate role of a government department or agency to determine the facts or interview parties involved with allegations of a potential criminal nature before referring the matter to police. Tasmania Police was the agency responsible for investigating criminal allegations of child sexual abuse in 2001 as it is in 2023. The matter should have been referred to and investigated by Tasmania Police in the first instance. We consider that the policy was inappropriate and not consistent with best practice at the time.

The Child Safety Services investigation ran from June 2001 to September 2001. While the investigation was underway, Zoe made further incremental allegations over time, as is common with victims of child sexual abuse.[305] On 25 June 2001, Zoe told Mrs Duncan that Dr Tim had 'put his hands inside her pants around her thighs' and put his finger 'inside her front bottom'.[306] On 27 June 2001, Zoe disclosed that Dr Tim had raped her. Mr Duncan recalled that Zoe asked Mrs Duncan whether she would be pregnant, and when Mrs Duncan asked Zoe why she had asked this question she said 'he put his thing in there'.[307]

The Duncans said that because of this allegation, they took Zoe to her general practitioner for a medical examination on 28 June 2001.[308] They said the general practitioner spoke with Zoe on her own before undertaking the examination.[309] We do not know whether Zoe's general practitioner had any specific training in interviewing children or in completing forensic medical examinations. The Duncans recalled that the general practitioner reported that the 'examination was inconclusive, but there was no evidence of trauma'.[310] They also considered that it was significant that the examination was conducted five weeks after Zoe's initial allegations.[311]

On 11 July 2001, Zoe's psychologist wrote a report for Child Safety Services outlining the allegations and the psychologist's observations.[312] On 22 July 2001, Zoe's general practitioner also wrote a letter to Child Safety Services advising of the outcome of the medical examination.[313]

The investigator from Child Safety Services contacted Zoe's general practitioner, who confirmed that the examination was inconclusive.[314] Zoe's general practitioner indicated that Zoe had said Dr Tim had kissed her, cuddled her and touched her chest, but had not indicated anything else had occurred when asked.[315] The general practitioner also told the investigator that they had informed the Duncans that they considered Zoe's latest allegation, namely that Dr Tim had raped her, to be implausible, because her account had become more serious as time went on and because she claimed the rape had occurred in the emergency department.[316] The investigator relied on the general practitioner's statement in compiling their report.

As part of the investigation, Child Safety Services interviewed the Duncans, Zoe and Dr Tim.[317] The investigation report records that the Duncans were interviewed on 18 and 20 June 2001.[318] They relayed what had occurred and discussed Zoe's health issues and school history with the investigator.

Zoe was interviewed on 19 July 2001. The investigator described her as 'relaxed', 'friendly' and 'quite clear' about why she was being interviewed.[319] Zoe provided an account of her recollection and the investigator explained that they would also need to speak to Dr Tim about what happened.[320]

Dr Tim was interviewed on 24 August 2001. The investigator described Dr Tim as 'quite anxious' and 'extremely defensive and distressed'.[321] Dr Tim declined an interpreter and declined to hear the details of Zoe's additional allegations. Dr Tim suggested to the investigator that the complaint had been made because he was a foreign doctor.[322] Dr Tim denied to the investigator that he had acted inappropriately and indicated that he could not imagine someone acting inappropriately with a child in an emergency department with staff everywhere and only curtain partitions.[323] Dr Tim's support person ultimately terminated the interview, with the investigator observing that Dr Tim 'was reluctant to cooperate in the interview' and that it was 'extremely difficult to get answers to questions'.[324]

Child Safety Services finalised the report of its investigation on 12 September 2001, around four months after Zoe's initial allegations. The report states that 'Zoe's allegations become more serious with time' and that, because Zoe had spoken to several people about her allegations before being interviewed, it was 'likely' her story had been contaminated.[325] The report further states that such contamination 'may have been avoided if the hospital had contacted Child Safety Services to discuss the best way to approach the situation, prior to acting on the information'.[326] The report also states that 'there are numerous reasons why a child may take time to talk about specifics of abuse', including experiencing overwhelming emotions that inhibit their ability to talk about an incident.[327]

Similar to the view of Zoe's general practitioner, the report assessed that Zoe's description of the alleged sexual abuse was 'difficult to accept'.[328] Notwithstanding the investigator's observations about Dr Tim at his interview, the report appears to accept the explanation given by him, and expresses doubt that 'anybody would take this kind of risk in a busy emergency department while they had their back to the entrance of the examination cubicle room, which is only screened by a material curtain'.[329] The report states that Zoe's cubicle was adjacent to the central station, where staff would write their notes, confer and make telephone calls, and that this area was 'unlikely' to have been unoccupied at the time.[330] This finding is in contrast to evidence given by Mr Duncan, who recalled in his statement to us that:

> After Zoe made her disclosure to me, I went outside the cubicle to see if I could talk to someone. There was no one at the nurses' station and I couldn't see any doctors or nurses around in the ward. I called Anne [Mrs Duncan] and told her what had happened, and she told me that I needed to report it. I recall telling Anne I had tried to report it, but I couldn't find anyone to report to. Later [we] were to discover this was a tea break period.[331]

Mr Duncan further stated:

> … I distinctly recall it wasn't a busy [emergency department] on that Saturday night. The only patients on the ward were Zoe, a man two cubicles to the left who appeared to me to be severely drug affected, and an elderly lady on the opposite

> side of the ward who was far from alert … I would describe the department as 'dead quiet'. When I went out to speak to someone following Zoe's disclosure, there was no one around. No nurses or doctors.[332]

The Child Safety Services investigation report concludes that it is not possible to determine what happened to Zoe but notes that '[s]omething certainly appears to have upset her'.[333]

The report recommended that the Department's protocol for investigating matters involving agency staff be reviewed because it 'does not provide instruction for referring matters of a possible criminal nature to police prior to the Department establishing the facts of a case and interviewing the involved parties'.[334] It also states that the matter highlights the importance of chaperone policies.[335]

The Child Safety Services investigator:

- received Dr Renshaw's account of events from the intake officer along with initial reports and file notes
- interviewed the Duncans, Zoe and Dr Tim
- spoke with and received a report from Zoe's general practitioner about the outcome of the medical examination
- received a medical report from Zoe's psychologist.[336]

It is apparent from the investigation report that the investigator did not speak with Dr Renshaw or any staff who were on duty the night of the incident, including the nurse on duty who received Zoe's allegations, the after-hours nurse coordinator and the registrar. Ms Lovell agreed that the fact neither Dr Renshaw nor any of the staff working on the night of the incident were interviewed suggested that the investigation process was not rigorous.[337]

The investigator appears to accept the views and accounts of adults, including Dr Renshaw, Zoe's general practitioner and Dr Tim, over Zoe's version of events.

Ms Lovell expressed concern that the Child Safety Services investigation report accepted Dr Tim's denial of Zoe's allegations over Zoe's clear and consistent allegations, especially in circumstances where Dr Tim declined to hear the allegations:

> It seems that she was making a consistent and clear disclosure that she had been sexually abused, and there doesn't seem to be reason to discredit that or disbelieve her, it's not that she's saying something that's untrue, so why would anyone preference the account of an adult, who's alleged to be responsible for abuse, who has every reason to not be honest about that abuse and in fact is unwilling to hear even the details of what's been alleged; it seems very unusual to me.[338]

The Child Safety Services investigation report accepts that the emergency department was busy at the time of the incident and that Zoe was not left alone with Dr Tim for

any significant period. As noted, Mr Duncan strongly disputes this, describing the emergency department as 'dead quiet' on the night of the incident. He is recorded in the report as having observed Dr Tim alone with Zoe on two separate occasions.[339]

The Duncans believe that Child Safety Services was selective in its use of information in the report and made value judgments about what was likely to have occurred.[340]

When asked to comment on the conclusion reached by Child Safety Services that it was unlikely Zoe's allegations could have occurred on a busy ward, former Commissioner Hine responded that 'you can never assume anything because, if you make an assumption, you may bring a biased mind to the investigation, so assumptions shouldn't be made'.[341]

Additionally, in this report and those of subsequent investigations (discussed later in this case study), the investigator referred to Zoe's evidence as being contaminated because she had to retell her account multiple times. In his statement to our Commission of Inquiry, Michael Salter, Scientia Associate Professor of Criminology, School of Social Sciences, University of New South Wales, opined that this view about contamination demonstrates a bias against children's testimony that is often not warranted.[342] We agree with Mr Salter, but also note that Zoe was remarkably consistent in her account—while she progressively disclosed more detail, she never swayed from her account that something bad happened to her that night and nor did she contradict herself.

Ms Lovell said the following with respect to her assessment of Zoe's matter based on the available material:

> On the balance of probabilities I would say that [Zoe] was sexually abused; she's repeatedly made a clear disclosure, there's nothing to say that that hasn't happened. It doesn't mean there's enough proof for charges or convictions, but certainly for child safety and our substantiation there's certainly enough there by today's standard to substantiate …[343]

Ms Lovell told us that the Child Safety Services investigation resulted in a poor outcome for Zoe and her family because it was apparent that Zoe had been sexually abused. She apologised for this outcome.[344]

Finding—Child Safety Services carried out an inadequate investigation of Zoe Duncan's allegations, which affected subsequent investigations

It is clear to us that the Child Safety Services investigation lacked rigour and was inadequate. The investigator failed to seek the evidence of key staff including Dr Renshaw and other staff who were on duty the night of the incident, such as the

nurse who received Zoe's allegations, the after-hours nurse coordinator and the registrar. We further consider that the investigator's report did not demonstrate an understanding of how children and young people disclose allegations of sexual abuse.

Regrettably, subsequent investigations, including by Tasmania Police in 2001 and the Medical Council of Tasmania in 2003, relied on the Child Safety Services investigation report. As discussed later in this case study, the limitations of the report have adversely affected subsequent investigations.

Secretary Pervan told us that if Zoe's allegations were made today, they would be referred to Tasmania Police and joint agency meetings to determine the response, including an approach that would minimise the need for Zoe to repeat her account multiple times.[345]

Secretary Pervan indicated that the approach to interviewing the alleged abuser would be planned in line with the memorandum of understanding that now exists between Tasmania Police and Child Safety Services.[346] Secretary Pervan also informed us that, today, Child Safety Services would not lead an investigation of a departmental staff member; rather, the matter would be referred to Tasmania Police and the Registrar of the Registration to Work with Vulnerable People Scheme.[347]

Ms Lovell also indicated that it would be her expectation that Dr Tim would be interviewed in a timely manner by Tasmania Police and not Child Safety Services.[348]

At our hearings, Dr Renshaw, unprompted by specific questioning, stated that he did not believe that Dr Tim had raped Zoe, saying: 'Because I know the layout, the set out of our emergency department, it is highly unlikely that [a rape] actually occurred'.[349]

It is unfortunate that Dr Renshaw made this observation. He ultimately accepted that he was not in a position to make an assessment of whether or not a rape had occurred.[350] In a subsequent appearance at our hearings, Dr Renshaw apologised for his comment: 'I know the suggestion caused additional grief to the Duncan family, and for that I … sincerely apologise to the family and to the Commission'.[351]

4.4 Tasmania Police investigation

Mr Duncan recalled to us that on 1 October 2001, after Child Safety Services had completed its investigation, Mrs Duncan reported Zoe's allegation of rape to Tasmania Police.[352] Mr Duncan said that the police asked Mrs Duncan why it took so long for her to make a report. Mrs Duncan told the police it was her belief that the matter would be reported by either Launceston General Hospital or Child Safety Services.[353]

Child Safety Services did eventually make an official notification to Tasmania Police on 8 October 2001. However, by this point, police were already investigating Zoe's

allegations.[354] Former Commissioner Hine told us that the five-month delay in Child Safety Services reporting Zoe's allegations to Tasmania Police was 'not best practice' and 'unacceptable'.[355]

As part of its investigation, Tasmania Police accessed the material provided to Child Safety Services, along with the investigation report.[356] They also interviewed the investigator at Child Safety Services, as well as Zoe and Dr Tim.[357]

The Tasmania Police report records that, at an interview on 2 October 2001, the Child Safety Services investigator said:

> The matter had not been referred to police as protocols at [Child Safety Services] stipulate that where an allegation involves employees of the Department of Health and Human Services, then the Secretary of the Department must notify Police.[358]

Tasmania Police interviewed Zoe on 3 October 2001. In the report, the investigating officer described Zoe as 'extremely confident'.[359] The officer also observed that Zoe had been asked many of the questions before and that her answers did not require a lot of thought.[360] Dr Tim was interviewed on 11 October 2001 and 'emphatically' denied all allegations.[361]

Tasmania Police finalised the report of its investigation on 12 October 2001, around five months after Zoe's initial allegations. The report states that there were no witnesses, forensic evidence or medical evidence to support Zoe's allegations.[362] The report concludes that 'the allegation of rape is unfounded' and that 'there may have been an initial incident that Zoe may have been distressed by, however the fact that she has added to her story on many occasions does not hold her version as credible'.[363]

Counsel Assisting asked former Commissioner Hine at our hearings whether the Tasmania Police investigation report demonstrated a misunderstanding of how children make allegations of sexual abuse, insofar as police interpreted Zoe's incremental allegations as her changing her account of what happened. Commissioner Hine responded that it is now known that a victim's account can evolve over time and that this does not mean they did not experience trauma.[364]

As occurred in the Child Safety Services investigation, Tasmania Police did not contact or interview any of the staff on shift the night of Zoe's allegations, including the nurse who received Zoe's allegations, the after-hours nurse coordinator or the registrar. Tasmania Police did not speak with Dr Renshaw either.

Commissioner Hine retracted his view expressed in an earlier statement to our Commission of Inquiry that the Tasmania Police investigation was 'comprehensive', acknowledging that the police investigation had deficiencies.[365] Commissioner Hine accepted that any investigation should include following up with corroborating witnesses and reviewing evidence that might verify the circumstances being described by a victim, including early observations of how the victim presented in the aftermath of an alleged offence.[366] He agreed that the registrar at the hospital, in particular, should have been contacted by police as part of its investigation.[367]

Finding—Tasmania Police carried out an inadequate investigation of Zoe Duncan's allegations

In conducting their investigation, it appears that Tasmania Police relied on the Child Safety Services investigation report, which we have earlier described as inadequate.

Relevantly, Tasmania Police imported whole paragraphs from the Child Safety Services' report into its own report. These paragraphs reflected the Zoe Duncan file note, the view of Child Safety Services that Zoe's description of the way she was alleged to have been sexually abused was 'difficult to accept', and that the central nursing station was unlikely to have been unoccupied at the time that the alleged rape occurred.[368]

We consider that the Tasmania Police investigation was inadequate.

Former Commissioner Hine told us that Tasmania Police would today take a completely different approach to matters of this nature. He told us that an investigation would now involve an experienced detective assessing the matter, intermediary support being provided to a child while their account of events was collected, and the provision of support to the child and their family throughout the process.[369]

5 Subsequent actions, complaints and investigations

5.1 Attempts to obtain the Child Safety Services investigation report and hospital policies

Mr Duncan recalled that after police read out parts of the Tasmania Police investigation report, they attempted to get a copy of the Child Safety Services investigation report. It was clear to them that the former report had influenced the police investigation, and they wanted to ensure the Child Safety Services report was accurate.[370]

On 14 November 2001, the Duncans met with senior executives at Launceston General Hospital and representatives from the Department to raise concerns about the response to Zoe's allegations.[371] At the meeting, they requested a copy of the Child Safety Services' report but were told they would need to make a Freedom of Information Act application, which they did on 15 November 2001.[372] In their application, they also requested a copy of Launceston General Hospital's policy on the reporting of child abuse and neglect and the investigation protocol applicable to the Child Safety Services investigation.[373]

When the Duncans did not receive a response to their application, they wrote to the Commissioner for Children on 11 December 2001.[374] The Commissioner for Children replied that the Solicitor-General's Office had advised the report was either exempt from the Freedom of Information Act or was given in confidence and therefore could not be released.[375] Over the following months, the Commissioner for Children made several enquiries about the practices and policies in place at the hospital at the time of Zoe's allegation, including in relation to whether there was a chaperone policy, a protocol for reporting suspected abuse and neglect, and procedures applicable to investigating departmental staff.[376] The Duncans also recalled writing to the Ombudsman on 19 December 2001 to appeal the decision not to release the Child Safety Services investigation report.[377] On 21 December 2001, they received 27 of the 43 pages of the investigation report (with six of these pages containing redactions), as well as a copy of Launceston General Hospital's policy on reporting child abuse and neglect.[378] It was now the end of 2001 and Dr Tim had left Tasmania.[379]

On 2 May 2002, sexual assault service Laurel House, wrote to Ms Stackhouse on the Duncans' behalf. Laurel House told Ms Stackhouse that the Duncans were dissatisfied with the hospital's response and that they did not believe the hospital was acting in Zoe's best interests.[380] Laurel House requested that appropriate processes be put in place to keep children safe at the hospital, and that any future allegations of sexual abuse be properly investigated.[381] Ms Stackhouse responded to Laurel House's letter on 8 May 2002. She enclosed a draft chaperone policy with the letter, for comment, along with the protocol for reporting suspected abuse or neglect.[382] As noted, the Launceston General Hospital executive approved and implemented the chaperone policy in June 2002.[383]

5.2 Medical Council of Tasmania investigation

On 28 August 2002, the Duncans lodged a complaint with the Medical Council of Tasmania ('Council').[384] In carrying out its investigation, the Council sought information from Dr Renshaw and Tasmania Police.[385] Two case managers interviewed the Duncans and, unlike the earlier investigations by Child Safety Services and Tasmania Police, these case managers also interviewed the after-hours nurse coordinator (in person) and the registrar (by phone) who were on shift the night Zoe made her initial allegations.[386] Zoe was not interviewed because the case managers did not believe anything would be gained from this, considering it would 'likely … cause undue stress to Zoe'.[387] The Council also sought and received a written response to the complaint from Dr Tim.[388]

The Council finalised its investigation on 19 March 2003. Its investigation report states that the complaint 'has been extensively investigated'.[389] The report further notes that the Tasmania Police investigation report concluded that the allegation of rape was unfounded, that Zoe's general practitioner had been interviewed and examined Zoe and found the allegation to be 'implausible' with no remarkable examination findings, and that Child Safety Services were of the view that Zoe's description of events 'is difficult to accept'.[390]

The Council's investigation report concluded that it is 'highly unlikely' a rape could have occurred without anyone noticing but that 'something that occurred then or at some other time has distressed Zoe'.[391] There was no further comment in the report on Zoe's other allegations, which included that Dr Tim had touched her on the breast, digitally penetrated her mouth, commented on her physical appearance and expressed a desire to marry her.

The report noted that Dr Renshaw should have reported the matter on 21 May 2001 rather than 29 May, as 'an early investigation by appropriate investigators may have resulted in a clearer picture of events and less emotional trauma for Zoe'.[392] The Council wrote to the Duncans on 22 May 2003 advising them that the complaint was determined to be 'unsubstantial in that the complaint could not be proven'.[393]

It is apparent that the findings and observations in the earlier investigation reports by Child Safety Services and Tasmania Police, both of which we have found to be lacking in rigour, heavily influenced the Council's investigation.

These findings were available to and considered by Ahpra in 2021 when it undertook an investigation in response to notifications it received about Zoe's allegations against Dr Tim.

In a statement to us, Matthew Hardy, National Director of Notifications, Ahpra, said that 'Ahpra does not have access to enough information to form a view about the management of the notification by the former Medical Council of Tasmania'.[394] Mr Hardy also stated to us that it appeared that 'subsequent decision-making by the Council was influenced by the investigatory activity already undertaken by [Child Safety Services] and Tasmania Police'.[395]

Mr Hardy said if allegations like those made by Zoe Duncan arose today:

> I would expect that it would lead to a mandatory notification to the National Board. Such a notification would be administered under the National Law which confers investigative and protective powers on the current Medical Board of Australia and other national Boards. These powers allow immediate action to be taken to suspend or restrict a practitioner's registration while an investigation is being undertaken. Advances in approaches to investigating allegations of sexual misconduct and advances in technology facilitating greater collaboration between investigating authorities also play a significant role in today's administration of notifications alleging that a registered health practitioner has engaged in serious and potentially criminal conduct.[396]

We note that Dr Tim was investigated for similar conduct in another jurisdiction in relation to another patient, which resulted in Dr Tim's practice registration being cancelled (although he was permitted to re-apply in due course).

6 Zoe's death

The Duncans recalled that Zoe's final visit to Launceston General Hospital was in April 2015.[397] After this admission, Zoe decided not to return to the hospital.[398] The Duncans said they tried to get Zoe to go back because of her escalating health issues. However, the Duncans said that for several reasons, including the hospital's management of Zoe's allegations in 2001 and Zoe's ongoing distrust of the medical care provided by the hospital, she refused to attend the hospital again. The Duncans recalled that she said to them: 'No one believes me, no one, I can't trust what goes on here, I can't go back'.[399]

The Duncans told us that they knew when Zoe made the decision not to go back to the hospital that they would 'lose her' because her ongoing medical conditions required attention.[400] Because Launceston General Hospital was the only hospital nearby, there was nowhere else for Zoe to go if she became unwell.[401] Zoe died alone at her home in November 2017 from her health issues.[402] We make no finding in relation to the cause of Zoe's death.

Reflecting on their experience, the Duncans told us they 'cannot fathom why the key players involved throughout Zoe's ordeal were unable or unwilling to provide her with the support, understanding and ultimately the justice she deserved'.[403]

Finding—Launceston General Hospital failed in its overall response and did not offer appropriate support to Zoe Duncan and her family

Despite many communications occurring across institutions about Zoe's allegations, at no time did Launceston General Hospital offer Zoe or her family any support. The Duncans recalled that when they did ask to access psychological support for Zoe they were told to make a request in writing to the chief executive officer of the hospital with the assistance of a lawyer.[404] The Duncans ended up arranging their own support for Zoe and, for a period of time, made regular trips to Hobart until Zoe decided to stop these visits.[405]

Ms Stackhouse conceded at our hearings that Launceston General Hospital's response to Zoe's allegations was 'inadequate'. She said the response 'did not prospectively protect other children from harm'.[406] She also said the matter was resolved 'in a manner that would not be considered appropriate today'.[407] Ms Stackhouse apologised to Zoe's family and acknowledged that the hospital had 'collectively let [Zoe's] family down'.[408]

The Department acknowledged the impact on the Duncan family. Kathrine Morgan-Wicks PSM, Secretary of the Department stated:

> To the memory of Zoe Duncan, to Mr and Mrs Duncan, and also to Amanda Duncan, you have waited a long time for Health to believe, and let me say that as the leader of Health, I believe. I am very sorry for what you have gone through for so many years to re-tell Zoe's story. I offer my deepest apology to you for our failure to hear what Zoe tried to tell us and which she ultimately revealed through incremental disclosure to her trusted parents and family.

7 Observations

Zoe's allegations have never been adequately investigated by Launceston General Hospital, Child Safety Services, Tasmania Police or relevant professional regulatory bodies. This failing may have exposed other children and young people to child sexual abuse.

This case study highlights key systemic issues relevant to responding to allegations and incidents of child sexual abuse within a health institution. We consider the lessons of this case study include:

- the need to have appropriate policies and procedures in place to protect children from abuse and to immediately respond to allegations and incidents of child sexual abuse
- the need to provide support to patients who make allegations of sexual abuse and their families
- the need for policies to ensure staff do not assume that their expertise enables them to make judgments about the veracity of abuse allegations by a patient, and that individual staff members at a hospital do not adopt the role of decision-maker and/or factfinder where a patient makes an allegation of sexual abuse
- the need for timely reporting and notification of allegations and incidents to appropriate external agencies
- the need for awareness-raising to break the myth that abusers do not perpetrate sexual abuse in locations where there is a 'high risk' of detection within health settings and elsewhere
- the need to apply independent and rigorous investigatory and disciplinary processes to complaints in health settings, and for these processes to use trauma-informed practices to minimise trauma for complainants.

The systemic deficiencies of Launceston General Hospital revealed by this case study, and ways to address them, are explored in more detail in Chapter 15.

By the time our report is published, 22 years will have passed since Zoe and her parents made a complaint to Launceston General Hospital, and some five and a half years will have passed since Zoe died.

Zoe, her parents, her sister and the broader community were entitled to a thorough and transparent investigation into the matters Zoe disclosed in May 2001. The deficiencies in the various investigations continued over many years. Our Commission of Inquiry has endeavoured to cast light on those events and on the subsequent inadequate investigations.

We acknowledge the pain and trauma these systemic failures visited upon Zoe, her parents and her sister. We acknowledge their love of Zoe, together with their dignity and determination in bringing these circumstances to the public's attention.

It is our hope that the systemic issues highlighted in this case study further increase awareness about the safety and wellbeing of children and young people across all health settings and inform action that is taken to safeguard children.

Case study 3: James Griffin

1 Introduction

James Geoffrey Griffin, also known as Jim, died at Launceston General Hospital on 18 October 2019 after an attempted suicide.[409] He was 69 years of age.[410] At the time of his death, Mr Griffin was facing serious criminal charges related to child sexual offending.[411] The coroner reviewing the circumstances of Mr Griffin's death found that: 'No doubt the charges he was facing at the time motivated his action'.[412]

Mr Griffin left devastation in his wake. Victim-survivors will not see him face accountability for his actions. During our Commission of Inquiry, we heard directly from many victim-survivors who experienced Mr Griffin's abuse and we became aware of more. We know there are many others who live with the uncertainty of never knowing whether they, or a loved one, experienced abuse by Mr Griffin, particularly if this may have occurred under the guise of medical care. Also, and notwithstanding the broad reach of our Inquiry, there are likely to be other victim-survivors of whom we are unaware.

Some victim-survivors of Mr Griffin's abuse were not in any way connected to Launceston General Hospital but came to know him through social or family connections. What they have in common with patients and former patients of Launceston General Hospital is the experience of traumatic abuse by a person they most likely trusted. All the evidence we received about Mr Griffin has been important in helping us understand the type of person he was and the tactics he used to groom and silence his victims. This information has explained, to some degree, how Mr Griffin was able to offend against children for as long as he did.

Mr Griffin's work and personal lives beyond Launceston General Hospital, including the abuse he perpetrated in other settings, were not considered by our Inquiry. This case study documents only the evidence about Mr Griffin's conduct during his employment at Launceston General Hospital and the responses of the Department, the Tasmanian Health Service, Launceston General Hospital and other agencies—including Tasmania Police and Child Safety Services—to his conduct. We also briefly mention his secondment to Ashley Youth Detention Centre.

We recognise that our insight into who Mr Griffin was as a person is somewhat limited because it is gained through the lens of his job at Launceston General Hospital and only a few people who were associated with him in a personal capacity.

1.1 Structure of this case study

This case study is divided into six sections. This section—Section 1—introduces the case study, outlines information sources and provides background information. Section 2 outlines our approach to findings and lists these. Section 3 is an overview of how those providing evidence to our Inquiry described Mr Griffin. Common themes emerged from these independent descriptions, including Mr Griffin's ability to charm those he sought to win over and to deflect and downplay concerns that arose about his behaviour. It is clear to us that Mr Griffin took advantage of his occupation as a nurse—including by positioning himself as going 'above and beyond' his duty to care for his patients—to disarm patients, parents and hospital staff.

We heard accounts of how Mr Griffin groomed young female patients by showing them affection, referring to them by pet names, spending social time with them and winning the trust and confidence of their parents. We also heard about Mr Griffin's opportunistic offending against patients who were admitted to the hospital for a short stay.

In Section 4, we document how leadership at Launceston General Hospital responded to the concerns raised, and complaints made, against Mr Griffin from when he began working on the paediatric ward until the suspension of his registration to work with vulnerable people on 31 July 2019.

The hospital received several complaints about Mr Griffin's behaviour over this period, most of which concerned his repeated breaches of professional boundaries with patients. Nurse unit managers often managed these complaints, sometimes with input from human resources staff. Mr Griffin was repeatedly cautioned and directed to undertake education to change his behaviour, but these low-level sanctions did not deter him. The hospital, Tasmania Police and Child Safety Services missed many opportunities throughout this period to piece together information held by each about Mr Griffin's inappropriate conduct towards children.

In Section 5 of this case study, we document how the hospital responded to the July 2019 notification that Mr Griffin's registration to work with vulnerable people had been suspended, and subsequent events relevant to Mr Griffin up until October 2021, at which time our Commission of Inquiry was underway.

In Section 6, we make some concluding remarks.

We heard about the variety of reactions that revelations of Mr Griffin's offending evoked in his colleagues, some of whom had known him for a long time and questioned whether they could or should have done more to protect the children and young people in their care. Some staff members also described their distress and frustration at the hospital's response, which some felt was not transparent or well communicated.

Presenting the large amount of information relevant to Mr Griffin was a challenge.

We have used a chronological format in Sections 4 and 5 of this case study to collate this information. We have documented the evidence against a timeline of the complaints about, and responses to, Mr Griffin's conduct at the hospital. However, within this chronological format we have sometimes included information from different periods, where that information either relates to the same issue and 'closes the loop' on a matter or where we think the information will clarify the circumstances of the event described.

In Section 4.2, where we summarise undocumented or undated complaints against Mr Griffin, we have grouped the information by source, rather than presenting the information by date. Sections 4 and 5 of this case study have been informed by witness statements, submissions and sessions with a Commissioner, some of which were provided anonymously. For procedural fairness reasons, we have been careful to use anonymous statements only to inform an understanding of the general themes in relation to Mr Griffin's conduct and not to inform our findings about the conduct of individuals.

1.2 Information sources

The information summarised in this case study came from the written statements and oral evidence of victim-survivors, their families and supporters, hospital staff and union representatives, members of the community and experts. Oral evidence was given at public hearings in June, July and September 2022. We also gathered information through public consultations and in private sessions with a Commissioner. Some information was clarified or further explained through our procedural fairness processes.

We also considered statements and oral evidence from senior managers and executives at Launceston General Hospital and the Department.

During Mr Griffin's employment at Launceston General Hospital, various bodies were responsible for the hospital's governance.[413] From 2016, overall governance of Launceston General Hospital sat with the Hospitals North Executive Committee.[414] This committee comprised the following operational roles (noting since this time some role titles may have changed):

- Chief Executive Hospitals North/North West (chair)
- Director Hospital Corporate and Support Services
- Director Launceston General Hospital Operations
- Director of Improvement
- Executive Director of Medical Services
- Executive Director of Nursing
- Nursing Director Primary Health.[415]

The Executive Director of Medical Services was the medico-legal lead for the hospital and police liaison in the response to Mr Griffin's case following the suspension of his registration to work with vulnerable people in July 2019.[416]

Human resources staff and management also played a significant role in managing complaints about Mr Griffin while he was an employee.

At our hearings, Kathrine Morgan-Wicks PSM, Secretary, Department of Health, told us that the executive structure at Launceston General Hospital has been in place for 'an incredibly long time'.[417]

The nursing management structure for the paediatric ward, Ward 4K, where Mr Griffin worked, comprised (in order from most senior to most junior):

- Executive Director of Nursing
- Nursing Director of Women's and Children's Services
- Nurse Unit Manager.[418]

In addition to receiving statements and oral evidence from individuals, we considered many volumes of documents produced by the State and others upon our request.

We received copies of some of Mr Griffin's Performance and Development Agreements on 20 December 2022, after an unmarked personnel file was discovered on Ward 4K. The staff members who found the file signed statutory declarations outlining the circumstances of the discovery. The file was securely provided to the Office of the Secretary of the Department, which provided it to us.[419]

The stated purpose of a Performance and Development Agreement ('Agreement') is to act as 'an essential tool intended to promote effective work practices across the Agency by clearly establishing the performance expected of our employees'.[420] We reviewed Mr Griffin's signed Agreements, which were in the unmarked personnel file described above, dated 31 December 2008, 31 March 2011, 6 March 2013, 21 March 2014, 27 March 2015, 23 March 2016, 25 May 2018 and 22 May 2019. We reference these Agreements throughout this case study.

We note more broadly that:

- We did not receive Agreements prepared before 2008, or those that would have been signed in 2009, 2010, 2012 and 2017. It is unclear whether Agreements were prepared in these years.
- The years when Agreements appear not to have been prepared coincide with years in which a number of complaints were made about Mr Griffin. In circumstances where (as we discuss in this chapter) education and support were the primary strategies to change Mr Griffin's behaviour, we expect that an

Agreement would and should have documented this information. It is unfortunate we have not been able to review these or confirm if they were prepared.

- There is no mention of past complaints about Mr Griffin in any of his Agreements, nor is there reference to behaviours that management identified as problematic.

1.2.1 Tasmania Police reviews

In late 2020 following the release of *The Nurse* podcast (discussed in Section 1.2.3), Tasmania Police initiated several internal reviews to examine the police response to reports from the public and other agencies about Mr Griffin. We outline these reviews here, and we refer to their findings throughout this case study.

On 26 August 2019, a detective inspector prepared the report *Investigation into Allegations of Sexual Assault by James Geoffrey Griffin (14 August 1950)* for the Deputy Commissioner.[421]

On 26 October 2020, a report titled *Griffin, James (Jim) Geoffrey (14/08/1950) - Investigative Review* was prepared by the same detective inspector for the then Acting Commander of the Northern District of Tasmania Police.[422] The following day, the Acting Commander provided a summary and attached a copy of the report in correspondence to the Deputy Commissioner of Tasmania Police, Jonathan Higgins APM.[423] This report was prepared after the Department began an internal and external review. This report documented a review of intelligence holdings and investigative actions by Tasmania Police relating to Mr Griffin.[424]

In November 2020, another investigative review was conducted. This review involved a 'critical analysis of investigations conducted in relation to the various information received in relation to Mr Griffin from 2009 until his death in October 2019'.[425]

On 23 December 2020, a *Revised Interim Report into the Review of Police Investigations Relating to James Griffin* was prepared by another detective inspector for the Commander of Professional Standards of Tasmania Police.[426] In February 2021, a *Review of Matters Surrounding James Geoffrey Griffin* was prepared by a Commander for the then Acting Deputy Commissioner, who is now the Commissioner of Tasmania Police.[427]

On 26 February 2021, the *Outcomes Report—Tasmania Police Internal Review of Police Actions Relating to James Geoffrey Griffin* was released. This report provides an overview of key findings from the abovementioned reviews.[428] The media release accompanying this report included an apology to victim-survivors who were let down by the failures of Tasmania Police in responding to complaints about Mr Griffin. The media release also stated:

> It's important to note that Tasmania Police acted to review our own response—before the Commission of Inquiry was announced—as we wanted to identify issues and areas for change as soon as possible.[429]

The report omits that Tasmania Police were informed about concerns regarding Mr Griffin in 2000 and 2019. The report commits Tasmania Police to developing new guidelines for investigating child sexual offences and new practices of information sharing with other agencies. These changes are discussed in our chapter on criminal justice responses (Chapter 16).

We acknowledge the initiative taken by Tasmania Police to accept responsibility for its failings, which it did so after Mr Griffin's offending became public knowledge. We nonetheless make a number of findings against Tasmania Police throughout this case study, in the interests of transparency and noting the brevity of the outcomes report. We also supplement the key findings of that report with additional information and reflections on Tasmania Police's conduct.

1.2.2 Independent investigation into the management of historical reports of child sexual abuse

As discussed in more detail below, on 22 October 2020, the former Premier, the Honourable Peter Gutwein MP and the then Minister for Health, the Honourable Sarah Courtney MP, announced the Independent Investigation into the Systems of the Tasmanian Health Service and Relevant Government Agencies/Organisations Relating to the Management of Historical Reports of Allegations of Child Sexual Abuse ('Independent Investigation').[430] This occurred after the Department began its own internal review. The terms of reference for the Independent Investigation required examination of the circumstances surrounding Mr Griffin's conduct. The terms of reference also required consideration of what previous or current systems used by the Tasmanian Health Service, the Department and/or other government agencies did or did not operate to:

- require or encourage people to report known or suspected child sexual abuse and/or require appropriate authorities to investigate or respond to the risk of child sexual abuse occurring in the Tasmanian Health Service, or
- alleviate to the best extent possible the risk of the repetition of child sexual abuse by an employee who is alleged to have perpetrated, or is under investigation for, child sexual abuse.[431]

The terms of reference also requested advice about other actions and changes to current systems that could minimise the risk of child sexual abuse within the Tasmanian Health Service, given the Tasmanian Government's agreement to implement recommendations from the National Royal Commission.[432]

Our Commission of Inquiry was announced a month later. The Order establishing our Commission of Inquiry created a remit across a range of government-led and funded institutions, beyond the terms of reference of the Independent Investigation. However, the Order also specifically required us to consider:

> The adequacy and appropriateness of the responses of the Tasmanian Health Service and the Department of Health to allegations of child sexual abuse, particularly in the matter of James Geoffrey Griffin (deceased 18 October 2019).[433]

As a result, the Independent Investigation ended, and information obtained as part of that investigation was given to our Commission of Inquiry to inform our work.[434]

1.2.3 *The Nurse* podcast

Throughout this case study we refer to *The Nurse* podcast, which was produced by freelance journalist Camille Bianchi. The podcast covered abuses at Launceston General Hospital, particularly by Mr Griffin, but also alleged abuses by other health practitioners including Dr Tim (a pseudonym), which we explore in Case study 2.

We recognise the important role *The Nurse* podcast played in bringing Launceston General Hospital's failings to light and contributing to the momentum to establish our Commission of Inquiry. We had the benefit of Ms Bianchi's evidence in hearings and full transcripts of the podcast and are grateful for her assistance.

The Nurse podcast informed our lines of enquiry with various witnesses, particularly in the early stages of seeking information and identifying appropriate witnesses. However, we have not relied on the information in the podcast in our findings, noting we have had the benefit of powers to compel documents and evidence from witnesses, which we have used to inform our conclusions.

2 Findings

We make findings throughout this case study. We explain our general approach to making findings in Chapter 1. For the purposes of this case study, the findings reflect our determination of what did and did not occur at various points throughout Mr Griffin's employment at Launceston General Hospital. Some findings were straightforward to make because we could verify the information we received through documents and independent witnesses, or because those involved conceded or admitted to the subject of the finding. In instances where we did not have corroborative documentary evidence, we have sometimes made a finding where, having assessed all available evidence, we consider it is more likely than not that a particular event or outcome occurred.

We note that as a commission of inquiry we are not bound by the rules of evidence nor the standards of proof that apply to a criminal proceeding. We have adopted a 'balance of probabilities' standard of proof. A commission of inquiry must not express a conclusion of law in respect of the legal liability of a person. We have not recommended any criminal investigation in relation to any of the people against whom we have made adverse findings.[435]

We are conscious that Mr Griffin's death shortly after he was charged put an end to any criminal prosecution against him that might otherwise have followed. This has removed the opportunity for Mr Griffin's conduct to be established as child sexual abuse beyond reasonable doubt as part of a criminal process. As discussed in Chapter 1, we have accepted the truth of the accounts of abuse from victim-survivors but acknowledge that their accounts have not been assessed against this higher criminal standard of proof nor against the civil standard of balance of probabilities.

Some of the information we received from witnesses provided relevant context to understanding what occurred at Launceston General Hospital during Mr Griffin's tenure, but we could not find enough supporting evidence to meet a 'balance of probabilities' threshold. As such, we cannot and do not make a finding. In these circumstances, we have presented the information received (where we had the permission of those providing it to do so) and explained why we could not make a finding.

We also heard several rumours and received other speculative information relevant to Mr Griffin, his perpetration of abuse and the hospital's response. Where this has not fallen within the scope of our Inquiry, or where we have had no means to verify such information, we have not given it any weight when making our findings or included such information in our report.

The findings we have made, particularly against individuals, were not made lightly. We took great care to ensure we considered all relevant information and provided a fair reflection of the evidence we received, including any qualifications, corrections or alternative explanations that witnesses provided us. We have set out much of the evidence that we have received below. It is important to note that no finding is made where we have not specifically identified it as such.

In Section 4, we find there were significant failures on the part of Launceston General Hospital to respond to Mr Griffin's repeated and escalating boundary breaches and his inappropriate contact with child patients. We make several findings in relation to these failings:

- Launceston General Hospital failed to respond appropriately to Kylee Pearn's disclosure of abuse by James Griffin in 2011 or 2012, leaving children exposed to potential risk for eight years.
- Luigino Fratangelo and James Bellinger received a disclosure of child sexual abuse from Kylee Pearn relating to James Griffin in 2011 or 2012.
- Launceston General Hospital did not have adequate processes to ensure the meeting with Kylee Pearn was recorded and that record was retained.
- Launceston General Hospital's response to Will Gordon's 2017 Safety Reporting and Learning System complaint did not comply with the requirements of a State Service Code of Conduct investigation.

- Launceston General Hospital failed to manage the risks posed by James Griffin.
- Launceston General Hospital leadership collectively failed to address a toxic culture in Ward 4K that enabled James Griffin's offending to continue and prevented his conduct being reported.
- Launceston General Hospital failed to consider the cumulative effect of complaints about James Griffin.
- The response of Launceston General Hospital to complaints about James Griffin suggested it was ultimately not concerned about his conduct.
- Leadership at Launceston General Hospital collectively failed to provide appropriate supervision and proactive oversight, which is a systemic problem.
- Launceston General Hospital did not have a robust system for managing complaints involving child safety.
- Launceston General Hospital had no clear system, procedures or process in place to report complaints about James Griffin to external agencies.
- James Griffin had the ability to take and misuse medications from Launceston General Hospital.

We consider that many of these failings may have contributed to staff deciding against reporting Mr Griffin's behaviour and contributed to Mr Griffin being able to offend for as long as he did.

We learned that Mr Griffin had come to the attention of other government institutions, including Tasmania Police and Child Safety Services, in the lead-up to and during his employment at Launceston General Hospital. Each agency held vital pieces of the information puzzle about Mr Griffin's risk to children and yet we saw failures to share such information and work collaboratively, noting that information held by Tasmania Police and Child Safety Services was not shared with the Department before July 2019.

Tasmania Police failed to appropriately act when reports of Mr Griffin's conduct were received—most notably in 2015, when Australian Federal Police passed on significant intelligence about Mr Griffin's offending that was not accessed by Tasmania Police until 2019. Despite receiving notifications about Mr Griffin, Child Safety Services took only perfunctory steps to assess the risk that Mr Griffin posed to children. We make the following findings against these agencies:

- Child Safety Services should not have closed its November 2011 case into James Griffin without making further enquiries and ensuring Tasmania Police had all the information it required.
- Tasmania Police should have made further enquiries to receive the notifier's identity and reviewed previous intelligence holdings relating to James Griffin when receiving the November 2011 information from Child Safety Services.

- Child Safety Services should have taken further steps to assess the risk James Griffin posed in 2013 when concerns were again reported about him.
- Tasmania Police should have reviewed all intelligence holdings about James Griffin in 2013 when a report to Child Safety Services was made.
- The child safety system in the mid-2010s was not designed to address child sexual abuse in institutional settings.
- Tasmania Police failed to act on highly probative evidence regarding James Griffin provided by the Australian Federal Police in 2015.

In Section 5, we find that Launceston General Hospital failed in multiple ways to appropriately respond to an extensive history of complaints against Mr Griffin after his registration to work with vulnerable people was revoked, and we make the following findings:

- The response of Launceston General Hospital to revelations about James Griffin's offending was passive and ineffective.
- Leadership at Launceston General Hospital was dysfunctional and this compromised its collective response to revelations about James Griffin.
- Launceston General Hospital did not have clear accountabilities for child safety.
- The lack of a coordinated and transparent response by Launceston General Hospital increased feelings of mistrust among hospital staff.
- Launceston General Hospital should ensure open disclosure processes are trauma-informed.

We have further found that some individuals failed to fully and accurately convey the knowledge they held about Mr Griffin's conduct to the Office of the Secretary of the Department, which had the effect of creating a misleading picture of the scale of the crisis and impairing fully informed decision making by the Secretary and that office. Some of this information was critical and may have changed the course of events, had it been escalated and shared. Our findings in this regard include:

- Dr Peter Renshaw misled the Chief Executive of Launceston General Hospital and the then Secretary of the Department by failing to fully and accurately convey information relating to James Griffin received from Tasmania Police on 31 July 2019.
- The human resources team failed to escalate information they received on 11 October 2019 about Kylee Pearn's 2011 or 2012 disclosure.
- Dr Peter Renshaw should have escalated and acted on knowledge of Kylee Pearn's disclosure to the hospital once advised of it by Tasmania Police on 29 October 2019.

- Dr Peter Renshaw misled the Secretary of the Department about James Griffin.
- James Bellinger did not conduct a proper investigation into James Griffin's complaints history and misled the Secretary of the Department and the Integrity Commission.

We found some significant failures to identify and manage conflicts of interest relating to the hospital's response to Mr Griffin. Our findings in this regard are:

- Launceston General Hospital's human resources team should not have been involved in the request or preparation of a statement from Stewart Millar regarding Kylee Pearn's disclosure.
- James Bellinger should not have taken the statement from Stewart Millar.

The response to Mr Griffin's conduct was further let down by Tasmania's Integrity Commission, which received a complaint in November 2019 outlining major concerns with how the hospital had managed complaints about Mr Griffin over the years. Despite the Integrity Commission's initial assessment of the complaint, which it recognised as serious, it decided to refer the matter back to the Department for investigation. We find that:

- The Integrity Commission should have ensured Will Gordon's complaint to them was robustly and independently reviewed.
- The Integrity Commission's monitoring of the Department's response to Will Gordon's complaint was insufficient and it should have sought further review.

As noted, we have found that one individual, Dr Peter Renshaw, former Executive Director of Medical Services, Launceston General Hospital, deliberately misled his superiors. We also consider he misled our Commission of Inquiry. Dr Renshaw withheld information from us, fundamentally frustrating our ability to fully understand what happened at Launceston General Hospital. Recognising the gravity of such a finding, we applied a high threshold to the evidence that supported it. We disregarded evidence that could be attributed to a mistake or failure of memory and, in relation to questions of fact and findings, we sought clarification and explanation from Dr Renshaw to ensure we did not misunderstand his intention, and to provide a right of response or further explanation. We took a similar approach to those who are subject to our findings.

We found Dr Renshaw misled our Commission of Inquiry about his state of knowledge. We consider this conduct was unprofessional and unethical and brings the State Service into disrepute. We therefore find that Dr Renshaw's conduct constitutes misconduct under section 18 of the *Commissions of Inquiry Act 1995*.

3 How people described Mr Griffin to us

Before we chronicle Mr Griffin's conduct and the hospital's response to it, it is important to summarise evidence we heard about Mr Griffin as a person. The evidence we received suggests that Mr Griffin's way of interacting with others was key to his ability to evade accountability for his actions.

Victim-survivor Tiffany Skeggs described to us how Mr Griffin groomed her:

> Griffin had an aura that oozed kindness and sincerity. He was sympathetic and compassionate. He provided me with all the attention a young girl could possibly want. I was fatherless. I was instinctively searching for a male role model in my life. Griffin provided love and safety. He was understanding and encouraging.[436]

Keelie McMahon, who was also abused by Mr Griffin, told us that Mr Griffin could adapt to whoever he was with to ingratiate himself:

> He made himself 'valuable' to other people. He was always able to find other people's interests so he could talk to them and please them. He would pump you up so you would feel good spending time with him. I can't recall many people ever speaking badly of Jim, and if they did, others around him would always jump to his defence.[437]

By most accounts, Mr Griffin was very effective at grooming young victims, some of whom were highly vulnerable because of their health conditions or family circumstances. A former colleague, who observed Mr Griffin's behaviour on Ward 4K, said:

> James Griffin didn't just groom kids, he groomed everyone. He groomed his colleagues and friends. Now that he's dead, people seem to think that he wasn't smart, but the reality is he was incredibly smart, both intuitively and from a nasty place.[438]

This same colleague described how Mr Griffin would use his age to justify some of his inappropriate jokes or behaviour in the workplace. We heard that when colleagues confronted Mr Griffin about using the term 'baby girl' with female staff, Mr Griffin:

> … replied with words to the effect of 'I'm old guard. I've always said these things. It gets me in trouble sometimes but that's the way I am'. That was James Griffin's tactic if he ever got pulled up on these things. He would say he doesn't do PC [political correctness] and that PC was a construct of generation X and generation Y.[439]

Mr Griffin often did favours for or showed kindness towards female colleagues. Many witnesses told us that they now understand this behaviour was part of his grooming process. A former colleague of Mr Griffin, Maria Unwin, described how he would take shifts for other staff to win their favour.[440] Another former colleague described Mr Griffin's behaviour as: 'He oozed "I'm here for you"'.[441]

Many witnesses shared stories about how Mr Griffin would paint himself as a 'hero'.[442] Mr Griffin told a regular patient of Ward 4K, Kirsty Neilley, that he had saved her life when she was having a seizure from an attempted drug overdose:

> From this day on, Jim would never let me forget that night. He would always tell me how he saved my life. I believed him and regarded him as my hero. My mum regarded him the same way. She still says now that Jim saving my life is worth more than any of the bad things he could have done.[443]

Another Ward 4K patient and victim-survivor abused by Mr Griffin told us: 'After not too long, he had developed a "friendship" with Mum and Dad and had gained their trust. They really trusted him'.[444] These dynamics made her less inclined to disclose the abuse because 'Jim was a big part of our family'.[445]

Kim (a pseudonym) described her experience of Mr Griffin caring for her daughter Paula (a pseudonym) in hospital: 'I observed him to be a "touchy-feely" person, but I thought he was friendly and caring'.[446] She stated that her trust in Mr Griffin developed as her daughter stayed in touch with him outside the hospital setting: 'I thought he could see how hard it was for me with four children, trying to work, trying to care for [Paula], and that his interest in [Paula] was part of him caring about other people'.[447]

One victim-survivor who was abused by Mr Griffin told us: 'In my opinion, James Griffin had a career that was structured around paedophilia'.[448] She described him as having a brazen persona, which seemed unaffected by the abuses he perpetrated. She told us:

> I never confronted James Griffin about what he did to me. He was so confident with everything he did that he just carried on around me like everything was normal and he had done nothing wrong. While he carried on as normal, he knew that I knew.[449]

Those who questioned or challenged Mr Griffin, or who were not the targets of his grooming tactics, often gave us a different view of his personality. One of the former colleagues we mention above stated that Mr Griffin 'appeared to not like the other male nurses on the ward. I think this was because we recognised things that he did openly, things that we as male nurses just would not do'.[450]

Ms Unwin expressed that she felt 'wary' of Mr Griffin from their first meeting. She said that when allocating patients to staff, she would divert vulnerable young female patients from Mr Griffin's care.[451] She described how Mr Griffin would 'glare' when she did this and how, one time, he confronted her in a small staff kitchen about this practice. She characterised his approach and body language on that occasion as 'intimidating'.[452]

Ms Unwin's experience was echoed by Ward 4K nurse Will Gordon, who told us:

> At times James was imposing. Although he wasn't overly tall he was broad, so when he got fired up, he cast a shadow. I felt that some of the nurses were intimidated by him when he did get fired up.[453]

Many victim-survivors believed they were the only one Mr Griffin abused. Ms Skeggs explained: 'The main reason I remained quiet and protected Griffin for such an extended period of time was because I thought I was special. He made me think I was the only one'.[454]

In offering his reflections on Mr Griffin, investigating police officer Detective Senior Constable Glenn Hindle told us that Mr Griffin would often enmesh victim-survivors with his own family so that victim-survivors believed speaking up about their abuse would cause harm to Mr Griffin's children:

> … he sought opportunity to touch children and then said to those children, 'You can never say anything because this is what I'll lose in life, these kids won't have a father' and those sorts of things …[455]

Understanding how Mr Griffin conducted himself goes some way to explaining why many colleagues, managers and others at Launceston General Hospital did not take appropriate action in response to his offending.

4 Complaints about Mr Griffin

Figure 14.1: Timeline of documented or acknowledged complaints about Mr Griffin

On foldout →

In this section—Section 4—we document how Launceston General Hospital responded to the concerns raised about, and complaints made against, Mr Griffin from when he started working on the paediatric ward until the suspension of his registration to work with vulnerable people in July 2019.

We consider the hospital's response to documented and undocumented complaints in turn and make findings in relation to both. Other matters of concern about Mr Griffin, including allegations of Mr Griffin's unauthorised use of hospital medications to drug patients, are considered at the end of this section.

4.1 Documented or acknowledged complaints against Mr Griffin

In this section, we consider the concerns raised and complaints made against Mr Griffin by patients, their family members, staff at the hospital and others that were documented or otherwise acknowledged by the hospital's management, Child Safety Services or Tasmania Police between the year 2000 and July 2019.

Figure 14.1: Timeline of documented or acknowledged complaints about James Griffin

2000

A report is made to Tasmania Police about images and browser history found on Mr Griffin's laptop

2001

September

Mr Griffin is employed on Ward 4K at Launceston General Hospital

2002

A complaint is made about non-care related touching of a patient

2004

July

The hospital receives a complaint about Mr Griffin hugging a former patient

2005

A parent complains about Mr Griffin kissing their daughter on the forehead

2009

Mr Griffin gives his personal mobile number to a patient

Complaints are made about Mr Griffin interfering with a behaviour management plan and cuddling a patient

February

Mr Griffin intends to 'give away' a former patient at her wedding

March

Tasmania Police receive information about Mr Griffin 'upskirting' young girls

May

An email chain that included a former patient is discovered

2011

2011 or 2012

Kylee Pearn discloses childhood sexual abuse by Mr Griffin to Launceston General Hospital

2011 or 2012

Ms Pearn and her friend have an informal discussion with Tasmania Police

2011 or 2012

Ms Pearn and her friend report their abuse to an organisation Mr Griffin volunteered with

November

Child Safety Services receives a report about Mr Griffin and notifies Tasmania Police

2012

November

Concern from the mother of a patient that Mr Griffin was a 'sleaze'

2013

April

A confidentiality breach follows a request that Mr Griffin not visit a patient and her mother

May

A report is made to Tasmania Police about Mr Griffin, which is passed on to Child Safety Services

2015

April

Tasmania Police receives information from the Australian Federal Police about Mr Griffin

November

A nurse raises concerns about Mr Griffin's professional boundaries with teenage girls

2017

March

A young patient reports discomfort with Mr Griffin using pet names

May

A student undertaking a placement complains about Mr Griffin

August

A nurse complains about Mr Griffin having an inappropriate conversation with young female patients

November

Mr Griffin is transferred to work in a fixed-term role at Ashley Youth Detention Centre

2019

July

A nurse complains about Mr Griffin's inappropriate comments and actions when administering medication

May

Tiffany Skeggs reports Mr Griffin's abuse to Tasmania Police

4.1.1 19 September 2000—A report is made to Tasmania Police about images and browser history found on Mr Griffin's laptop

On 19 September 2000, Tasmania Police received information of concern about Mr Griffin.[456] The person who contacted police had purchased a laptop computer from Mr Griffin. Sometime later, having connected the computer to the internet, the person discovered concerning bookmarked links to websites with titles that suggested child exploitation material, as well as a cache of photographs of apparently pre-pubescent girls, naked or wearing only underwear.[457] In correspondence to Tasmania Police, this person wrote: 'I need to know if anything can be done … especially given that he is a [practising registered nurse], possibly working with children'.[458]

We heard that, following some back and forth and a review of the images, Tasmania Police ultimately declined to act, with the person recalling that Tasmania Police said that 'not enough was found on the computer to move forward'.[459] In some of those communications with Tasmania Police, the new laptop owner acknowledged that none of the images he witnessed were 'openly pornographic' but found them concerning nonetheless.[460] Upon learning of our hearings, this person contacted us and told us that 'it is very likely that I was the first person to alert any authorities about [Mr Griffin]' and that, although police decided not to take further action, 'at least my contact would put his name in a detective's mind and create a dot for any future join the dots inquiry'.[461]

Many years later, on 30 November 2019, Detective Senior Constable Glenn Hindle, who was then in charge of an investigation into Mr Griffin, answered a call from the same person who had contacted police in September 2000 about the disturbing laptop content. Detective Senior Constable Hindle told us that during this call the person explained that they had purchased a computer from Mr Griffin many years ago and later identified what they believed to be child exploitation material on the device, which they had reported to the police at the time. Detective Senior Constable Hindle described being 'a little bit perplexed' he hadn't previously come across this information.[462] Detective Senior Constable Hindle could not find evidence in any Tasmania Police records of this person's earlier report to police.[463]

Based on this person again describing the images discovered on Mr Griffin's old laptop, Detective Senior Constable Hindle formed the view that it was unlikely these images met the legal definition of child exploitation material, and hence, while being a moral concern, were not a legal concern to him.[464] He made a record of their 2019 conversation on 1 December 2020.[465] Detective Senior Constable Hindle acknowledged it was possible that he made the record a year after the conversation had taken place, although it is unclear to us how or why this occurred and he had difficulty recalling specific dates.[466]

Former Commissioner of Tasmania Police, Darren Hine AO APM, clarified that hard-copy records indicated the original complaint was escalated to a senior level and referred for investigation in 2001.[467] He confirmed that police in New South Wales carried out a forensic examination of the laptop and that no offences were detected.[468] Commissioner

Hine acknowledged that Tasmania Police had only limited information about this report because it was not entered into a police database until Detective Senior Constable Hindle did so in December 2020. However, Commissioner Hine concluded: 'I am satisfied from the scant information available on this matter that Tasmania Police acted appropriately on this occasion'.[469]

While we recognise information that suggests inappropriate conduct can appear less significant or probative in isolation, such information can become more significant over time when other complaints or concerns are reported to police. It is unfortunate, therefore, that the initial complaint was not recorded in a way that would allow easy access to the information for police in the future so they could 'join the dots', acknowledging that Tasmania Police did not implement an online intelligence system until 2002.[470]

4.1.2 September 2001—Mr Griffin is employed on Ward 4K at Launceston General Hospital

On 11 September 2001, Mr Griffin started working as a registered nurse on Ward 4K—the paediatric ward—at Launceston General Hospital.[471] The evidence we have indicates that he held this role until August 2019, except for two intervening temporary assignments:

- Between 14 June and 11 July 2009, Mr Griffin was assigned as a nurse to the Launceston General Hospital emergency department.[472]
- Between 19 November 2017 and 27 April 2018, Mr Griffin was seconded as a nurse to Ashley Youth Detention Centre.[473]

In all these roles, Mr Griffin had access to children and young people. His secondment to Ashley Youth Detention Centre is discussed in Section 4.1.29.

4.1.3 2002—A complaint is made about non-care related touching of a patient

We have received evidence that Mr Griffin was spoken to about professional boundaries in 2002. However, aside from records later made in 2009 by Sonja Leonard, when she was the Nurse Unit Manager of Ward 4K, and Clinical Nurse Educator Michael Sherring, we have little detail about this incident. As discussed further below, as part of her response to a complaint made on 14 January 2009 concerning Mr Griffin handing out his personal phone number to patients, Ms Leonard met with Mr Griffin on 11 February 2009. Ms Leonard's undated notes from this meeting state that she reminded Mr Griffin of the previous times that she or others counselled him about his behaviour. Her notes included the following reference:

> I mentioned there were other times [I had counselled Mr Griffin about professional boundaries] that he obviously didn't recall the time I spoke to him as a Level 2 [registered nurse] re prof. boundaries with [a person] and Michael Sherring and [a nurse unit manager] when he was doing Grad Cert course.[474]

We do not know the identity of the person and we did not request this information.

On 21 January 2009, around the time Ms Leonard was managing this complaint, Mr Sherring was asked by Ms Leonard to document his 2002 meeting with Mr Griffin about his behaviour. In response, Mr Sherring prepared a file note:

> The 2002 discussion concerning professional boundaries has centred around overly friendly behaviour regarding children and young people exhibited by Jim. This includes hugging on greeting and other non care related touching. I identified the inappropriateness of this and the potential risk of people misinterpreting such behaviour. Jim did not appear to identify anything wrong with his behaviour despite advice from myself that it was inappropriate and however innocent would be considered unprofessional.[475]

During the hearings, Mr Sherring was asked to reflect on this 2002 complaint:

> Q [Counsel Assisting]: So is it fair that in the conversation you had with him in 2002, he demonstrated to you a lack of insight into the impropriety of his behaviour?
>
> A [Mr Sherring]: Yep.
>
> Q: Why was he permitted to continue working with children?
>
> A: I can't answer that.
>
> Q: Do you think that a minimum prerequisite was that he understand that what he did was inappropriate?
>
> A: Yes.[476]

Mr Sherring agreed that the 2002 complaint should have been recorded, and that this type of complaint would generally be kept on ward personnel files held in the Nurse Unit Manager's office.[477] This summary is captured in the following exchange:

> Q [Counsel Assisting]: What were the processes for escalating concerns about a person whose behaviour was inappropriate where they failed to appreciate it?
>
> A [Mr Sherring]: Those details would have gone to the Nurse Unit Manager at the time and they as the performance managers would have been the people to pursue that in that first instance.
>
> Q: I've been unable to locate any documents reflecting those 2002 issues. Is it your evidence that there should be some?
>
> A: Yes.
>
> Q: Where would they have been stored?
>
> A: To the best of my knowledge, there were personnel files kept on the ward at that time, in two D-ring folders in the Nurse Unit Manager's office, and my understanding would have been that any documentation related to nurses, whether it was employment records or other file notes, would have been kept in those.[478]

As noted above, we received Mr Griffin's personnel file in December 2022. It did not include any documentation about the 2002 complaint.

In his 2009 file note, Mr Sherring also appears to reference a complaint discussed in Section 4.1.5 regarding Mr Griffin kissing a patient on the head.[479]

4.1.4 July 2004—The hospital receives a complaint about Mr Griffin hugging a former patient

In July 2004, the then Nurse Unit Manager of Ward 4K received an incident form about the way Mr Griffin greeted an adolescent girl who had previously been an inpatient and was visiting the ward.[480] A copy of the form has not been located. The Nurse Unit Manager at the time recalls that it stated Mr Griffin hugged the girl. The Nurse Unit Manager told us that while they had some difficulties recollecting this incident, they agreed that the physical contact amounted to 'professional misconduct'.[481] They described their practice in response to such circumstances as having a conversation with the relevant staff member and then giving them a letter.[482] In this case, their final words in the letter to Mr Griffin cautioned: 'Whilst this behaviour may seem innocent to you, it may well have potential implications in the future and we ask that it is not repeated'.[483]

The Nurse Unit Manager said that a copy of this letter was sent to the human resources team, to be placed on Mr Griffin's file.[484] The Nurse Unit Manager also told us that they would have notified their manager, Sue McBeath, who was Director of Nursing, Women's and Children's Services, about this complaint.[485] However, Ms McBeath did not recall the incident in her statement to us and was not asked for her recollection of the matter during her oral evidence.[486]

4.1.5 Late 2005—A parent complains about Mr Griffin kissing their daughter on the forehead

In late 2005, the same Nurse Unit Manager recalled receiving a phone call from the concerned parent of a young girl. This parent informed the Nurse Unit Manager that Mr Griffin had kissed their daughter on the forehead, resulting in their daughter 'vigorously rubbing her face'.[487] The parent did not wish to make a formal complaint but did tell the Nurse Unit Manager that the incident had made them feel uneasy and that they wanted to express their concern.[488] The Nurse Unit Manager agreed that Mr Griffin's behaviour was 'most inappropriate' and gave Mr Griffin a letter indicating their concern and requesting that he provide them with a written explanation of his conduct.[489]

Mr Griffin responded in writing, acknowledging that the incident did occur. He explained it as a 'spontaneous action' in response to the patient not wanting to go to bed. He added:

> In retrospect I believe I did this as a way of establishing a level of friendship, rather than being seen by her as some kind of authoritarian figure. While this may have been seen by [the parent] in [their] context as a [professional role],

> as an inappropriate act, giving a child a kiss as a show of something caring is something that is done often on the ward by many, nursing, and other, staff. I do, however, accept that this may not be seen as appropriate.[490]

The Nurse Unit Manager again wrote to Mr Griffin, formally requesting that he speak with the Clinical Nurse Educator, Mr Sherring, to 'further discuss issues around associations, care provision, and boundaries relating to gender issues and the workplace'.[491] They included a copy of the document *Professional Boundaries Standards for Nurses in Tasmania* with the letter.[492]

Mr Sherring told us he was concerned about Mr Griffin's behaviour because it was 'outside [the] acceptable professional boundaries guidelines' that applied at the time.[493] Mr Sherring had a discussion with Mr Griffin, which he reported back to the Nurse Unit Manager in a memo.[494] Mr Sherring made several points in the memo about his conversation with Mr Griffin, including that:

- Mr Griffin acknowledged that the incident involving the forehead kiss went beyond what he would normally consider 'an appropriate comfort measure' and that it occurred due to the 'specific circumstances of the events'.[495]
- Mr Griffin agreed to 'step back from direct care', despite a specific request from a patient or their family that he care for them, where doing so may not be appropriate in the circumstances. Mr Sherring and Mr Griffin discussed ways to do this 'without distressing either the child or family'.[496]

Mr Sherring also noted in his memo that:

> Jim recognises that there may be a disproportionate focus on the interactions of males in nursing roles with children in paediatric settings and that there is an increased need for awareness of how nursing behaviours with children may be viewed by others.[497]

The Nurse Unit Manager submitted all the relevant documents to the human resources team, to be placed on Mr Griffin's file 'in case any future issues arise'.[498]

The Nurse Unit Manager believes they 'would have verbally spoken to Sue McBeath, Director of Nursing Women's and Children's Services' about this complaint and the previous complaint of July 2004.[499] They also said there were regular meetings between ward managers and clinical nurse managers and the human resources team.[500] Ms McBeath recalls that the complaint was only informally reported to her after the Nurse Unit Manager had responded to the complaint.[501] She also recalls only discussing a complaint in relation to a male nurse kissing the forehead of a young female patient, and not that it specifically involved Mr Griffin.[502]

Reflecting on their own handling of Mr Griffin's behaviour, the Nurse Unit Manager told us they did not have any professional education about child sexual abuse throughout their nursing career and that they had not had to manage child abuse matters prior to complaints about Mr Griffin.[503] They added:

> At the time I felt I addressed the incidents appropriately, however my focus was on professional boundaries, not sexual abuse. In hindsight, I now understand my concerns were inadequately acted upon.[504]

A subsequent Nurse Unit Manager, Sonja Leonard, told us she was aware that Mr Griffin had kissed a patient on the forehead, but she was not aware of the circumstances surrounding the complaint.[505]

4.1.6 November 2008—Sonja Leonard becomes the Nurse Unit Manager on Ward 4K

A number of current and former staff of Ward 4K described a workplace culture, both post and prior to ward staff's knowledge of Mr Griffin's offending, that was tense, defensive and discouraging of feedback and reflection.

Ms Leonard, who was the Ward 4K Nurse Unit Manager from November 2008 until December 2020, conceded in evidence that she had a different management style to her predecessor and that her style was not well received by staff.[506] Shortly after starting in the role, we were told Ms Leonard was met with a no-confidence motion from staff on the ward. Former Ward 4K nurse, Annette Whitemore, described what happened after this:

> An external facilitator was then engaged to 'rebuild the nursing team' on the ward. I recall the facilitator talking to staff, asking us to blow up a balloon, put our worries in the balloon and pop it.[507]

Ward 4K staff took part in other team building initiatives over the years. In August 2012, for example, Mr Griffin signed a document titled *4K Leadership Team: Agreed Values*, which was in his personnel file.[508] This read in part:

> Following much team building and time, we the members of the 4K … leadership team have agreed on the following values. We believe that following these values and ensuring we work according to these values that our team will build in strength. By doing so we will regain the trust of our leadership team colleagues, and also the respect of 4K staff. As leaders of the 4K team it is important we do this, not only for ourselves, but also our 4K team.[509]

The document included overarching values of 'respect', 'constructive communication' and 'trust'—including 'safety to be able to speak up'.[510] It is unclear why Mr Griffin signed this document given he was not formally on the ward's management team.

Will Gordon, a registered nurse mentioned earlier, recalled that before starting work on Ward 4K in 2016, several nurses told him to 'watch out for the Nurse Unit Manager'.[511] He described the culture when he started on the ward as one of 'tension' and 'high anxiety', adding that nurses were 'constantly watching their backs' and afraid to make any sort of error.[512] Ms Whitemore similarly described an ongoing 'culture of mistrust' and a ward that was 'divided and disjointed'. She added:

> I believe the culture on Ward 4K made it easier for [Mr Griffin] to do what he did. He saw the cracks and put himself in there. He would take Sonja's side. I've been told by other staff they believed he reported things back to her. He tried to win her favour.[513]

It was difficult for us to determine the degree to which the hospital's leadership was aware of the problems with Ward 4K's culture at this time. When questioned about the culture on Ward 4K, Janette Tonks, former Director of Nursing, Women's and Children's Services, replied that on starting her role in 2013: 'I was aware that there was a grievance; I wasn't aware that the culture was as toxic as what I am now led to believe'.[514] Ms Tonks later told us that her observation of Ward 4K was that staff were very happy and noted that none of the nurses had approached her with 'anxieties or lack of confidence in Ms Leonard'.[515] At our hearings, Ms Tonks conceded that she was responsible for making sure Ms Leonard had the tools to properly manage Ward 4K and she did not do so.[516]

Ms Leonard told us that she believed senior nursing management was well aware of the dysfunctional dynamics on the ward.[517] At hearings for our Inquiry, Helen Bryan, the then Executive Director of Nursing, gave evidence that she accepted cultural change was required at the hospital in relation to transparency, openness and honesty.[518] Ms Bryan also later gave evidence that she considered that progress has been made towards effecting those changes.[519]

4.1.7 31 December 2008—Mr Griffin's Performance and Development Agreement is signed off

On 31 December 2008, a Ward 4K staff member acting as the ward's Nurse Unit Manager signed off on Mr Griffin's Performance and Development Agreement.

There were two particularly notable entries in this Agreement. In response to the question 'What has worked well/been done well in the review period?', the Acting Nurse Unit Manager commented on Mr Griffin's 'management of adolescent mental health patients'.[520] Also of note, in response to the question, 'What hasn't worked so well/been done so well in the review period?', was the entry: a 'lack of encouragement and feedback (positive and negative from management)'.[521]

4.1.8 Early 2009—Mr Griffin gives his personal mobile number to a patient

In early 2009, a staff member told Ms Leonard about a professional boundary breach by Mr Griffin. The concern was that Mr Griffin had offered his phone number to a young patient, saying he would 'come back to work and sit with the distressed patient if needed' after his shift.[522] A 'handover memo' written by two staff members indicates that the rostered staff members assured Mr Griffin that the patient was fine and it was not necessary for him to return to work, despite Mr Griffin's insistence that he be called if the patient became distressed.[523] Later, when the patient was upset and staff members

sought to comfort her, she became more distressed saying 'Jim had promised' her that the staff would call him if she wanted him to return.[524]

Ms Leonard told us that she was 'unsure' if this concern relates to the same patient referred to in a complaint made by a Senior Psychiatric Registrar (described in Section 4.1.9), noting that the Registrar also complained that Mr Griffin had given his mobile phone number to a patient and that the concern was 'considered at the same time and in the same manner' as this complaint.[525]

Ms Leonard met with Mr Griffin in February 2009 and directed him to not give out his mobile number to patients.[526] Ms Leonard's handwritten diary note of her discussion with Mr Griffin states: 'Verbal warnings not previously effecting change in [behaviour]' and that Mr Griffin's intention does not equal the 'effect and outcome'.[527] We discuss Ms Leonard's file note of this conversation in more detail in the next section.

Ms Leonard told us that she met with the patient's mother and that the mother advised Ms Leonard that she had deleted Mr Griffin's number from her child's phone.[528] Ms Leonard does not recall whether she reported this incident to her supervisor (who was Ms McBeath at the time).[529] Ms McBeath informed our Inquiry that she did not recall this matter being reported to her.[530]

4.1.9 Early 2009—Complaints are made about Mr Griffin interfering with a behaviour management plan and cuddling a patient

In early 2009, Ms Leonard received a written complaint from a Senior Psychiatric Registrar ('Registrar') about Mr Griffin. The Registrar described having developed a behaviour management plan with a treating paediatrician to overcome a young girl's extreme separation anxiety, which demanded 'a consistent approach from both her parents and ward staff in responding to her distress and demands for company'.[531] The Registrar wrote that in a previous session with this patient's parents they had expressed a view that all nurses should befriend their daughter 'like Jimbo has' to be therapeutically effective.[532]

The care of this young girl had been previously discussed at a weekly multidisciplinary team meeting, where the Registrar was 'surprised' to see Mr Griffin in attendance because Mr Griffin was on annual leave at that time.[533] As recounted by the Registrar in his letter to Ms Leonard, at this meeting Mr Griffin outlined his concerns with the treatment plan, stating that he believed it was 'unkind to leave the patient in a distressed state'. The Registrar explained in some detail the justification for the approach, which Mr Griffin then reluctantly accepted.[534]

In his letter, the Registrar also informed Ms Leonard that Mr Griffin's behaviour had come to his attention on a separate occasion, after Mr Griffin had given his personal mobile number to a highly vulnerable young woman who had been an inpatient on Ward 4K, encouraging her to contact him whenever in crisis.[535] The Registrar wrote to Ms Leonard

that he was finding it 'particularly difficult to reach a mutual understanding' with Mr Griffin on the appropriateness of Mr Griffin's interactions with patients more broadly.[536] The letter said:

> I am deeply concerned about this and request that you address it immediately and thoroughly and that Mr Griffin be referred to a caring professional himself. I imagine referral to a psychologist or psychiatrist would be the most appropriate choice initially.[537]

The Registrar further informed Ms Leonard that he had notified the Clinical Director, Mental Health Services North, of his concerns about Mr Griffin and that the Clinical Director had indicated 'his intention of raising this with management as a performance issue, if the situation persists'.[538] Ms Leonard recalls notifying human resources staff and Ms McBeath about the Registrar's concerns.[539]

Ms Leonard told us that she responded to the Registrar, notifying him that she was going on leave and that the Acting Nurse Unit Manager would take responsibility for the matter.[540] Ms Leonard told us that, during handover, the Acting Nurse Unit Manager told Ms Leonard that they had seen Mr Griffin cuddling the same patient who was the subject of the Registrar's letter. This, the Acting Nurse Unit Manager said, took place in a recliner chair in the patient's room after her mother had left.[541] In a file note that the Acting Nurse Unit Manager prepared for Ms Leonard, they wrote that they 'accepted Jim's actions as being caring and consoling, even though it was an action I would not deem appropriate in my nursing care'.[542] The Acting Nurse Unit Manager acknowledged in their file note that they had since learned that Mr Griffin's actions were in contravention of the patient's treatment plan (as outlined by the Registrar).[543]

A meeting was held between the Acting Nurse Unit Manager, a member of the human resources team and Ms McBeath to discuss the complaint.[544] The file note from this meeting records the following items under the heading 'Issues discussed':

a. Physical touch of patients outside therapeutic boundaries.

b. Giving out mobile phone number to patients/families for contact outside work hours.

c. Development of simpler, more clear cut protocol outlining professional boundaries for staff on Children's Ward LGH.

d. Development of above protocol to be done within a group forum setting inclusive of J. Griffin.

e. Letter to be written by [the Acting Nurse Unit Manager] to James Griffin re confirming our expectations in respect to his professional relationships and boundaries. After inspection by [the human resources staff member] and [Ms McBeath] this will be given to James on his return after Annual leave.

f. This letter will specify the need to refer the matter to the Nursing Board of Tasmania if any further incidents arise.[545]

Our Commission of Inquiry was provided with a letter that is undated and marked 'draft'. Ms Leonard told us that this was the letter the Acting Nurse Unit Manager sent to Mr Griffin at the time.[546] The letter reflected the discussions described above and reiterated that Mr Griffin should not:

- have contact with patients and ex-patients outside a clinical setting
- attend care meetings for patients on days that he is not rostered to work
- continue to care for patients where colleagues or peers identify that this has become 'counterproductive to the team goal'
- have physical contact with patients beyond providing their medical care.[547]

The letter also explicitly warned Mr Griffin that if there was a similar complaint about him in the future, there would be no option but to raise the matter with the Director of Nursing, which may result in the complaint being referred to the Nursing Board of Tasmania.[548]

Later on in early 2009, a message from Ms Leonard's email address (but signed by the Acting Nursing Unit Manager) was sent to the Registrar informing him that Mr Griffin had asked for the letter of complaint that the Registrar had written so he could 'formulate a response to the matter at hand'. This email indicates that the Acting Nurse Unit Manager sought advice from then Human Resources Consultant, Luigino ('Gino') Fratangelo, about providing the letter of complaint to Mr Griffin.[549] Mr Fratangelo was apparently satisfied with it being provided if the Registrar was informed.[550] We have not enquired as to whether (or how) the Registrar responded to this request. Ms Leonard's notes suggest that the complaint was provided to Mr Griffin.[551]

Ms Leonard met with Mr Griffin about the complaint and took notes of their discussion. In these notes, Ms Leonard records that Mr Griffin was upset about the Registrar's letter of concern.[552] The notes record that she asked Mr Griffin how many times similar matters had been discussed with him, and he reportedly replied 'only twice', being this instance and the incident of kissing a patient's head (described in Section 4.1.5). Ms Leonard's notes include the following: 'I mentioned there were other times that he obviously didn't recall … so speaking about it hadn't changed the behaviour'.[553] Her notes go on to indicate that since the complaint had been made by another area of the health service, it was necessary to take appropriate action so the quality of services provided by Ward 4K were without question.[554] This appears to reflect a desire by Ms Leonard to manage the reputational risks (even within the hospital) associated with Mr Griffin's conduct.

In Ms McBeath's view, the wording of the Acting Nurse Unit Manager undated 'draft' letter to Mr Griffin suggested that it was 'more of a warning'.[555] Ms McBeath, noting the letter's reference to a potential report to the Nursing Board of Tasmania, told us 'the issue was obviously viewed as professional role confusion/professional boundary issue and the first time it emerged with Mr Griffin'.[556]

On the evidence, this was at least the fourth time professional boundary issues had been raised about Mr Griffin.

4.1.10 February 2009—Mr Griffin intends to 'give away' a former patient at her wedding

Ms Leonard told our Commission of Inquiry that, in February 2009, Mr Griffin advised her of his intention to 'give away' a former patient, Angelique Knight, at her wedding, which was to take place in several days' time. Ms Leonard said she was concerned when Mr Griffin told her this because it suggested an 'unusually close relationship for a nurse to have with an ex-patient'.[557]

Ms Leonard noted that her manager, Ms McBeath, was not available to advise her; consequently, Ms Leonard sought advice from the then Executive Director of Nursing, Helen Bryan, who was Ms McBeath's manager. Ms Leonard stated that Ms Bryan told her that Mr Griffin could attend the wedding but that he should not 'give away' the bride.[558]

Ms Leonard stated that, on 25 February 2009, she met with Mr Griffin to discuss the matter. At this meeting he confirmed he would not 'give away' Ms Knight.[559] Ms Leonard also stated that, on 2 March 2009, she reiterated their discussion in a letter to Mr Griffin, in which she referred to the importance of maintaining 'appropriate relationships with patients on the ward'.[560] She said that in this discussion she flagged an intention to develop a protocol on the topic of professional boundaries to 'assist all staff members'.[561] As referenced above, Mr Griffin was encouraged to contribute to this protocol.[562] It does not appear that Ms Leonard's letter to Mr Griffin was passed on to the human resources team at the time.

Ms Leonard did ultimately forward a copy of the letter to former Human Resources Consultant Mathew Harvey some time later on 6 March 2017, in response to another complaint about Mr Griffin (described in Section 4.1.26).[563]

As noted above, because of Mr Griffin's conduct, a protocol for Ward 4K staff on professional boundaries was developed.[564] Ms Leonard noted that this protocol was drafted in a group forum, which included Mr Griffin, in mid-2009.[565]

4.1.11 March 2009—Tasmania Police receive information about Mr Griffin 'upskirting' young girls

In March 2009, Victoria Police shared information with Tasmania Police that Mr Griffin had been captured on closed-circuit television 'upskirting' young women—that is, taking sexually intrusive photographs without their permission—while contracted to work as a medic on the *Spirit of Tasmania*.[566]

That same day, a Tasmanian police officer submitted an information report to the relevant Tasmania Police database describing the information received from Victoria Police. The information report included reference to Mr Griffin's role at Launceston General Hospital, stating: 'Unsubstantiated dialogue suggests he may also be employed at Launceston Children's Hospital'.[567] The information was not passed on to the Department or Launceston General Hospital.

Tasmania Police obtained still images from the *Spirit of Tasmania* showing Mr Griffin holding a camera 'in a suspicious manner'.[568] In April 2009, Tasmania Police conducted a search on Mr Griffin's property and asked him about the upskirting allegations.[569] Mr Griffin reportedly could not recall the events.[570] Mr Griffin's computer was examined and, while no unlawful images were found, officers did find hundreds of images of young girls in bathing attire at pools and beaches, as well as girls playing netball.[571] Police noted that Mr Griffin was clearing his internet search history daily.[572]

Mr Griffin refused to take part in a formal interview at this time. Tasmania Police decided there was not enough evidence to proceed with criminal charges, but noted the following in an information report:

> Although there was no evidence of any unlawful behaviour by Griffin this pattern of dealing with young girls … may cause rise to suspicion should other matters be reported in the future.[573]

In relation to the 2009 complaint, all information was ultimately filed in April 2009 with no caveats and was freely accessible to other investigators.[574] We note that this complaint predated the Registration to Work with Vulnerable People Scheme.

A 2020 investigative review into Tasmania Police's handling of information received about Mr Griffin found that a 'thorough and timely' investigation was undertaken in this matter, noting that, while the investigators were suspicious of some of his behaviours, no unlawful images were located in the search. This review does not explain how relevant the still images of Mr Griffin (or the footage it was drawn from) was in substantiating the upskirting allegations. However, this review did conclude the information from the upskirting allegation should have been considered when later reports about Mr Griffin were made, stating that 'not enough weight was placed on these comments when Griffin was investigated in 2011, 2013 and 2015'.[575] Those subsequent investigations are described in later sections.

Former Commissioner Hine told us: 'This matter was investigated appropriately at the time by Launceston detectives, with no offences detected.'[576]

4.1.12 May 2009—An email chain that included a former patient is discovered

In May 2009, Ms Leonard received an email from Mr Griffin on her personal email account, which had also been sent to a broader group, including other Ward 4K staff.[577]

Mr Griffin had also included a former patient in the email chain.[578] Ms Leonard stated that she was aware Mr Griffin knew the former patient's family socially but felt it was inappropriate that Mr Griffin was emailing a former patient.[579] Ms Leonard stated that she met with Mr Griffin and asked that he not send her personal emails or communicate with current or former patients outside a professional capacity.[580]

Based on the evidence we have received, this was the fourth time in six months that Ms Leonard had personally responded to Mr Griffin's inappropriate behaviour, and the sixth such incident that was recorded about Mr Griffin in connection with his role at the hospital.

We note that in December 2020, Ms Leonard forwarded Mr Griffin's email to the human resources team with a note saying: 'I met with Jim to discuss this email as it contained the email address of a patient and detailed that it was inappropriate and directed him to cease'.[581] We do not know what prompted her to send this to the human resources team more than 10 years after Mr Griffin sent it. We note that, by that stage, the Department had initiated its Independent Inquiry and our Commission of Inquiry had been announced.

We did not receive a 2009 Performance and Development Agreement for Mr Griffin.[582] We do not know whether one was completed and not filed, or never completed. Such Agreements should have been an important tool to manage Mr Griffin's behaviour.

Given Mr Griffin's failure to comply with repeated instructions from his manager to stop his inappropriate behaviour towards patients, we consider that, at this point, there was enough evidence that Mr Griffin was engaging in improper contact with current and former patients and should have resulted in formal action.

4.1.13 31 March 2011—Mr Griffin's Performance and Development Agreement is signed off

On 31 March 2011, Mr Griffin's Performance and Development Agreement was signed off by a Ward 4K staff member, who had acted as the Nurse Unit Manager for a period, and Ms Leonard.[583]

Notable aspects of this Agreement include that Mr Griffin wanted to attend an eating disorder workshop but could not because of staffing issues.[584] His performance objectives included a focus on developing knowledge and clinical skills in eating disorders and adolescent mental health.[585]

It seems that Mr Griffin expressed significant confidence in his abilities and his qualification to advance to a Grade 4 position, as the Agreement states: 'He believes his role as a senior nurse on the ward plays an important role in facilitating staff learning and development and assisting management'.[586]

4.1.14 2011 or 2012—Kylee Pearn discloses childhood sexual abuse by Mr Griffin to Launceston General Hospital

In March 2011, Kylee Pearn started as a social worker at Launceston General Hospital.[587] She described finding it 'incredibly confronting' to come across Mr Griffin working on Ward 4K because she had been sexually abused by him as a child.[588] She came to know Mr Griffin as a family friend.[589] Soon after starting work at the hospital, Ms Pearn spoke to a friend who disclosed during a 'chance conversation' that she also had been abused by Mr Griffin when she was young.[590] Ms Pearn expressed feeling 'terrified' after her own child was admitted to the hospital that Mr Griffin would be in contact with her child.[591]

In relation to her decision around that time to report Mr Griffin's abuse, Ms Pearn said:

> I had this innate feeling that other children were at risk on the ward and I knew I couldn't pretend it didn't happen anymore. It was no longer just about me and I had a duty to do something about it, both as a mum and as a social worker.[592]

Ms Pearn 'summoned up the courage' to disclose Mr Griffin's abuse of her to Stewart Millar, who was the head of the social work department and her manager at Launceston General Hospital at the time.[593] Ms Pearn told us that:

> Stewart believed me, supported me and offered options on what I could do. Within a day or two, and with my permission, he organised a meeting with [the human resources team] so I could tell them what happened.[594]

Ms Pearn said that at this meeting she told human resources staff that Mr Griffin had sexually abused her and her friend when they were children. Ms Pearn recalled feeling at the time that the representatives had come to the meeting 'pre-prepared'.[595]

The following reflects Ms Pearn's recollection of the response she received from the human resources staff at the meeting:

> They told me they had looked into Jim, that he had been on the [kids'] ward for a long time and that he was [a union] member. They told me that Jim would ask too many questions and would cause 'too much of a fuss' if he was moved from the children's ward … They then said that there was nothing they could do without a conviction. The meeting was short and would not have gone longer than 20 or 30 minutes. I was stunned at their response and felt quite powerless. I got the sense that my information wasn't going to be acted on unless I got a conviction. At the time I felt I had done everything I could by alerting them and that it was now up to them. They didn't offer me any support after the meeting; however, I was offered support by Stewart.[596]

Mr Millar told us he thought the human resources staff would take the information Ms Pearn provided at the meeting 'and view it within the context of any other information that they had and come to a reasonable, rational decision about how to proceed'.[597] If this had occurred, then the six previous complaints of Mr Griffin's inappropriate behaviour towards child patients could have been considered together with Ms Pearn's

very serious disclosure. Mr Millar said he considered there appeared to be a shared sense among the human resources representatives attending the meeting that the weight of the disclosure 'was not as much as if it had been a formal complaint'.[598] Mr Millar said he did not make a mandatory report to Child Safety Services because the concern related to historical events and there was no evidence of current abuse of a child, aside from the risk arising from an historical abuse.[599]

Ms Pearn said she had hoped that her disclosure to human resources staff would result in having Mr Griffin removed from the paediatric ward.[600]

There was no consensus as to the date of the meeting with the human resources team. Mr Millar recalled Ms Pearn's disclosure occurred in either 2011 or 2012.[601] Ms Pearn's best recollection was that the meeting occurred sometime after March 2011, when she started working at the hospital.[602] Ms Pearn explained that the meeting with human resources took place before she disclosed her abuse to Tasmania Police (on an informal basis) and the head of another organisation, although we have been unable to confirm when these reports (which we describe in Sections 4.1.15 and 4.1.16) were made.[603] Ultimately, we could not conclude when the meeting occurred but consider that it was likely to have taken place in 2011 or 2012.

There is some dispute about who from the human resources team attended the meeting with Ms Pearn and Mr Millar. At hearings, Ms Pearn gave us her best recollection:

> Q [Counsel Assisting]: Who else attended the meeting?
>
> A [Kylee Pearn]: I'm not 100 per cent sure but I believe it was Gino Fratangelo, who was an HR representative, I'm not 100 per cent sure about that. It was certainly a man.
>
> [...]
>
> Q: You say in your statement you think it was Mr Fratangelo, you can't be sure, it may have been two people but you can't be sure; is that right?
>
> A: Yeah, that's correct.[604]

Mr Millar told us that he 'made a phone call to [human resources]' and that 'both James Bellinger and Gino Fratangelo came straight down to my office'.[605] Mr Millar told us he recalled speaking to either Mr Fratangelo or to Mr Bellinger when he placed the call, saying 'I'm 99 per cent sure [Mr Bellinger] was there, and I'm 100 per cent sure the meeting occurred'.[606]

In their statements to us, neither Mr Bellinger nor Mr Fratangelo acknowledged attending the meeting with Ms Pearn and Mr Millar, but neither disputed that the meeting with the human resources team had occurred.

In his statement to us, Mr Fratangelo said: 'My inability to recall this meeting continues to frustrate me'.[607] When the very strong recollections of both Mr Millar and Ms Pearn that

he had been at the meeting were put to Mr Fratangelo at our hearings, he maintained that he could not recall the meeting. Mr Fratangelo did, however, concede that he 'may have been there'.[608] Mr Fratangelo said:

> I've got no reason to doubt Mr Millar … and I've got no reason to doubt Ms [Pearn], and so where they say I may have been there, then I've got no reason to say that, no, I definitely wasn't there; maybe I was and I just can't remember it.[609]

Mr Bellinger's initial statement to us reflects an understanding that the meeting with Ms Pearn occurred in 2010 or 2011 (because he suggests this is what he was told by someone in the Department). In this regard, he said:

> I have no independent recollection or written record of attending any such meeting. If that meeting occurred, as is suggested, in 2010 or 2011, I was not working for the hospital at the time but working for the Human Services portfolio.[610]

At that stage, the Department was the Department of Health and Human Services. Mr Bellinger's evidence is that he was working in the Human Services area of the Department until April 2012 (which we describe as 'the Human Services portfolio'), when he began to provide support to the Health area (which we call 'the Health portfolio')—assuming responsibility for human resources work for Launceston General Hospital at that time.[611]

After reviewing his statement, it was not clear if Mr Bellinger's evidence was that he might have been at the meeting but could not recall attending or that he did not attend.[612] Counsel Assisting sought to clarify Mr Bellinger's evidence at our hearings:

> Q [Counsel Assisting]: Yes. Each of Mr Millar and Ms Pearn said they believed that you attended that meeting; what do you say to that?
>
> A [Mr Bellinger]: I do not believe I was working for the hospital at that time.
>
> Q: I understand that. Did you attend the meeting?
>
> A: No.
>
> Q: In your statement you say you do not recall. Is your evidence that you do not recall attending such a meeting or that you did not attend such a meeting?
>
> A: My apologies, I do not recall.
>
> Q: Is it possible that you attended that meeting, considered it of such little import that you did not remember it?
>
> A: No.
>
> […]
>
> Q: Is it possible you attended this meeting, Mr Bellinger?
>
> A: No.

> Q: So your statement's gone from, you don't recall, to you're certain you didn't attend; is that right?
>
> A: My apologies. I do not recall attending that meeting, I do not believe it's possible, which I have understood to be the question.[613]

We were struck by Mr Bellinger's careful wording. Nevertheless, we consider, based on his statement and his evidence at the hearing, that Mr Bellinger's position is that he was not present at the meeting. We consider Mr Bellinger's evidence around his attendance at this meeting in light of his actions from 2019 onwards, when Ms Pearn's report again came to light (which we discuss in Section 5).

Ms Pearn was less certain that Mr Bellinger attended the meeting than she was about Mr Fratangelo's attendance. She also accepted there was a possibility that only one human resources representative attended the meeting:

> Q: In your evidence earlier, Ms Pearn, and again now you've referred to 'they' in relation to HR.
>
> A: Yeah.
>
> Q: 'They did this, they couldn't do that, they said this.' I know you're not 100 per cent sure.
>
> A: Yep.
>
> Q: Do you think that there was or may have been a second HR representative in that meeting?
>
> A: It's a possibility in my mind.
>
> Q: Do you want to say anything about who that person might have been, if there was a second HR representative?
>
> A: I believe, if there was a second person there, it would have been James Bellinger.
>
> Q: But you're not 100 per cent sure?
>
> A: No, I'm not 100 per cent sure, no.
>
> ...
>
> Q: I expect that Mr Bellinger will say that he has no recollection of that meeting and that he was working in HR outside the hospital at the time. Do you have anything you want to say in response to that evidence?
>
> A: That's possible, yep.[614]

Mr Millar, while not certain, has consistently recalled that Mr Fratangelo or Mr Bellinger 'or both' attended the meeting. This position is reflected in Mr Millar's sworn statements to the Department in 2021 and to our Commission of Inquiry.[615] We also note that Mr Millar made a notable amendment to his draft statement (drafted by Mr Bellinger) to the Department, which was to add the last two words to the phrase

'I believe it was either Gino Fratangelo or James Bellinger *or both*' [emphasis ours].[616] We explain the circumstances surrounding this statement in Section 5.

Mr Millar told us he could not recall who held the relevant portfolio for the social work department at the time of the meeting (noting, as we explain above, Mr Bellinger's evidence that he only assumed the Health portfolio, which included Launceston General Hospital, from April 2012), but confirmed his recollection that Mr Bellinger and Mr Fratangelo attended the meeting:

> Q [Counsel Assisting]: You said you were assigned an HR advisor. Who was your assigned HR advisor?
>
> A [Mr Millar]: Look, my recall isn't fantastic in this regard, but you know, Gino Fratangelo was at some stage and James Bellinger was at some stage. My recall is that they both attended that meeting.[617]

We received information that the human resources team adhered to its portfolio responsibilities. If so, this might make it unlikely that Mr Bellinger would have been involved in such a meeting, at least until assuming responsibility for supporting Launceston General Hospital in April 2012.

Even if the meeting occurred before April 2012, we cannot conclude on the evidence that Mr Millar, as part of the social work department in the hospital, would not have called a human resources representative from the Human Services portfolio and we do not consider it conclusively rules out that Mr Bellinger may have attended to support Mr Fratangelo. If the meeting occurred after April 2012, Mr Bellinger's evidence that it was not possible that he attended does not apply. Mr Bellinger denies he attended the meeting, regardless of when it occurred.[618]

When pushed on the proposition that Mr Bellinger was not at the meeting, Mr Millar recalled that Mr Bellinger attended this meeting:

> Q: Just out of fairness, Mr Millar, Mr Fratangelo has provided a statement to the Commission and he says he doesn't recall that meeting between you and Ms Pearn. Do you have anything to say to that?
>
> A: Well, simply that I'm 99 per cent sure he was there.
>
> Q: And again, out of fairness to Mr Bellinger, he's provided a statement to the Commission and he says that he doesn't recall a meeting and he wasn't working for the LGH at the time. Do you have anything to say to that?
>
> A: Again, I'm 99 per cent sure he was there, and I'm 100 per cent sure the meeting occurred.[619]

We made significant efforts to find an independent method to verify when Ms Pearn's meeting with human resources staff occurred and the attendees. Our enquiries included seeking sworn statements from all human resources staff employed at the hospital at that time to determine any knowledge of Ms Pearn's disclosure, as well as requesting records, calendar entries and emails from that period from the human resources team.

Some of the difficulty in obtaining information was attributed to IT limitations. The Secretary of the Department, Kathrine Morgan-Wicks PSM, explained in a statement to us that there were 'legitimate circumstances that could account for historical emails being "lost" and not retrievable'.[620] This included that:

- the email accounts of staff who left the Department prior to an email system migration in June–July 2019 were not retained
- since around 2012, shared mailboxes have been subject to 'technical challenges' that make them difficult to access
- emails archived by staff may not have been backed up or may have been deleted.[621]

Despite Secretary Morgan-Wicks' statement that the email accounts of former staff members were not retained after 2019, we are aware Mr Bellinger had some access to Mr Fratangelo's emails from 2012 onwards when he responded to a query from Detective Senior Constable Hindle in October 2019 (noting Mr Fratangelo had retired by that time).[622] This is discussed in Section 5.

No other staff member reported knowledge of this meeting with Ms Pearn and Mr Millar. We did not obtain any records of the meeting. The absence of any records of the meeting is a source of great concern to us.

At our hearings, Counsel Assisting asked Mr Fratangelo whether he would have expected there to have been a record of Ms Pearn's disclosure on Mr Griffin's personnel file. He said:

> I'm trying—ah—yeah, I guess it's fair to say I would have expected a note to be made of the meeting, and equally would have expected—well, I would have expected that I would have spoken to my manager about the meeting, if I was there, and equally I suppose I expect that Mr Millar would have spoken to his manager as well.[623]

When asked about how acceptable it would be to not have a record of this critical disclosure, Mr Bellinger responded: 'There should be a file note of that conversation'.[624]

Mr Millar stated he was 'pretty certain' that the human resources representatives took notes during the meeting.[625]

When questioned about what he would have done if he received Ms Pearn's disclosure, Mr Fratangelo said he would have told Ms Pearn to go to the police.[626] Mr Fratangelo also described what he perceived to be limitations on taking disciplinary action against a staff member under the State Service Code of Conduct, a part of which requires employees to abide by Australian law, which often relies on evidence that a person has been convicted of a crime in order to be satisfied.[627] We note that this statement largely mirrors what Ms Pearn recalls being told in the meeting with the

human resources team in 2011 or 2012. We also understand that, at the time, the Department was reluctant to initiate State Service Code of Conduct investigations unless complainants were willing to be identified and departmental staff were sure that 'a termination of the employment' was likely.

Finding—Launceston General Hospital failed to respond appropriately to Kylee Pearn's disclosure of abuse by James Griffin in 2011 or 2012, leaving children exposed to potential risk for eight years

Ms Pearn's disclosure of her sexual abuse by Mr Griffin to the hospital in 2011 or 2012 reflected a level of risk for the hospital of a significance that cannot be overstated. The failure to take any action in response to this disclosure failed to reduce the very significant risks Mr Griffin posed to paediatric patients on the ward for another eight years (and that those risks may have continued beyond this period had another victim-survivor, Tiffany Skeggs, not reported her abuse by Mr Griffin to police in 2019).

That a meeting occurred between Ms Pearn, Mr Millar and at least one representative of the human resources team is not contested. As described earlier, we consider the meeting most likely happened in 2011 or 2012. Launceston General Hospital was given credible information that Mr Griffin had a history of perpetrating child sexual abuse and was provided with an opportunity to prevent other potential risks to children, but did not act. The hospital did not even record the information to provide future weight or context to interpreting Mr Griffin's behaviour, which at that time included multiple allegations of 'boundary breaches' involving inappropriate non-medical contact with child patients.

We could not identify a specific hospital or departmental policy in place at the time for responding to allegations of child sexual abuse about a staff member. We consider it unlikely that any policies would have guided the human resources team to manage Ms Pearn's disclosure in the way it did. However, if the policies of the time did do so, we consider the hospital, at a minimum, should have taken the following action:

- Launceston General Hospital should have requested and examined all available complaints data or relevant information it held relating to Mr Griffin, which would have uncovered six prior complaints of inappropriate and unprofessional behaviour towards child patients. It should have taken steps, based on these complaints alone, to investigate the possibility of a disciplinary process that would mitigate risks to children on the ward.

- Launceston General Hospital should have discussed with Ms Pearn an intention to make a notification to the then Tasmanian Nursing Board, acknowledging that it would need to be sensitive to Ms Pearn's wishes in relation to whether and how this complaint could be made.

We note that no report was made to Child Safety Services by either Mr Millar or the human resources team. We consider this may have arisen because of confusion about obligations when there is a potential risk to a group of children (rather than a specific child) and when a report is made by an adult who requests confidentiality, which we have seen in other cases. We view this potential confusion as a systemic problem and make no findings regarding their failure to report. A best practice response could have considered whether Ms Pearn's disclosure activated mandatory reporting requirements to Child Safety Services and, if not, discussed whether Ms Pearn would be open to the hospital making such a notification (or making one herself). In future, there should be clarity about where to best report such a disclosure and the role of Child Safety Services in responding to institutional child sexual abuse, particularly when Tasmania's Reportable Conduct Scheme commences (discussed in Chapter 18).

We note that, because Ms Pearn was an adult, it was appropriate for hospital staff to defer to her wishes about making a formal police complaint, which we accept she was not willing to do at that time. We note Ms Pearn's initial disclosure predated the Registration to Work with Vulnerable People Scheme. We consider Ms Pearn's belief that no further steps were taken by the hospital to be true, but we cannot discern whether the hospital's failure was the result of a desire to downplay or minimise the disclosure, or because there was a genuine belief that nothing could be done.

Finding—Luigino Fratangelo and James Bellinger received a disclosure of child sexual abuse from Kylee Pearn relating to James Griffin in 2011 or 2012

We consider, on the balance of probabilities, that both Mr Bellinger and Mr Fratangelo were present at the meeting with Ms Pearn and Mr Millar in 2011 or 2012, in which she disclosed childhood sexual abuse by Mr Griffin. We are more confident in Mr Fratangelo's presence but consider there is enough evidence to find that Mr Bellinger was also present. We base this conclusion on the strength and consistency of Mr Millar's evidence (including a variety of documents we reviewed, not all of which have been described for legal reasons), Mr Bellinger's actions in 2019 when Ms Pearn's disclosure again became known (discussed further in Section 5), and because we found Mr Millar to be a more credible witness than Mr Bellinger.

Finding—Launceston General Hospital did not have adequate processes to ensure the meeting with Kylee Pearn was recorded and that record was retained

We could not determine whether a record of the meeting was not taken or was lost or destroyed. However, it is concerning to us that the human resources representatives who attended the meeting would not document a meeting of this nature, sensitivity and significance.

A disclosure of this kind, which describes child sexual abuse at the hands of a person employed on a paediatric ward, is a disclosure that should be treated with the utmost concern and urgency. The disclosure warranted a clear and accurate record being taken of the discussion and escalation to senior managers to determine appropriate action and ensure children on the ward were safe. Responding to the disclosure required care, concern and steps taken to ensure Ms Pearn had appropriate support, particularly given that she often had to encounter Mr Griffin at the hospital. Failure to take action was a missed opportunity to protect children and young people in the hospital from further abuse by Mr Griffin. It also meant that this information was not considered when subsequent complaints against Mr Griffin arose.

The absence of a record of such a serious disclosure is a significant and unacceptable failing. Eric Daniels, then Chief Executive North/North West ('Chief Executive') conceded the absence of a record constituted a 'substantial and catastrophic failure'.[628] We note Mr Daniels was not Chief Executive until 2016 and did not work at Launceston General Hospital at the time of Ms Pearn's disclosure. We agree with Mr Daniels' observations and consider that it suggests the hospital had inadequate processes to ensure the meeting with Ms Pearn was recorded, and that the record was retained.

4.1.15 2011 or 2012—Ms Pearn and her friend have an informal discussion with Tasmania Police

Sometime after Ms Pearn's meeting with the human resources team in 2011 or 2012, she and her friend (who had also been sexually abused by Mr Griffin) spoke informally with a person they knew at Tasmania Police. In Ms Pearn's words, that person gave them a 'very realistic' assessment of their prospects of securing a conviction against Mr Griffin, so they decided not to proceed with a formal police report at that time.[629] However, Ms Pearn recalls that they did discuss the option of putting information about her experiences on the police system 'so it could sit there in case anyone else came forward, I could back them up'.[630] In her statement to our Commission of Inquiry, Ms Pearn qualified this statement and said she believed this option was discussed and agreed but that she wasn't '100 per cent sure'.[631] No record was made on Tasmania Police systems of this discussion.[632] We consider this lack of record is unfortunate, but note

Ms Pearn did not recollect exactly what was agreed. Ms Pearn also reflected positively on the person from Tasmania Police with whom she had the discussion, including their deference to Ms Pearn and her friend about how they wished to proceed.[633]

Ms Pearn told us that she made a promise to herself at this point that she would come forward, if anyone else did, to have Mr Griffin charged—a commitment she honoured in September 2019 when Tiffany Skeggs reported her abuse by Mr Griffin.[634] Both events are discussed in Section 5.

4.1.16 2011 or 2012—Ms Pearn and her friend report their abuse to an organisation Mr Griffin volunteered with

After speaking to their contact at Tasmania Police, Ms Pearn and her friend decided to speak to the head of an organisation where they knew Mr Griffin volunteered.[635] Ms Pearn recalled that the person they spoke to at the organisation was not shocked by the disclosure, telling them that Mr Griffin gave them 'the creeps'.[636] The person gave Ms Pearn and her friend assurances that Mr Griffin would be restricted in some of his volunteering activities and be monitored at all times.[637] Ms Pearn said: 'I remember feeling relieved that we had at least prevented him from accessing children in this setting and how simple the process had been. If only [Launceston General Hospital] had taken similar steps'.[638]

Following the death of Mr Griffin on 18 October 2019, Ms Pearn's disclosure of her abuse to Launceston General Hospital was again raised with the hospital—this time by Tasmania Police and Ms Pearn herself. We discuss the hospital's knowledge and treatment of Ms Pearn's complaint following the death of Mr Griffin in Section 5.

4.1.17 November 2011—Child Safety Services receives a report about Mr Griffin and notifies Tasmania Police

On 17 November 2011, Child Safety Services received a report about Mr Griffin.[639] The notifier stated that they were very concerned after being visited by two people who disclosed that they had been abused by Mr Griffin when they were children.[640] The notifier provided information about Mr Griffin's contact with children in this particular organisation's context.

On 26 November 2011, Child Safety Services passed on the notification about Mr Griffin to Tasmania Police and, on 28 November 2011, to Child Safety Services for a regional response.[641] On 29 November 2011, Child Safety Services recommended that the matter be closed because Tasmania Police had been notified and because a particular organisation with which Mr Griffin was associated was aware of the risks.[642] There is no evidence that Child Safety Services examined the information it may have held (or had access to) to determine whether there was any more information that suggested Mr Griffin posed a risk to children, including in other settings.[643]

On 21 December 2011, an officer from the Launceston Police contacted Child Safety Services seeking information about the name of the notifier to enable them to follow up.[644] The Child Safety Officer who responded advised him that this information could not be shared. The relevant police officer pressed the Child Safety Officer for the information and, when it was not forthcoming, the police officer asked Child Safety Services to request that the notifier contact police directly because, without this information, police could not take the matter further.[645]

Claire Lovell, Executive Director, Children and Family Services within the former Department of Communities, explained to us that the laws and policies around information sharing were 'very confusing' at the time, and police were not included in relevant legislation as an information-sharing entity. She said the guidance that Child Safety Services staff would have received was to 'protect notifier identity at all costs'.[646] She conceded that the failure to contact the notifier to seek their consent for their identity to be revealed to police was 'a missed opportunity', highlighting that legislation is now more conducive to information sharing.[647]

Former Commissioner Hine told us of long-term problems with Child Safety Services sharing information with Tasmania Police:

> The review of the Griffin matter highlighted that there was still some resistance to providing information in instances up until 2021. Anecdotally, police officers have reported that on occasions, [Child Safety Services] Officers had baulked at providing information about reporting persons and required a warrant.[648]

Commissioner Hine stated that Tasmania Police had sought to improve information sharing between Child Safety Services and Tasmania Police by developing a memorandum of understanding in 2021.[649]

Finding—Child Safety Services should not have closed its November 2011 case into James Griffin without making further enquiries and ensuring Tasmania Police had all the information it required

As we note above, Child Safety Services closed this matter after referring it to Tasmania Police. Yet in doing this, it also failed to pass on all the information it held to enable the police to take any meaningful action. This essentially meant that no one acted on the information received through the notification. While it is impossible to know whether a police investigation would have led to earlier charges or actions to limit Mr Griffin's contact with children, it reflected another potential opportunity to disrupt his offending.

As Ms Lovell notes, it is unfortunate that this critical information was not passed on to Tasmania Police to support an investigation at that time. If staff did not feel empowered to provide this information, they could have contacted the notifier to seek their consent or to request the notifier speak to Tasmania Police.

We asked Tasmania Police what steps it took in relation to the formal notification it received from Child Safety Services in November 2011. In his statement to us, former Commissioner Hine reflected that the investigating officer could have escalated this matter to the relevant detective inspector when Child Safety Services told them they could not provide information about the notifier, but this did not occur.[650] There is also no record that the investigating officer examined the police intelligence system, which would have revealed the 2009 report against Mr Griffin relating to the upskirting that flagged Mr Griffin's employment at Launceston General Hospital (described in Section 4.1.11).[651] Instead, Tasmania Police simply filed this information for intelligence purposes on 21 December 2011.[652]

We note again that a police examination of the intelligence system would have also revealed the 2000 report about concerning material found on a laptop previously owned by Mr Griffin had the 2000 report been recorded in an accessible system, even if an electronic records system was not available at that time.

Finding—Tasmania Police should have made further enquiries to receive the notifier's identity and reviewed previous intelligence holdings relating to James Griffin when receiving the November 2011 information from Child Safety Services

While we accept that Tasmania Police made some efforts to obtain information about this 2011 notification and was not assisted by Child Safety Services, we nonetheless consider this should have been escalated to superiors within Tasmania Police, who may have been empowered to remedy the failure to share information. If the relevant officers had checked the intelligence holdings (which former Commissioner Hine noted there was no record of having occurred), the 2009 upskirting complaint made to police about Mr Griffin would have been on the system (which noted he was a paediatric nurse). This should have then added even greater impetus for police to obtain the necessary information from Child Safety Services so it could investigate.

4.1.18 November 2012—The mother of a patient reports concerns that Mr Griffin was a 'sleaze'

On 30 November 2012, a mother of a patient raised concerns about Mr Griffin with Ms Leonard. She told Ms Leonard that she had heard from staff that Mr Griffin was a 'womaniser' and a 'sleaze' (it was unclear if staff told the mother directly or she overheard something to that effect).[653] Ms Leonard's file note of this concern records the mother as saying: 'You've got men here looking after children—bad things happen we all know this'.[654]

Ms Leonard recalled that she subsequently spoke to her manager, Ms McBeath, who told her that 'the complaint would be noted but there was no need to progress the matter' because 'the patient was due to be discharged shortly after the concern was raised'.[655]

Ms McBeath told us that although she recalls Ms Leonard raising this incident in an informal conversation, Mr Griffin was not identified by name.[656]

4.1.19 6 March 2013—Mr Griffin's Performance and Development Agreement is signed off

Ms Leonard and another unnamed person signed off Mr Griffin's Performance and Development Agreement on 6 March 2013.

Notable features of this Agreement include that Mr Griffin was to have key responsibilities in relation to 'inservice sessions to raise the profile and education of resources' for the admission of patients with eating disorders.[657] It also included '[Nurse Unit Manager] role and responsibilities', beginning in March 2014, with Mr Griffin to 'consider topics for support/education'.[658] Rather than reflecting any concern about Mr Griffin's performance, this Agreement reflects a desire to allow Mr Griffin to have greater management responsibility and to pursue professional development activities that related to a highly vulnerable cohort of young female patients.

4.1.20 April 2013—A confidentiality breach follows a request that Mr Griffin not visit a patient and her mother

In April 2013, the mother of a patient made a request to a hospital staff member that Mr Griffin not visit her or her child on the ward. The mother told the staff member that her request was due to 'family issues' and she did not wish to elaborate further.[659]

This request was then raised with Ms Leonard. Ms Leonard told us that she understands that, in response to the request, the staff member asked Mr Griffin not to attend the room where the young patient was staying—a direction that Mr Griffin appeared to accept.[660] Ms Leonard further stated that a few hours after she was told of the request, the mother advised the staff member that she had received a call from a family member.

This family member had asked the mother about Mr Griffin being excluded from the treatment room because 'someone from the hospital' had called the family member and asked questions about the mother's request.[661] As only a few staff knew about the request, the implication was that Mr Griffin had made the call to the family member, in breach of confidentiality.[662] The staff member notified Ms Leonard and Clinical Nurse Educator, Michael Sherring, about this potential breach. The mother also spoke to Ms Leonard and Mr Sherring directly.[663]

Ms Leonard and Mr Sherring met with Mr Griffin to discuss the breach of confidentiality, which culminated in Ms Leonard sending another letter to Mr Griffin. Mr Fratangelo, from the human resources team, edited this letter before it was sent.[664] The letter, dated 17 April 2013, stated there is 'no situation that is acceptable to disclose any information to another person in relation to patients or families [admitted to the hospital]' and cited a range of professional codes and obligations for Mr Griffin's reference.[665] Ms Leonard concluded the letter as follows:

> I trust that as a result of discussions at our meeting you now fully understand the implications of breaches of [patient] confidentiality and that if there is any further breach, that this will require me to explore disciplinary action via formal processes.[666]

In his statement to our Inquiry, Mr Sherring confirmed that he and Ms Leonard met with Mr Griffin on 17 April 2013 to 'discuss the issue'.[667] Mr Sherring stated that his role in attending the meeting was as 'a third party witness of discussions'.[668] When giving evidence at our hearings, Mr Sherring recalled that Ms Leonard communicated to Mr Griffin the inappropriateness of the patient confidentiality breach, that such breaches were a significant issue, and that a number of attachments relating to Nursing Board guidelines were included with the letter.[669]

Ms Leonard stated that the final copy of the letter was also sent to Mr Bellinger in the human resources team.[670] We note that Mr Bellinger did not report to us that his team had knowledge of this complaint.[671]

At the time that Ms Leonard became aware of the request that Mr Griffin not have contact with a patient and their mother on Ward 4K, she was already aware of a series of boundary breaches by Mr Griffin—several concerns had been raised about Mr Griffin with Ms Leonard in 2009 and a further concern had been raised by a parent in 2012.

4.1.21 8 May 2013—A report is made to Tasmania Police about Mr Griffin, which is passed on to Child Safety Services

Tiffany Skeggs was a young girl when she came to know Mr Griffin outside the hospital environment. On or around 8 May 2013, when Ms Skeggs was 15 years old, her mother shared concerns with Tasmania Police at Launceston that Mr Griffin and her daughter were spending a lot of time together and had constant contact over phone, social media

and email.[672] She also reported that she had witnessed Mr Griffin touching her daughter inappropriately and cuddling her excessively.[673] References in this section to Ms Skeggs are to Ms Tiffany Skeggs and not her mother.

On 13 May 2013, police spoke with Child Safety Services about the mother's concerns. We understand the notification included reference to Mr Griffin's employment on Ward 4K.[674]

In response to the notification, Child Safety Services indicated an intention, in the first instance, to contact a counsellor to talk (presumably) to Ms Skeggs about Mr Griffin's behaviour. Child Safety Services told Tasmania Police that they would advise Mr Griffin that a notification had been made to them about his behaviour.[675] At our hearings, Ms Skeggs recalled receiving contact from an officer from Child Safety Services (we are unclear whether this was a counsellor) and the fear this contact provoked in her. Ms Skeggs stated:

> It had been building up to a point that there was so many questions being asked that I knew by this point that it wasn't right and the behaviour wasn't normal, but I was already in so deep that I couldn't get myself out; I needed to get out but I was too scared to do that, and he had told me that it would destroy me and that he would destroy me if I ever said anything.[676]

Ms Skeggs described feeling blamed during a phone call with the officer from Child Safety Services, saying 'her words to me was that I should not continue engaging in that behaviour, that I should know that it's inappropriate to sit on his knee, I need to change what's happening'.[677] When we asked Ms Skeggs to reflect on the way Child Safety Services engaged with her, she responded:

> You heard from … Ms Pearn … that it was known to police by this point, it was known to [Child Safety Services], and no person with an ounce of experience in engaging with children or taking child sex abuse disclosures from children engaged with me in any way, and the only opportunity that I had at that point to disclose was on a phone call with a stranger in front of my mother.[678]

Tasmania Police sought updates from Child Safety Services on 24 and 25 June 2013, but could not reach the relevant person.[679] Eventually, police spoke with the relevant person, who reported that Ms Skeggs did not disclose any abuse or inappropriate conduct by Mr Griffin.[680]

Child Safety Services ultimately formed the view that Ms Skeggs' mother was having difficulties accepting the 'fatherly relationship' that Ms Skeggs had with Mr Griffin.[681] The officer from Child Safety Services informed police that Mr Griffin had stated he was angry that Ms Skeggs' mother had misread his behaviour.[682] The Child Protection Information System record contains a file note of the conversation with Mr Griffin on 14 May 2013:

> This worker stated that at this level he is better being aware of the concerns and making sure everyone is protective of each other. Jim was ok about this and was pleased that it was at this level rather than anything worse but was still dumbfounded that someone would interpret his behaviour as anything but what it was … This worker stated that there had been no more concern around cuddles and sitting on his lap, but in today's world it was up for [misinterpretation] and precautions needed to be taken. Jim said he could understand this but it was still not nice to destroy a person's reputation. This worker stated that it had not but he needed to be aware of the potential.[683]

Ms Lovell conceded that this framing of the matter by Child Safety Services could be construed as agreement with Mr Griffin that there had been an overreaction to his behaviour but added: 'I think this was their way of cautioning him and trying to disrupt the behaviour'.[684]

In his statement to us, former Commissioner Hine said there was no evidence that police searched the police intelligence system after Ms Skeggs' mother made the report. Rather, investigating police formed the view, based on information from Child Safety Services, that Ms Skeggs would be 'hostile' towards police and contact would cause her 'stress and anxiety'.[685] Tasmania Police closed the report, and the information from Ms Skeggs' mother was filed for intelligence purposes on 23 July 2013.[686] Commissioner Hine said this was 'not appropriate and would not be in keeping with the [Tasmania Police Manual] and guidelines as they now stand'.[687]

The Tasmania Police internal review into the handling of its investigation of Mr Griffin acknowledged that it found no evidence of any 'protective, legal or employment interventions' in response to reports about Mr Griffin in 2013 (and in 2011).[688] The review concluded that: 'In the absence of any meaningful follow up enquiries being apparent, Griffin's status was unaffected or impacted upon, and he remained potentially able to continue his behaviours'.[689]

Counsel Assisting asked Ms Lovell whether she would expect a child protection worker to make enquiries about prior concerns reported to police. Ms Lovell acknowledged that information about the upskirting complaint in 2009 would have been relevant to a risk assessment on this notification.[690] She also acknowledged that the information in the notification about Mr Griffin's involvement at the paediatric ward of the hospital meant that he clearly posed a risk to children and young people in professional settings.[691]

Child Safety Services undertook a risk assessment on this notification, which deemed the 'harm consequence' as 'concerning', the 'harm probability' as 'unlikely' and the 'future risk' as 'low'.[692] When asked to reflect on this classification, considered together with all the information about Mr Griffin that was available to, or easily attainable by Child Safety Services, Ms Lovell stated:

> I don't think that's a low risk of future harm. I think that [the child safety officer] overlooked the pattern and history; if [the child safety officer] had seen that, even followed up on that one matter [the 2009 upskirting] or located more information that we had on file [potentially the report made to Child Safety Services on 17 November 2011] I think [the child safety officer] would have seen that there was a pattern of this, it wasn't a one-off incident that was misunderstood.
>
> So I think that [the child safety officer] … either underestimated the likelihood of future harm or potentially it's a form of confirmation bias which isn't necessarily a cognitive action of the officer involved, it can actually be systemic as well; it can actually be a way of justifying the closure of a matter, where you know that you can't do any more or you feel that you can't do any more with it in order to accept the next matter that's waiting for assessment.
>
> I don't think that's right, I think that's very wrong. I think that it should have been—I think the information should have been gathered and that was an oversight. I think that in an ideal world there would have been more done, but I think for its time that seems to me that that's the type of practice that people were engaging with, quite possibly driven as much by necessity as anything else …[693]

Ms Lovell further stated that since 2013 there has been greater understanding about the manipulation that accompanies sexual abuse and how this manipulation may lead a young person to deny that they were being harmed.[694] She stated that: 'I think that today it would be assessed quite differently to what it was then in 2013'.[695] Ms Lovell added: 'We should have protected Ms Skeggs and we didn't protect her, and for that I barely—It's hard to find the words to say how sorry I am. I'm deeply sorry'.[696]

Finding—Child Safety Services should have taken further steps to assess the risk James Griffin posed in 2013 when concerns were again reported about him

Upon receiving the notification, Child Safety Services should have taken more steps to assess the risk Mr Griffin posed to Ms Skeggs and others—particularly given Child Safety Services' knowledge about his opportunities to offend in several settings, including in his professional role. Child Safety Services should have:

- taken the concerns of Ms Skeggs' mother seriously, particularly given her close relationship with Ms Skeggs and the fact that she directly witnessed some of the behaviour that concerned her
- undertaken a records check for any information to suggest Mr Griffin had previously been the subject of a notification—this would have raised the prior notification in 2011 from the head of an organisation who reported that two people had disclosed to them that Mr Griffin had abused them as children

- engaged with Ms Skeggs in person and in a location that was child-centred and created a sense of safety to disclose—if Ms Skeggs did not disclose, she should have been reassured and given the steps for who to contact if she wanted to talk in the future
- sought more information regarding the 2009 notification to Tasmania Police about Mr Griffin to inform its risk assessment process, noting that, in 2011, Child Safety Services had received information about child abuse allegations involving Mr Griffin.

If this matter was reported to Child Safety Services now, we would expect that it would seriously assess the risk a person posed to any children with whom it was aware an alleged perpetrator had contact—including through their family and through social, professional and volunteer roles. We would also expect that it would report all relevant information to the Registrar of the Registration to Work with Vulnerable People Scheme and relevant professional registration bodies (such as the Australian Health Practitioner Regulation Agency, 'Ahpra').

Finding—Tasmania Police should have reviewed all intelligence holdings about James Griffin in 2013 when a report to Child Safety Services was made

Tasmania Police relied entirely on the information it received from Child Safety Services and, having received the information, did not conduct any searches of its own records.[697] If it had, it would likely have found the previous two reports about Mr Griffin:

- the 30 March 2009 'upskirting' complaint
- the November 2011 report from Child Safety Services.

We note also that information provided to the police about the material found on Mr Griffin's computer in 2000 was not entered into the police database until December 2020.

We note that Tasmania Police has since adopted measures to clarify minimum requirements for investigating child sexual abuse matters and established a memorandum of understanding to facilitate better information sharing with Child Safety Services.

Finding—The child safety system in the mid-2010s was not designed to address child sexual abuse in institutional settings

The above findings concerning Child Safety Services and Tasmania Police indicate failures within each of those agencies but also point to a broader system that failed to adequately address risks to children in institutional settings.

The findings against Tasmania Police and Child Safety Services reflect the following:

- Child Safety Services tended to focus primarily on the risk specifically articulated in a notification. In relation to the 2013 complaint, Child Safety Services confined its risk assessment to the risk that Mr Griffin posed to Ms Skeggs, while in 2009 it confined its risk assessment to the risk that Mr Griffin posed in a particular organisational setting. Child Safety Services did not consider the risk that Mr Griffin posed to others, including other children he may have had contact with in professional or other settings.
- Tasmania Police similarly focused on investigating a specific allegation (and considering whether it would meet the relatively high standard for a criminal prosecution), rather than working proactively with other agencies to address the broader risk posed by Mr Griffin.

This narrow focus from both agencies was further hampered by poor information sharing between them.

We note that some of these issues have been overcome through the introduction of the *Registration to Work with Vulnerable People Act 2013* ('Registration to Work with Vulnerable People Act') on 1 July 2014 (and its related information-sharing provisions), which focuses on assessing risk in occupational and organisational contexts, and can act as a trigger for protecting children more broadly (as it indeed did, in the case of Mr Griffin, on 31 July 2019). Tasmania's introduction of Child and Youth Safe Standards and a Reportable Conduct Scheme (discussed in Chapter 18) will further strengthen safety for children in institutional settings.

Ms Skeggs told us she would often visit Mr Griffin on Ward 4K at Launceston General Hospital and that she could enter the secure unit without any problems because nurses would let her in.[698] She told us:

> Griffin sexually assaulted me on several occasions both on the ward and during our travels throughout the hospital … On one occasion, Griffin was almost caught assaulting me by another staff member whom he did not realise was in the office when we entered the room.[699]

A Ward 4K staff member recalled becoming aware at some point that a young girl had moved into the home that Mr Griffin shared with his wife and children.[700] The staff member said the situation confused them but that they understood it was more of a 'surrogate parenting arrangement'.[701] The staff member also recalled thinking

it was strange when they learned Mr Griffin was taking this young person overseas alone, but given the trip was referred to in the local paper, they said they ultimately considered the trip must have been 'above board'.[702] While she was not named, we infer this recollection relates to Ms Skeggs (her overseas trip with Mr Griffin is described further in Section 4.1.23).

When Counsel Assisting asked Ms Leonard whether she recalled Ms Skeggs visiting Ward 4K, she indicated that she did and that 'it was around netball training and going to netball after school or something like that'.[703]

4.1.22 21 March 2014 and 27 March 2015—Mr Griffin's Performance and Development Agreements are signed off

On 21 March 2014, Ms Leonard signed off another of Mr Griffin's Performance and Development Agreements. A notable entry in this Agreement is Ms Leonard's comment that: 'Jim has participated in supporting staff and providing feedback over the past 12 months. He was [integral] in [providing] detailed specific feedback [designed] to support the improved performance and care provided by staff'.[704] The Agreement also states that Mr Griffin would like 'exposure and support to learn the [Nurse Unit Manager] role and responsibilities – double up days'.[705]

One year later, on 27 March 2015, Mr Griffin's next annual Performance and Development Agreement was signed off. In this Agreement, Mr Griffin's key responsibilities are listed as 'leadership, education, portfolio, advanced clinical skills, clinical knowledge, assist management roles, role model'. Ms Leonard writes that Mr Griffin would like assistance to develop his skills through '[o]ngoing [eating disorder] education'.[706]

4.1.23 10 April 2015—Tasmania Police receives information from the Australian Federal Police about Mr Griffin

On 10 April 2015, the Australian Federal Police shared information with Tasmania Police about Mr Griffin. The Australian Federal Police became aware of this information through its work disrupting the production and distribution of child exploitation material.

The information shared with Tasmania Police revealed that a person was communicating with an undercover law enforcement officer through an encrypted messaging application. This person described various acts of abuse against young girls and sent sexual exploitation material to the undercover officer. The person stated that he was a nurse and that he used antihistamines to sedate his victims.[707] The Australian Federal Police traced the internet protocol ('IP') address of this person to Mr Griffin's home.[708]

Not long after, on 16 April 2015, notes on an Australian Federal Police database indicated that federal police were aware that Mr Griffin was travelling with a then 17-year-old girl, Tiffany Skeggs, for two weeks.[709] Presumably this information was shared with Tasmania Police because the system entry noted: 'Comment from [a Tasmania Police detective inspector] happy to allow travel'.[710]

A later internal investigation by Tasmania Police into its handling of Mr Griffin commented: 'At the time Tiffany was 17 and her mother … was well aware of these travel plans. As such nothing further could be done to stop Griffin and Tiffany Skeggs travelling together'.[711] We note that in Tasmanian law, child sexual abuse refers to offences committed against a person under 17 years of age. However, we also note that Tasmania Police received the information about Mr Griffin travelling with Ms Skeggs in the context of known concerns about Mr Griffin's production and exchange of child exploitation material and prior concerns expressed by her mother about Mr Griffin's conduct towards her in 2013.

On 15 April 2015, the same Tasmania Police detective inspector wrote to the Australian Federal Police as follows:

> We have had extensive conversation regarding this one and have decided not to progress a warrant until we receive the … package [of materials]. We need to be confident the picture/s exchanged depict child exploitation material. We [have] considered his travel plans and the risk the child may or may not be in when making our decision. In the past he has declined to be interviewed and has also displayed … knowledge of hiding his PC history so we need to have as much information as possible in the first instance.[712]

On 26 April 2015, the investigating officer from the Northern Criminal Investigation Branch ('Northern CIB') in Launceston made a note that more information about Mr Griffin, being the evidence or 'package' requested from the Australian Federal Police, was available on the relevant secure system, ready for Tasmania Police to access. The note also stated that the police officer from Tasmania Police's Fraud and e-Crime unit in Hobart, who had access to the secure system, was out of the State but would 'return on Monday'.[713]

On 28 April 2015, the investigating officer from Northern CIB filed the Australian Federal Police report as 'pending further review', with the comment: 'See notes below re additional information now available on relevant system – awaiting package'.[714] On the same day, the Australian Federal Police transmitted the package to Tasmania Police on the secure system, which could be accessed by the Tasmania Police Fraud and e-Crime unit.[715] Although former Commissioner Hine confirmed that the package of materials 'was in the possession of Tasmania Police', it was not received by Northern CIB, not accessed by the Fraud and e-Crime unit, and no further action was taken at the time.[716] Northern CIB first obtained the package more than four years later, on 2 September 2019.[717]

Ms Skeggs described being met by Australian Border Force on her and Mr Griffin's return from overseas on 11 May 2015. Australia Border Force searched their luggage and electronic devices and asked Ms Skeggs and Mr Griffin about their travel, accommodation arrangements and the nature of their relationship. They were told it was a 'random inspection', which Ms Skeggs described as a 'poor effort to lie'.[718]

Ms Skeggs said she and Mr Griffin remained within a few metres of each other through the entire search.

Ms Skeggs said that at no point was she asked directly about whether Mr Griffin had offended against her, and she was not made to feel that she could disclose the abuse she was experiencing:

> Perhaps if authorities had been a little more honest with me, or at the very least a little more competent, I may have disclosed then. If I had been told that Griffin was suspected of committing wrongdoing and that there were other children involved, I may have spoken out. If they had told and demonstrated to me that they could protect me from Griffin, I might have been more honest.[719]

Ms Skeggs told us that despite both of their phones containing images of Mr Griffin's abuse of her, Australian Border Force took no further action: 'After the search of our devices was completed by the ABF they handed them back, told us we were free to go and apologised for causing us to miss our connecting flight to Launceston'.[720]

In response to media reporting of this encounter on *60 Minutes*, Australian Border Force issued a statement: 'The ABF has thoroughly reviewed this matter and is satisfied that the officers conducting the intervention took the appropriate action in compliance with our legislative obligations'.[721] We have not investigated this encounter because the conduct of the Australian Border Force is not within the scope of our Inquiry.

An internal investigative review into Tasmania Police's handling of complaints about Mr Griffin conducted in 2020 noted that the package of materials the Australian Federal Police provided to Tasmania Police contained images and information 'of a high evidentiary value and would have most likely resulted in a conviction'.[722] The report also noted:

> Launceston CIB were directly involved in communications concerning the matter and it was their responsibility to lead, drive and manage the police investigation and external agency notification.[723]

This review further determined that due to Tasmania Police filing the Australian Federal Police information without investigation, there was no direct requirement to notify the Registrar of the Registration to Work with Vulnerable People Scheme, although 'a general ability did exist due to a catch-all clause'.[724] The report noted that an investigation would likely have given the Registrar 'solid facts' to take into account in relation to a risk assessment on Mr Griffin's registration.[725]

In addition, the internal review found no record of Tasmania Police making a referral to Child Safety Services in line with mandatory reporting obligations. This is despite Tasmania Police receiving evidence of an identifiable child being a victim of child sexual abuse.[726] Former Commissioner Hine acknowledged that 'the police response to this report was clearly unacceptable'.[727]

Finding—Tasmania Police failed to act on highly probative evidence regarding James Griffin provided by the Australian Federal Police in 2015

From 28 April 2015, Tasmania Police had a package of information about Mr Griffin in its secure system. This secure system was accessible to Tasmania Police's Fraud and e-Crime unit, and to Northern CIB on request. Tasmania Police took no further action to access that data until 2019, when Detective Senior Constable Hindle sought it as part of his investigation into Mr Griffin.[728] While it is somewhat unclear exactly why this happened, it appears to have essentially involved two errors on Tasmania Police's part, as established from an internal investigative review conducted by Tasmania Police:

- Officers from Northern CIB in Launceston failed to seek the information from Tasmania Police's Fraud and e-Crime unit. The investigating officer from Northern CIB filed the report as 'pending further information' when it should have been filed 'pending review', which would have triggered various reminder system alerts to follow up the material.[729] However, given the officer in charge was aware the package was already available and just needed an officer in the Fraud and e-Crime unit to return the following Monday to access the material, we find it surprising they did not remember to do this irrespective of the way the report was filed. However, we note in Chapter 16 that we were told many times police often gave child sexual abuse matters lower priority when pulled into other matters.
- The Fraud and e-Crime unit failed to provide the material to Northern CIB. We find it difficult to understand why this error occurred but consider it had to do with a limited number of officers having access to the material, the relevant officer being away at the time, a miscommunication with the Australian Federal Police about where the material was going to be sent as a result of the officer being away, and it being unclear between themselves and Northern CIB who had ultimate responsibility for following up on the material.[730]

Two Northern CIB police officers were subsequently disciplined for failing to act with care and diligence in this matter.[731] We learned that a range of system changes now prevents a similar error occurring. A new database has an embedded 'supervisor approval' function, which means that a matter cannot be filed away without a superior reading the investigation notes and determining whether closure and filing is, in fact, appropriate.[732] We also understand that since 2015 the process of providing material through secure files has changed, such that material is physically collected from the Australian Federal Police.[733]

We note that on the public release of Tasmania Police's report on the internal review of its handling of complaints against Mr Griffin in February 2021, former Commissioner Hine issued an apology.[734] This was reiterated at our public hearings, where Commissioner Hine added:

> The impact of [Tasmania Police's] failures are deeply felt and we are committed to improving how we protect children within our community.[735]

We acknowledge Tasmania Police's self-initiated internal review and the apology given to victim-survivors of Mr Griffin's abuse before beginning our Commission of Inquiry. However, we cannot overstate the significance of the failure by Tasmania Police to act in a timely way on credible, probative evidence of child sexual abuse perpetrated by Mr Griffin that would likely have resulted in criminal charges and prevented other children and young people from being harmed.

4.1.24 November 2015—A nurse raises concerns about Mr Griffin's professional boundaries with teenage girls

On or around 2 November 2015, Ms Leonard received a handwritten note about Mr Griffin from a colleague. The note reported concerns raised by another nurse on the ward.[736] It described this nurse feeling uncomfortable about inappropriate behaviour on Mr Griffin's part and stated that Mr Griffin was 'overstepping many boundaries'.[737] The note further relayed that the nurse who had raised the concern felt that one-on-one care of patients should be 'ideally same gender, particularly important for adolescent female[s]'.[738] The note also indicated that the nurse holding the concerns was willing to be contacted for more information.[739]

Ms Leonard was not working at the time the concern was raised and cannot recall what the complaint related to precisely.[740] In relation to the conduct that her colleague had described in the note, Ms Leonard said:

> I observed Mr Griffin frequently greet familiar patients with a hug, including standing side by side with patients and hugging them. From my observations children and parents reacted positively to these gestures. The staff witnessing these hugs did not respond negatively to this. Notwithstanding this, I had directed Mr Griffin to desist from this behaviour as in my view it was not a professional manner in which to greet patients.[741]

A diary note from around the same time (4 November 2015) records Ms Leonard telling Mr Griffin not to sit on patients' beds or hug patients.[742]

Ms Leonard did not take further steps in relation to this complaint, such as contacting the person reporting the concerns, and it does not appear that anyone, including staff in the human resources team, was made aware of it.[743]

4.1.25 21 March 2016—Mr Griffin's Performance Development Agreement is signed off

On 21 March 2016, Ms Leonard signed off Mr Griffin's annual Performance Development Agreement. In this Agreement, Ms Leonard documents that Mr Griffin enjoyed his 'leadership role and supporting junior staff, [graduates] and students' and 'enjoy[s] and appreciate[s] the management role when opportunities arise'.[744] Mr Griffin's continued interest in developing professional skills in relation to patients with eating disorders, and supervising more junior staff, are again reflected in the Agreement.[745] Concerns about Mr Griffin's continued boundary breaches were not referenced.

4.1.26 March 2017—A young patient reports discomfort with Mr Griffin using pet names

Ms Leonard told us that on 3 March 2017, she became aware that a highly vulnerable patient was uncomfortable with Mr Griffin calling her 'babe' and 'sweetheart'.[746] A Child and Adolescent Mental Health Services worker reported this discomfort to Ms Leonard and Mr Sherring.[747]

In relation to Mr Griffin's use of pet names for patients, Ms Leonard told us:

> I recall Mr Griffin calling patients by such names, as well as members of staff. While I did not think it was professional, from my observations, children and their parents reacted positively to the names such that it did not concern me until the complaint was made.[748]

Ms Leonard said that due to the 'complex needs' of this patient, she discussed the complaint more broadly—including with Mathew Harvey, the then Human Resources Consultant within the human resources team, Mr Sherring, broader Ward 4K staff, social workers, staff from Child Safety Services and Child and Adolescent Mental Health Services, the patient's paediatrician and the then Director of Nursing Women's and Children's Services, Janette Tonks.[749] Ms Leonard said she then discussed the matter with the patient and 'following her feedback and request, determined that male staff would not care for the patient overnight, and Mr Griffin would not care for the patient at all'.[750]

Ms Tonks did not refer to this complaint in her statement to our Commission of Inquiry nor in her evidence.[751] Mr Bellinger reported that his team had made him aware of this complaint and described it as being 'appropriately dealt with within the employment framework that existed at this time'. Mr Bellinger added that Ms Leonard 'set clear expectations with respect to [Mr Griffin's] behaviour, appropriate relationships and supported these directions with education'.[752] Mr Bellinger did not have any specific documentation relating to his knowledge of, or extent of involvement in, this complaint.[753] He acknowledged, with the benefit of hindsight, that all parties should have documented 'more specific details about the child's concerns'.[754]

Mr Sherring told us he became aware of this incident on 3 March 2017, through a conversation with the Child and Adolescent Mental Health Services staff member.[755] He said that he and Ms Leonard met with Mr Griffin on 6 March 2017 'to discuss the concerns and provide direction'.[756] He told us that during this discussion Mr Griffin's behaviour was 'clearly identified as a breach of professional boundaries' and Mr Griffin was directed to familiarise himself with his professional responsibilities as a nurse and to amend his behaviour.[757]

Ms Leonard wrote a letter to Mr Griffin following the meeting, on 6 March 2017, copied to Mr Harvey. In this letter, she wrote:

> As this is not the first instance of a complaint of this nature brought forward regarding a patient under your care and that external agencies have been made aware of this concern expressed by the patient, I feel that this is a serious breach of your professional boundaries. As such the benefits from focused education on communication style and non-verbal communication with vulnerable children and families would be advantageous in developing a more flexible communication style that is more responsive to [patients'] needs and circumstances.[758]

The wording of this letter suggests Ms Leonard considered Mr Griffin's complaints history, yet the sanction remained the same—education. Accompanying the letter was the companion document to the Code of Professional Conduct for Nurses, entitled *A Nurse's Guide to Professional Boundaries*.[759] In the letter, Mr Griffin was encouraged to identify and attend an education session to support a change in his practice.[760]

At hearings, Counsel Assisting questioned Ms Leonard on the significance, to her mind, of external agencies being aware of Mr Griffin's conduct, noting that this was specifically referenced in her letter. She explained: 'I think it's in relation to other health professionals with experience in child and adolescent mental health that increases the gravity for me'.[761] The letter from Ms Leonard to Mr Griffin canvasses other matters about the importance of maintaining therapeutic relationships, and then warns:

> … if there is a reoccurrence of such a breach of professional behaviour, I may be required to refer this matter to the Director of Nursing or to an external forum for further investigation.[762]

This comment suggests that Ms Leonard had not escalated the matter to Helen Bryan, the then Executive Director of Nursing, either personally or through Ms Tonks. Ms Leonard noted the hospital had a culture of trying to resolve things 'at a low level in the first instance', which she agreed had the effect of keeping matters 'in-house'.[763] She added there was 'not an openness' to engage with regulatory bodies such as Ahpra or the Nursing Board.[764]

4.1.27 May 2017—A student undertaking a placement complains about Mr Griffin

On 19 May 2017, a clinical facilitator from the University of Tasmania notified Mr Sherring that a student had raised concerns about Mr Griffin, who was her clinical instructor during her placement at Launceston General Hospital.[765] The student objected to Mr Griffin calling her 'babe' and touching her on the arm on more than one occasion; she asked not to work with him again.[766] Mr Sherring told us he spoke to the student on 22 May 2017 and requested an email from the Clinical Facilitator to document the issue.[767] On 23 May 2017, the Clinical Facilitator emailed Mr Sherring and Ms Leonard, and this email was forwarded to Mr Bellinger in the human resources team.[768]

Mr Sherring took on this complaint and reported back to Ms Leonard that it was in fact 'some students' who had expressed discomfort with Mr Griffin's 'familiarisations'.[769] Mr Sherring reported that Mr Griffin could not recall using such terms with the students but acknowledged he had done so in the past and had been counselled by Ms Leonard and Mr Sherring about this.[770] Mr Sherring recommended that no students be allocated to Mr Griffin for the remainder of the placement and advised Mr Griffin he would 'let him know' if he heard him using such inappropriate language with students, staff or anyone else in future.[771] Mr Sherring did not recall having to correct Mr Griffin for using terms such as 'babe' and 'baby' following this incident because he did not observe, or have reported to him, any further incidents of Mr Griffin using such terms.[772]

This is the sixth professional boundary breach by Mr Griffin that we have evidence Mr Sherring was aware of and the eighth boundary breach that we have evidence of Ms Leonard being aware of. By this stage, it should have been apparent that a conversation with, or letter to, Mr Griffin, was not having the effect of altering his behaviour.

4.1.28 26 August 2017—A nurse complains about Mr Griffin having an inappropriate conversation with young female patients

Will Gordon, a nurse on Ward 4K, recalled supervising four teenage female patients as they ate dinner on 26 August 2017.[773] He overheard their discussions about 'messaging guys' on the social media app Snapchat. The patients then asked Mr Gordon what they should say to guys.[774] When Mr Gordon said that the topic was not appropriate for him to comment on, he recalls the patients responded: 'Jim talks to us about this stuff'.[775] Mr Gordon told the patients that Mr Griffin should not be discussing such matters with them.[776] One of the patients then said that Mr Griffin described a woman who worked at the hospital as 'titsy' and that 'he wanted to shag her because she had massive tits'.[777] They also said Mr Griffin gave them advice on 'what guys like'.[778] This summary is based on the evidence provided to us by Mr Gordon. We note that there are minor variations in the multiple documents relating to this matter, but we do not consider these variations consequential.

Mr Gordon recalled speaking with colleagues about what these patients had told him. These colleagues encouraged him to report the conversation to Ms Leonard.[779] The next day, Mr Gordon sent Ms Leonard an email summarising the conversation and asked for his complaint to be treated confidentially.[780]

During hearings, Mr Gordon described why he made the complaint:

> … the nature of the conversation and the way they were talking, the tone, some of the other— you know, the way they were talking about the subject matter, it felt highly sexual in nature … it felt like the comments that James had made to them were sexual themselves.[781]

According to Mr Gordon, Ms Leonard asked that he lodge a report in the Safety Reporting and Learning System, which is the hospital's database for reporting incidents. (Note that some statements and transcripts quoted in this chapter refer to this system as the 'SRLS'.) Ms Leonard told us that she does not recall asking him to do so. She instead referred to Mr Gordon's email, which stated 'I have not completed an SRLS tonight as I did not have the time … but the information that I have provided you is the same information that I would put in an SRLS' as being indicative that he already intended to make a report in the system.[782] Mr Gordon did this on 29 August 2017.[783] When lodging the complaint on the system, Mr Gordon designated it an 'SAC4' incident, which is considered a low-level matter.[784] During the hearings, Ms Leonard conceded that the allegation was one of sexualised commentary and not just a boundary violation, and it should have been escalated as such.[785]

Ms Leonard recalled forwarding Mr Gordon's complaint to Mr Harvey in the human resources team on 28 August 2017 and asking to meet with him to discuss it.[786] It is not clear whether Mr Harvey met with Ms Leonard to discuss the complaint before Mr Gordon lodged the Safety Reporting and Learning System report on 29 August 2017. However, Mr Harvey told us he did recall discussing the complaint with Ms Leonard during their 'regular catchups to discuss HR matters on the Ward'.[787]

Ms Leonard was allocated the Safety Reporting and Learning System file of the incident and was therefore responsible for reviewing it, assessing risk and seeking further information from others named in the report, namely the staff members with whom Mr Gordon discussed the incident before making the complaint.[788] The staff members Ms Leonard sought information from were not witnesses to the actual conversation.[789] Ms Leonard emailed five staff members requesting information.[790] Ms Leonard received two responses, although we note that some staff may have missed her email.[791] The two staff responses were pasted into the progress notes on the Safety Reporting and Learning System.[792]

Mr Harvey was granted access to the Safety Reporting and Learning System file on 4 September 2017, which he reviewed and discussed with Ms Leonard.[793] Mr Harvey told us he provided some advice to Ms Leonard about whether these allegations could

be substantiated, although he did not give us the details of this advice. Mr Harvey then helped prepare a letter to Mr Griffin seeking his response to the concerns outlined in the complaint.[794] On 4 September 2017, Ms Leonard emailed the letter to Mr Griffin.[795] The letter clearly identifies Mr Gordon as the complainant and includes a copy of the allegation raised in the Safety Reporting and Learning System as an attachment.[796]

At hearings, Counsel Assisting asked Mr Harvey why Mr Gordon's identity was revealed to Mr Griffin, noting Mr Gordon's request for confidentiality. Mr Harvey explained that while Mr Gordon had requested confidentiality in his email to Ms Leonard, he later made the Safety Reporting and Learning System entry in his name when he had the option to enter it anonymously.[797] Under questioning by Counsel Assisting, Mr Harvey admitted that the complaint could have been progressed without disclosing Mr Gordon's identity.[798]

Ms Leonard seemed to anticipate the potential for conflict arising from revealing Mr Gordon's identity to Mr Griffin. She notes in her letter to Mr Griffin: 'As you may encounter Mr Gordon or such persons named in the complaint during this process, I expect you will conduct yourself in a professional manner towards them'.[799] Ms Leonard also noted in her letter to Mr Griffin:

> I must advise that while this matter is being addressed internally, there is a possibility that at some point during, or after, that this matter may be referred to an external forum through the actions of a party to this complaint.[800]

Mr Gordon told us that Mr Griffin made veiled comments to him that made it clear he was aware that Mr Gordon had made the complaint. Mr Gordon described an interaction with Mr Griffin prior to Mr Griffin's transfer to Ashley Youth Detention Centre, only a short time after Mr Gordon had made what he thought was a confidential complaint. Mr Gordon said:

> We heard that he was going to Ashley and I went up to him and I said, 'I heard you're going to Ashley, how come you're leaving the ward?' And he said, he looked at me in the eyes and he said, 'There's no one but fucking dibber-dobbers on this ward,' and his tone of voice, his body language, that sort of standing tall, broadening the shoulders and staring me straight in the eye; I knew from that moment that he knew I made the report against him, and he—it almost felt like he wanted me to know that he knew as well.[801]

On 6 September 2017, Ms Leonard received Mr Griffin's response to her letter.[802] Mr Griffin admitted that a patient had asked him what he thought guys liked in girls and that: 'I replied briefly something along the lines of being natural and being themselves, and that pictures of airbrushed girls in magazines wasn't seen as natural'.[803] He stated to Ms Leonard that this was the only time he had a conversation like this with patients. Mr Griffin further replied that his use of the term 'titsy' to describe a staff member was likely overheard by one of the patients when he was speaking to their mother outside the hospital setting.[804] He framed the use of this terminology as a benign 'pet nickname' and 'private joke', rather than a derogatory or sexual comment.

Ms Leonard sent Mr Griffin's response to Mr Harvey. Ms Leonard told us that she and Mr Harvey then discussed the matter and concluded that 'the inappropriate communication did not occur in the course of Mr Griffin's employment and the event should be closed'.[805]

Curiously, the determination that Mr Griffin's conduct did not occur in the course of his employment mirrors the language of what is often considered in a formal investigation pursuant to an Employment Direction under the State Service Code of Conduct (discussed in Chapter 20). We note that neither Ms Leonard nor Mr Harvey had authority to unilaterally initiate or determine a disciplinary matter under the State Service Code of Conduct and it is clearly open to question whether either was sufficiently independent to make a finding about the incident at all. Some of the steps taken in response to Mr Gordon's report gave us the impression of those taken in response to concerns that a breach of the State Service Code of Conduct occurred. Across our case studies, we identified a systemic problem of undertaking such quasi-investigations without the protections accorded through a formal process (including independent investigation and procedural fairness).

Mr Harvey and Ms Leonard made efforts to collate previous complaints about Mr Griffin, but Mr Harvey considered they could not base a decision on these.[806] Mr Harvey told us he believed they were unable to consider 'unsubstantiated' prior complaints when considering fresh complaints against an employee.[807] Mr Harvey stated his understanding of this limitation as follows:

> Q [Counsel Assisting]: And [Mr Griffin's complaints history] nonetheless didn't cause you concern that Mr Griffin's conduct might be seen in a different light?
>
> A [Mr Harvey]: No, because we look at each investigation independently of itself, and then, if we can see that an allegation is proven, then you can look back at the history to say, yes, here is an escalation of what occurred previously. In this one we were able to substantiate that he made the comment about what guys like and we said, yes, that is a concern, that is a breach of your professional boundaries.
>
> Q: So, once a complaint is unsubstantiated it effectively gets put in a memory hole?
>
> A: That is right, because if you can— if you haven't substantiated a claim you can't use that as a basis for finding guilt in future allegations.[808]

Mr Harvey told us that this limitation has been upheld in a matter before the Tasmanian Industrial Commission as recently as 2021.[809] In contrast, Mr Bellinger, also a former member of the hospital's human resources team, told us that 'previous allegations are considered when dealing with new matters and consideration is given to whether the allegations suggest a pattern of behaviour'; however, he was not explicit about the extent to which unsubstantiated complaints could be relied upon.[810] Mr Bellinger also mentioned the 2021 case referenced by Mr Harvey, which suggests a lack of overall clarity about the hospital's position on taking previous complaints into account.

In any event, we note in relation to Mr Griffin that there had been previous substantiated boundary violations with written directions and education that Mr Harvey and Ms Leonard could have considered. In his statement to us, Mr Harvey made a point of noting that Ms Leonard was the delegate responsible for determining the matter and that she ultimately made the decision.[811]

In her statement, Ms Leonard told us that Mr Harvey drafted the letter to Mr Griffin, advising him of the outcome of the investigation, which she signed and sent on 11 September 2017.[812] Mr Harvey initially accepted this evidence during oral evidence but has since clarified that Ms Leonard drafted the final outcome letter and he provided amendments for consideration before the final outcome letter was issued.[813] In part, this letter stated:

> Based on my review of the allegations and with due consideration of the evidence presented, I find that the allegations against you cannot be substantiated.
>
> I am satisfied that the information that you have provided me that the comments made in relation to [another adult] were not made in the course of your employment with Ward 4K.
>
> In relation to patients requesting advice from you, I am satisfied that the response you made was reasonable, well intended and appropriate.
>
> As such, I will not be taking any further action regarding this matter at this point and now consider both matters resolved and closed.[814]

The letter also included a general reminder about maintaining appropriate relationships with patients and their families to ensure 'therapeutic relationships are not compromised'.[815]

In the context of Mr Griffin having received multiple warnings, education and counselling for his unprofessional conduct, Counsel Assisting asked Ms Leonard to explain what she considered to be the threshold for taking more decisive action in response to Mr Griffin's behaviour.

> Q [Counsel Assisting]: At what stage should someone simply be moved away from children? That was a question.
>
> A [Ms Leonard]: Okay, I'm not sure of the answer to that question.[816]

Ms Leonard told us in her statement that 'it was my understanding that meeting with staff, providing education and direction/directives were the first steps in resolving complaints and grievances'.[817] She further stated: 'I always thought that education and redirection would change [Mr Griffin's] behaviour'.[818] As far back as 15 January 2009, in response to a complaint about Mr Griffin, Ms Leonard's own notes stated: 'I mentioned [to Mr Griffin] there were other times that he obviously didn't recall … so speaking about it hadn't changed the behaviour'.[819]

Counsel Assisting questioned Mr Harvey about the characterisation that Mr Griffin's response was 'reasonable, well intended and appropriate'. Mr Harvey conceded that such a description was wrong.[820]

Mr Harvey defended his handling of this incident. In his statement to us, he wrote:

> If the evidence provided in the SRLS indicated that James Griffin made sexual comments to patients, then … I would have recommended further witness statements to assist in determining whether the allegations could be substantiated.[821]

Under questioning, and as later acknowledged by him, Mr Harvey eventually accepted that his view at the time was ill-informed and that the statements (as alleged) were sexual in nature, deeply inappropriate and constituted potential grooming behaviours.[822]

When Counsel Assisting asked Mr Harvey to explain why the patients were not interviewed, Mr Harvey said this was discussed with Ms Leonard but that they ultimately felt they should not interview the patients because 'it would cause a detrimental effect to them whilst they were still under our care'.[823] He added:

> And, yes, obviously now we can say we should have potentially gone to the children. At the time that's the information we received and we thought that was sufficient to make a finding.[824]

Ms Leonard told us that she had no recollection of this decision or turning her mind to whether the patients should be interviewed. She said it would have been important to have external, skilled interviewers undertake this, and that did not happen because the response from Mr Griffin seemed reasonable at the time. Ms Leonard said she felt 'deep regret' and accepted that she should have made further enquiries.[825]

Ms Tonks told us that the Safety Reporting and Learning System complaint was the first time she had heard 'there were concerns with Mr Griffin'.[826] Ms Tonks told us that she did not have regular meetings with Ms Leonard and felt Ms Leonard would come to her if she had any concerns 'as and when required'.[827] Ms Tonks told us at hearings that when she became aware of the Safety Reporting and Learning System complaint, Ms Leonard had alerted her that 'there had been previous … breaches of professional boundaries, but didn't really go into any details about that'.[828] Ms Tonks told us she did not enquire further and understood they occurred prior to 2013 and had been 'addressed appropriately'.[829]

Ms Tonks initially told us that she was satisfied with the response to the complaint at the time, but when asked to reflect on whether she remained satisfied, she replied: 'No, absolutely not.'[830] Ms Tonks reflected:

> I believe that I should have been more actively involved and acknowledge that I should have provided much more support to [Ms Leonard] given that they had absolutely no experience in dealing with grooming behaviours of perpetrators.[831]

Ms Tonks conceded none of the staff had this expertise:

> I don't think any of us had any skills in that area in training and education around potential sexual perpetrators. I don't believe that it was something that we engaged in at all. Should we have been? Absolutely, yes.[832]

Counsel Assisting also asked Mr Harvey about other actions taken to verify Mr Griffin's response, such as contacting the person (the mother of one of the patients) that Mr Griffin said he had the 'titsy' conversation with.[833] Mr Harvey cited a range of barriers to verifying Mr Griffin's account, including that he did not have the mother's contact details and could not access them via patient files. He eventually conceded that Ms Leonard could have obtained this information.[834] Mr Harvey also conceded that no one asked Mr Gordon for more information after he made his report on the system.[835]

Mr Harvey placed great emphasis on his and Ms Leonard's belief that Mr Griffin's comments were not made on the ward and that if they had been made on the ward, there would have been a 'greater escalation'.[836] We note that, in his initial email complaint to Ms Leonard, Mr Gordon contemplated that some of the conversations may have occurred off the ward; however, this did not diminish his concern about Mr Griffin's conduct.[837]

Mr Bellinger was also asked about the management of this complaint, given that he was more senior than Mr Harvey. In his initial statement to our Commission of Inquiry, Mr Bellinger indicated that he accepted Mr Griffin's explanation that the comments were made outside of work.[838] Mr Bellinger noted, as he did in relation to the March 2017 complaint against Mr Griffin, that Ms Leonard 'reminded and set requirements' for Mr Griffin in response to this complaint.[839] Mr Bellinger also stated that a 'more appropriate' response to this situation would have been for Mr Griffin to refuse to engage in any kind of conversation with female patients about 'what guys like' and that 'with the benefit of information that is now available', Mr Griffin's account of the incident should have been tested by speaking with the patients who had relayed the conversation to Mr Gordon.[840]

At hearings, Mr Bellinger told us that Mr Harvey and Ms Leonard should have considered whether Mr Griffin had breached the State Service Code of Conduct. Mr Bellinger also acknowledged that the complaint was of a sexual nature and that it should have been escalated and investigated.[841] He said: 'Given the pattern of behaviour displayed, these matters could and should have been considered differently and more significantly'.[842] He also agreed with the suggestion that a lack of training and awareness likely contributed to their failure to do so.[843] We note that Mr Bellinger was copied into a response that Ms Tonks sent to Mr Gordon on 2 December 2019, after Mr Gordon again raised concerns about how complaints regarding Mr Griffin were managed, following Mr Griffin's death (this is described in Section 5.2.26).

Mr Gordon told us that by reporting the incident to management, he believed he had acquitted his responsibility and therefore he did not notify Ahpra of the incident. He recalled that, at the time he made his report, he received no information about

making a mandatory report. He stated: 'I had faith and trust in the Tasmanian Health Service back then and believe I had fulfilled my obligations by making the SRLS report'.[844]

After logging the report in the system, Mr Gordon said:

> I didn't receive any feedback from Sonja Leonard about the matter. She didn't speak a word to me about it. In my view there should have been some sort of feedback after I made the report. There should have been some follow up to let me know what the outcome of the complaint was. I also expected there would be some sort of investigation, including interviewing the girls. To my knowledge there was no further investigation.[845]

After no action or feedback was provided in response to his complaint, Mr Gordon said he did not report further concerns about Mr Griffin: 'I felt that if I did make a complaint, it wouldn't go anywhere'.[846] Mr Gordon believes that if his Safety Reporting and Learning System complaint was followed up, further abuse of children and young people on Ward 4K would have been prevented.[847] He told us:

> I now feel personally responsible for the children that James abused on the ward following my complaint in 2017. I regret that I didn't pursue the complaint and now refuse to let it go.[848]

We consider that the hospital had the onus to respond appropriately to Mr Gordon's complaint. We discuss Mr Gordon's actions in advocating for greater transparency in how the hospital responded to complaints about Mr Griffin, including his own, in Section 5.

Finding—Launceston General Hospital's response to Will Gordon's 2017 Safety Reporting and Learning System complaint did not comply with the requirements of a State Service Code of Conduct investigation

The response to Mr Gordon's complaint was effectively an informal investigation, which seemed to act as a proxy for escalating Mr Griffin's conduct to the Secretary of the Department for a formal Employment Direction No. 5 investigation for a breach of the State Service Code of Conduct. We are concerned that this reflects a systematic practice we have identified across our case studies of informal investigations being undertaken in response to serious allegations relating to children (whether through one incident or a pattern of conduct), when it would be more appropriate to initiate a State Service Code of Conduct investigation. A formal process can support matters to be investigated by those with the necessary expertise, with appropriate senior management oversight.

There was an inappropriate focus on whether the alleged conduct occurred within or outside the course of employment, which reflects another problem we have identified across our case studies. In this context, such a focus detracts from important considerations, such as whether the person subject to a complaint may pose a risk to children, regardless of how (or where) a complaint about their conduct arises.

Having an independent investigator can increase transparency and confidence in the investigation process and avoid actual or perceived conflicts of interest. In this instance, we consider that the failure to have a suitably independent investigation may have affected the participation of staff witnesses in the investigation. Also, not all relevant people, including the children involved or the adult Mr Griffin referenced regarding the complaint, were spoken to.

Previous complaints were not considered, even when they had been substantiated and responded to with education or direction. In addition, the outcome of the complaint was not appropriately communicated to Mr Gordon.

We consider that Mr Gordon took reasonable steps and acquitted his responsibilities by reporting to the Nurse Unit Manager and lodging a complaint on the Safety Reporting and Learning System. We consider health practitioners should be made aware of mandatory reporting obligations and how to enact them, and of how to make complaints to Ahpra. However, in the context of his overall conduct (including escalation to management), we do not consider that Mr Gordon failed in his duties. We note, also, the general lack of clarity about reporting obligations of junior staff in the hospital (which we discuss in Section 4.2).

4.1.29 4 November 2017—Mr Griffin is transferred to work in a fixed-term role at Ashley Youth Detention Centre

Between 4 November 2017 and 27 April 2018, Mr Griffin was assigned, as a registered nurse, to Correctional Primary Health Services in Ashley Youth Detention Centre (sometimes referred to by witnesses as 'AYDC' or 'Ashley').[849]

Mr Griffin remained a Department employee during this time.[850] Jacqueline Allen, Acting Executive Director, People and Culture at the then Department of Communities, told us that Department was not required 'to conduct any pre-employment checks in relation to employees from other agencies performing duties at AYDC'.[851] Barry Nicholson, Group Director, Forensic Mental Health and Correctional Primary Health Services, told us that health staff at Ashley Youth Detention Centre are employees of the Department of Health and therefore would have already been subject to criminal conviction checks and required to hold registration to work with vulnerable people.[852] Mr Bellinger noted that beyond practicalities (such as determining whether the area that was releasing the potential secondee could effectively backfill them), the hospital would

not take any other steps to determine the suitability of a staff member before they were transferred to Ashley Youth Detention Centre.[853]

It was difficult to find authoritative information about Mr Griffin's transfer to Ashley Youth Detention Centre. Secretary Morgan-Wicks noted that the secondment opportunity was not advertised and that '[t]here is no information in the records available as to how Mr Griffin was known to the Correctional Primary Health team and who requested the transfer'.[854] There is nothing on Mr Griffin's personnel file that made any reference at all to this secondment.[855]

Mr Sherring recalled being included in email exchanges about Mr Griffin's appointment to Ashley Youth Detention Centre, but he could not recall who authorised the transfer or whether it was connected to concerns or disciplinary proceedings.[856] Mr Bellinger was also not aware of the circumstances surrounding Mr Griffin's transfer.[857]

Ms Leonard could also not illuminate the circumstances that led to Mr Griffin's transfer and the process that facilitated it.[858] She was not asked to provide a reference, recommendation or information about Mr Griffin's work history.[859] When asked how she learned of the secondment, Ms Leonard said:

> That's difficult to recall, but I don't know if Mr Griffin told me directly or I was contacted by the manager at Ashley, but I understand as it was a secondment that the HR team were involved in arranging that secondment.[860]

Mr Nicholson speculated that Mr Griffin may have been recruited by an Acting Nurse Unit Manager of Correctional Primary Health Services.[861]

We heard of concerns about Mr Griffin's behaviour while he was at Ashley Youth Detention Centre, although we are not aware of any complaints being made. Former Ward 4K nurse Annette Whitemore told us:

> One of the things I was told by some staff was that J [Mr Griffin] would show them photos of kids' files he had on his phone from when he worked at Ashley Youth Detention Centre. Other nurses would talk about it and say he shouldn't have those photos on his phone, but J never showed them to me.[862]

Mr Gordon also recalled that Mr Griffin, after returning from his secondment in 2018, showed him photographs that appeared to be head shots of children and young people in Ashley Youth Detention Centre. Mr Gordon remembers Mr Griffin describing the offences the young people had committed.[863]

4.1.30 25 May 2018 and 22 May 2019—Mr Griffin's Performance and Development Agreements are signed off

On 25 May 2018, not long after completing his secondment at Ashley Youth Detention Centre on 27 April 2018, Ms Leonard signed off on Mr Griffin's Performance and Development Agreement. His recent secondment to Ashley Youth Detention Centre was not referenced in this document.

In response to a question in the Agreement about how Mr Griffin emulated the values of the organisation, the following was recorded:

- Demonstrating the care and understanding of the challenges and issues surrounding a young patient and family who find themselves in a position of being a patient in a strange environment surrounded by people they don't know.
- Communicating effectively and appropriately to patient.
- Utilising Hospital and Ward policies and procedures to ensure the best health and personal outcomes for young patients and their families.[864]

Performance measures in the Agreement include: 'To provide best possible care to our young patients and their families, and make their hospital stay as enjoyable and stress free as possible' and 'To be a positive role model and provide in-service education and support to fellow staff, junior staff and students on the ward'.[865] We note that in May 2017 a student made a complaint about Mr Griffin's behaviour (refer to Section 4.1.27), yet there is no reference to this in the Agreement, nor any suggestion that Mr Griffin should step back from mentoring or supervising junior staff or students.

Again, there is no mention of any of the complaints about Mr Griffin in the previous year. This indicates to us that Mr Griffin's behaviour apparently bore no consequence to the assessment of his professional performance.

Approximately a year later, on 22 May 2019, Ms Leonard signed off on the next of Mr Griffin's Performance and Development Agreements. This Agreement would be Mr Griffin's last. It largely mirrors, in some parts word for word, the previous year's Agreement.[866]

4.1.31 July 2019—A nurse complains about Mr Griffin's inappropriate comments and actions when administering medication

In mid-July 2019, a nurse on Ward 4K was caring for a patient who required controlled medication, which has additional safeguards in its administration.[867] Mr Griffin prepared the relevant medication, which was checked and administered to the patient with his nursing colleague present.[868] Mr Griffin made a comment to the nurse about the taste of the medication, invited her to put out her hand and placed a drop of the medication on her finger for her to taste.[869] The nurse discreetly disposed of the medication and withdrew from the situation.[870] She then overheard Mr Griffin speaking to the parent of the patient saying 'that's why it is used as a date rape drug'.[871]

The nurse reported this incident to a colleague, who alerted Ms Leonard.[872] Ms Leonard met with the nurse on 22 July 2019 and requested that she put her concerns in the form of a statement.[873] Ms Leonard recalled relaying the complaint verbally to Mr Harvey and Ms Tonks on the same day.[874]

On 31 July 2019 (around the time this complaint was being addressed), hospital staff, including human resources staff, became aware that Mr Griffin's registration to work with vulnerable people had been revoked and that Tasmania Police were investigating him for child sexual abuse. Tasmania Police briefed Dr Peter Renshaw (the then Executive Director of Medical Services) and Mr Harvey about the allegations. Mr Griffin was suspended from duties that day. We discuss this in more detail in Section 5.

On 7 August 2019, Ms Leonard received the written account of the incident from the nurse. As Ms Leonard was aware that Mr Griffin had been stood down in light of a police investigation, and that human resources staff and senior management were managing the hospital's response, she forwarded the written complaint to Mr Harvey and Ms Tonks, describing the concerns reported by the nurse as 'very alarming to me'.[875]

On the same day, Mr Harvey advised Ms Leonard that the complaint would be sent to Tasmania Police through Dr Renshaw to 'determine whether it may be relevant to their ongoing investigation against Mr Griffin'.[876] Ms Leonard told our Commission of Inquiry that she had no further involvement in this complaint and was unsure how it was ultimately resolved.[877] We consider this reasonable given that, by this stage, all matters relating to Mr Griffin (who was by then not in the workplace) were being overseen by the human resources team and senior management.

On 7 August 2019, Mr Harvey forwarded the nurse's complaint to Mr Bellinger and to the Department's former Director of Employee Relations.

Mr Harvey also forwarded the complaint to Dr Renshaw on 7 August 2019, suggesting he send it to Detective Senior Constable Hindle of Tasmania Police. Detective Senior Constable Hindle had initiated an investigation into potential abuse by Mr Griffin following a report, which we describe in Section 5.[878] Dr Renshaw forwarded the complaint to Detective Senior Constable Hindle on 13 August 2019, with a message that it contained 'information from a hospital staff member that may be relevant to your investigation'.[879]

4.2 Undocumented or undated concerns or complaints from staff

In addition to the complaints outlined in Section 4.1, which the hospital acknowledges as having been reported or recorded, we received other information from staff and former staff of Launceston General Hospital about Mr Griffin's behaviour.

We heard that the hospital's practice was to minimise or dismiss concerns, which we consider provides context for why the complaints described below were not documented.[880] In reflecting on the evidence before our Commission of Inquiry, Secretary Morgan-Wicks said:

> From the evidence and from my conversations with several witnesses, including staff that have come forward to report, they all share a common story of feeling fobbed off … or their complaint ignored and they did not feel supported in relation to the serious harms or incidents they reported.[881]

At hearings, Emily Shepherd, Branch Secretary, Australian Nursing and Midwifery Federation (Tasmanian Branch), described some of the discussions she had with staff after Mr Griffin's death, during which many staff members told her of their concerns about Mr Griffin. Ms Shepherd acknowledged that some of the concerns shared by staff members may not have met the threshold for mandatory reporting, but added:

> … their concern was that there was … what appeared to be a pattern of incidents that, you know, was bordering on unprofessional behaviour, and I think that was really a concern about, well, how is it that it is captured over time and how is that escalated?[882]

We also heard of confusion among staff about how to raise a complaint or a concern about the conduct of a work colleague. Ms Shepherd reported staff telling her of multiple and inconsistent approaches taken by the hospital when a concern about a colleague was reported, which ranged from requests to send an email report, to verbal reporting to a manager to lodging a complaint in the Safety Reporting and Learning System.[883]

This evidence was consistent with the documented evidence we received regarding how Ms Leonard managed different complaints about Mr Griffin. For example, as outlined above, in August 2017, Mr Gordon's complaint was recorded and managed through the Safety Reporting and Learning System, whereas in July 2019, Ms Leonard asked a staff member to write a formal statement and forward it by email. At other times, Ms Leonard recorded concerns in her diary or as a file note. Some complaints were managed via email or letters to Mr Griffin.

We consider that it would have been difficult for staff to raise concerns formally if there was no clear process for doing so and if they did not know what process to expect. Ms Shepherd told us that hospital reporting systems should be improved by implementing a consistent approach for raising concerns across the Tasmanian Health Service.[884]

Several staff described their casual or contracted work status as a disincentive to speaking up about concerns they may have held about a colleague. For example, Maria Unwin, a nurse who worked on Ward 4K between 1993 and 2009, told us:

> I further believe that people who ask questions and make complaints at [Launceston General Hospital] are punished for doing so and treated as trouble makers. In my view there is a very strong practice of choosing and promoting people who say 'yes'. I have witnessed this with staff who are highly qualified for positions missing out, in place of staff who are known to agree with management.[885]

Mr Gordon said that fears about not securing a permanent position at the hospital deterred him from raising early concerns about Mr Griffin:

> … I was quite junior at the time and I did not have permanency on 4K and, in order to not upset the apple cart, I sort of didn't raise any concerns that I deemed were what I thought weren't minor but would cause tension between myself and other staff members. I did want to stay there and I thought, if I … started throwing accusations about James Griffin, the other staff members would not take too kindly to it.[886]

Another former employee echoed these sentiments:

> People are reluctant to challenge things because they don't want to jeopardise their career. Obtaining a permanent contract is also a big carrot for nurses at [Launceston General Hospital], and is something nurses don't want to jeopardise by making waves.[887]

Several other undocumented staff complaints that we outline below show that when staff did raise concerns they did not receive a satisfactory response. Sometimes they were told 'that's just Jim' or were encouraged to resolve the concern with Mr Griffin directly. Mr Gordon told us:

> When a complaint was made the managers would often say 'have you spoken to Jim about it', but most staff felt too nervous to confront him. I'm only aware of one nurse that did confront him and that was before I started.[888]
>
> …
>
> I have been told by other 4K nursing staff that numerous grievances on 4K that should have been reported by staff were not reported because they felt 'why bother'.[889]

As discussed earlier in this section, Ms Leonard acknowledged a 'complicated culture' on the ward.[890] She accepted that this culture impeded the reporting of concerns.[891] She conceded that staff would likely be unwilling to escalate their complaints to more senior nursing managers if they doubted they would manage them fairly.[892] We note that Ms Leonard also defended her management of some of the complaints about Mr Griffin on the basis that the staff members who raised concerns 'did not seek feedback, information on outcomes, or advise that they were not satisfied with the outcome of the process'.[893]

Some of the complaints we outline below raise the question of why staff did not independently report their concerns to external bodies such as Child Safety Services or Ahpra. While this would have been ideal, we do not hold any of the staff mentioned below responsible for not reporting their concerns. We consider that any suggestion otherwise fails to adequately take account of the relevant context. In particular, we consider that there was a culture at Launceston General Hospital of not reporting without the permission of senior management.

Ms Unwin told us that although mandatory reporting under child safety legislation was something all staff were required to know about, 'in practice we were told that mandatory reporting would always be managed by the paediatric registrar or paediatrician'.[894] While we accept that we did not seek evidence from a paediatrician on this point, Ms Unwin's comments reflect what is now current policy in the *Tasmanian Health Service Protocol – Complaint or Concern about Health Professional Conduct*. The protocol, which applies to all Tasmanian Health Service staff since November 2020, states:

> In the case of reporting an offence complaint, this should be undertaken through the relevant Executive/Medico-Legal Advisor (South) through Human Resources. Mandatory reporting of a registered health professional, as represented by the organisation, must be sanctioned formally (in writing) and in accordance with line delegations.[895]

We discuss our concerns with this policy in Chapter 15 but note here that it appears to reflect what several staff told us about reporting practice. We could not find an earlier policy about this.

In addition to what Ms Unwin told us, Ms Whitemore said: 'We all knew we were mandatory reporters, and I don't think we were deliberately not told this, but until 2019 when all this happened … I never knew I could go straight to Ahpra'.[896] Mr Gordon told us that most nurses on Ward 4K did not realise they could report their colleagues to Ahpra.[897] He said: 'We just didn't know, we weren't told about it, there was no education about that sort of complaint process'.[898]

Another Ward 4K staff member said it was their practice as a registered nurse to 'escalate concerns first to management and then be directed as to which direction to take next'.[899]

Given an apparent practice of escalation for reporting, which we accept will often be operationally appropriate, we were concerned that the former Executive Director of Nursing, Helen Bryan, told us she was not aware of the Strong Families, Safe Kids Advice and Referral Line—the first point of contact for child safety and wellbeing concerns and the place to which mandatory reports under child safety legislation should be made.[900] Ms Bryan told us, however, that she had no experience with managing child safety allegations and that she was aware of the legislation underpinning the mandatory reporting scheme and her duties as a mandatory reporter.[901]

4.2.1 Maria Unwin

As a former Ward 4K nurse, Ms Unwin told us about a conversation she had with the Nurse Unit Manager who preceded Ms Leonard, sometime in the early 2000s. Ms Unwin expressed that, at the time, she had a general feeling of unease around Mr Griffin and her concern grew when his preference for caring for, and becoming 'new best friends' with teenage female patients, became apparent.[902] She said that when she told the Nurse Unit Manager about her concerns:

> I clearly recall [the Nurse Unit Manager's] response, which was 'everyone has something to offer'. I don't recall if [they] said anything else but recall this being the end of the conversation … As a result of this, I initially felt guilty for judging Jim and not giving him the benefit of the doubt. I also felt there was nowhere else for me to go with my concerns and that the matter had been dealt with.[903]

Ms Unwin felt she couldn't raise concerns with the Nurse Unit Manager again, but she did talk to a more experienced staff remember (whose name she could not recall) and was met with a response along the lines of 'that's just Jim'.[904]

Ms Unwin noted that she generally had 'a great deal of respect for' the Nurse Unit Manager.[905]

4.2.2 A Ward 4K staff member

Another Launceston General Hospital staff member, who worked alongside Mr Griffin on Ward 4K from 2002 and at times acted as Nurse Unit Manager of Ward 4K, told us:

> I also have knowledge of many other occasions through conversation with other staff members of where Mr Griffin overstepped boundaries by physically touching or being physically overfamiliar with patients. These patients appeared to be mostly highly vulnerable teenage girls or chronic illness type diagnoses.[906]

The staff member said that ward staff often noted Mr Griffin's preference for caring for teenage girls.[907]

The staff member stated that Mr Griffin 'regularly referred to his patients as "chicki-babe, babe or princess", and also referred to female staff members in the same way'.[908] They told us that Mr Griffin was verbally affectionate with females and that multiple staff members had observed Mr Griffin being asked to stop using this language.[909] The staff member also told us of having multiple conversations over the many years they worked with Mr Griffin about Mr Griffin's 'overly affectionate behaviour towards teenage girls both internal and external to the ward'.[910]

The staff member further described witnessing an incident in which Mr Griffin carried a patient with a physical disability from a bathroom outside her room to her bed without first drying and dressing her. They recalled that other staff followed Mr Griffin into the patient's room 'to advocate for the patient'.[911] While the staff member found this behaviour concerning, they thought that because the patient's family was in the room, 'she would be safe once there'.[912]

4.2.3 Will Gordon

In addition to the documented complaint Mr Gordon made about Mr Griffin in 2017, he told us about witnessing other concerning incidents involving Mr Griffin:

- Mr Griffin referred to the drug midazolam as being 'like a date rape drug' in the presence of a young patient and her parents while Mr Gordon was

a junior nurse, in either 2016 or 2017.[913] We note that this account is similar to the documented complaint made by another staff member about Mr Griffin in July 2019 (refer to Section 4.1.31).

- Mr Griffin commented on a female infant's lips in 2018, saying 'people would pay thousands of dollars for lips like that'. Mr Gordon noted that Mr Griffin frequently cared for this patient, often by himself.[914]
- Mr Griffin pulled up the nappy of the same female infant, after what Mr Gordon assumed must have been a nappy change, in the absence of a chaperone. This made Mr Gordon's 'hairs stand up on end'.[915]
- Mr Griffin came out of a communal bathroom, unaccompanied, with the same female infant. Mr Gordon added that he was aware of other occasions when Mr Griffin took patients, unaccompanied, to this bathroom.[916]

4.2.4 Other staff

A number of staff or former staff of Launceston General Hospital provided anonymous statements to our Commission of Inquiry about Mr Griffin. Others asked that their identity not be publicly revealed. We have only included information from these statements where the person directly observed or experienced the conduct.

We are conscious that many of these accounts have not been meaningfully tested with key witnesses. For this reason, we have not relied on them in making our formal findings, which we consider can be made on the strength of documented and acknowledged incidents alone. We have not made efforts to draw conclusions about the accuracy or veracity of any individual concern or complaint. However, we considered it important to include this information for completeness and to provide the public with as much information as possible about Mr Griffin's conduct.

A nurse who worked alongside Mr Griffin described to us the following incidents:

- A senior nurse said to them: 'You know Jim likes the young girls, don't you?'. When the nurse questioned what this meant, the senior nurse replied: 'You watch at handover, he will go for the young girls'.[917] The nurse then observed Mr Griffin nominating to care for young patients with eating disorders or chronic illnesses, which confirmed what the senior nurse had said.[918]
- Mr Griffin cared for several girls on Ward 4K and fulfilled the role of a male figure in their lives, including attending a former patient's wedding.[919]
- When caring for a patient who had electrocardiogram dots on her body after an operation, Mr Griffin removed the dots himself. The nurse believed that nurses would usually tell patients that they should remove the dots themselves.[920]

Another nurse who worked alongside Mr Griffin on the ward relayed the following:

- The nurse reported feeling 'immediately uncomfortable' in Mr Griffin's presence, particularly noticing the way he behaved around women and young women.[921]
- Mr Griffin told a sexual joke about a young girl to a group of nursing staff at handover in the presence of a manager, who laughed.[922] When the witnessing nurse raised the inappropriateness of the joke, the response provided was that Mr Griffin had worked on the ward for a long time.[923]
- The nurse verbally raised two concerns about Mr Griffin's behaviour with management—one involving Mr Griffin inappropriately touching a patient's thigh, and the other concerning Mr Griffin specifically choosing to care for physically or emotionally vulnerable female patients, even when he was not their allocated nurse.[924] The nurse recalled raising concerns about Mr Griffin's behaviour with management another 'half a dozen times' while working on Ward 4K.[925] The nurse described these concerns as being based on their 'own observations and gut instinct' and included Mr Griffin's use of pet names for patients and staff, such as 'baby girl', 'gorgeous', 'sweetheart', 'beautiful girl' and 'sexy'.[926]
- The nurse felt they needed to watch Mr Griffin 'because of the way he would invest in patients lives, not just their care', regularly checking in with female patients who were allocated to Mr Griffin and having to watch Mr Griffin's care of these patients.[927]
- The nurse spoke with a senior nurse about feeling uncomfortable with Mr Griffin's 'presence and bedside manner'.[928]
- The nurse observed Mr Griffin spending a lot of time building trust with patients, saying:

  > He did this subtly, often gaining the trust of single mums before he would try with the patients themselves. He had a clear method of gaining trust quickly and cleanly, and it worked. He would pick vulnerable children and then act in a way that he would say was designed to make them feel safe and secure. He'd place himself as the father figure in the lives of young girls who didn't have a father. He would have deep conversations with them, asking them questions beyond what a nurse needed to know.[929]

- The nurse observed a young female visiting the ward 'on several occasions' during 2016 or 2017 to have her knees and ankles strapped due to injury by Mr Griffin in the treatment room, where the blinds and door would be closed.[930]

Another hospital employee described attending to a young female patient in the emergency department in 2019. They observed Mr Griffin 'hovering in the examination bay standing quite close to the patient'.[931] When the staff member questioned why Mr Griffin was there, he told the staff member that he was a friend of the patient's family.

The employee told Mr Griffin he should leave, which he did.[932] This staff member also recalled that, in or around 2019, Mr Griffin was given responsibility to provide one-to-one care to a highly traumatised teenage girl overnight in a single room.[933]

A nurse at the hospital also told us about having a 'creepy' feeling around Mr Griffin.[934] This nurse observed Mr Griffin's behaviour towards a particular young female patient who was highly vulnerable. The nurse recalled observing Mr Griffin calling this patient pet names, such as 'sweetie', and rubbing her back. The nurse says other people witnessed the behaviour. The nurse could not recall saying anything to management but said 'it stuck in my mind', adding 'I remember thinking, you're a creep. It didn't look good'.[935]

4.2.5 Managers

The Nurse Unit Manager who worked on Ward 4K before Ms Leonard between 2001 and 2008 gave evidence to our Commission of Inquiry about several recollections relating to concerns raised about Mr Griffin.

They had a scant memory that a staff member reported seeing Mr Griffin at a sporting match with a former patient and that they felt they needed to address this with Mr Griffin as a potential breach of the State Service Code of Conduct.[936] Mr Griffin admitted taking the former patient to the game along with his own family.[937] When Mr Griffin was reminded that he should not have contact with former patients, he reported to this Nurse Unit Manager that he had stopped contacting the patient.[938] The Nurse Unit Manager accepted his explanation and did not document the incident.[939]

In addition to the complaints that Ms Leonard directly received or documented about Mr Griffin, which we have outlined above, Ms Leonard also made some general observations to us about Mr Griffin's conduct.

For example, she told us that she tried to ensure procedures involving intimate engagement with paediatric patients, such as bathing, were conducted by a nurse of the same gender as the patient, and that she sometimes reallocated patients to different nurses accordingly.[940] Ms Leonard said:

> In my view, Mr Griffin, as well as other staff, did not always demonstrate an awareness of procedures involving intimate engagement with paediatric patients. By this, I mean that if there had been an inappropriate allocation made [and Mr Griffin was assigned to bathing a female patient], he would not raise the issue and request that it be changed.[941]

Ms Leonard gave evidence that she was aware of Mr Griffin having contact with a patient outside the hospital but was not concerned because this patient knew Mr Griffin socially.[942]

4.3 Undocumented or undated concerns or complaints from patients and their family members

We received numerous accounts of Mr Griffin's conduct that were not the subject of a documented complaint from former Ward 4K patients and their families. These accounts of Mr Griffin's behaviour and abuse had many similarities and reflected staff observations of Mr Griffin's grooming practices. This is not an exhaustive account of all the abuses described to us because some people chose to provide information to us confidentially and did not consent to us publishing this information in our report. We are also conscious that some former patients and victim-survivors have chosen not to share their experiences with us.

We note that, like employees of the hospital, patients and their families commonly experienced barriers to making a formal complaint about Mr Griffin, including a lack of response from hospital staff when raising concerns.

4.3.1 Angelique Knight

Angelique Knight was a patient on Ward 4K on and off from the ages of five to 21. She first complained to nursing staff about Mr Griffin when she met him in around 2001, when she was 14 years old. At this time, she found him to be 'touchy feely' with her and recalled screaming at one point 'get that man away from me'.[943] Ms Knight believes that her mother also requested that Mr Griffin not care for her, but her mother's complaints were not acknowledged or responded to, and, after a short period, Mr Griffin was caring for her again.[944]

Ms Knight stated that nursing staff would observe Mr Griffin 'hug and kiss me in the hallways of ward 4K'.[945] However, staff told her Mr Griffin 'was just a touchy feely kind of guy'.[946] She also stated that nursing staff were aware of how close Mr Griffin had become to her while she was a patient and afterwards, including that he intended to give her away at her wedding (refer to Section 4.1.10).[947] When hospital management told Mr Griffin that it would be inappropriate to give Ms Knight away, he acted as master of ceremonies at her wedding instead.[948]

In a statement that Ms Knight made to Tasmania Police and shared with us, she described Mr Griffin:

- adding her on Facebook and giving her his personal mobile number so they could communicate via Facebook and text message[949]
- physically touching her, including hugging her, giving her bear hugs and putting his arm around her waist while engaging in conversation with other nurses[950]
- helping her prepare for showers and baths, including sometimes helping her to undress and washing her back[951]

- helping her to remove electrocardiogram dots from her body, which had been placed over her breasts, chest and abdomen[952]
- placing his hand on the inside of her thigh and resting his hand on her vagina while he sat with her and talked[953]
- kissing her 'for longer than a usual peck'[954]
- referring to her as 'baby girl', 'my princess', 'you're my girl' or 'my favourite girl' and telling staff 'she is my girl'[955]
- questioning her about the details of her relationship and whether she had been intimate.[956]

Ms Knight said in her statement to police:

> People tell me I am lucky it never went down 'that line'. I think that if I had [have] taken him up on his invitations to go away with him what he would have done to me. It crosses my mind constantly and I honestly do not feel lucky at all. I feel disgusting and violated all the time, it just always seems to be on my mind.[957]

4.3.2 Kirsty Neilley

Kirsty Neilley first met Mr Griffin when she was admitted to Launceston General Hospital in October 2015, at the age of 16.[958] Soon after her admission, Mr Griffin began to overstep professional boundaries.[959] Ms Neilley recalled Mr Griffin looking at her Facebook account with her, including photos on her phone, sending her a message to allow her to see his Facebook account and photos, and exchanging messages with Mr Griffin via Facebook, including on his days off.[960] She said that 'Jim was the only nurse that would look at Facebook with me and send me messages'.[961]

Soon after they began exchanging messages via Facebook, Mr Griffin told Ms Neilley he 'wasn't allowed to talk to me on Facebook anymore, and that he would get into trouble if anyone saw our messages'.[962] Mr Griffin gave Ms Neilley his phone number so they could text instead, telling her that if anyone saw those messages they would not know who they were from.[963] Consequently, they started exchanging messages by phone.[964]

Ms Neilley also described Mr Griffin giving her a 'hug and a kiss in my room' before leaving after a night shift, adding that he would never do this during the day.[965] She described Mr Griffin's hugs as 'long'.[966]

Ms Neilley further recalled Mr Griffin taking her out of Ward 4K to get coffee and, on one occasion, to a shop in the hospital to get lollies. She said Mr Griffin once took her to the top of the hospital to look out over Launceston. On this occasion, he held her close while in the elevator and then stood behind her giving her a hug while they were at the top of the hospital.[967]

One night, Ms Neilley awoke to Mr Griffin 'standing beside my bed, holding his phone up with what appeared to be the torch on'.[968] When she asked what he was doing, Mr Griffin responded he was waking her because he was finishing his shift.[969] Ms Neilley said this 'didn't feel right or normal' and that it occurred 'a couple more times'.[970]

Ms Neilley said that at one point she received a phone call from Mr Griffin, who told her that someone had put in a complaint that he was becoming too close to her and that he had been told not to care for her anymore or have any contact with her.[971] Ms Neilley said Mr Griffin laughed before saying he would always care for her but that it would 'depend who was on shift'.[972] Mr Griffin continued to visit Ms Neilley in her room at least once each shift, shutting the door behind him before sitting with her, talking, looking at Facebook and doing puzzles.[973]

Ms Neilley had later admissions to Launceston General Hospital, during which Mr Griffin provided her with nursing care. On one admission she couldn't walk and needed a shower. Mr Griffin helped her to the shower using a wheelchair, but when she finished showering, she noticed she had left her clothes in her room. Mr Griffin told her no wheelchairs were available before picking her up and carrying her back to her room wrapped in a towel.[974] Ms Neilley did not recall whether anyone saw this, but she said she was carried past other rooms on the ward.[975] When Ms Neilley was discharged from the hospital following this admission, she continued to exchange messages with Mr Griffin by phone 'about once a month'.[976]

Ms Neilley got married in 2018. Mr Griffin attended the wedding and posed for photos, telling everybody he was proud of his 'baby girl'.[977] He said it so much that the photographer asked Ms Neilley whether she wanted a photo with her father before calling Mr Griffin over.[978] Ms Neilley recalled that this was the first time Mr Griffin had called her 'baby girl' in front of others and that he had sometimes called her this when she was in hospital.[979]

Ms Neilley had her first child in 2019. During a visit around this time, Mr Griffin said words to the effect of 'I'm so proud of how much you've grown up baby girl. I've still got all your photos of our time together as a memory'.[980] This statement confused Ms Neilley, who assumed he was talking about her wedding photos. It also prompted Ms Neilley's husband to question Ms Neilley about what photos Mr Griffin was referring to, but Ms Neilley did not think anything of it at the time.[981]

4.3.3 Angela

In 2018, Angela (a pseudonym) raised concerns about the care her daughter Lilian (a pseudonym), who has cerebral palsy, was receiving at Launceston General Hospital from nursing staff, including Mr Griffin.[982] Angela said she first became concerned when she saw Mr Griffin rubbing Lilian despite noticing that Lilian was obviously uncomfortable. Angela asked Mr Griffin to stop.[983] When Mr Griffin left the room, she asked Lilian whether she wanted him to be her nurse, to which Lilian responded 'no' using her hand signals.[984]

Angela became increasingly concerned when she noticed on more than one occasion that somebody had been putting cream on Lilian's vagina. When she queried staff about who was applying the cream, she did not get an answer.[985] Angela requested that the cream not be applied and confronted Mr Griffin, who said to Angela 'show me where the issue is'.[986] At Mr Griffin's insistence, Angela pulled her daughter's nappy down slightly. Mr Griffin tapped his hand on Lilian's vagina and said, 'she'll be fine'.[987] Angela instructed that no more males were to change her daughter's nappy and asked that this instruction be put in writing on Lilian's file.[988] Angela recalled the nurse in charge said she would refer the incident to people higher up in the hospital.[989] It is not clear whether this occurred.

Angela also raised her concerns about Mr Griffin and other staff with Child Safety Services, but these concerns were dismissed and no action taken.[990] We have not been provided with a copy of Angela's complaint about the incident.

4.3.4 Other patients

The material below is drawn from anonymous submissions. We have not been able to independently verify this material, nor the identity of all those who made anonymous submissions. We consider, however, that these disclosures reveal common themes about Mr Griffin's conduct, and it is in the public interest to present this material.

One female patient who was admitted to Ward 4K in 2004 told us that Mr Griffin asked other nurses if they would swap patients so he could treat her.[991] She described Mr Griffin as initially being 'just friendly and cuddly' and said he was like this with a lot of the patients.[992] But he soon started insisting that he be present when she showered.[993] He then began 'pulling my tops up and my pants down to check me and touch my private parts' under the guise of medical care.[994] Mr Griffin then started to enter her room at night and sexually assault her while she pretended to be asleep.[995] The patient frequently discharged herself from the hospital to avoid being around Mr Griffin.[996]

The parents of another female patient who was admitted to Ward 4K for lengthy periods from 2008 described Mr Griffin as befriending them 'very quickly' and becoming their daughter's regular nurse. They recalled Mr Griffin:

- saying to their daughter words to the effect of 'don't worry I'll be your nurse', 'you'[re] my special girl', 'you'[re] my only special one' and 'don't worry I'll look after you'
- being 'handsy, rubbing [their daughter's] back, brushing her hair, touching her in some way, carrying her and putting her on his knee'
- regularly calling the patient's mother 'sweetheart' and saying 'I'll look after our special girl, you go have some tea' or 'I'll shower her today, you go have a cup of tea'

- giving his mobile number to their daughter without their knowledge or consent (the parents were not aware of this until a senior nurse told them not to accept phone numbers from staff)
- adding their daughter on Facebook
- telling them he gave a previous patient away at her wedding and that they were still close
- undertaking 'routine nightly checks' where he would come into their daughter's room and use his torch to check the bed and look around her legs and lower half (Mr Griffin explained this to the parents as 'protocol' for the child's medical condition even though other nurses did not do the same)
- randomly turning up at their holiday home when their daughter was on day release from the hospital.[997]

When they asked another nurse whether it was normal for males to shower female patients and use their phone and torch to check under the bed covers at night, the reply they received was 'it's just Jim and how he does his job'.[998]

The mother of another patient who entered the hospital in the early 2010s contacted our Commission of Inquiry to advise of a negative experience her daughter had with Mr Griffin. The mother told us Mr Griffin was forceful with her daughter in attempting to provide medical care and was rubbing and touching her leg, leaving her daughter to describe Mr Griffin as a 'creep' and threatening to walk out if Mr Griffin continued to treat her.[999] The mother told us she complained to one of the nurses. The nurse reportedly said there was nothing that could be done because Mr Griffin had been allocated to her daughter's care. Yet, the mother said this nurse then quietly approached her and assured her that Mr Griffin would not care for her daughter, telling our Inquiry: '[The nurse] gave me a basic acknowledgment she understood what I was saying and what I was referring to'.[1000] The mother is not sure whether this incident was ever documented.

A female patient who was admitted to Ward 4K in around 2012 told us that Mr Griffin was commonly assigned as her nurse.[1001] She described Mr Griffin:

- touching and rubbing her buttocks, neck and inner thighs[1002]
- frequently hugging her for long periods[1003]
- giving her medication when she was distressed, after which she would wake up hours later[1004]
- watching her when she went to the toilet and shower[1005]
- threatening to show the nurses photos of her naked if she did not comply with her treatment plan.[1006]

This patient told us that Mr Griffin was friendly with her family. She also described abuse by Mr Griffin outside of the hospital.[1007]

Another female patient who was admitted to Ward 4K in 2012 and placed under the care of Mr Griffin described her first interaction with him as 'a bit hostile'.[1008] However, after this, he 'suddenly became very charming and charismatic'.[1009] This patient told us that Mr Griffin called her pet names, which she found 'patronising, gross and inappropriate'.[1010] She said that Mr Griffin 'would mostly sit on my bed when he came to my bedside' and that she felt Mr Griffin 'imposed himself on my personal space and acted too familiar'.[1011] Mr Griffin also asked her about her 'personal life and boys', which she found 'strange' as she 'had never liked conversations about "boys", especially with much older men'.[1012] The patient described other incidents including:

- Mr Griffin insisted she expose more of her body than was necessary and against her will, and stared 'intensely at my groin region' when administering an injection.[1013]
- Mr Griffin insisted that he remove sticky dots from her chest, noting that he went to leave when she objected but then checked if anyone was looking and 'walked back to my bed, pulled down the front of my hospital gown, ran his hands over my chest, and also took these sticky dots off'.[1014] The patient was frozen in shock at this interaction, yet Mr Griffin continued to 'act like everything was normal' afterwards.[1015]
- The patient reported Mr Griffin 'shuffling around the room on multiple occasions' during the night when she was in hospital and 'waking to a light on at least one occasion'. She told us that Mr Griffin gave her a 'threatening "look"' while holding something behind his back with his right hand, when he realised she was awake.[1016]

She also recalled Mr Griffin attending to another unaccompanied young female patient in her room at night and hearing the young patient was 'very distressed'.[1017] At the time, she thought Mr Griffin was performing a medical procedure on the other patient, but on reflection she considered 'it would be highly unlikely that such a distressing medical procedure would have been carried out on this child at the middle of the night and by a solo male nurse'.[1018]

Another female patient who was admitted to Ward 4K in 2014 and 2015 recalled Mr Griffin:

- saying to her parents 'I think of her as a daughter'
- touching her thigh while engaging in conversation (she stated that Mr Griffin 'was very touchy-feely and cuddly, always cuddling me, putting hands on me, touching my thigh and rubbing my leg')
- making her shower in her room with the door open and, on one occasion, coming in to talk to her while she was showering

- taking a photo of her on his phone
- holding her down in the presence of a female nurse to collect blood for a blood test.[1019]

Yet another female patient who was admitted to Ward 4K in or around 2014 or 2015 told us that one night Mr Griffin said he needed to check her heart lead stickers and he touched her breast. She said there was no need for Mr Griffin to touch her breast because there were no lead stickers on them.[1020] She also noted that other nurses had previously asked her to check these stickers herself.[1021] The patient recalled:

> That night I called my mum crying and told her I was scared. When mum came up, I was surprised to see her in the morning. I couldn't remember ringing her. I believe that I must have been under the influence of drugs. Mum says I told her what Jim had done and begged her not to leave me there.
>
> Mum stayed that night in the bed next to me. Later she said during the night Jim entered my room and immediately left when he saw my mum.[1022]

In a separate submission to us, this patient's father outlined these same events and described Mr Griffin as giving him 'the creeps'.[1023]

Another female patient who was admitted to Ward 4K at a young age in the mid-2010s recalled that Mr Griffin, who was her night nurse, showed 'inappropriate favouritism to her' by not requiring her to comply with a medical plan.[1024] She further recalled that Mr Griffin:

- touched her breast and buttocks while undertaking observations[1025]
- frequently visited her even when he was not her assigned nurse[1026]
- sat on her bed and rubbed her leg and inner thigh 'towards my vagina' when her parents were not present[1027]
- gave her back rubs and called her 'baby girl', 'darling' and his 'special girl'[1028]
- insisted she change into a hospital gown in his presence, when other nurses would give her privacy[1029]
- tied her hospital gown at the back and touched her buttocks and the side of her breast while doing this, saying 'don't tell anyone', 'that's what friends do', 'this is our thing' and 'this is our little secret'.[1030]

This patient recalled expressing multiple times that she did not want a male nurse. The patient understood that this request was passed on to the Nurse Unit Manager by her mother, but Mr Griffin continued as her nurse.[1031] The patient said that she complained directly to the Nurse Unit Manager about Mr Griffin touching her but that the Nurse Unit Manager 'was dismissive' and 'brushed off my concerns', saying words to the effect of 'he's just a nurse. You know he has to touch you in those places'.[1032]

The patient also told us that she complained to the Nurse Unit Manager about Mr Griffin watching and talking to her when she showered and insisting on drying her off, which other nurses did not do.[1033]

She recalled also telling a senior nurse that she was uncomfortable with Mr Griffin calling her 'darling' and 'baby'.[1034] She said the senior nurse responded with words to the effect of 'oh, that's fine, Jim just says things like that', which she said made her feel she was acting strangely for bringing it up.[1035]

The patient further described Mr Griffin befriending her family members and 'welcoming himself into our family and making himself a part of our lives by stepping in and acting as a father or grandfather figure'.[1036] She told us that Mr Griffin abused her outside the hospital.[1037]

Another female patient who was admitted to Ward 4K in 2018 told us that 'Jim did lots of touching and showed lots of interest in me'.[1038] She described Mr Griffin:

- being 'overfriendly' and calling her 'baby girl' and his 'special girl'[1039]
- sitting on her bed on top of the covers and touching her upper thigh while a parent was present[1040]
- frequently checking in on her when he was on shift[1041]
- helping her shower[1042]
- coming into her room, touching her leg and moving his hand slowly towards her vagina.[1043]

This patient also described instances of grooming and abuse by Mr Griffin outside of the hospital.[1044]

Another patient who made a submission to us said Mr Griffin sexually abused her on Ward 4K during the 2010s while she was an inpatient. She said she had numerous admissions, sometimes for lengthy stays.[1045] She did not provide further details.

In 2005, a young woman disclosed childhood sexual abuse (which occurred outside the hospital) by Mr Griffin to her general practitioner. She told us:

> My reason for seeking his help, other than for personal reasons, was because I was aware James Griffin was employed at Launceston General Hospital in the paediatrics ward. I was concerned he would come into contact with children through his work.[1046]

This woman described her doctor being somewhat surprised by her disclosure because he knew Mr Griffin through local sport. The doctor arranged a referral for her to sexual assault support service, Laurel House, and told the woman he would 'take care of' the issue of Mr Griffin working in the hospital.[1047]

When she came back to the doctor for an appointment sometime later, she recalled the doctor telling her words to the effect of 'you don't need to be worried about LGH'.[1048] She told us:

> When he said this I felt relieved. In my mind I reconciled that I must be the only victim. My GP didn't tell me who he had spoken to or elaborate on why I didn't need to worry. I trusted my GP and felt reassured by what he told me so didn't take it any further with him. I now wish I had asked more about the steps he had taken, but in a way, it was the answer I was expecting because I always thought it was only me.[1049]

She didn't discuss the matter with the general practitioner again and, shortly after, moved away and changed doctors.[1050]

When we contacted this general practitioner, he stated that he had no recollection of this woman's disclosure and had no clinical records to refer to because his records had been handwritten and were lawfully destroyed following the relevant retention period.[1051] We could not confirm whether the doctor contacted Launceston General Hospital about the disclosure.

4.4 Findings

Below, we make a series of findings about the appropriateness of Launceston General Hospital's response to concerns and complaints about Mr Griffin, as well as the systems and processes the hospital used in response to complaints. As noted above, all these findings are based on recorded and acknowledged complaints alone.

Finding—Launceston General Hospital failed to manage the risks posed by James Griffin

There were at least 14 complaints that related to breaches of professional boundaries and confidentiality and of sexualised, unprofessional behaviour by Mr Griffin during his time at Launceston General Hospital. These were never escalated beyond an education and direction response. Launceston General Hospital was on notice to the potential that Mr Griffin posed a serious risk to children and young people—at least from 2011 or 2012, when Ms Pearn made her disclosure, if not before—and should have known this posed a risk to patient safety. In the following findings we identify different aspects of this failing.

Finding—Launceston General Hospital leadership collectively failed to address a toxic culture in Ward 4K that enabled James Griffin's offending to continue and prevented his conduct being reported

From late 2008, we understand there was a hostile working environment in Ward 4K. Throughout our report we have highlighted how the culture of an organisation can enable abuse to occur, as well as prevent it being reported or appropriately dealt with when it does occur. In Chapter 13, we have also described a range of cultural problems that have been highlighted in previous reviews that show significant cultural problems existed within Tasmanian health services, including Launceston General Hospital. We continued to observe many of these problems in our examination of this case study.

The specific culture of Ward 4K, as described to us by many witnesses, combined with the 'hands off' nature of the senior nursing management, created an environment that enabled Mr Griffin to offend unabated. Ms Leonard acknowledged this, stating that the culture and conflict on the ward was 'a perfect storm for Mr Griffin to take advantage of'.[1052] Ms Leonard also described feeling groomed by Mr Griffin and him taking advantage of the poor culture of the ward:

> I have a lot to learn, as we all do, and part of the challenge in responding is that I feel deep, deep, deeply that we were deceived, we were manipulated, and we were sold a version of Mr Griffin that he wanted us to believe; and, unfortunately with all of the distractions and the difficult personalities and the difficult situations on the ward, it's—I feel that it might have opened up opportunities for Mr Griffin to take advantage of and manipulate us.[1053]

There were at least 14 complaints about Mr Griffin's unprofessional behaviour that were never properly escalated. We suspect there were many more concerns that were raised and not addressed or not raised at all. The culture of an organisation is the responsibility of leadership. We find there was a collective failure of leadership in not addressing this toxic culture at Launceston General Hospital.

Finding—Launceston General Hospital failed to consider the cumulative effect of complaints about James Griffin

Each complaint about Mr Griffin was responded to as if it was the only complaint, rather than one in a series of regular boundary breaches against vulnerable children. This meant that the cumulative effect of concerns about Mr Griffin's conduct were not considered and escalated. Professional boundary breach complaints should not be considered as separate individual incidents—such an approach misses the cumulative weight of past complaints or patterns of behaviour when assessing individual

complaints. This is a significant deficit because grooming-related boundary violations often involve multiple individual incidents that on their own may be interpreted as innocuous or one-off instances of poor judgment.

When Ms Pearn's serious complaint was made against Mr Griffin in 2011 or 2012, if not earlier, Launceston General Hospital leadership should have been briefed to support a formal disciplinary response to Mr Griffin under Employment Direction No. 5 for a breach of the State Service Code of Conduct. Around the time we estimate Ms Pearn's disclosure occurred, there were at least seven complaints about Mr Griffin's conduct of breaching professional boundaries. There should have been an escalation to the leadership about the cumulative effect of the concerns to enable an increase in the sanctions imposed on Mr Griffin for repeated unprofessional behaviour.

We accept that in early 2009 some effort was made to consider previous complaints, but only a formal letter was sent to Mr Griffin—there was no evidence of a formal briefing to anyone in the executive. This was the sixth letter sent to Mr Griffin about similar concerns.

In 2017, there were also efforts to collate previous complaints about Mr Griffin, but again, there was no evidence that the leadership was informed about this consolidation of complaints, nor was Mr Griffin reported to Child Safety Services, the Registrar of the Registration to Work with Vulnerable People Scheme (after 2014) or the Nursing Board/Ahpra.

There were several options for reporting Mr Griffin's behaviour. While we accept that many of the individual complaints against Mr Griffin may not have been enough in and of themselves to warrant a report to Child Safety Services, the Nursing Board/Ahpra or the Registrar of the Registration to Work with Vulnerable People Scheme, if the cumulative effect of Mr Griffin's conduct had been considered, a report to external agencies would have been warranted. Alternatively, if Mr Griffin's cumulative conduct had been reported to leadership, it is more likely that the hospital would have treated Mr Griffin's conduct more seriously, triggering a report to these external agencies.

Finding—The response of Launceston General Hospital to complaints about James Griffin suggested it was ultimately not concerned about his conduct

None of the numerous concerns raised with Mr Griffin resulted in a disciplinary response harsher than a letter, education and direction. A disciplinary process was only recommended when there was no other option but to do so, namely, when Mr Griffin was unable to perform his duties when his registration to work with vulnerable people was suspended on 31 July 2019. Ms Leonard described the

focus on further education and maintaining professional boundaries as being 'most generous to Mr Griffin' and that in hindsight 'it is difficult to consider the actions in relation to [the] complaints made about Mr Griffin [to be] adequate'.[1054]

Mr Griffin's continual noncompliance with management directions was not even treated as a performance management issue. At least seven of Mr Griffin's Performance and Development Agreements, all of which were positive about his performance, made no mention of his conduct or the reprimands he had received, which suggested efforts to address his behaviour were not embedded, formalised and documented. Despite Mr Griffin being disciplined through counselling and letters in response to numerous concerns about his behaviour, endorsements of Mr Griffin's Performance and Development Agreements would have given Mr Griffin the impression that management was satisfied with his performance.

We consider that allowing Mr Griffin to act as a supervisor of nursing students and to continue to receive development opportunities and assume greater seniority and responsibility sent the wrong message to Mr Griffin. It had the practical effect of undermining the credibility of management's warnings and would have reinforced Mr Griffin's view that there would be no meaningful consequences for his actions.

In addition, Mr Griffin continued to breach professional boundaries with patients even after being asked to stop (in some instances, in writing). Section 9(6) of the State Service Code of Conduct requires employees to comply with any lawful and reasonable direction given by a person having authority to give that direction.[1055] We consider Mr Griffin's continued non-compliance with instructions from his nurse unit managers was likely to have constituted a breach of such a direction, and we consider this would have been sufficient cause for disciplinary processes to be initiated for a breach of the State Service Code of Conduct.

Finding—Leadership at Launceston General Hospital collectively failed to provide appropriate supervision and proactive oversight, which is a systemic problem

We were struck by the relative invisibility of management in the responses to Mr Griffin. We received evidence that senior managers, despite for many years having had responsibilities over Ward 4K or for medico-legal matters, had little to no idea about Mr Griffin's complaints history.

Helen Bryan, who held the role of Executive Director of Nursing said that 'no informal concerns were raised with me in the early stages but in hindsight they should have been'.[1056] In relation to her reported lack of knowledge about Mr Griffin's conduct, Ms Bryan stated:

> Without being able to comment on the specifics of the complaints, I have a general concern that some of the ward staff who received complaints and/or concerns … from staff, patients and/or families did not appropriately escalate those matters and therefore the response to those matters would have been inadequate. I appreciate that this could have had a significant impact on whoever made the complaint.[1057]

Ms Bryan and Eric Daniels, the then Chief Executive responsible for Launceston General Hospital (noting he began this role in 2016), also told us they were not aware of any concerns about Mr Griffin until 2019.[1058]

As we heard from Professor Erwin Loh, Group Chief Medical Officer and Group General Manager, St Vincent's Health Australia, who is an expert in clinical governance and management of complaints and conduct concerns:

> If senior management isn't aware of problems at the ward or unit level, this is generally because middle managers are only sharing the good news … or they're incompetent or ineffective. Either way, it's a problem for senior management. Senior management has to do its bit to ensure that middle managers have what they need to be effective (e.g. funding and workforce resources).[1059]

Janette Tonks, Nursing Director of Women's and Children's Services from 2013 until 2022, conceded that a culture of active and visible leadership 'certainly could have been done a whole lot better' at the hospital.[1060] During oral evidence, Mr Daniels also conceded that there was a catastrophic failure in management, structures and processes at Launceston General Hospital.[1061] Mr Daniels later said that he was unable to explain his answer fully during his oral evidence and has reiterated that he 'had not been made aware of the nature of, nor extent of many of the allegations'.[1062]

Finding—Launceston General Hospital did not have a robust system for managing complaints involving child safety

As noted above, there were at least 14 complaints about Mr Griffin during his employment at Launceston General Hospital that we could find some record of.

We note that the failings in the responses of some individuals to complaints about Mr Griffin were partly a consequence of inadequate policies, processes and systems at the hospital. It is obvious to us that there was no clear and consistent approach to managing complaints about Mr Griffin. Ms Bryan told us:

> … in my opinion we do not have good systems and we do not have good processes, we do not have record keeping and documentation, and we don't have the resources within the organisation with the expertise and experience to handle such situations.[1063]

Standards of behaviour for staff working in child-facing roles should have been in place so that Mr Griffin's conduct could be transparently assessed, and disciplinary action triggered, in response to his repeated failures to comply with the standards.

The State Service Code of Conduct is not sufficient to assess child safety complaints, given its very general nature. In particular, a professional conduct policy would have assisted in identifying boundary breaches that might amount to grooming behaviour.

We note that Ms Leonard recognised the absence of such standards in 2009 when she initiated a professional boundaries protocol for Ward 4K. We do not consider it should have fallen to a role-holder at Ms Leonard's level to have to address this gap—this should have been a hospital-wide policy (or indeed, a statewide departmental policy).

Management's inconsistent approaches to recording and documenting complaints had the effect of fragmenting and isolating important information about Mr Griffin, which made it difficult to identify a pattern of conduct and to respond decisively to his offending.

Complaints against Mr Griffin were not recognised as a patient safety concern that should be consistently recorded in the Safety Reporting and Learning System. Logging the complaints in this system would likely have increased visibility and oversight of Mr Griffin's behaviour and generally improved the integrity of the hospital's response.

Further, the hospital did not have a defined pathway for escalating complaints. Nursing staff were not guided on what kind of incidents should be reported, to which bodies and by whom, and local managers were not guided as to when they should tell human resources and/or nursing management about a complaint. The absence of a defined pathway for escalating complaints contributed to failures by local managers or ward staff to involve other parties consistently in responding to complaints.

The informal and ad hoc practice of escalating some complaints and not others allowed local managers too much discretion about what they escalated, to whom and when. This lack of formality was a particular risk given that managers may have, at times, had self-interested reasons for not alerting their superiors to problems on their ward and because managers appeared to have had little training for determining the potential seriousness of complaints.

While we accept that policies and systems play an important role in any organisation, we also consider that it was incumbent on managers to apply their common sense and professional judgment in response to complaints. If the hospital's systems were not working, managers should have raised their concerns with those empowered to rectify them.

We discuss recent reforms to complaint management processes in Chapter 15.

Finding—Launceston General Hospital had no clear system, procedures or process in place to report complaints about James Griffin to external agencies

During the time that Mr Griffin was employed at Launceston General Hospital, not one of the internal complaints against him resulted in any referrals or notifications to external agencies such as Child Safety Services, the Tasmanian Nursing Board, Ahpra or the Registrar of the Registration to Work with Vulnerable People Scheme. This hampered the ability of external agencies to scrutinise Mr Griffin's behaviour and to identify continuing risks to child and patient safety.

Matthew Hardy, National Director, Notifications, Ahpra, advised us that the agency received its first (and to that point) only notification about Mr Griffin from Dr Peter Renshaw on 1 August 2019.[1064] Mr Hardy said:

> I am sympathetic to the view that the subsequent alleged extent of Mr Griffin's offending against children, if known to others, could have been acted on sooner had appropriate disclosures have been made to law enforcement, or our agency. I regret that we were not informed of the concerns well before the ultimate notification in August 2019.[1065]

Ms Leonard attributed the failure to notify external agencies about Mr Griffin's conduct to there not being 'an openness that there is today around engaging with those regulatory bodies'. She told us that the tendency was to keep problems in house.[1066] Ms Bryan observed that the hospital did not manage the issue of child safety well and needed to improve, adding:

> Could I guarantee that every nurse, and I'll talk nurse, in our organisation is fully aware of their responsibilities? And I'll be honest and I'll say I couldn't sit here with hand on heart and say yes: I'm going to say no.[1067]

Across the period from 2000 to 2019, there were multiple avenues for reporting Mr Griffin's behaviour, including some mandatory reporting obligations. These reporting options included:

- reporting to a police officer the abuse of a child, noting the offence of failing to report the abuse of a child without a reasonable excuse was only introduced on 2 October 2019[1068]
- informing Child Safety Services (or its predecessor), the Secretary with responsibility for Child Safety Services or a community-based intake service, pursuant to section 13 of the *Children, Young Persons and Their Families Act 1997* ('Children, Young Persons and Their Families Act'), noting that there is only an obligation to 'inform' (including making a report) if the person 'knows or gains knowledge, or believes or suspects on reasonable grounds, that a child is suffering, has suffered or is likely to suffer abuse or neglect'[1069]

- informing and/or making a mandatory report to Child Safety Services, the then Communities Tasmania Secretary or a community-based intake service as an employee of a government agency that provides health services under section 14 of the Children, Young Persons and Their Families Act, noting that there is only an obligation to report when, in carrying out official duties or in the course of their work, the employee 'believes, or suspects, on reasonable grounds, or knows … that a child has been or is being abused or neglected'[1070]
- making a complaint to the Nursing Board of Tasmania from 24 November 1995 to 1 July 2010, noting that this would have been a voluntary complaint in circumstances where a person 'is aggrieved by the conduct of a nurse'[1071]
- mandatory reporting to Ahpra from 1 July 2010 to present, noting that during this time registered health practitioners have been subject to mandatory reporting obligations, including the obligation to notify Ahpra if another health practitioner 'forms a reasonable belief' that a 'second health practitioner has engaged, is engaging, or is at risk of engaging, in sexual misconduct in connection with the practice of the practitioner's profession'.[1072] There is also an option for any person to make a voluntary report to Ahpra in circumstances including, among other things, where a registered health practitioner's professional conduct is or may be of a lesser standard than what might be reasonably expected by the public or the practitioner's professional peers; or the practitioner is not, or may not be, a suitable person to hold registration in the health profession because, for example, the practitioner is not a fit and proper person to be registered in the profession[1073]
- making a report of a registered person that has 'engaged, or may have engaged, in reportable behaviour', even if that behaviour was raised to the Registrar of the Registration to Work with Vulnerable People Scheme before or after 27 November 2015.[1074] Reportable behaviour is 'behaviour that poses a risk of harm to vulnerable persons, whether by reasons of neglect, abuse or other conduct'.[1075]

We note that even if, on the facts, there was not a mandatory reporting obligation to some of these bodies, best practice would be to make a voluntary report in a broader range of circumstances.

It was difficult to determine if there were formal policies relevant to the hospital's reporting obligations. In any event, the evidence we heard from several Launceston General Hospital nursing staff suggests there was no clear system, procedure or process in place for reporting concerns about a colleague's conduct during Mr Griffin's employment. This reflects that there was either no relevant policy or that it was

not embedded and followed. As a result, ward staff, nurse unit managers, senior management and members of the executive were not aware of their distinct roles and responsibilities in relation to reporting and could not appropriately guide and support staff on the issue.

The hospital did not have reporting protocols in place to ensure complaints of misconduct, such as those made against Mr Griffin, were reported to Child Safety Services, the Tasmanian Nursing and Midwifery Board, Ahpra or the Registrar of the Registration to Work with Vulnerable People Scheme.

Hospitals should have systems, procedures and processes in place to ensure staff comply with mandatory reporting and to educate and support individual staff members on such reporting. There needs to be a clear process of responsibility for reporting and documented escalation of matters within an organisation. In addition, an organisational reporting protocol should not mean staff cannot make a mandatory report themselves when they have concerns. They can and should.

We discuss recent reforms to support mandatory reporting obligations in Chapter 15.

4.5 Other matters relating to Mr Griffin between 2000 and 2019

4.5.1 Allegations of Mr Griffin's misuse of medication

In light of information from the Australian Federal Police, victim-survivor Tiffany Skeggs and a hospital colleague that Mr Griffin used medication that he sourced from the hospital in his abuses, we enquired further about medication protocols and practices on Ward 4K.

As earlier outlined, in 2015 Australian Federal Police traced chat logs to Mr Griffin in which he identified that he was a nurse who used antihistamines to stupefy his victims before sexually abusing them.[1076] Ms Skeggs told us that Mr Griffin would steal medications from the hospital or ask inexperienced nursing staff to sign out medication for him.[1077] She said that Mr Griffin was very open about the fact that he never paid for medications and simply took them from the hospital.[1078] Ms Skeggs added that:

> The medication that he had included antihistamines, anti-psychotics, numerous types of sleep medication, pain relief including high strength anti-inflammatories, Panadol, tramadol and panadeine forte. He would hand the medication out to myself and other children.[1079]

Ms Skeggs stated that numerous nursing staff told her that Mr Griffin would steal medications, but that they were afraid to come forward because of the potential consequences for not earlier reporting such breaches.[1080] She also relayed that a Ward

4K nurse had told her that they had witnessed Mr Griffin give a patient medication against doctor's advice and take medications (including the sedating controlled drug Rohypnol) out of the hospital.[1081]

We also heard, as previously outlined, that Mr Griffin's administration of medication was unsafe and unprofessional in at least one instance when he encouraged a colleague to taste a restricted medication and then referred to it as a 'date rape drug' to the father of a patient. Another patient described feeling like she was under the influence of heavy drugs while being cared for by Mr Griffin (refer to Section 4.3.4).

We asked Ms Leonard, Ms Bryan and Ms Tonks about how medication was secured and dispensed on Ward 4K to ascertain how Mr Griffin's procurement of medication could have occurred. Ms Bryan and Ms Tonks had limited information to contribute, noting that they were not performing clinical roles on the ward.

Ms Leonard told us that, in her experience, policies and procedures about storing and dispensing controlled drugs, which are subject to strict access and dispensing controls under legislation, 'were generally adhered to'.[1082] Ms Leonard told us that when she started on the ward in 1999, controlled drugs were stored in a double-locked cupboard in a secured room.[1083] If someone wanted to get medications from the cupboard, they would need to ask the nurse in charge, who carried what were referred to as the 'red keys'.[1084] However, Ms Leonard said that if the nurse in charge was busy or unavailable, they would give the 'red keys' to a registered nurse who would (or should) return them as soon as possible.[1085] She said it was 'possible' to remove drugs undetected under this old system.[1086]

From around 2014, a more secure system was introduced, which required swipe access that was traceable to the individual staff member. Any discrepancies in medication access or stores could then be checked against those who accessed the drug cupboard during the relevant times.[1087] Ms Leonard said that when this system was introduced it was 'common practice' for a second nurse to witness the removal of drugs.[1088]

However, in her statement, Ms Leonard gave an example of when the integrity of the system was compromised:

> I understand there was a SRLS event where discharge medication that had been delivered in the late afternoon by the pharmacist was found to be missing from the Ward 4K drug room when nursing staff were preparing the patient for discharge. I am unable to verify the date this incident took place, however having spoken to [a colleague] I understand it is likely to have occurred prior to 2017. Upon investigation, it was determined that the nursing staff working the late and night shifts had been wedging the swipe card access door open with a towel to prevent it from slamming and waking up nearby patients and families. The event was logged, investigated (including by Tasmania Police) and ultimately processes were changed to ensure that appropriate control measures were in place regarding the safety of controlled medications.[1089]

When Ms Skeggs' assertion that Mr Griffin was stealing drugs from the hospital was put to Ms Leonard, she responded that if this were occurring it would have been detected in the controlled drugs count, which occurred daily. She further replied that any discrepancies in the count were required to be logged on the Safety Reporting and Learning System.[1090] At hearings, Counsel Assisting asked how other drugs, such as antibiotics or antihistamines, which were not subject to particular regulation, were stored and accessed. Ms Leonard said that such drugs were also stored within the secured room, which required swipe access, but that there was no formal reconciliation of stock levels like there was with controlled drugs.[1091]

Ms Tonks told us in her statement that since Ward 4K's redevelopment in 2021, there are two drug rooms that each have swipe card access and are video monitored, providing greater security and traceability of improper access.[1092] Ms Tonks also confirmed that this level of security extends to non-controlled drugs.[1093]

Finding—James Griffin had the ability to take and misuse medications from Launceston General Hospital

We did not find conclusive evidence that Mr Griffin took and misused medications from the hospital, and we have no way to verify that he did. No staff came forward to disclose that they witnessed thefts or otherwise facilitated Mr Griffin's access by not following appropriate procedures for signing out and administering drugs. However, based on the evidence heard, we consider that Mr Griffin did have the ability to take and misuse medications from the hospital. We consider that access (and use) of medications is a unique risk that arises in the context of health practitioners.

4.5.2 1 May 2019—Tiffany Skeggs reports Mr Griffin's abuse to Tasmania Police

On 1 May 2019, a now-adult Ms Skeggs contacted Tasmania Police in Hobart and reported Mr Griffin's sexual abuse of her when she was a child.[1094] On 7 May 2019, Ms Skeggs gave a formal statement to Hobart police.[1095] The Department was not aware of Ms Skeggs' complaint until 31 July 2019 (discussed in Section 5).

Ms Skeggs told police that she met Mr Griffin when she was about eight years old at her netball club, where he volunteered.[1096] Ms Skeggs formed a close friendship with Mr Griffin, which extended to going to his house and joining him on camping trips.[1097] Mr Griffin started abusing Ms Skeggs when she was 13 years old. At this time, he advised her on how to covertly communicate with him via an app on her phone.[1098] The sexual abuse of Ms Skeggs by Mr Griffin continued up until, or soon after, Ms Skeggs turned 17.[1099]

Ms Skeggs told us that Mr Griffin was able to groom her because she lacked the 'family stability' required to protect her and that he 'secluded me and generated maximum distance between me and my family and friends'.[1100] Ms Skeggs also stated that Mr Griffin used her interests, such as in Australian military history, to lure her in.[1101] Ms Skeggs said 'he provided me with all the attention a young girl could possibly want'.[1102] Ms Skeggs described Mr Griffin as having 'perfected the art of grooming children'.[1103]

Ms Skeggs' statement against Mr Griffin was not transferred to the Northern CIB until early July 2019 because the officer taking the statement was 'waiting for Ms Skeggs to provide some more information'.[1104] Launceston Police received the statement on 18 July 2019, and on 19 July 2019 it was allocated to Detective Senior Constable Glenn Hindle to investigate.[1105]

In commenting on the impact of her disclosure to police, Ms Skeggs said that 'from a personal perspective I regret opening my mouth', but she went on to say, 'I would do it all over again in a heartbeat to help others and create the change that is happening now'.[1106]

5 Launceston General Hospital's response to revelations about Mr Griffin's offending

Section 4 provides useful context for what various people already knew, including Launceston General Hospital staff, about Mr Griffin's offending behaviour towards children. In this section—Section 5—we focus on the response of Launceston General Hospital to the police investigation into child sexual abuse by Mr Griffin and continuing concerns among staff and victim-survivors about how the hospital managed prior complaints about Mr Griffin. The report Tiffany Skeggs made to police, described in Section 4.5.2, triggered the police investigation.

On 31 July 2019, Mr Griffin's registration to work with vulnerable people was suspended due to the police investigation. This suspension was ultimately the catalyst for action by Launceston General Hospital because it legally prevented Mr Griffin from performing his employment duties.

News of a police investigation into Mr Griffin for child sexual abuse should have been a matter of significant concern to the executive at Launceston General Hospital and treated as a critical incident. The hospital was aware that Mr Griffin was a longstanding employee, having worked as a paediatric nurse at the hospital since 2001, and that he had the opportunity to form close relationships with young patients over the years. As we describe in Chapter 13 about the particular risks that can arise within health services, Mr Griffin's role as a nurse gave him unique opportunities to abuse children.

The hospital would also have been aware that once Mr Griffin was charged, which occurred in September 2019, there would be significant public concern about his role as a paediatric nurse, with attendant reputational and potential legal risks for the hospital.

We acknowledge that responding to an event such as this is never easy and is rarely perfect. There are complex issues to manage, among them the need to respect confidentiality where justified to ensure sensitivity to victim-survivors (and potential victim-survivors), and to take care not to compromise a police investigation. There is also an understandable desire not to alarm or distress people unnecessarily or to inadvertently create harmful misinformation, particularly where information is emerging in a developing situation. Managing information effectively can also be challenging in a small community, where information can be shared quickly and informally and can sometimes become distorted as it passes through multiple people. We recognise that most organisations are not well equipped to respond to events of this scale and complexity, given their relative infrequency. We kept all this in mind when reflecting on the hospital executive's unenviable task.

When a police investigation arises in relation to child sexual abuse and the suspect is (or was) in a child-facing role, we consider it irrelevant whether the alleged conduct occurred within, or in connection to, the workplace. We also consider it irrelevant whether any complaints of child sexual abuse were 'historical' in nature. The starting point for any organisation's response is assessing and responding to any risks to children in the organisation's care. In this case, this extended not only to managing the immediate risks Mr Griffin posed (before his death) but also in assessing—to the extent possible—whether his conduct may have affected current or former patients.

A police investigation can act as a trigger for an organisation to review its child safeguarding systems. If approached with care and a genuine desire to protect children, a 'root and branch' review can uncover previously unknown abuses and harms. Failures can be acknowledged and affected victim-survivors appropriately supported. Improved child safeguarding strategies and practices can then be adopted and implemented to protect children from future risk.

The hospital's response to Mr Griffin's suspension and the circumstances surrounding it was primarily led by its then Executive Director of Medical Services, Dr Peter Renshaw, with assistance from the human resources team. We heard that Dr Renshaw assumed leadership of the hospital's response because of his medico-legal responsibilities. He was the liaison for Tasmania Police and the person responsible for key briefings to the Secretary of the Department on 31 July 2019 and 5 November 2019.

At our hearings, Counsel Assisting asked an expert in health service governance, Professor Erwin Loh, whether, in his experience, responsibility for medico-legal matters tends to sit with a single hospital executive member or across several individuals.

Professor Loh said good governance requires that a single executive member is clearly accountable for such issues but that they should work in a team and draw on the expertise of others.[1107]

Rather than working to understand the scale of Launceston General Hospital's failure to act on potential risks that were known about Mr Griffin and examine the systems, processes and practices that contributed to that failure or even to identify victim-survivors and offer them support, the evidence suggests that the hospital worked to downplay its knowledge and distance itself from Mr Griffin. This was evident in the failures to conduct a prompt and thorough review of all the information the hospital held about Mr Griffin's complaints history and to ensure briefings up the line about the hospital's knowledge of the potential risks Mr Griffin posed to former patients were accurate and comprehensive. Indeed, the hospital only conducted such a 'review' reluctantly, after staff activated the union into advocating for greater transparency.

Much of the leadership of the hospital was noticeably absent from the response to Mr Griffin's offending. We did not receive evidence (or meeting minutes) to suggest this issue was regularly discussed by hospital leadership. The then Chief Executive Eric Daniels and then Executive Director of Nursing, Helen Bryan, in particular, were not referenced by witnesses to our Inquiry, and their names did not often appear in the documents we reviewed relevant to the hospital's response to Mr Griffin's offending. In their evidence to us, they appeared to have little knowledge of the situation; it seemed that they learned the extent of Mr Griffin's offending from *The Nurse* podcast and from our hearings.

The practical effect of their absence from the response is that the evidence we received focused more on the conduct of those who were directly involved, including many who were significantly more junior than those tasked with the hospital's governance.

In some of these findings we include evidence to provide context or to show an enduring problem that predates leadership role-holders at Launceston General Hospital at the time Mr Griffin's offending became known.

We make specific findings that Dr Renshaw misled superiors, including Secretary Morgan-Wicks, in failing to escalate critical information he received about Mr Griffin's behaviour. We also find Dr Renshaw misled our Commission of Inquiry.

In Chapter 15, we discuss the expert evidence we received about responding to critical incidents and recommend that the Department develops a critical incident response plan to respond to traumatic events such as this (refer to Recommendation 15.19). The absence of a plan like this leaves an organisation at risk of compounding trauma and distress when such an event does occur. This is what happened at Launceston General Hospital.

5.1 Overview of Launceston General Hospital's leadership response

Several members of the hospital's leadership indicated to us that they were largely unaware of the extent of Mr Griffin's complaints history until our hearings, which occurred more than three years after Mr Griffin's registration to work with vulnerable people was suspended.

We saw no evidence that Launceston General Hospital took steps to promptly and thoroughly review Mr Griffin's complaints history to satisfy itself of what was known to the hospital about him and to determine whether there was any indication that children may have been harmed under his care.

We requested minutes from any executive meetings at which Mr Griffin was discussed and were told that none existed.[1108]

Ms Bryan told us that she was not aware of any investigations into Mr Griffin's conduct after 31 July 2019: 'I didn't see a report; I had no further input or feedback. I got a lot of my information from the two podcasts I listened to'.[1109] Ms Bryan agreed that although she should have been given more information about the matter, it was an omission on her part not to have sought further information.[1110] Ms Bryan told us that the hospital did not have good systems and processes in place—including in relation to record keeping, resourcing and expertise within the organisation—to respond to situations of this nature.[1111] She agreed that there was a complete failure of senior leadership to respond appropriately to Mr Griffin's conduct.[1112] Ms Bryan later told us that she considers that, since 2022, the hospital has taken steps to improve its systems and processes in relation to child safety.[1113]

When Counsel Assisting asked Dr Renshaw, in September 2022, what changes were made to the hospital's systems and processes in the aftermath of Mr Griffin's suspension, he replied: 'I'm not certain that there have been any marked changes'.[1114] When he was asked how he could be sure the hospital was safe considering this observation, he responded: 'As I'm not aware of any formal action items and what they would be intended to achieve, I really can't answer that.'[1115]

Mr Daniels acknowledged that as the hospital's Chief Executive he had an obligation to ensure Launceston General Hospital was safe.[1116] However, when Counsel Assisting asked why he did not initiate a robust investigation once allegations about Mr Griffin emerged on 31 July 2019, he responded: 'I can't answer that, I'm sorry'.[1117] He added that he believed the police investigation would have acted as an external review.[1118] Mr Daniels later told us that he did not have the opportunity to fully explain his answer in oral evidence and reiterated that he was not aware of the nature or extent of many of the allegations until our hearings.[1119]

Finding—The response of Launceston General Hospital to revelations about James Griffin's offending was passive and ineffective

Senior leaders appeared to have a complete lack of curiosity or sense of duty to examine the systems, practices, policies and work cultures that may have contributed to Mr Griffin continuing to work on the ward for 18 years, despite a series of concerns (many documented by the hospital) about his behaviour. The police investigation into Mr Griffin should have been a catalyst for the hospital's leadership to review child safeguarding systems and processes more broadly at the hospital—and to learn and improve, based on weaknesses uncovered. Yet at no stage did any member of the hospital's leadership seek to comprehensively and independently investigate whether the risks Mr Griffin posed to children could have been foreseen and whether the hospital had the best possible policies, practices and systems in place to safeguard its child patients. Most of this information would have been readily discoverable had the hospital's leadership taken an active interest.

We find that the following should have occurred when the hospital was alerted to the police investigation:

- The risk posed by Mr Griffin, particularly following the laying of charges against him on 17 September 2019, should have been explicitly discussed at executive meetings. Such discussions would have prompted better information sharing between the broader team and provided grounds for a considered and collective response.
- The hospital should have overseen a thorough and rigorous review of all complaints relating to Mr Griffin, rather than relying on the manifestly deficient reviews undertaken by the human resources team (described later in this section), which arguably held a conflict of interest given its role in responding to complaints to Mr Griffin in the past. Such a review would have revealed several systems, process and cultural barriers to effectively managing complaints. These issues should have been escalated to Mr Daniels and the Secretary.
- The hospital should have developed a response strategy to the police investigation of Mr Griffin, including a plan for communicating with staff (particularly Ward 4K staff), patients, their families and the public. This strategy should have anticipated different scenarios—for example, if Mr Griffin was convicted or acquitted—and recognised the ways in which the hospital's interests overlapped or differed from the police investigation (in having a broader systemic focus on safeguarding, for example). The plan

should have supported information sharing with Tasmania Police and other agencies, such as Ahpra, and developed strong information-sharing practices with all relevant agencies.

- The hospital should have taken proactive steps to determine the possibility that patients were harmed by Mr Griffin. This should have included reviewing Mr Griffin's complaints history (described in Section 4) and learning as much as possible from Ward 4K staff about any suspicions and concerns they may have held that could help the hospital determine if particular patients and their families should be contacted or provided with support. The hospital should have liaised with Tasmania Police throughout this process.

Finding—Leadership at Launceston General Hospital was dysfunctional and this compromised its collective response to revelations about James Griffin

We received evidence that the culture among the leadership at Launceston General Hospital was dysfunctional. This evidence provided further context to us for why the hospital's response to Mr Griffin's conduct was manifestly inadequate.

Former Executive Director of Nursing, Ms Bryan, described having 'very little involvement with the allegations relating to Mr Griffin' after 31 July 2019, despite Ward 4K being within her area of responsibility.[1120] She indicated that Dr Renshaw and the human resources team managed the response.[1121] She conceded that she should have been involved, given Mr Griffin was a nurse, but she described feeling 'disconnected' and 'not included in the process'.[1122] She said:

> I don't know [whether Dr Renshaw] deliberately excluded me, but … there were multiple meetings that I had become aware of either after the event that I was never invited to attend or included to attend; that doesn't dissolve my accountability and I accept that and I would do things very differently if this happened tomorrow.[1123]

Ms Bryan apologised for allowing others to exclude her from the process, stating that she 'probably' omitted to properly fulfil her responsibilities.[1124] We also accept Ms Bryan's evidence that Dr Renshaw excluded her, despite her being his peer on the executive.

Dr Renshaw initially did not agree that it was open to us to find that leadership at Launceston General Hospital was dysfunctional and had no clear focus on protecting children from sexual abuse.

Dr Renshaw told us:

> In my view, this was an absolutely unprecedented situation that … nobody had had any experience in, and yes, we muddled through, but it was not ideal. Probably what we could be criticised for was not being dysfunctional but not being resilient or flexible enough to try and work out better ways of ensuring the safety of children in the hospital as a result of this experience.[1125]

When questioned on this point by Commissioner Benjamin, noting (among other things) the evidence of leadership failures in Case study 2 (which occurred while Dr Renshaw was employed at the hospital), Dr Renshaw was invited to closely reflect whether he truly stood by the position he articulated above. He conceded it would be open for us to find that the leadership of the hospital was dysfunctional. We do so.

Finding—Launceston General Hospital did not have clear accountabilities for child safety

Elizabeth Stackhouse, a former Chief Executive Officer of Launceston General Hospital, told our Commission of Inquiry that, during her time in the role between 1998 and 2003, the hospital did not have any strategic plans, performance measures or key indicators that directly or indirectly related to child safety, including allegations of physical or sexual abuse of children.[1126] Dr Stephen Ayre, who was in the role from 2004 until 2008, could not recall whether or what plans were in place.[1127] John Kirwan, who acted in the role from mid-2008 until 2015, also told us that there were no indicators relating to child safety. He explained that, at the time, 'the focus was to move away from detailed input-based metrics to outputs and have the key strategic focus captured on one page'.[1128]

We saw no indication that one individual, committee or role-holder was responsible for ensuring child safety at the hospital.[1129] Ms Stackhouse could not recall whether there was a separate role-holder responsible for child safety during her tenure. She told us that patient safety generally, for adults and children, was monitored by the quality committee.[1130] Dr Ayre said that during his tenure 'the overall safety of the patients and staff at the hospital rested with the executive team and every staff member'.[1131] Mr Kirwan also did not recall the hospital having a specific role-holder responsible for child safety. He stated: 'If it was a requirement of the then National Safety and Quality Health Service accreditation standards, I am sure [there] would have been'.[1132] Despite this, he could not identify which roles held ultimate accountability for child safety.

A shared responsibility for child safety should not be interpreted as a diffused responsibility in which no one is ultimately accountable.

Speaking to the more recent governance arrangements at Launceston General Hospital, Mr Daniels wrote in his statement to us:

> There is no one specific committee for [child safety]. All governance committees with Hospitals North, inclusive of the LGH have oversight of child safety. All committees have representation from Women's and Children's Services, representing our paediatric patients. Paediatric needs and child safety issues are addressed under the umbrella of all consumers of our services through the application of the National Safety and Quality Health Service (NSQHS) Standards across all areas of service provision.[1133]

When giving evidence at our hearings, Mr Daniels said he had only recently become aware of some reports about Mr Griffin, and with that knowledge he would reconsider his views about whether the management accountability structures were appropriate. He said:

> [The hospital's governance is] not robust. … it doesn't provide the appropriate amount of accountability, and it doesn't provide for the sorts of things we've been discussing today in terms of ensuring that the safety of children in our care is appropriate.[1134]

We note that Mr Daniels, himself a registered nurse, admitted that he did not know what constituted grooming behaviours.[1135] He was also not familiar with the National Principles for Child Safe Organisations, which emerged from the National Royal Commission (described further in Chapter 18).[1136] He agreed that it was fair for us to conclude that child safety was not embedded in the leadership, governance and culture of the hospital and hadn't been for a number of years.[1137]

5.2 Timeline of response following the suspension of Mr Griffin's registration to work with vulnerable people

Figure 14.2: Timeline of Launceston General Hospital's response, 2019–2021

2019

July 31

Mr Griffin's registration to work with vulnerable people is suspended

Tasmania Police briefs Dr Renshaw and Mr Harvey

The Secretary of the Department is briefed about Mr Griffin's suspension

August 1

Dr Renshaw notifies the Australian Health Practitioner Regulation Agency about Mr Griffin

August 7

Mr Griffin's nursing registration is suspended and Tasmania Police advises the hospital of concerns for Mr Griffin's welfare

August 8

Mr Griffin resigns his role at Launceston General Hospital and surrenders his nursing registration

August 8–14

The then Secretary is briefed on Mr Griffin's resignation and provided advice on his disciplinary investigation

September 2019

Kylee Pearn makes a complaint to police about Mr Griffin

August–September

Tasmania Police investigate and charge Mr Griffin with child sex offences

October 11

Tasmania Police ask human resources staff about Ms Pearn's disclosure

October 8–14

The Acting Secretary is briefed on the status of Mr Griffin's criminal charges

October 18

Mr Griffin dies by suicide

October 29

Tasmania Police briefs Dr Renshaw further about child exploitation images taken on Ward 4K and about

October 29–November 5

The Secretary is briefed on a 'potential legal issue' relating to Mr Griffin

November

Human resources staff review complaints about Mr Griffin

November 21

The Integrity Commission notifies the Secretary of a complaint about Launceston General Hospital's management of complaints about Mr Griffin

2020

January 30

COVID-19 is declared a Public Health Emergency of International Concern

April–August

The Integrity Commission complaint is followed up

September 10

The Secretary responds to the Integrity Commission about its investigation of the complaint

October 13

The first episode of *The Nurse* podcast is released

October 14

The Secretary recommends an immediate review to the Minister for Health

October 22

The Department announces an independent investigation into the management of complaints about Mr Griffin

November 23

The intention to establish a Commission of Inquiry is announced

2021

March 15

Our Commission of Inquiry is formally established

5.2.1 1 July 2019—A search warrant is executed on Mr Griffin's property

On the morning of 31 July 2019, Tasmania Police executed a search warrant on Mr Griffin's property. During this search, police became aware that Mr Griffin sometimes looked after a former patient of the hospital, Penny (a pseudonym), including at his home.[1138] Tasmania Police was already aware of Penny because Ms Skeggs had expressed some concern for Penny's welfare after seeing Mr Griffin with Penny in a chance encounter before making her police report.[1139] She also told police that her concern for Penny was a motivation for making the report.[1140]

Detective Senior Constable Hindle told us that, on 31 July 2019, he shared information about Ms Skeggs' allegations, and the resulting search warrant on Mr Griffin's home, with two risk assessment officers from the Registration to Work with Vulnerable People Unit at the Department of Justice.[1141] The purpose of sharing this information was to expedite the immediate suspension of Mr Griffin's registration to work with vulnerable people.[1142]

On 2 August 2019, Detective Senior Constable Hindle submitted a Child Safety Notification to Child Safety Services, which noted Mr Griffin's care arrangement involving Penny.[1143] The purpose of the notification was to advise Child Safety Services of 'any perceived ongoing risk if exposed to [Mr Griffin] and allow them to act appropriately'.[1144] The notification was allocated to a Child Safety and Wellbeing worker for action.[1145] Detective Senior Constable Hindle was not aware whether Child Safety Services took any further action in response to his notification, and we have not examined this matter.[1146]

In his first statement to us, dated 21 June 2022, Detective Senior Constable Hindle did not mention Penny. At our prompting, after we became aware of Penny's connection to the hospital from other documentation, Detective Senior Constable Hindle told us about her in a subsequent statement, dated 9 November 2022. We understand that the initial omission was due to Detective Senior Constable Hindle's understanding of our request for statement, which asked for information about any formal complaints police had received about Mr Griffin in relation to child sexual abuse. While police held concerns in relation to her, Penny was not the subject of a formal complaint. However, we are of the view that it should have been clear to Detective Senior Constable Hindle when responding to our request for a statement that Tasmania Police's awareness of concerns about Mr Griffin's care of Penny (particularly given her status as a former patient of Mr Griffin's) would have been of particular interest to us.

At a briefing later this day on 31 July 2019, Detective Senior Constable Hindle told Dr Renshaw that police were concerned about Penny.[1147] Dr Renshaw made a commitment to police to confirm whether Penny was a former patient or if she may have had contact with Mr Griffin at the hospital.[1148]

Tasmania Police's knowledge of the care arrangement of Penny (and evidence it advised Dr Renshaw of this) is important because it ultimately formed part of the hospital's notification to Ahpra relating to Mr Griffin, referencing her status as a former patient.

It indicated that Dr Renshaw was aware from this point that Mr Griffin's offending was potentially connected to former patients of the hospital.

5.2.2 31 July 2019—Mr Griffin's registration to work with vulnerable people is suspended

On 31 July 2019, Dr Renshaw received an email notification from the Acting Registrar of the Registration to Work with Vulnerable People Scheme that Mr Griffin's registration had been suspended under the Registration to Work with Vulnerable People Act.[1149] While the notification did not mention a police investigation into sexual abuse nor provide any reasons for the suspension, Dr Renshaw told us he understood that the suspension had been precipitated by such a police investigation.[1150]

On receiving the email, Dr Renshaw immediately sought out Ms Bryan and Mathew Harvey (former Human Resources Consultant within the human resources team), who were in a meeting with union officials. Dr Renshaw asked to speak with Ms Bryan urgently.[1151] Ms Bryan excused herself from the meeting while Mr Harvey remained. After Mr Harvey concluded the meeting, he also joined the discussion with Dr Renshaw and Ms Bryan, as did Janette Tonks, the former Director of Nursing Women's and Children's Services.[1152]

Ms Tonks recalled being told at this meeting that the police were investigating an allegation of sexual assault involving Mr Griffin.[1153] She also recalled being advised that Mr Griffin's devices, including his computer, had been seized, which suggested to her that the police suspected there was child exploitation material on these devices.[1154] Ms Bryan's recollection of the meeting broadly accords with Ms Tonks' account.[1155] Both Ms Tonks and Ms Bryan described being 'shocked'.[1156] Ms Bryan added: 'I had no suspicion at all of any of this behaviour. Nothing had ever been raised at my office in relation to these allegations'.[1157]

At this meeting, Dr Renshaw asked Ms Tonks when Mr Griffin was working next, to ensure that Mr Griffin did not provide further care to children.[1158] Ms Tonks discovered Mr Griffin was, in fact, rostered to work that afternoon, so she went to the ward to wait for him.[1159] Seeing him there early, Ms Tonks asked Mr Griffin to go to Dr Renshaw's office, where Dr Renshaw advised him that because of the suspension of his registration to work with vulnerable people, he was not able to work. Dr Renshaw then requested that Mr Griffin leave the hospital.[1160] Dr Renshaw told us that this was the first and only contact he had with Mr Griffin.[1161] Ms Tonks recalled that Mr Griffin 'seemed very calm about it'.[1162]

Ms Tonks said she escorted Mr Griffin to collect his bag and walked him out of the ward.[1163] Detective Senior Constable Hindle later told to us that allowing Mr Griffin to collect personal items 'undermined' the police investigation because police had intended to search Mr Griffin's work locker.[1164] We are not clear whether Detective Senior Constable Hindle had communicated this intention to anyone at the hospital.

As she was escorting Mr Griffin out, Ms Tonks asked Mr Griffin if he was okay and asked what she should tell the other staff. He told her she should tell staff he was off sick due to a chronic issue with his back.[1165]

Ms Leonard recalled learning about these events from Ms Tonks the following day, on 1 August 2019. Ms Leonard also recalled that the human resources team directed nursing staff to not discuss the allegations about Mr Griffin due to the police investigation. Ms Leonard recalled that this direction was due to a recommendation of Tasmania Police. She told us that Mr Harvey, James Bellinger, Human Resources Manager, Ms Tonks, Ms Bryan and Dr Renshaw all reiterated this 'recommendation' at various points.[1166] There does not appear to have been any formal policy or plan guiding management's response. We note that such a policy could have identified what information could reasonably be provided to staff.

Dr Renshaw described other steps he took following the notification from the Acting Registrar of the Registration to Work with Vulnerable People Scheme that Mr Griffin's registration had been suspended. Dr Renshaw told us that he contacted Tasmania Police to request a briefing. We are not clear who Dr Renshaw spoke to when making this request but consider it most likely to have been Detective Senior Constable Hindle. This briefing occurred later on 31 July 2019. Mr Harvey was with Dr Renshaw during the police briefing.[1167] In a statement to us, Dr Renshaw described himself as 'the defacto executive liaison between Tasmania Police and the LGH'.[1168]

Dr Renshaw told us that he then made a mandatory notification to Ahpra by phoning its state manager on 31 July 2019, followed by a written notification that was emailed on 1 August 2019.[1169] Dr Renshaw said that Ahpra notifications are generally made by the 'professional lead', which in this case should have been Ms Bryan because Mr Griffin was a nurse. However, in this instance, Dr Renshaw assumed responsibility for liaising with Ahpra.[1170] Dr Renshaw did not explain why he assumed this responsibility.[1171] Dr Renshaw also prepared a briefing or 'Minute' for the then Secretary of the Department, Michael Pervan, which was reviewed by Mr Daniels and sent on 31 July 2019.[1172]

These events all assume significance because they establish what Dr Renshaw, in particular, knew and when, as well as the extent to which he shared important information with his superiors about the connection between the investigation of Mr Griffin and possible offending by Mr Griffin against patients. For this reason, we explore these events in some detail.

5.2.3 31 July 2019—Tasmania Police briefs Dr Renshaw and Mr Harvey

As mentioned earlier, Dr Renshaw and Mr Harvey met with Detective Senior Constable Hindle on 31 July 2019 to receive a briefing on Mr Griffin.[1173] What exactly was discussed at this meeting was difficult to ascertain. Detective Senior Constable Hindle's

recollections were confused, and the descriptions of the meeting in both Dr Renshaw and Mr Harvey's statements were brief. However, there seems to be a general consensus, supported by an email from Mr Harvey sent to human resources colleagues on the afternoon of 31 July 2019 capturing the substance of the meeting, that Detective Senior Constable Hindle told Dr Renshaw and Mr Harvey:

- Charges had not yet been laid against Mr Griffin, but police considered they had 'enough evidence' to charge Mr Griffin in relation to child exploitation material and 'maintaining a sexual relationship with a minor'.[1174]
- There were photographs on Mr Griffin's phone in a folder entitled 'Ward 4K', which appear to have been taken of patients in Ward 4K and the intensive care unit between 2015 and 2019.[1175] Other evidence from Tasmania Police indicates photographs were taken from the late 2000s to mid-2010s; however, it is not clear to us the basis upon which Tasmania Police formed that view.[1176] It is also not clear to us if these photographs are additional to the ones discussed at this meeting.

It is unclear whether Detective Senior Constable Hindle stated or implied to Dr Renshaw and Mr Harvey at the meeting that the photos taken at the hospital were potentially child exploitation material. In the email that Mr Harvey sent his human resources colleagues (noted above) on the afternoon of 31 July 2019, he wrote that the photos were 'nothing of a sexual nature'.[1177] However, in evidence to us, Dr Renshaw said that he was advised at this meeting that some child exploitation material may have been taken in the hospital, thus creating a potential connection between Mr Griffin's sexual offending and hospital patients.[1178]

Detective Senior Constable Hindle's oral evidence was that it was on 29 October 2019 that he first became concerned that the photographs in Mr Griffin's phone were evidence of offending by Mr Griffin in his role as a nurse or in connection with patients.[1179] He was unable to explain how Dr Renshaw had become aware of that possibility on 31 July 2019. Detective Senior Constable Hindle said he was not the person who initially showed the photographs to Mr Harvey and Dr Renshaw on 31 July 2019, and he was unaware what information had been exchanged when those photographs were revealed.[1180] Detective Senior Constable Hindle's evidence was that his first contact with Dr Renshaw about the connection between the photographs and patients occurred at the same time he asked Dr Renshaw to convene a panel to help identify those patients, which ultimately occurred on 5 December 2019.[1181]

The fact that Dr Renshaw was aware of the imagery potentially constituting child exploitation material around this time is confirmed by the recollection of Paul Turner SC, Assistant Solicitor-General (Litigation), who reportedly had a conversation with Dr Renshaw 'shortly after 31 July 2019'.[1182] The Solicitor-General, Sarah Kay SC, reported this recollection in a statement to us:

> His recollection, as conveyed to me, is that Dr Renshaw called him, advising that Tasmania Police had identified a number of photographs on Mr Griffin's telephone that appeared to be of paediatric patients at the Launceston General Hospital. The discussion is said by Mr Turner to have centred upon identifying the patients where possible and notifying the patients or their families.[1183]

Ms Kay shared her understanding that Mr Turner 'did not make any notes of the discussion and that he cannot be certain of the exact dates or whether there was more than one discussion'.[1184] We were surprised to learn no notes were taken, given the significance of the query. The absence of these records is a source of frustration for us. Ms Kay asked Mr Turner for his recollections and records about this matter, but we did not.

On balance, we consider it possible that Detective Senior Constable Hindle did not describe the images as sexual and in connection with the hospital at his meeting with Dr Renshaw and Mr Harvey on 31 July 2019, and that Mr Harvey's recollection was correct. However, we consider that Mr Griffin's possession of images of patients, in the context of a police investigation, should have been a significant source of concern to Mr Harvey and Dr Renshaw regardless. It should have also been clear that, given the images had only just been seized, closer analysis might confirm that they constituted child exploitation material.

Dr Renshaw did not mention Penny in his initial statements to us, despite a question that should have elicited this information. Mr Harvey also did not mention Penny in his statement, but said he was not told about her in the meeting and was not present for part of the discussion between Detective Senior Constable Hindle and Dr Renshaw, which we accept.[1185]

It was upon a review of documents received from Ahpra that we noticed a reference to Penny (including her status as a former patient) as part of its communication with Dr Renshaw regarding the mandatory notification he made to them about Mr Griffin on 1 August 2019 (discussed at Section 5.2.5). As previously indicated, Penny is significant in this context because her status as a former patient established a clear and early link between the hospital and the police investigation.

We already noted above that Detective Senior Constable Hindle also did not mention Penny in his initial statement to us. Detective Senior Constable Hindle's subsequent statement to us on 9 November 2022 confirmed that Penny and her potential connection to the hospital was discussed at this meeting:

> As previously stated, Dr Renshaw and a member of his HR team attended the police station following the execution of the search. It was at this time that Dr Renshaw was made aware of the presence of concerning material on Mr Griffin's electronic devices, as well as the continued care/relationship of Penny as a 'private arrangement'.[1186]

Detective Senior Constable Hindle also recalled Dr Renshaw advising him at this meeting that he would check hospital patient records to confirm whether Penny had been a former Ward 4K patient.[1187] Detective Senior Constable Hindle added: 'Dr Renshaw contacted me back in a timely manner (potentially the same day) to confirm that [Penny] was a former patient of Ward 4K and was most likely exposed to Griffin'.[1188] We understand this reference to indicate that Penny most likely had contact with Mr Griffin on the ward.

We asked Dr Renshaw about his knowledge of Penny when he gave evidence at a hearing on 8 September 2022. Dr Renshaw acknowledged that he was aware of Mr Griffin's care of Penny outside the hospital on 31 July 2019 because she was mentioned in his notification to Ahpra.[1189] Dr Renshaw also acknowledged that the question of whether Penny was a former patient of the hospital was significant because it established a clear link between the police investigation of Mr Griffin and Mr Griffin's employment at the hospital.[1190]

The failure to inform us at the earliest opportunity about Penny and her status as a former patient was an omission by Dr Renshaw and Detective Senior Constable Hindle. We note that there were more opportunities for Dr Renshaw, who was leading the hospital's response, to register that Penny was significant to both the police investigation and the hospital's response.

We do not know why this information was not provided to us in a more forthcoming way by Dr Renshaw. We are particularly concerned by Dr Renshaw's misleading responses to our original request for a statement. We discuss this further in our finding of misconduct against Dr Renshaw in Section 5.2.44.

5.2.4 31 July 2019—The Secretary of the Department is briefed about Mr Griffin's suspension

Following Mr Griffin's suspension, Dr Renshaw prepared a briefing for then Secretary Pervan. This briefing was forwarded to Mr Daniels late on the afternoon of 31 July 2019.[1191] The briefing appeared to go directly to Mr Daniels for approval before going to Secretary Pervan that same day because it is not listed as having been endorsed by any other role-holders.

The briefing informed Mr Daniels and the Secretary of the suspension of Mr Griffin's registration to work with vulnerable people and summarised, at a high level, what had occurred that day in terms of the procedural steps to direct Mr Griffin away from the workplace and to block his swipe access to the hospital.[1192] It also stated:

> The [Executive Director Medical Services] is currently conducting a look-back in the SRLS complaints reporting system for any previous issues involving this staff member.[1193]

Ms Bryan recalls being asked (it is unclear by whom and exactly when) to look at the Safety Reporting and Learning System for any incidents concerning Mr Griffin, and that upon doing so she found Ward 4K staff member Will Gordon's complaint from August 2017.[1194] The audit trail of this entry (which we discuss further in Section 5.2.26) shows that Ms Bryan was granted access to Mr Gordon's complaint on the system on 7 November 2019.[1195] Mr Harvey was granted access on 4 September 2019.[1196] This suggests that this 'look-back' was not undertaken immediately but occurred some months later.

We are unclear when Dr Renshaw may have considered Mr Gordon's complaint but believe that he did before briefing staff about the police investigation, which began on 29 October 2019. Staff briefings are described in Section 5.2.22. Mr Gordon's complaint was not mentioned in the subsequent briefing to Mr Daniels or the Secretary, nor were the numerous other complaints against Mr Griffin that were reported to Mr Griffin's managers (including the previous Nurse Unit Manager and Ms Leonard) and the human resources team.

In relation to information received from Tasmania Police, Dr Renshaw's briefing to the Secretary merely notes:

> The [Executive Director Medical Services] and Human [Resources] Consultant have met with Tasmania Police
>
> ...
>
> The Tasmania Police investigation is ongoing.[1197]

Further, Dr Renshaw does not mention in the briefing that Detective Senior Constable Hindle notified him about Penny's status as a former patient, nor that images of patients were found in Mr Griffin's possession.

When asked about his failure to accurately reflect this important information in the Minute to the Secretary, Dr Renshaw stated it was an 'oversight'.[1198] Despite assuming such a central role in responding to the concerns about Mr Griffin—Dr Renshaw was the contact for the Registrar of the Registration to Work with Vulnerable People Scheme and Tasmania Police, he managed Mr Griffin's suspension from work, and he drafted the Minute to the Secretary—Dr Renshaw sought to distance himself from the management of the situation in evidence to us at hearings.

Dr Renshaw told us that 'at that point the management of the issue had passed ... into HR and into the Secretary's office'.[1199] Reflecting on his actions on 31 July 2019, Dr Renshaw concluded that he had 'fulfilled' his medico-legal responsibilities, stating: 'I'm not certain what actions I could have taken beyond what I did'.[1200] For reasons that become clearer as we further explain Dr Renshaw's central role in this matter, we do not agree with this assertion.

The only caution that Dr Renshaw provided Secretary Pervan in the 31 July 2019 Minute was about adverse media attention: 'It is anticipated that if this matter does result in prosecution, there will be significant public concern and media attention'.[1201] Dr Renshaw provided no further context to the Secretary.

We make a finding below that Dr Renshaw misled Mr Daniels and the Secretary by omitting critical information from the brief. Before making this finding, we explain Dr Renshaw's interactions with Ahpra in the days following this briefing, which reveal the extent of the information he withheld.

5.2.5 1 August 2019—Dr Renshaw notifies the Australian Health Practitioner Regulation Agency about Mr Griffin

On 1 August 2019, Dr Renshaw made a formal notification to Ahpra about Mr Griffin. Having received the notification, a staff member called Dr Renshaw for more information. A file note of this discussion, captured by the Ahpra staff member on the day, includes the following:

> PR [Peter Renshaw] advised that he believes a complaint was made to Tas Police in relation to an alleged 'inappropriate sexual relationship with a child under the age of 12'. This child is advised to be a … former patient.[1202]

The file note of Dr Renshaw's advice did not accurately reflect the actions of Tasmania Police, which was investigating Ms Skeggs' complaint. To be clear, there was no police investigation into Mr Griffin's behaviour with Penny, or any other former patient, at this point.

In oral evidence to us, Dr Renshaw agreed that the file note captures the substance of what he told Ahpra, although he could not recall the words he used.[1203] We conclude, based on this file note, that Dr Renshaw told Ahpra about the information he received from Detective Senior Constable Hindle on 31 July 2019.

The Ahpra file note goes on:

> Tas Police have asked the Hospital for info regarding specific patients. They have also advised the hospital that having seized JG's [James Griffin's] mobile phone and home computer, they have found a folder on his phone containing a large number of images of female patients under the age of 16 (non-sexual in nature).
>
> …
>
> PR advised that he did not have access to JG's HR record but believes that there have been prior vague concerns surrounding JG similar in nature but unconfirmed and not to the same extent with patients.[1204]

The extent of the information Dr Renshaw provided Ahpra is in stark contrast to the briefing he provided the Secretary the day before, yet he had the same state of knowledge on both occasions.

On 5 August 2019, an Ahpra staff member contacted Detective Senior Constable Hindle to confirm what information they could rely on to determine any action they might take against Mr Griffin without interfering with the police investigation.[1205]

Finding—Dr Peter Renshaw misled the Chief Executive of Launceston General Hospital and the then Secretary of the Department by failing to fully and accurately convey information relating to James Griffin received from Tasmania Police on 31 July 2019

Dr Renshaw received two critical pieces of information that linked the police investigation into Mr Griffin to the hospital. These two pieces of information were the possibility that images found on Mr Griffin's devices were taken of patients in the hospital (whether they were deemed child exploitation material or not) and the possibility of Mr Griffin's inappropriate contact with Penny, a patient of the hospital.

This information is relevant to the hospital's response to revelations about Mr Griffin's offending for the following reasons:

- The information suggested a risk that photos Mr Griffin took of patients in the hospital constituted child sexual exploitation material.
- Even if the photos of patients did not constitute child exploitation material, Mr Griffin's possession of them suggested a significant breach of professional conduct and a major breach of patients' privacy. Tasmania Police has since told our Inquiry that, to their knowledge, the images of some children would not constitute 'child exploitation material as described in statutory definitions'.[1206]
- Depending on the police's assessment on a closer inspection of the images, it was possible that the hospital would need to undertake an open disclosure process with affected parties. An open disclosure process involves:

  > … a discussion with a patient and carer about an incident that resulted in harm to the patient while receiving health care. The criteria of open disclosure are an expression of regret, and a factual explanation of what happened, the potential consequences, and the steps being taken to manage the event and prevent recurrence.[1207]

- Open disclosure is a process health providers use to transparently acknowledge and explain any errors or adverse events to patients receiving health care. Accepting that Dr Renshaw did not have conclusive information that this would be required, he nonetheless should have cited it as a possibility in his briefing to the Secretary.

- Mr Griffin's 'private care arrangement' of his former patient Penny likely constituted a breach of his professional obligations.
- Given Mr Griffin's connection to Penny was through the hospital, it should have been apparent that other former patients had similar contact with Mr Griffin and had therefore also been at risk from Mr Griffin.
- An examination of Mr Griffin's complaints history would have revealed a pattern of boundary breaches, including Mr Griffin contacting patients outside the hospital setting, which in turn would have alerted the hospital that other patients had been placed at risk. As we noted earlier, there did not appear to have been any effort to review Mr Griffin's prior complaints history within the Safety Reporting and Learning System (and otherwise) at this time.

We find that Dr Renshaw misled Mr Daniels and then Secretary Pervan by failing to convey information fully and accurately to them about the police briefing on 31 July 2019. Dr Renshaw's initial briefing, which positioned Mr Griffin's offending as occurring entirely outside the hospital setting, set the tone for subsequent briefings to the Secretary.

5.2.6 August–October 2019—Rumours circulate in the community about Mr Griffin

After Mr Griffin was removed from the workplace, staff were told that he had taken leave due to an issue with his back.[1208] Mr Griffin had asked Ms Tonks to tell staff that he was 'off with a bad back' and she did so in order to be 'respectful' of Mr Griffin's wishes because no charge had yet been laid.[1209] However, rumours soon began to circulate about the real reasons for Mr Griffin's departure. Former Ward 4K staff member Annette Whitemore told us:

> After J [Mr Griffin] left there was talk among nurses that he was being investigated for something of a sexual nature. I was told that a young girl had made a statement to Police about historical sexual assaults by J. I recall myself and other staff checking to see if he was still registered as a nurse.[1210]

Around August 2019, Ms Leonard took leave and an Acting Nurse Unit Manager stepped into her role.

Mr Gordon told us that when the rumours about Mr Griffin's absence began to circulate, some Ward 4K staff attended a meeting with human resources staff to discuss how to handle questions from the public about Mr Griffin. Mr Gordon did not attend this meeting and we do not have any other information about it.[1211] However, Mr Gordon told us that not long after this meeting, associate nurse unit managers verbally directed Ward 4K staff to not talk about any allegations connected to Mr Griffin.[1212] Ms Tonks confirmed this, particularly given that a police investigation was underway.[1213] Ms Tonks later recalled that this instruction came from Dr Renshaw.[1214]

Ms Leonard told us that Mr Harvey also directed nursing staff to not discuss the allegations made against Mr Griffin because of the ongoing police investigation.[1215] Ms Leonard believed that this direction was given to preserve the integrity of the police investigation and had been recommended by Tasmania Police.[1216] She said:

> The direction for staff not to discuss the allegations against Mr Griffin was very difficult to support, and I was deeply challenged and conflicted by this, frequently requesting the ability for staff to talk about the topic and be offered support. The staff clearly needed the opportunity to talk and were struggling, however I was unable to meet their needs, and support open conversations.[1217]

Dr Kate Brady, a researcher with expertise in supporting communities to recover from traumatic events, explained to us that the close control of information management because of concerns about interfering with investigations can impede appropriate responses to critical incidents:

> … it is important to empower managers to treat people as affected community members first, and as legal witnesses second. In my experience, I have observed that some managers and organisations can be so concerned about what they are 'allowed' to say or what the legal ramifications of any communications are that it impairs their ability to think about responding as humanistically as possible.[1218]

5.2.7 2–8 August 2019—Employment Direction processes relating to Mr Griffin

Dr Renshaw told us that a formal investigation of Mr Griffin, under Employment Direction No. 6, began on or about 2 August 2019.[1219] Employment Direction No. 6 outlines the State Service disciplinary processes for determining whether an employee can perform their duties. This becomes relevant for child-facing roles in circumstances when a person no longer holds registration to work with vulnerable people. We discuss the operation of the Employment Directions, and how they are applied in child sexual abuse matters, in Chapter 20.

On 5 August 2019, then Secretary Pervan approved the suspension of Mr Griffin under the Employment Direction No. 4 process (which outlines the process for suspending employees with or without pay) and a letter was sent to Mr Griffin advising him of this decision on the same day.[1220] We consider it appropriate that Mr Griffin was advised immediately to not attend work on 31 July 2019 and that his formal suspension occurred shortly after.

5.2.8 7 August 2019—Mr Griffin's nursing registration is suspended and Tasmania Police advises the hospital of concerns for Mr Griffin's welfare

On 7 August 2019, Ahpra advised Mr Griffin that the Nursing and Midwifery Board of Australia had proposed to suspend his registration.[1221]

Early that morning, Detective Senior Constable Hindle emailed Dr Renshaw outlining concerns Mr Griffin's family had expressed about Mr Griffin's welfare.[1222] Detective Senior Constable Hindle noted: 'It is not uncommon for people in his current situation to make the ultimate decision'.[1223] Detective Senior Constable Hindle informed Dr Renshaw that Mr Griffin had been provided the details for Lifeline and offered transportation for a mental health assessment, which he declined. Detective Senior Constable Hindle asked Dr Renshaw whether the hospital had taken all steps to offer Mr Griffin follow-up support in relation to his suspension from work.[1224] Mr Harvey attempted to contact Mr Griffin to check on him the following day.

5.2.9 8 August 2019—Mr Griffin resigns his role at Launceston General Hospital and surrenders his nursing registration

On 8 August 2019, Mr Griffin wrote to Ahpra to surrender his registration as a nurse.[1225] Notwithstanding this, the Nursing and Midwifery Board determined to investigate Mr Griffin. The Board ultimately took no further action after Mr Griffin's death.[1226]

Mr Griffin also resigned from the Tasmanian Health Service on 8 August 2019. His employee exit form listed his reason for departure as 'Retirement–Voluntary' and was signed off by Ms Leonard on 9 August 2019.[1227]

Mr Harvey attempted to call Mr Griffin to do a welfare check, but he did not answer.[1228] Mr Harvey then emailed Mr Griffin with information about the hospital's Employee Assistance Program and other support services.[1229]

5.2.10 8–14 August 2019—The then Secretary is briefed on Mr Griffin's resignation and provided advice on his disciplinary investigation

On 9 August 2019, Mr Harvey prepared a Minute to then Secretary Pervan to advise of Mr Griffin's resignation and that Mr Griffin would likely be charged by Tasmania Police, 'which may attract media attention'.[1230] The Minute largely focused on the Employment Direction No. 6 process (triggered by the loss of Mr Griffin's registration to work with vulnerable people) and recommended that disciplinary processes be aborted because Mr Griffin was no longer an employee of the State Service and therefore any determination or sanctions would not have effect.[1231]

The Minute also notes that Ahpra was notified of the police investigation into Mr Griffin and had cancelled his nursing registration. In relation to the Tasmania Police investigation, the briefing states:

> Tasmania Police [is] conducting enquiries and has advised of pending charges being laid which relate to child exploitation and maintaining inappropriate relations with a minor. Further charges may be considered following Tasmania Police interviews with other parties.[1232]

This Minute was endorsed by the then Acting Chief People and Culture Officer. It does not appear that Dr Renshaw had any involvement in this Minute. The then Secretary Pervan approved the advice to abort the Employment Direction No. 6 investigation on 14 August 2019.[1233]

Mr Daniels recalls speaking with then Secretary Pervan around this time, but this conversation did not appear to cover more than Mr Daniels acquitting his responsibilities to advise Secretary Pervan on the actions taken to respond to Mr Griffin, which were reflected in the briefing.[1234]

Dr Renshaw gave the following explanation as to why the disciplinary process in relation to Mr Griffin was aborted:

> My understanding is that the [Employment Direction] processes only apply to current State Service employees and therefore, if a [State Service] employee resigns, the Department of Health no longer has jurisdiction.[1235]

We accept that it was common practice in 2019 to end a disciplinary process if an employee resigned. We also note that this practice means that the institution does not have the opportunity to learn from any systemic issues that may have arisen by examining the alleged conduct, and that once such a process stops, there is no record preventing the ex-employee from being re-employed by the State Service at a later date. This means that even in circumstances where a former employee causes serious harm, they may be able to continue their predatory behaviour in another workplace. We note that the introduction of a Reportable Conduct Scheme in Tasmania will require heads of regulated entities to continue investigations into reportable allegations regardless of whether the relevant worker resigns or is otherwise no longer an employee.[1236]

Given that early indications from the police suggested a link to hospital patients connected to Mr Griffin, we consider an investigation of some form should have continued, notwithstanding Mr Griffin's resignation.

5.2.11 September 2019—Kylee Pearn makes a complaint to police about Mr Griffin

In September 2019, Ms Pearn reported her abuse by Mr Griffin to Tasmania Police. As we discussed in Section 4, Ms Pearn made a promise to herself that she would come forward to support another victim-survivor's police report, if one were ever made. In her statement to Detective Senior Constable Hindle, Ms Pearn referenced her earlier disclosure to human resources staff at Launceston General Hospital in the presence of her then manager, Stewart Millar.

5.2.12 August–September 2019—Tasmania Police investigates and charges Mr Griffin with child sex offences

On 27 August 2019, before Ms Pearn made her report to police, Detective Senior Constable Hindle wrote to the Australian Federal Police about the child exploitation images that Tasmania Police had overlooked in 2015 (refer to Section 4.1.23).[1237] This material was ultimately forwarded to Detective Senior Constable Hindle on 2 September 2019.[1238]

On 3 September 2019, Tasmania Police interviewed Mr Griffin, during which he made several admissions.[1239] After this interview, he was charged with one count of sexual intercourse with a young person under 17 years of age and was bailed to reappear in the Launceston Magistrates Court on 23 October 2019.[1240] Detective Senior Constable Hindle told us that Tasmania Police did not oppose bail at this time because they believed the bail conditions, which included that Mr Griffin not be in the company of a minor without another adult present, were sufficiently stringent.[1241]

On 13 September 2019, Tasmania Police sought approval from the Director of Public Prosecutions to authorise the more serious charge of what is now referred to as persistent sexual abuse of a young person. The Director of Public Prosecutions gave approval shortly after, on 17 September 2019.[1242]

Also on 13 September 2019, Mr Harvey spoke to Tasmania Police. He recalled police telling him that it was unlikely hospital staff would have to make statements because 'the incidents occurred outside the workplace'.[1243] At the time of Mr Griffin's arrest, Dr Renshaw was on long service leave overseas and did not return until after Mr Griffin's death, which would be sometime after 18 October 2019.[1244]

On 3 October 2019, based on a review of the materials Tasmania Police received in 2015 from the Australian Federal Police, Tasmania Police conducted a second search on Mr Griffin's home. This search resulted in Mr Griffin being charged with offences relating to possessing, producing and distributing child exploitation material.[1245] Mr Griffin was also charged with another eight counts of indecent assault relating to four victim-survivors, who had since made a report of their abuse to police, including Ms Pearn and Keelie McMahon.[1246]

Mr Griffin was detained and Tasmania Police opposed bail on the basis that Mr Griffin had 'sought loopholes' on his previous bail conditions and reportedly had plans to attend a recreational event with young people.[1247] However, the Court granted him bail and he was released that day.[1248]

5.2.13 19 September 2019—Secretary Morgan-Wicks visits Ward 4K

On 19 September 2019, the then new Secretary of the Department, Kathrine Morgan-Wicks PSM, who began in the role on 2 September 2019, visited Ward 4K for a site tour

of the new Women's and Children's ward redevelopment. She told us that Mr Daniels and 'key LGH staff' accompanied her on this tour.[1249] Secretary Morgan-Wicks stated that: 'To the best of my recollection, the circumstances of Mr Griffin were not raised during the tour or in meetings that day'.[1250]

5.2.14 9 October 2019—*The Examiner* publishes a brief article about Mr Griffin's criminal charges without identifying him

On 9 October 2019, *The Examiner* newspaper published a brief article about a paediatric nurse in Launceston, which read:

> A former nurse has been accused of possessing, producing and distributing child exploitation material as well as maintaining a sexual relationship with a young person.
>
> The 69-year old Legana man has been charged with eight counts of indecent assault, distribution of child exploitation material, involving person under 18 years in production of child exploitation material, produce child exploitation material, possess child exploitation material and maintain a sexual relationship with a young person.
>
> It is alleged the man maintained a sexual relationship with a young person between August 2009 and August 2013.
>
> He is also accused of involving a person under 18 years in the production of child exploitation material in South Launceston on March 6, 2015. The charges for producing and distributing child exploitation also relate to March 6. The indecent assault charges span across 25 years, with the first alleged offence occurring between 1987 and 1990, and the most recent sometime between 2011 and 2012.
>
> On July 19 this year, the man was also allegedly found in possession of child pornography photos. He will appear in Launceston Magistrates Court on November.[1251]

5.2.15 11 October 2019—Tasmania Police ask human resources staff about Ms Pearn's disclosure

Mr Bellinger told us that on 11 October 2019, Detective Senior Constable Hindle called to 'ask if we had any records about a disclosure by Kylee Pearn or Stewart Millar'.[1252] When Counsel Assisting asked Mr Bellinger for more detail about what Detective Senior Constable Hindle said, Mr Bellinger replied that the request was specific enough to confirm to him that the disclosure related to Mr Griffin's inappropriate conduct in relation Ms Pearn as a child.[1253] Mr Bellinger recalled that Detective Senior Constable Hindle told him that Ms Pearn's disclosure to the hospital was estimated to have occurred in 2010 or 2011.[1254]

Mr Bellinger said that after hanging up from the call with Detective Senior Constable Hindle he searched the human resources team's records and spoke to another, more senior, member of the human resources team to seek their recollection.[1255]

Later that day, Mr Bellinger emailed Detective Senior Constable Hindle, copying in this same member of the human resources team. As referenced in Section 4.1.14, this email included the following:

> I was not working with the LGH at that time, Gino Fratangelo and [the member of the human resources team] were at the LGH at that time. Gino has since retired, [the member of the human resources team] is still in HR with the THS and I have copied [them] in. I have access to Gino's emails from 2012 onwards and a record of some matters dating back to 2004.
>
> I have been unable to find a record of [Ms Pearn's] complaint.[1256]

We note that Mr Bellinger did not try to contact Mr Fratangelo at this point to find out whether Mr Fratangelo could recall the meeting or whether he may have held records or notes relating to it that could have assisted police. Nor did Detective Senior Constable Hindle contact Mr Fratangelo. Mr Bellinger did not make a file note of his conversation with Detective Senior Constable Hindle.[1257]

The reference in Mr Bellinger's email to 'a record of matters dating back to 2004' suggests that Mr Bellinger did at least review some of Mr Griffin's complaints history, given the first recorded complaint with which the human resources team was involved was made in 2004 (described in Section 4.1.4). We understand that information about Mr Griffin's complaints history was never provided to Tasmania Police, noting also that it may not have been requested.

We asked Ms Leonard whether she was asked to provide the human resources team with information to do with the complaints about Mr Griffin, noting that complaints were not always escalated to the human resources team.

> Q [Counsel Assisting]: After Griffin was arrested you [were] asked for all the records concerning Griffin; is that right?
>
> A [Ms Leonard]: I don't recall that.
>
> Q: Did you gather all of the records concerning Griffin after his arrest?
>
> A: I don't recall that.
>
> Q: Did HR ask for access to all of his records after Mr Griffin's arrest?
>
> A: At some stage they asked for all the records.
>
> Q: And you gathered them for them?
>
> A: Yes.
>
> Q: And you made everything available to HR for review at that stage?
>
> A: Yes.[1258]

We are unclear when human resources staff requested Ms Leonard's records in relation to complaints about Mr Griffin. We consider it likely that this request was made in November 2019 when the human resources team conducted a review into complaints about Mr Griffin (discussed in Section 5.2.25).

We expect that the phone call from Detective Senior Constable Hindle would have been a source of significant concern to Mr Bellinger, given our finding that he was at the meeting when Ms Pearn's disclosure was made. The call would also have put Mr Bellinger on notice that his and Mr Fratangelo's inaction in the face of that disclosure was likely to be scrutinised.

Despite having reasonably good recall of a wide variety of matters, including some from many years ago, Mr Bellinger could not recall whether he had escalated his correspondence with Detective Senior Constable Hindle to others, other than copying the member of the human resources team into his email response to Detective Senior Constable Hindle.[1259]

> Q [Counsel Assisting]: Did you speak to anyone else about the conversation you'd had with [Detective] Hindle?
>
> A [Mr Bellinger]: Not that I can recall.
>
> Q: Did you speak to Dr Renshaw?
>
> A: I don't recall.[1260]

Counsel Assisting then asked Mr Bellinger whether he was aware of Dr Renshaw's medico-legal expertise and his role as police liaison. This information is relevant because the failure to take action in response to Ms Pearn's disclosure in 2011 or 2012 exposed the hospital to litigation on the basis that it had prior knowledge of the risk Mr Griffin posed as a paediatric nurse.

> Q [Counsel Assisting]: So, that being [Dr Renshaw's] position, is that the sort of thing that you would have taken to his attention?
>
> A [Mr Bellinger]: Yes.
>
> Q: And, did you take it to his attention?
>
> A: I don't recall.
>
> Q: Would it have been your practice to do so?
>
> A: Yes.
>
> Q: Do you have any file notes that tell us whether or not you did?
>
> A: No, I don't.

Mr Bellinger also could not recall advising the Chief People Officer at the Department about his correspondence with Detective Senior Constable Hindle, despite it being his practice to share information of this nature with the Department.[1261]

Counsel Assisting asked Mr Bellinger whether he appreciated the significance of the information he had received from Detective Senior Constable Hindle.

> Q [Counsel Assisting]: Did you understand [Kylee Pearn's previous disclosure to the hospital] to be a serious matter?
>
> A [Mr Bellinger]: Yes.
>
> Q: Did you not escalate it?
>
> A: I don't know.
>
> Q: You didn't make any records about it beyond that email, did you?
>
> A: Correct.
>
> Q: You didn't formally brief anyone about it, did you?
>
> A: Correct.[1262]

While Dr Renshaw was on leave at the time of Detective Senior Constable Hindle's call, we would have thought the call was something Mr Bellinger or other members of the human resources team would report to Dr Renshaw on his return, as a matter of urgency. Indeed, Mr Daniels and the Secretary should have been alerted immediately. Mr Bellinger's failure to so alert them is notable.

Below, we discuss the possibility that Mr Bellinger or other members of the human resources team told Dr Renshaw about Ms Pearn's disclosure. Another member of the human resources team could not take part in our Commission of Inquiry and we make no findings in relation to them.

5.2.16 8–14 October 2019—The Acting Secretary is briefed on the status of Mr Griffin's criminal charges

While Secretary Morgan-Wicks was on planned annual leave between 9 and 20 October 2019, the Acting Secretary approved a Minute to the Secretary about the status of criminal charges relating to Mr Griffin, dated 14 October 2019.[1263] This Minute was prepared by the former Director of Employee Relations at the Department on 8 October 2019 and was approved by Mr Bellinger on the same date. The Acting Chief People and Culture Officer at the time formally endorsed the Minute on 9 October 2019.

The Minute recapped some of the information provided in earlier briefings to then Secretary Pervan, including that:

- Mr Griffin had been suspended on 5 August 2019 by former Secretary Pervan, following notification that his registration to work with vulnerable people had been suspended pending criminal charges relating to offences involving children.[1264]

- An Employment Direction No. 6—Inability was considered the most appropriate course given that Mr Griffin was not able to fulfil an essential requirement of his nursing role; however, as Mr Griffin resigned on 8 August 2019, no further action was taken.[1265]
- Ahpra had been notified and had cancelled Mr Griffin's nursing registration.[1266]

The Minute noted that the Tasmanian Health Service had cooperated with Tasmania Police and that:

> To date, there has been no notification that offences are linked to Mr Griffin's employment as a Paediatric Nurse with the THS.[1267]

The Minute also flagged that the matter had attracted media attention but that no action was required.[1268]

This Minute had serious omissions and was misleading on numerous fronts. There is no information to suggest that its author, the former Director of Employee Relations at the Department was aware that this document was misleading.

The Minute was technically correct in stating that Mr Griffin's charges were not directly connected to the hospital because Mr Griffin was charged in relation to child sexual abuse of Ms Skeggs, and others who were not patients.[1269] Also, the charges related to child exploitation material and were based on information discovered in the review of the materials that Australian Federal Police had obtained in 2015, not the images of patients at the hospital found on Mr Griffin's devices and described by police at the 31 July 2019 briefing.[1270] However, we consider the following omissions from the Minute to be material:

- As with the earlier Minutes of 31 July 2019 and 9–14 August 2019, the substance of the 31 July 2019 briefing from Tasmania Police was not reflected in this Minute. We received no evidence to suggest that Tasmania Police had categorically ruled out the images of patients as constituting child exploitation material, noting its investigation of Mr Griffin was ongoing. Even if it had, this information should have been included in the Minute.
- By the time the Acting Secretary signed off on the Minute on 14 October 2019, Mr Bellinger and another member of the human resources team were formally on notice about Ms Pearn's disclosure, as Mr Bellinger had received the call from Detective Senior Constable Hindle asking for records relevant to this disclosure on 11 October 2009. Although Mr Bellinger is listed as having endorsed this briefing on 8 October 2019, before receiving the call from Detective Senior Constable Hindle on 11 October 2019, he should have immediately sought to update the Minute or prepared another Minute to reflect this information before it went to the Acting Secretary. When Counsel Assisting asked Mr Bellinger why he did not seek to update the Minute before it was sent to the Office of the Secretary, or to prepare

a subsequent urgent Minute, he agreed that another Minute should have been prepared.[1271] When asked why this did not occur, Mr Bellinger said: 'I can't answer that.'[1272] This is an inexplicable response in the circumstances.

- Mr Bellinger appears to have undertaken at least a cursory examination of Mr Griffin's complaints history in response to Detective Senior Constable Hindle's request, noting the reference in his email to Detective Senior Constable Hindle about 'records dating back to some matters in 2004'.[1273] The Secretary should have been informed of this complaints history at the earliest opportunity—ideally by Dr Renshaw on 31 July 2019—however, there is no justification for the omission in a subsequent briefing to the Secretary.

Dr Renshaw returned from leave sometime after 18 October 2019, after this Minute was approved.

It took until our public hearing on 28 June 2022 for Mr Daniels and Secretary Morgan-Wicks to learn of Mr Bellinger's correspondence with Detective Senior Constable Hindle in October 2019.[1274] In relation to Ms Pearn's disclosure to the hospital in 2011 or 2012, Mr Daniels stated that he only learned of this fact through our hearings.[1275] When Counsel Assisting asked Mr Daniels for his response to learning that people in his organisation did not tell him about the disclosure before the hearings, he replied:

> I am very disturbed about that because, as I think I've indicated in my statement, that I rely very heavily on the advice from those people who manage those processes to advise me, because I can say in all honesty that, had I been aware at the time—not that I was in the role then [at the estimated time of the disclosure]—if that occurred today and that report was made available to me and I was told, I'd take immediate action and that action would be to report it to Tasmania Police and expect some outcome from it, as well as the notifications that are required because of the practitioner.[1276]

Secretary Morgan-Wicks recalls learning of Ms Pearn's disclosure to the hospital on 20 October 2020, which we describe in Section 5.2.45. We established that Dr Renshaw told her and Mr Daniels in an email in general terms about Ms Pearn's disclosure on 16 October 2020 following the release of the podcast *The Nurse*.[1277] Ms Pearn also attempted to alert others to her disclosure once *The Nurse* podcast was released. However, Secretary Morgan-Wicks did not know that Tasmania Police had spoken to the human resources team about this disclosure in 2019.

Secretary Morgan-Wicks gave evidence that, had she been advised of the circumstances of Ms Pearn's missing complaint in her review of the draft response to the Integrity Commission on 10 September 2020, or if it had been escalated earlier to her, she believes she would have immediately instituted an independent investigation into the management of complaints relating to Mr Griffin, given the seriousness of the missing complaint and the behaviour reported in 2011 or 2012.[1278]

Finding—The human resources team failed to escalate information they received on 11 October 2019 about Kylee Pearn's 2011 or 2012 disclosure

As we have described above, the call to Mr Bellinger from Detective Senior Constable Hindle on 11 October 2019 should have been a catalyst for immediate and urgent action from Mr Bellinger and other members of the human resources team. We consider that the human resources team, including Mr Bellinger, should have taken steps to ensure Mr Daniels and Secretary Morgan-Wicks were advised of the request and its implications for the hospital.

The information that human resources staff held about Ms Pearn's disclosure should have been escalated given it indicated that the hospital had known about Mr Griffin's potential offending from that time. This includes fully informing the Secretary of the query human resources staff received from Detective Senior Constable Hindle about Ms Pearn's disclosure—and describing what was known about that disclosure. We understand that for Mr Bellinger in particular, given his attendance at the meeting at which the disclosure was made, acknowledging such a fundamental error of judgment is confronting. However, the implications of mishandling Ms Pearn's disclosure should have been acknowledged at the earliest opportunity.

The tone of the briefing to the Secretary worked to distance the hospital from Mr Griffin's offences and to suggest there was no potential connection or risk to the hospital, beyond a possible and generic reputational risk associated with media attention of Mr Griffin's charges. This framing contributed to the hospital doing nothing and significantly undermined the opportunity for Mr Daniels and Secretary Morgan-Wicks to get on the front foot of the crisis by taking the following actions:

- They could have initiated an investigation into the specific circumstances of Ms Pearn's disclosure to understand exactly what happened and to enable any relevant information to be provided to assist Tasmania Police in its investigation of Mr Griffin.
- They could have closely examined Mr Griffin's personnel file and complaints history to determine whether there was any information that gave rise to concerns he may have harmed or abused patients in any way. This would have uncovered a significant complaints history at the hospital, as described in Section 4. Such a review would have also revealed that Mr Griffin was transferred to Ashley Youth Detention Centre in November 2017, providing an opportunity for the Department to investigate whether there were any complaints or concerns about Mr Griffin during his assignment there, and to determine the full extent of the Department's legal and reputational exposure.

- They could have prepared a plan on how to respond effectively to the hospital's failure to act on Ms Pearn's disclosure and the ongoing police investigation. This plan could have designated appropriate roles and responsibilities for managing the hospital's response and ensured any conflicts of interest were avoided, that legal advice and assistance was sought, and that relevant records and documents were secured and quarantined. This plan could also have guided the Department in responding to any patients and families that may have been affected by Mr Griffin's conduct and in providing accurate information to staff and the community as it was appropriate to do so. Further, contemplation of such a plan may have triggered a realisation that external expertise and assistance may be required, given the scale of this event.

5.2.17 18 October 2019—Mr Griffin dies by suicide

On 13 October 2019, Mr Griffin was found unresponsive at home, because of a suicide attempt.[1279] He was taken to Launceston General Hospital where he received treatment in the Intensive Care Unit, but died on 18 October 2019.[1280] The Coroner later stated in relation to Mr Griffin's death:

> The evidence viewed as a whole satisfies me to the requisite legal standard that the cause of Mr Griffin's death was a mixed prescription intoxication which caused hypoxia. I am satisfied that there are no suspicious circumstances surrounding Mr Griffin's death and that when he took the drugs which caused his death he did so with the express intention of ending his own life, voluntarily and alone. No doubt the charges he was facing at the time of his death motivated his action.[1281]

Shortly after Mr Griffin's death, Ms Leonard told us she learned from a staff member that community members were contacting Ward 4K staff with questions about Mr Griffin. These community members had learned of his death informally, presumably via friends and family of Mr Griffin.[1282]

Ms Leonard told us that she was not aware of Mr Griffin's family having formally announced his death and felt that his family should be entitled to confidentiality and privacy surrounding his hospitalisation. She said she did not think it was appropriate to formally share the news with staff.[1283] Acknowledging rumours were circulating, when conducting morning handover on 21 October 2019, Ms Leonard verbally briefed staff to not discuss the matter. She provided information about how they could access counselling and invited staff to meet with her to discuss any questions or concerns they may have. Ms Leonard acknowledged that not being informed of the circumstances of Mr Griffin's death at this time would have been challenging for some staff.[1284] She added:

> I found this a very difficult path to navigate, so I sought guidance and direction from Ms Tonks, Mr Harvey and Mr Bellinger once they were at work later this morning. I was hoping to receive guidance on how to proceed and I recall that they supported this approach [of not discussing the circumstances of Mr Griffin's death].[1285]

Ms Leonard said she did not receive any support or guidance from the then Executive Director of Nursing, Helen Bryan. Ms Bryan told us: 'I am unaware of any other directions made by LGH to staff on Ward 4K'.[1286] Ms Bryan also told us that, as a patient at the hospital prior to his death, Mr Griffin was entitled to 'the same privacy any other patient would receive' and this right to privacy continued after his death. Ms Bryan said that the hospital has:

> … an obligation to keep confidential from the general nursing staff on Ward 4K the fact that Mr Griffin had been a patient at the Hospital, the reason for his admission to the Hospital, and the fact of Mr Griffin's death, just as Hospital staff would keep confidential the admission and prognosis or health outcome of any other patient from the general staff at the Hospital who were not caring for the patient. This obligation meant that there was a tension between the Hospital's leadership taking steps to provide information to the nursing staff on Ward 4K in an effort to reduce the staff's distress and respecting the obligation to keep Mr Griffin's health information private and confidential.[1287]

Dr Renshaw also said that he was 'unaware' of any directions to staff on Ward 4K and that he consistently encouraged nursing staff to report any useful information to police or to his office.[1288]

Ms Leonard sent an email to staff on Ward 4K later in the day on 21 October 2019. The email read:

> Dear 4K staff,
>
> Due to recent events within the hospital, it has come to my attention that a former employee has recently passed away. I understand that this situation may cause you some distress, can I please again offer you the support of [an employee assistance program, with phone number]. However, due to patient confidentiality issues this should not be discussed by 4K nor any other Hospital employee. I would like to remind you about the ethical requirement as nurses to work within our code of ethics and code of conduct as state service employees. With appreciation for the difficult situation that we find ourselves in and kindest regards, Sonja.[1289]

According to some recipients who gave evidence to our Commission of Inquiry, this email was not well received by staff. Mr Gordon said there was no recognition from Ms Leonard of the fact that some staff had been friends with Mr Griffin for nearly 20 years. He stated: 'One 4K nurse I spoke to told me that she had never felt as insulted or degraded as she did receiving that email'.[1290] Mr Gordon described the rest of his shift that day as the 'worst shift' he had ever worked, as 'we essentially got told by her to shut up and do our jobs'.[1291] He explained: 'Many staff were trying to deal with the conflict of having James as a close friend but then knowing what he was alleged to have done. They were struggling'.[1292]

Mr Gordon also felt that Ms Leonard and the associate nurse unit managers were watching staff to make sure they did not talk about Mr Griffin.[1293] A Ward 4K staff member at the time, Annette Whitemore, agreed with Mr Gordon's recollections of how the email was received and the instructions not to talk. She told us: 'There was no reason to send it out like this … It was really blunt. I told Sonja that I thought it was blunt'.[1294] Ms Whitemore added that Ms Leonard was very upset at the time too:

> She told me that she didn't know [about Mr Griffin's offending]. Nobody knew. … I've been told by a colleague that they observed Sonja write and rewrite that email a number of times. It was very difficult for her to send.[1295]

Ms Leonard said in her statement to us that after Mr Griffin died 'I remember there was more transparent communication'.[1296] When Counsel Assisting asked whether she felt she received enough direction or leadership around managing the issues in the aftermath of Mr Griffin's death she responded: 'No, I don't think so'.[1297]

Meanwhile, Dr Renshaw continued to be the contact point for people concerned about Mr Griffin's actions in the months after his arrest and death. He described being contacted by staff and patients' families reporting concerns or looking for information about whether it was possible their child was harmed under the care of Mr Griffin.[1298] As described above, there seemed to be no clear plan to manage this contact, with responses largely ad hoc and driven primarily by Dr Renshaw.

We heard that over the following weeks staff began to agitate for a group debriefing process. We understand that the desire of staff to talk with each other was to help them process complex emotions, which for some extended to examining their own complicity in tolerating or overlooking Mr Griffin's inappropriate behaviour. In our view, many staff were experiencing what researcher and expert in community trauma recovery Dr Kate Brady calls 'moral injury'. The term moral injury refers to a person's psychological reaction to a serious event that involves a betrayal of their deeply held moral beliefs.[1299] Moral injury can involve feelings of guilt, remorse and anger and may cause a person to blame themselves for failing to prevent an event.[1300]

Mr Gordon described feeling 'extremely guilty' for not speaking up after observing the way Mr Griffin failed to demonstrate best practice in line with the chaperone protocol with a particular patient:[1301]

> … as a result of all the allegations being made against [Griffin] later on down the track, I look at that—I replay that, you know, those two seconds, that two-second memory, and I feel like that patient, without a shadow of a doubt, was a victim, purely because of the way that he would talk about her as well. The way he would talk to the family, the relationship he had with the parents. He would always try and look after this patient; even if he wasn't allocated, he was there. Yeah, without a doubt, I believe she was a victim.[1302]

Ms Whitemore shared with us her experience of working alongside Mr Griffin as a graduate nurse in around 2002 and witnessing him washing a patient:

> … but he moisturised over her chest, and that just keeps coming back, that I— I think I told somebody but I didn't put a complaint in, but it made me feel, 'Is that what we do?' But I knew I wouldn't do that, I wouldn't— if I was a male … So I sort of regret that I never took that further.[1303]

After he completed his shift on the day of Ms Leonard's email to staff, Mr Gordon, who was one of the nursing union delegates on the ward, contacted the union to request assistance. He told us: 'I was already furious about the way staff were being treated by management, the cone of silence that had been imposed and the lack of support offered'.[1304] This led to a meeting between the union and ward staff on 24 October 2019, which we describe in Section 5.2.20.

Some victim-survivors of Mr Griffin's abuse also described insensitive responses from Tasmania Police when they sought information or attempted to make a statement after Mr Griffin's death.[1305]

5.2.18 Sometime after 18 October 2019—Dr Renshaw returns from leave and hears 'corridor rumours' about Ms Pearn's disclosure

Dr Renshaw told us that after he returned from leave at an unspecified date after Mr Griffin's death, he gained 'vague knowledge' that a staff member had raised a concern with Stewart Millar about what Dr Renshaw described as a 'relationship' that the staff member had with Mr Griffin when she was a child.[1306] As we describe in Section 4.1.14, Mr Millar was Ms Pearn's manager at the time she reported Mr Griffin to human resources staff in 2011 or 2012 and attended the meeting held with human resources representatives at that time.

Dr Renshaw described the context in which he heard this information as 'one of these sort of corridor rumour-type situations'.[1307] Dr Renshaw could not recall who passed on this rumour, stating to us: 'How does anybody know when they pick up a rumour?'[1308] He described the hospital being 'rife with rumour' at the time, saying 'you basically had to be there at the time to actually understand the way decision making was being made and so on'.[1309] We do not have evidence of who told Dr Renshaw this 'rumour'.

When asked what enquiries he made to test the accuracy of the 'rumour' he had heard, Dr Renshaw explained that, by then, matters relating to Mr Griffin were largely with the Secretary of the Department and he did not think he should take it upon himself to make enquiries.[1310] We note that the Department disputes that the Secretary was tasked with any actions in relation to Griffin's offending.[1311] After further questioning, Dr Renshaw conceded that he believed the rumour at the time he heard it.[1312] He also told us that he did not believe it was appropriate to escalate this information 'on the basis of a rumour heard in a corridor' despite his belief in its veracity, and that there was not enough information for him to do so.[1313] During our hearings, Dr Renshaw conceded that not advising the Secretary of the rumour was a failing.[1314]

We recognise there were likely rumours swirling around the hospital. However, as reported to us, Dr Renshaw did receive specific information as part of this 'rumour' (namely the fact the disclosure involved Mr Millar) that he could have escalated for closer examination. We consider Dr Renshaw's failure to pass on information arose once Tasmania Police confirmed this 'corridor rumour' to him on 29 October 2019 and find as such in Section 5.2.21.

5.2.19 21 October 2019—The Secretary is verbally briefed on Mr Griffin's death

Secretary Morgan-Wicks told us that when she returned from leave:

> I recall that [the Acting Secretary] briefed me on critical issues of note that occurred during my period of leave, including the prolonged death following attempted suicide of a former employee, Mr Griffin, on 18 October and the earlier information that had been received on 14 October in relation to criminal charges against Mr Griffin.[1315]

Secretary Morgan-Wicks said that when she spoke to the Acting Secretary, she queried whether supports had been put in place for staff in light of Mr Griffin's death, and whether anything further needed to be done.[1316] She recalled that:

> … no further action was recommended at that time, that the Tasmania Police investigation was ongoing and that there was no notification that Mr Griffin's alleged offending was linked to his employment as a Paediatric Nurse with the THS.[1317]

Secretary Morgan-Wicks' impression was that the criminal allegations against Mr Griffin were related to his personal life, as she understood that the Department would be told if the victim-survivor was a patient, or the offending had occurred at the hospital.[1318] Secretary Morgan-Wicks also stated that the specific details of the police charges laid against Mr Griffin do not appear to have been shared with the Department until 2 November 2020, after the Department requested more information.[1319]

5.2.20 24 October 2019—The Australian Nursing and Midwifery Federation convenes a meeting for Ward 4K staff

Following Mr Gordon's contact, the Australian Nursing and Midwifery Federation convened a meeting for Ward 4K staff on 24 October 2019. Mr Gordon told us that the response of almost all attendees at this meeting was 'essentially a vote of no confidence' in Ms Leonard's leadership.[1320] Mr Gordon added: 'Everyone had had enough of the lack of support, information, and the direction to remain silent'.[1321]

Emily Shepherd, Branch Secretary, Australian Nursing and Midwifery Federation (Tasmanian Branch), gave her recollections of this meeting, which she attended, as follows:

> There was one report that was quite recent from 2016 which was made by one of our workplace delegates. [Note we consider this to be Mr Gordon's 2017 complaint.]

> That information was shared, but then there were also other members indicating that they were aware that other reports had been made, both verbally, via email, on paper-based incident reporting some time ago, and there was a collective recognition that there had been a pattern of reporting over a number of years.[1322]

Sometime after the meeting on 24 October 2019, Ms Shepherd contacted Ms Leonard and Ms Tonks to relay staff concerns and foreshadow the Australian Nursing and Midwifery Federation's intention to put those concerns in writing.[1323] On 28 October 2019, Ms Shepherd wrote to Ms Leonard, requesting a staff group debriefing facilitated by an independent counsellor 'without any management or HR representatives present'.[1324]

Mr Gordon recalled that, as a result of the Australian Nursing and Midwifery Federation's advocacy, the hospital engaged a private counsellor for individual sessions with staff.[1325] When Mr Gordon encountered this counsellor in the staffroom, he learned that their professional expertise was in counselling parents and staff following stillborn births.[1326] He felt that this was not the right skill set for what the nurses required and so did not arrange a session with the counsellor.[1327] Mr Gordon said that other staff were also wary of speaking to this person because there was a perception that the counsellor was reporting back to management.[1328]

The letter Ms Shepherd sent to Ms Leonard on 28 October 2019 also stated that:

> Members articulated an aggrievement with the way their previously lodged complaints regarding Jim have been handled. Members note that they did not receive any acknowledgement, or they were not advised that their complaint/ concern was handled. Considering recent events, the lack of transparency around their concerns is causing them significant distress, it is also driving a lack of confidence in their management. The [Australian Nursing and Midwifery Federation] requests that all previously lodged complaints in relation to Jim Griffin are reviewed and that the complainant is contacted and advised of the action take[n] at the time.[1329]

The request triggered a meeting between the Australian Nursing and Midwifery Federation and hospital management, which is described in Section 5.2.24.

As noted earlier, we did not see evidence of any meaningful examination of complaints about Mr Griffin in the three months from when he became the subject of a police investigation. There is considerable confusion about which complaints concerning Mr Griffin that Dr Renshaw was aware of at this stage. We note that Dr Renshaw had committed, on 31 July 2019, to examining the Safety Reporting and Learning System. At the time of our hearings, Dr Renshaw said that he was only aware of one complaint by a staff member in relation to Mr Griffin.[1330] Dr Renshaw, however, later told us that the search of the Safety Reporting and Learning System 'did not yield any results'.[1331]

5.2.21 29 October 2019—Tasmania Police briefs Dr Renshaw further about child exploitation images taken on Ward 4K and about Ms Pearn's disclosure

Dr Renshaw told us that on 29 October 2019, he received another briefing from Tasmania Police. On this day, he was advised that police had formed the belief that some of the photos that Mr Griffin had taken of Ward 4K patients constituted child exploitation material and that the police investigation was now focused on identifying the children in those photographs.[1332] This advice is confirmed in Detective Senior Constable Hindle's written summary of the meeting:

> Dr RENSHAW informed of the existence of in excess of (50) photographs regarded as Child Exploitation Material which were located on a device (phone) seized from GRIFFIN.[1333]

Detective Senior Constable Hindle told us that he informed Dr Renshaw about Ms Pearn's disclosure at this meeting, although this is not expressly captured in the meeting summary he prepared.[1334] Dr Renshaw said he did not recall Ms Pearn's disclosure being discussed at the meeting but that he had no reason to doubt Detective Senior Constable Hindle's recollection.[1335]

Finding—Dr Peter Renshaw should have escalated and acted on knowledge of Kylee Pearn's disclosure to the hospital once advised about it by Tasmania Police on 29 October 2019

We consider that Detective Senior Constable Hindle told Dr Renshaw about Ms Pearn's disclosure on 29 October 2019. Dr Renshaw had a responsibility to tell the Department and the hospital executive, particularly the Chief Executive Mr Daniels, that there had been a significant failure of systems and processes at the hospital resulting in a paedophile continuing to work in a paediatric ward for several more years. Dr Renshaw, as part of the executive, should have been looking for ways to ensure similar failures did not reoccur. He should also have been ensuring that others were informed of the failures in systems and processes so they could support those affected and take their own actions to ensure similar failures were not repeated.

5.2.22 30 October, 1 November and 13 November 2019—Dr Renshaw facilitates Ward 4K staff information sessions

On top of the distress staff were experiencing about the circumstances of Mr Griffin's death, we heard that staff were also becoming increasingly frustrated about the lack of information from management about how the hospital was responding to allegations against Mr Griffin.

Dr Renshaw facilitated three information sessions with Ward 4K staff to share information about Mr Griffin. These sessions took place on 30 October 2019, 1 November 2019 and 13 November 2019.[1336] Dr Renshaw told us that the 'overall strategy' for these sessions was 'driven by human resource advice'.[1337] Dr Renshaw said that the purpose of the sessions was to provide 'factual information regarding the current situation of the investigations into Griffin', noting that all the information he provided was cleared by Tasmania Police.[1338] Dr Renshaw stated that he advised staff that 'gossiping and innuendo were potentially destructive and unhelpful when the focus should be on supporting the legal processes and healing the broken team'.[1339] We consider it likely that Dr Renshaw was referring to the Tasmania Police investigation when referring to legal processes.

Ms Tonks, who was present during these sessions, told us that the information provided at the sessions was consistent on each occasion and included the timing of the police complaint (and when the hospital became aware of it), the suspension of Mr Griffin and the fact that the investigation (to the extent that it was occurring after Mr Griffin's death) was being managed by Tasmania Police.[1340]

At the hearings for our Commission of Inquiry, Ms Whitemore described a change in Dr Renshaw's approach towards staff during these sessions, saying 'it changed from "We'll support you, we'll support the nursing staff with whatever they need", to "You all should have been mandatory reporting": no respect, no respect'.[1341]

We understand Ms Tonks advised the meeting that there were no outstanding complaints against Mr Griffin. Ms Tonks later explained that she told staff this because she 'could only trust that [she] had been given accurate information by HR'.[1342] Ms Bryan did not take part in these sessions. She told us: 'I was not included in those meetings and so I am unaware of what response/reaction there was to [them]'.[1343]

Dr Renshaw felt the sessions he facilitated were generally well received. He recalled that some staff members sent him emails thanking him for the information provided at the sessions.[1344] However, Dr Renshaw also noted that 'two or three' staff were disappointed that the sessions were information-based and not group debrief sessions and 'expressed themselves quite clearly' on that front.[1345]

On 12 November 2019, before the final session, Mr Gordon, in his capacity as a union representative for Ward 4K, wrote to Dr Renshaw thanking him for hosting two meetings with Ward 4K staff.[1346] In this email, Mr Gordon said he had heard nothing but 'praise and gratitude' for answering staff questions.[1347] However, he reiterated the desire of staff to hold a group debriefing session because many were personal friends of Mr Griffin and felt both saddened by his death and shocked and conflicted by the information that had emerged about his offending.[1348]

Dr Renshaw sought advice from Mr Bellinger, Mr Daniels and Ms Bryan on how to respond to Mr Gordon's request.[1349] We note that this was one of the rare occasions that we are aware of when members of the executive discussed decisions in relation to Mr Griffin.

Mr Bellinger gave Dr Renshaw several options for responding to the request, including encouraging staff to use the services of the counsellor and directing staff to the usual Employment Assistance Program. Mr Bellinger also advised Dr Renshaw to explain that staff debriefs were 'not clinically or therapeutically recommended in these circumstances' because they may contribute to further staff upset or trauma.[1350] Mr Bellinger suggested that Dr Renshaw guide Mr Gordon and other staff 'back towards [Women's and Children's Services] management' to rebuild trust.[1351] Mr Bellinger's advice to Dr Renshaw concluded:

> I am deeply concerned by the breakdown this is now causing and think we need to be very careful to provide appropriate support, and resolve their perceived issues (which in my view are not reasonably held in these circumstances).[1352]

In the final of the three information sessions facilitated by Dr Renshaw, Mr Gordon asked Dr Renshaw whether he was aware of his 2017 complaint.[1353] Mr Gordon told us that Dr Renshaw replied that he had not seen Mr Gordon's complaint, but he was corrected by Ms Tonks, who said that Dr Renshaw had in fact seen the complaint.[1354] Mr Gordon described what happened next:

> I then asked [Dr Renshaw], 'Is this a minor incident?' And he said, 'No, it's not.' So I was like, 'Well, did you actually see it, did you read it?' It felt heavily implied by the contradicting statements of, you know, [Janette] Tonks and Peter Renshaw at the time that one of them wasn't being truthful and it felt heavily like it was Peter Renshaw who was not being truthful at the time.[1355]

Mr Gordon went on to ask why Ms Leonard did not report his complaint to Ahpra. Mr Gordon described Dr Renshaw's response:

> He said, 'Well, if you're going to blame [Ms Leonard]' and he pointed his finger and looked in my general direction, he said, 'Why didn't you report him?' And that's when it truly hit me that this was dead in the water, the THS [Tasmanian Health Service] were not going to do anything about it.[1356]

Mr Gordon reflected on this, telling us:

> It also felt quite personal as if, you know, it was my fault, and the big problem was, is that, he was actually right. Why didn't I? Because I didn't know I could report my own [colleagues] to Working with Childrens. The majority of nurses on that ward, after hearing about this, didn't realise they could report their colleagues to Ahpra, otherwise we might have done.[1357]

Ms Tonks also gave evidence about this exchange between Mr Gordon and Dr Renshaw at the third information session. She said she did not believe Dr Renshaw intended his response to sound accusatory but conceded: 'I believe it was certainly delivered in a way that people would have felt that it was their fault, and that's regretful that's occurred'.[1358]

On 13 November 2019, after the final information session, Dr Renshaw received an email from a nurse on Ward 4K who expressed 'extreme disappointment' about how the session was facilitated.[1359] The nurse complained that Dr Renshaw had not answered staff questions satisfactorily and had 'conducted' the meeting rather than allowing for debrief and discussion.[1360]

In his response to this staff member, Dr Renshaw clarified that his sessions with staff were not intended to be therapeutic debriefings but focused on delivering factual information to 'minimise the impact of gossip and hearsay'. He wrote to the staff member:

> I have been provided with expert advice, both from within the THS and external advice from my colleagues in other jurisdictions that strongly indicates that the 'open de-brief' such as you are requesting can be very damaging to individual members of the ward team … For this reason, and as an LGH/THS member who is personally accountable for the safety and well-being of our staff attending any session for which I am the lead, at the present time, I will not be supporting the open debrief 'quiet chat' approach.[1361] [Emphasis is Dr Renshaw's.]

Dr Renshaw also provided information to the staff member about how the hospital was responding to the allegations against Mr Griffin:

> Relevant members of the LGH Executive (specifically myself, James [Bellinger] – HR Director, Helen [Bryan] – EDON [Executive Director of Nursing] and Janette [Tonks]) have reviewed any matter relevant to Mr Griffin's behaviour of which we have a record. In each instance we can find the matter was reasonably addressed with Mr Griffin. This is not to say there are other matters of which we are unaware of which need to be considered and I welcome the opportunity to review these in order to bring you some closure.[1362]

Mr Gordon told us that it was after this final staff briefing on 13 November 2019 that he made an anonymous complaint to the Integrity Commission about the way senior staff at the hospital responded to concerns about Mr Griffin:

> I made the report to inform the Secretary of Health of the situation on the ward. I was desperate for some sort of investigation into the THS over the handling of the situation.[1363]

Other evidence suggests the Integrity Commission received this complaint on 4 November 2019, after the second briefing session, but that Mr Gordon was engaged with the Integrity Commission about the complaint on 13 and 15 November.[1364] Mr Daniels told us he was not aware of the complaint to the Integrity Commission until our hearings.[1365]

Mr Daniels told us that Dr Renshaw briefed him about these sessions with staff. Mr Daniels recalls Dr Renshaw describing the purpose of the sessions as part of the 'counselling and debriefing for them' and expressed the view that staff would benefit

from further training (presumably about mandatory reporting).[1366] Mr Daniels further stated at hearings for our Inquiry: 'The feedback we've received [from staff] to date [has] been really positive from my perspective'.[1367]

Finding—The lack of a coordinated and transparent response by Launceston General Hospital increased feelings of mistrust among hospital staff

We have received evidence that Launceston General Hospital leadership did not have access to records relating to many potential complaints about Mr Griffin, and that the human resources team did not raise complaints about Mr Griffin with leadership, other than Mr Gordon's complaint.[1368] A review of complaints about Mr Griffin was not conducted until November 2019. We discuss the quality of this review in Section 5.2.25.

We saw no evidence to suggest that Launceston General Hospital leadership actively sought information from human resources staff or anyone else about previous complaints against Mr Griffin, nor was a process conducted to test the rigour or quality of the hospital's records of complaints by human resources or anyone else. Therefore, the assurances provided to staff that complaints about Mr Griffin had been thoroughly examined were misleading.

Instead, staff were given assurances that there were no relevant concerns about Mr Griffin's employment at the hospital, notwithstanding knowledge that:

- Mr Griffin had taken photos of patients on the ward, some of which Tasmania Police considered to be child exploitation material.
- Tasmania Police had advised that Mr Griffin had a care arrangement with a former patient of his, which may have been a breach of his professional boundaries.
- A former staff member, Ms Pearn, had made a disclosure of child sexual abuse by Mr Griffin to the hospital in 2011 or 2012.

While we accept that it would not have been appropriate to share all this information with staff, false assurances should not have been provided.

We were particularly concerned about suggestions that staff felt blamed for not making mandatory reports to Child Safety Services, the Registrar of the Registration to Work with Vulnerable People Scheme and Ahpra. We hold this concern in light of our earlier findings about the hospital's lack of a clear process for staff reporting concerns to external agencies.

The hospital's response would have been assisted if there had been a critical incident response plan informed by open disclosure principles (refer to Chapter 15, Recommendation 15.19). This may have assisted the hospital to:

- seek external guidance on how to respond to staff
- provide accurate, transparent and clear communication to staff, including being honest about what was and what was not known
- trigger an early review of what could be learned about Mr Griffin's conduct within the hospital.

The absence of these elements in the response led to staff mistrusting the leadership team.

5.2.23 29 October–5 November 2019—The Secretary is briefed on a 'potential legal issue' relating to Mr Griffin

On 29 October 2019, the same day that Dr Renshaw received the second briefing from Tasmania Police, he prepared a Minute to the Secretary. Mr Daniels endorsed this Minute the same day, as did the human resources team on 31 October 2019. The Secretary signed the Minute on 5 November 2019. The Minute is significant, and, for this reason, we replicate significant parts of it. As stated in the Minute, the purpose of the briefing to the Secretary contained within the Minute was to:

1. Update you re the status of a Tasmania Police investigation into James Geoffrey Griffin, a previously registered Paediatric Nurse who was suspended from duty at the Launceston General Hospital (LGH) on 31 July 2019 on advice that his Working with Vulnerable People Registration was withdrawn.
2. Update you as to the actions taken by the Tasmanian Health Service (THS) in relation to this investigation.[1369]

We note that at hearings, there was significant back and forth between Counsel Assisting and Dr Renshaw as to how the first three dot points of the Minute under the heading 'Summary of key issues' (refer below) should be interpreted. In essence, Dr Renshaw sought to argue that the chronological nature of the briefing was intended to recap key events for the Secretary and to reflect the hospital's state of knowledge at particular times in the chronology. We do not intend to recount this back and forth, but note our frustration at Dr Renshaw's responses under questioning, when it was clear that what was at the heart of questioning by Counsel Assisting was to seek Dr Renshaw's response to a suggestion that the Minute he drafted was not comprehensive nor accurate.

We have considered the dot points in the Minute in line with how Dr Renshaw felt they should be interpreted—that is, as reflecting his state of knowledge as at 31 July 2019. We consider they are misleading even on this reading.

Under the heading 'Summary of key issues', the Minute starts with the following two dot points:

- Mr Griffin was suspended from duty from the LGH Paediatric Ward (Ward 4K) on 31 July 2019 following the cancellation of his registration for Working with Vulnerable People on the advice of Tasmania Police received by the Executive Director of Medical Services (EDMS).
- At that time, Tasmania Police were investigating a complaint external to the hospital pertaining to his alleged relationship with a young person and possession of child exploitation material. At that time, Tasmania Police advised that there was no evidence to suggest that any criminal activity had taken place within, or connected to, the LGH.[1370]

As described above, at the 31 July 2019 briefing from Tasmania Police, Detective Senior Constable Hindle told Dr Renshaw about police awareness of Mr Griffin's contact with Penny, a former Ward 4K patient. Detective Senior Constable Hindle also advised that photos of patients had been found in Mr Griffin's possession. Dr Renshaw specifically referenced Penny, and her status as a former patient, as part of his Ahpra notification made the following day. Dr Renshaw also told us that during this briefing, he identified that some of the photos, which did not include child exploitation material, were taken in Ward 4K.[1371] This state of knowledge is not reflected in the second dot point above. Dr Renshaw later told us that the absence of any references in the briefings prepared prior to October 2019 to the possibility that photographs may have been taken in the hospital was not an attempt to mislead his superiors, as the possibility was 'obvious to anyone'.[1372] Dr Renshaw also told us that he considered it unnecessary to make specific reference to Penny in the Minute.[1373]

As Dr Renshaw explained to us, the third dot point also relates to his state of knowledge on 31 July 2019:

- The LGH had <u>not</u> received <u>any</u> complaints from patients or their families regarding inappropriate behaviour by Mr Griffin that would warrant a Code of Conduct investigation, [Australian Health Practitioner Regulation Agency] notification or Tasmania Police notification.[1374] [Emphasis is Dr Renshaw's.]

In Section 4, we outline a succession of complaints about Mr Griffin's breaches of professional boundaries and inappropriate behaviour with young patients. We consider that several of the complaints against Mr Griffin, particularly those related to non-care touching of patients, independently met the threshold for disciplinary action. Considered cumulatively, there was no justification for not taking further action in response to Mr Griffin's conduct.

At hearings, Dr Renshaw stated that he had based the content of the third dot point on his interrogation of the Safety Reporting and Learning System, which only included one complaint by a staff member (Mr Gordon).[1375] Dr Renshaw later told us that the search of the Safety Reporting and Learning System 'did not yield any results'.[1376] Dr Renshaw, however, conceded that the content in this third dot point was inaccurate.[1377]

As noted above, Mr Bellinger acknowledged that consideration should have been given to conducting a State Service Code of Conduct investigation in response to Mr Gordon's Safety Reporting and Learning System complaint.[1378] We are not convinced that Dr Renshaw had properly reviewed this complaint, such that he could have formed a view at the time on the appropriateness of a State Service Code of Conduct investigation.

When asked why he did not reflect any potential connections between Mr Griffin's criminal investigation and the hospital in the Minute, Dr Renshaw provided a confused explanation, but ultimately said he 'overlooked it' and that the omission was 'unintentionally misleading'.[1379] Dr Renshaw conceded that the second dot point under the heading 'Summary of key issues' 'should have been worded better than that', and he agreed the term 'connected to' was 'wrong' and 'misleading', given he himself had referred to Penny as a former patient in his Ahpra notification on 1 August 2019, and that he knew images of patients had been found in Mr Griffin's possession.[1380]

The dot points in the Minute following the three discussed above are unremarkable in summarising subsequent events. They include content on the cancellation of Mr Griffin's nursing registration by Ahpra on 4 August 2019 (although we note that the cancellation in fact happened on 7 August 2019); Mr Griffin's resignation from the Tasmanian Health Service on 8 August 2019; the article of 9 October 2019 in *The Examiner*; and Mr Griffin's death, which Dr Renshaw noted was subject to a coronial investigation.[1381]

After this content, the next dot point summarised the information Dr Renshaw received from Tasmania Police on 29 October 2019:

> Tasmania Police met with the Executive Director of Medical Services on his return from leave on 29 October 2019 to provide additional information from their ongoing investigation. They advised that they had found a significant number of photographs classifiable as 'child exploitation material' possibly taken within the hospital over a period of some years. Tasmania Police are working to identify the children involved in this material.
>
> The information provided on 29 October 2019 by Tasmania Police was the first information that illegal / criminal behaviour may have occurred within the LGH.[1382]

We note that Detective Senior Constable Hindle told Dr Renshaw about Ms Pearn's disclosure to the hospital at the 29 October 2019 meeting. This critical information was not reflected in the summary of what Dr Renshaw learned that day. We also note that the human resources team signed off on this Minute and was aware of Ms Pearn's disclosure, noting Mr Bellinger's discussion with Detective Senior Constable Hindle on 11 October 2019. Dr Renshaw acknowledged that the Minute failed to include all relevant information, including Ms Pearn's disclosure: 'I would concede that there should have been a mention towards the bottom of the chronology regarding the most recent information from Tas Police'.[1383] The omission was more significant than this. The

statement that this 'was the first information that illegal / criminal behaviour may have occurred within the LGH' was clearly misleading.

The Minute goes on to detail what was occurring on Ward 4K:

> There is considerable gossip and innuendo in respect of this case across the Launceston community which is generating significant pressure on LGH management to provide statements in relation to this matter.
>
> Some staff on the Paediatric Ward (Ward 4K) have also shown levels of stress which has resulted in a letter from the ANMF (Australian Nursing and Midwifery Federation) claiming, without foundation, that LGH management had ignored potential warning signs in Mr Griffin's behaviour. The LGH offered one-on-one individual counselling to all nursing staff on the ward in addition to the standard Employee Assistance Program. Group debriefs, which the ANMF has requested, is not clinically recommended in circumstances such as this.[1384]

This part of the briefing was of particular concern to us. We consider it appalling to suggest, in the context of Mr Griffin's complaints history, that the concerns staff expressed via the union were 'without foundation'. The inaction on Ms Pearn's disclosure alone, which was known to Dr Renshaw and some members of the human resources team by this point, was a clear demonstration of the hospital ignoring potential warning signs.

The Minute continues:

> Peter Renshaw met with 4K staff on Wednesday 30 October 2019 and the Executive Director of Operations, Executive Director of Nursing and HR are currently arranging to meet with Dr Renshaw with respect to the purpose and content of the meeting.[1385]

We note that Dr Renshaw prepared the Minute on 29 October 2019, before the 30 October 2019 meeting, and suspect that the tense used—that is, that Dr Renshaw had 'met' with staff—was likely changed by those endorsing the Minute up the line, who recognised that the session with staff had happened by the time the Minute reached the human resources team.

The next heading of the Minute is 'Analysis of Issues' and reads:

> This is a serious and sensitive matter, even prior to the new information about potential criminal activity within the hospital. If and when Tasmania Police provide details of LGH patients that may have been the victims of the former staff member's alleged crimes whilst in LGH care, it will be imperative that the THS undertake Open Disclosure with the affected individuals and families.
>
> There is a need for ongoing management in relation to issues of open disclosure, staff assistance (EAP) for stressed or concerned staff members, liaison with Tasmania Police and media liaison as appropriate.

> There may also be publicity surrounding the Coroner's findings into Mr Griffin's death although this is fully dependent on the amount of information that the Coroner chooses to release with his or her findings.
>
> Advice has been sought from Crown Law (through the Assistant Solicitor-General, Mr Turner) regarding the THS response to this matter.[1386]

Dr Renshaw told us at hearings that the request for legal advice was confined to advice on the open disclosure process.[1387] We discussed in Section 5.2.3 the evidence we received from the Office of the Solicitor-General about Dr Renshaw's queries, including the frustrating absence of any records relating to this request for legal advice.

The recommendation in the Minute was simply that Secretary Morgan-Wicks 'note the above advice'.[1388] The previous 31 July 2019 Minute to the Secretary was listed in the 5 November 2019 Minute as an attachment.

On 5 November 2019, Secretary Morgan-Wicks marked the Minute as 'noted' with the following handwritten comment: 'Please advise if/when TasPol share information re past patients identified in any material so that approach to disclosure can be approved'.[1389]

Counsel Assisting invited Mr Daniels, who also received the Minute, to reflect on the many opportunities he had to receive frank advice from Dr Renshaw, given how little he seemed to know about Mr Griffin until our public hearings. Mr Daniels said he felt 'a loss of trust' in Dr Renshaw.[1390] Dr Renshaw said he could understand why Mr Daniels felt this way, given that he did not pass on information that may have assisted Mr Daniels to respond appropriately.[1391]

Counsel Assisting also invited Secretary Morgan-Wicks to reflect on the Minute:

> Q [Counsel Assisting]: From reading this note [the 5 November 2019 Minute], did you learn anything about the Pearn disclosure?
>
> A [Secretary Morgan-Wicks]: No, I did not.

Secretary Morgan-Wicks also agreed that the Minute did not make her aware of Mr Griffin's care of a former patient of the hospital, Penny. Counsel Assisting continued:

> Q: Are those matters that you would expect to be briefed to you if they were known to any person providing you with this briefing?
>
> A: Absolutely.[1392]

Secretary Morgan-Wicks described being 'absolutely horrified' about not having received critical information in the Minute and agreed that it was 'misleading'.[1393] Secretary Morgan-Wicks also told us that she would have liked to have understood the extent of staff anxiety and concerns in late 2019 rather than 2020 so she could have 'better [supported] Ward 4K staff to recover from this traumatic incident'.[1394] She stated that she only became aware of the extent of staff distress once she met with staff after the release of *The Nurse* podcast.[1395]

Reflecting on the importance of briefings to the Secretary being accurate, Secretary Morgan-Wicks said:

> As the Secretary of a department that has some close to 16,000 employees, I rely on the accuracy of information that comes up to me. It's certainly impossible for me to dive into every single issue that actually crosses a Secretary's desk on any day of the week, so certainly I absolutely do rely on the information that comes to me.[1396]

Secretary Morgan-Wicks also said that the information about Ms Pearn, in particular, would have influenced her decisions at this time:

> … if it had been escalated earlier to me at the time of contact from TasPol in October 2019, I believe that I would have immediately instituted an independent investigation in relation to the management of complaints relating to Mr Griffin (as I did on 21 October 2020 upon receipt of this information).[1397]

We discuss the independent investigation in Section 5.2.46.

Finding—Dr Peter Renshaw misled the Secretary of the Department about James Griffin

Of all the Minutes to the Secretary, we consider the Minute of 5 November 2019 to be the most significant and the most misleading. The following reflects the specific information we consider should have been included in the Minute. We then make observations about its overall tone.

Other information that should have been included in the Minute was:

- Mr Griffin was a paediatric nurse on Ward 4K for 18 years. His length of service is relevant given the number of paediatric patients who would have had exposure to him. It is also relevant to understanding the impacts on staff of his conduct and death because many would have known him for a long time.
- Mr Griffin was temporarily assigned to Ashley Youth Detention Centre in November 2017. Mr Griffin would have had contact with a group of highly vulnerable young people in a high-risk setting during this assignment. Steps should have been taken to confirm whether there were any concerns or complaints about Mr Griffin during his time in this role.
- Mr Griffin had an extensive complaints history within the hospital. All the complaints and concerns listed under 'Documented or acknowledged complaints' in Section 4 were known or knowable to the hospital. There were 14 documented complaints about Mr Griffin's inappropriate behaviour and professional boundary breaches in the hospital during his employment.

- In addition to these complaints, a staff member, Ms Pearn, disclosed to the hospital in 2011 or 2012 that she had been sexually abused by Mr Griffin as a child. Inaction by the hospital following this disclosure, including allowing Mr Griffin to remain on the ward, was a major litigation and reputational risk for the hospital and the Department.
- Tasmania Police had raised a private care arrangement regarding a former patient of Mr Griffin's, Penny, which may have constituted a breach of Mr Griffin's professional obligations.

While the Minute gave the Secretary some sense of the seriousness of the situation and the distress of ward staff, it also conveyed that the hospital had no knowledge of the risk Mr Griffin posed to children until 31 July 2019. We consider the wording of what was included, combined with what was excluded, to have been calculated to give the impression to the Secretary that the hospital was not implicated in Mr Griffin's conduct. Secretary Morgan-Wicks agreed, telling us she felt that the wording of the Minute was designed to 'reassure me that there was nothing to see here in terms of the LGH'.[1398]

Dr Renshaw conceded that 'in retrospect' the briefing was significantly deficient, although he qualified that the briefing was written in 'good faith based on the information' he had at the time and 'there was no deliberate intent to mislead'.[1399] He said 'it was just one of those situations where the amount of information we had was pretty well overwhelming'.[1400] Dr Renshaw later told us that he did not include some information in the briefing, because it was 'unnecessary' (in relation to Penny), did not 'warrant advising the Secretary' (in relation to the 'corridor rumour') or was 'well known' (in relation to Mr Griffin's length of employment).[1401] This does not explain why Dr Renshaw did not include information about Ms Pearn's disclosure when it was confirmed by Detective Senior Constable Hindle on 29 October 2019. Dr Renshaw also stated that he regretted his failure to pass on critical information, which contributed to the Secretary not taking appropriate steps in response to the allegations against Mr Griffin and in support of staff.[1402]

The concessions Dr Renshaw made were reluctant and highly qualified and we found his evidence on this Minute to be unconvincing. Overall, we consider that he attempted to minimise his responsibility by suggesting that the Department was taking the lead on coordinating investigations and that any enquiries he may have made to provide more comprehensive advice could have cut across the Department's work.[1403] This position overlooks the obvious fact that the Office of the Secretary was relying on Dr Renshaw's advice—as a senior executive who was receiving or had access to all material information—to inform her decisions on the need for and nature of further enquiries.

5.2.24 6 November 2019—The Australian Nursing and Midwifery Federation meets with hospital management

As noted above, the Australian Nursing and Midwifery Federation wrote to Ms Leonard on 28 October 2019. This letter reiterated staff requests for a group debriefing and raised concerns that hospital management had not properly addressed complaints about Mr Griffin.

After not receiving a response, Ms Shepherd contacted Ms Tonks and was told that her letter had been escalated to Mr Daniels.[1404] On 31 October 2019, Mr Daniels wrote to Ms Shepherd noting that her letter had caused 'significant distress to Ms Leonard as well as the then Nursing Director of Women's and Children's Services [Ms Tonks]'.[1405] Mr Daniels requested a meeting with Ms Shepherd and proposed that it would be 'appropriate to have both the LGH Executive Director of Nursing … Helen Bryan, and James Bellinger, Manager of Human Resources for the North and North West of the THS also attend'.[1406] Mr Daniels ended the letter: 'I am particularly concerned to ensure that relevant executive management staff at LGH are involved' and requested union correspondence to be directed to Ms Bryan in the first instance.[1407]

Ms Shepherd said Mr Daniels' request that she direct correspondence to Ms Bryan was outside usual processes and that the Australian Nursing and Midwifery Federation had previously been directed to always raise concerns with the relevant nurse unit manager in the first instance.[1408]

Our review of the correspondence between the hospital and the Australian Nursing and Midwifery Federation suggests that the relationship between hospital management and the Federation at this point was strained at best.

A meeting involving Ms Shepherd, Mr Daniels, Ms Bryan and Mr Bellinger took place on 6 November 2019.[1409] Ms Shepherd told us that a range of issues were discussed at this meeting. Of note, Ms Shepherd recollected that:

- Mr Daniels asked for evidence to support members' claims that complaints about Mr Griffin had been made and not acted on, to which Ms Shepherd referenced Mr Gordon's 2017 Safety Reporting and Learning System complaint.[1410]
- Ms Shepherd had to advocate strongly for a commitment from the hospital representatives attending the meeting that feedback be provided to staff who had previously raised complaints about Mr Griffin, without staff members having to request this feedback themselves.[1411]
- Mr Daniels produced a copy of the Children, Young Persons and Their Families Act to suggest that any members who held concerns about Mr Griffin should have made a mandatory report.[1412]
- Mr Daniels strongly advised against staff speaking to the media, stating that this would be a breach of the *State Service Act 2000* ('State Service Act') and place their employment at risk.[1413]

We did not receive evidence from Mr Daniels or Ms Bryan about this meeting. We note Mr Daniels' evidence that human resources staff and Dr Renshaw informed him that all complaints against Mr Griffin had been 'critically investigated and not substantiated'.[1414]

5.2.25 November 2019—Human resources staff review complaints about Mr Griffin

As we have foreshadowed at various points, despite the assurances given to Ward 4K staff and the Australian Nursing and Midwifery Federation, it was unclear to us what, if any, reviews the hospital undertook into Mr Griffin's complaints history and its state of knowledge of the risks he posed to children.

Mr Bellinger told us that sometime in November 2019 he conducted a review of records in response to staff concerns about how management had dealt with complaints about Mr Griffin.[1415] We note that on 11 October 2019, Mr Bellinger had conducted at least a cursory search of human resources records when Detective Senior Constable Hindle called him asking about Ms Pearn's 2011 or 2012 disclosure to the hospital. As outlined earlier, Ms Leonard recalled the human resources team asking for her records of complaints about Mr Griffin 'at some stage' and we consider it likely this occurred around this time.

Secretary Morgan-Wicks told us that she understood a review of the complaints history against Mr Griffin was conducted after the 6 November 2019 meeting with Ms Shepherd.[1416] It is our view that this review was only conducted because of pressure from the Australian Nursing and Midwifery Federation.

At our hearings, Mr Bellinger stated that after undertaking this review he formed the belief that all complaints relating to Mr Griffin had been 'handled appropriately'.[1417] He subsequently qualified this statement, asserting that it was more accurate to say that the complaints were managed in line with the practice at the time.[1418] Under questioning from Counsel Assisting, Mr Bellinger conceded that Mr Griffin's complaints history suggested a pattern of behaviour that should have been identified and addressed:

> Q [Counsel Assisting]: We've heard the evidence that Griffin was cautioned three times at least that he would be subject to escalation if his conduct did not change. So, as far as you were aware did any escalation ever take place in accordance with those threats?
>
> A [Mr Bellinger]: No.
>
> Q: And is that a matter of concern for you?
>
> A: Yes.
>
> Q: Can you tell the Commissioners why it is a matter of concern for you?
>
> A: Given the pattern of behaviour displayed, these matters could and should have been considered differently and more significantly.[1419]

Of significant concern was that Mr Bellinger's review failed to consider and reflect all available material relevant to complaints about Mr Griffin. Mr Bellinger admitted that Ms Pearn's complaint to the hospital—which, on his evidence, he became aware of from Detective Senior Constable Hindle on 11 October 2019—was not included in his review.[1420] This is a striking omission. Mr Bellinger sought to justify the omission by explaining that his review was limited to complaints that were addressed with Mr Griffin.[1421] He accepted, in retrospect, that the limited scope of the review was not appropriate and that Ms Pearn's disclosure should have been included.[1422] However, he denied that his failure to include Ms Pearn's disclosure in his review was an attempt to cover up that the disclosure was first made to the hospital in 2011 or 2012:

> My involvement may not have been adequate, it may not have been sufficient, but 'cover-up' implies that there was an intent to cover up … That was not the intent; [the review] may not have been exhaustive enough, but it was not the intent to bury it.[1423]

We are not convinced of this and return to this point later.

Reflecting on the review of Mr Griffin's complaints history, Secretary Morgan-Wicks noted that, at the time, she was not provided with the review's findings:

> Although this was not a formal investigation, I am informed that this review took place and feedback was provided to staff involved. No further escalation regarding the review of complaints was made to the Secretary.[1424]

We did not receive evidence to suggest that any such feedback was given to staff about the complaints made or about the outcome of the November 2019 review (noting Ward 4K staff had received assurances before this review that all complaints had been managed appropriately in the staff briefings described in Section 5.2.22).

Mr Bellinger then conducted two 'reviews' into Mr Griffin's complaints history, but there was no evidence before us that those reviews went beyond the initial review. As a result, we consider that the deficiencies and omissions from the first review infected the subsequent reviews. This is significant because one of the later reviews was undertaken on behalf of the Secretary, in response to a complaint to the Integrity Commission. We return to Mr Bellinger's failings in relation to the various 'reviews' in our finding in Section 5.2.38.

Dr Renshaw confirmed his involvement in Mr Bellinger's November 2019 review; however, he was at pains to emphasise that human resources staff were leading this review and that he did not consider all the information that informed it.[1425] This suggests that Dr Renshaw was not aware of Mr Griffin's full complaints history.

5.2.26 November 2019—Mr Gordon becomes concerned his Safety Reporting and Learning System complaint could be modified

After the staff briefings with Dr Renshaw, described above, Mr Gordon became increasingly suspicious of the hospital's response to Mr Griffin's complaints history. So much so that, sometime in November 2019, he took photographs of his complaint in the Safety Reporting and Learning System to ensure he had a record in case the entry was altered or deleted.[1426]

On 14 November 2019, Ms Tonks emailed Mr Gordon stating: 'Peter [Renshaw] and I both share concerns with your comments [at the staff information session] relating to "unanswered complaints"'.[1427] Ms Tonks requested more information from Mr Gordon so she could 'personally review these complaints'.[1428] Ms Tonks followed up this request on 28 November 2019, writing to Mr Gordon that she 'remained concerned' with his assertions. Given Mr Gordon had not provided further information, she requested a meeting, that Mr Bellinger would also attend, on 2 December 2019.[1429]

Mr Gordon ultimately responded to Ms Tonks on 1 December 2019, noting that he had forgotten to send a previous draft response. He wrote: 'Regarding the unanswered complaints I, and the nurses who raised concerns with me on the ward as their ANMF Rep have decided not to pursue these concerns with the THS'.[1430] Mr Gordon indicated that staff had shared their concerns with the Australian Nursing and Midwifery Federation and that they had met with Mr Daniels and were ultimately satisfied. Mr Gordon, did, however, express concern about what happened to his complaint of August 2017, which Dr Renshaw had committed to following up.[1431] Mr Gordon indicated he did not think a meeting was necessary.

Ms Tonks responded to Mr Gordon's email on 2 December, copying in Mr Bellinger. Her email stated:

> I assure you that we have reviewed the matter you raised via SRLS in regards to Jim's behaviour, that particular event was addressed by Sonja with Jim at the time and I am satisfied with the outcome. I can confirm for you that (as [union] delegate) that all of the matters that we have on record were addressed with Jim in a reasonable manner. As I am sure you will appreciate, it can be difficult for managers to share the outcomes of these processes however I hope the assurance that they were addressed provides some comfort.[1432]

Mr Gordon formed a view at around this time that his Safety Reporting and Learning System entry had been changed to remove a specific reference to the comments Mr Griffin made to patients being sexual in nature. He began making enquiries with the hospital's IT team and the administrator in charge of the system about whether this could have happened.[1433] Mr Gordon stated to us that this administrator told him that pursuing his own investigation 'may result in an ED5 [Employment Direction No. 5—Breach of Code of Conduct] and could potentially result in termination of my contract'.[1434] Mr Gordon discontinued his enquiries.

A staff member in the Quality Patient Safety Service North at Launceston General Hospital told us that most staff at health services are 'default reporters', which means they can only report a Safety Reporting and Learning System event, not view, access or manage it.[1435] We were told that staff can see the file status of the event (for example, 'submitted', 'awaiting review', 'being reviewed/under investigation', 'referred for closing' or 'closed').[1436] Changes to safety events logged in the Safety Reporting and Learning System can also be seen via an audit trail, which shows the name of the person who made the changes as well as the date and time of the change and the actual change made.[1437]

We requested information to examine whether Mr Gordon's complaint entry had been altered in any way. As previously outlined, the audit trail shows that a staff member in the Quality Patient Safety Service granted file access to former Human Resources Consultant Mathew Harvey on 4 September 2017 and to Helen Bryan, former Executive Director of Nursing, on 7 November 2019, for review purposes only.[1438] This staff member told us that they did not alter or update the report other than to grant this file access to Mr Harvey and Ms Bryan.[1439] The audit trail also revealed that none of the staff who originally had access to Mr Gordon's complaint, including Ms Leonard and Ms Tonks, made any changes to the event.[1440] We were satisfied with our review of this entry and the audit trail that the entry had not been improperly changed. Mr Gordon was also ultimately satisfied with this conclusion once it was put to him at our hearings.[1441]

5.2.27 21 November 2019—The Integrity Commission notifies the Secretary of a complaint about Launceston General Hospital's management of complaints about Mr Griffin

As we noted above, in his frustration with the staff briefing process, Mr Gordon made an anonymous complaint to the Integrity Commission about the response of certain Launceston General Hospital managers to information about Mr Griffin.[1442] On 21 November 2019, the then Chief Executive Officer of the Integrity Commission wrote to Secretary Morgan-Wicks advising that he had received a complaint on 4 November 2019 about an employee at Launceston General Hospital.[1443] The Chief Executive Officer told Secretary Morgan-Wicks that the 'complaint raises allegations which, if established, might constitute misconduct'.[1444] The Chief Executive Officer referred the allegations raised in the complaint to Secretary Morgan-Wicks as the principal officer of the relevant public authority for investigation and action under section 38(1)(b) of the *Integrity Commission Act 2009*.[1445] His letter outlined the Integrity Commission's expectation that Secretary Morgan-Wicks would 'make sufficient inquiries to satisfy yourself as to whether any act of misconduct has occurred, and if so, to ensure that misconduct is dealt with in an appropriate way'.[1446] His letter also noted that the complaint may 'be an opportunity for you to review any relevant policies and procedures'.[1447]

While we have referred to Mr Gordon as the complainant in this section for clarity, the Chief Executive Officer's letter did not identify the complainant. However, the Chief Executive Officer indicated in his letter to the Department that he would advise the complainant that the matter had been referred to Secretary Morgan-Wicks. [1448] The Chief Executive Officer also noted in his letter that the complaint was 'a protected disclosure for the purposes of the *Public Interest Disclosures Act 2002* and that the protections provided under the Act applied to the disclosure'.[1449]

The Chief Executive Officer's letter did not provide details about the specific conduct of employees who were the subject of the complaint but enclosed a copy of the Integrity Commission's report, *Assessment Greystone*, with the letter. *Assessment Greystone* reflected a summary of the initial assessment of the complaint.[1450] It included the following:

> Multiple complaints were made to the Tasmanian Health Service over the past 18 years about Mr Griffin relating to his inappropriate conduct against minors and others on Ward 4K however that, due to personal relationships between key staff and Mr Griffin, these complaints were not properly investigated and any documentation destroyed.[1451]

The complaint alleged that the employees 'failed to properly deal with reports and complaints about James Griffin relating to his inappropriate conduct on Ward 4K of Launceston General Hospital'.[1452] Their conduct was described as a possible breach of the State Service Code of Conduct, which provides that 'An employee must behave honestly and with integrity in the course of State Service employment' and that 'An employee … must comply with all applicable Australian law'.[1453] *Assessment Greystone* noted that medical practitioners and nurses have mandatory reporting obligations under the Children, Young Persons and Their Families Act.[1454]

Assessment Greystone considered a range of issues raised in the complaint, including Mr Griffin's behaviour, management's response to reports and complaints, the police investigation, workplace culture and mandatory reporting of child abuse.[1455] It made explicit that the Integrity Commission's assessment had not considered any reports or management responses to Mr Griffin's behaviour, apart from a report made in August 2017 (Mr Gordon's Safety Reporting and Learning System report).[1456] This reflects the preliminary nature of the assessment.

The report also referenced Mr Gordon's belief that 'staff stopped making reports about Mr Griffin given management failure to respond to the reports and a fear of losing their jobs if they spoke out'.[1457] In this regard, Mr Gordon referenced an earlier matter where a former nurse on the ward was believed to have been 'bullied out of [their] position' after raising concerns about a procedural change they believed was detrimental to patients.[1458] The complainant surmised that the way this complaint was managed may have influenced staff against reporting future issues.[1459]

Assessment Greystone notes that the Integrity Commission contacted Mr Gordon on 13 and 15 November 2019. It recorded that Mr Gordon indicated he believed that he had been 'targeted' for speaking out at a meeting about Mr Griffin on 13 November 2019 because he was the only one who had received email contact after doing so, despite several other nurses also raising issues at the meeting.[1460] We note this description would likely have made Mr Gordon identifiable as the complainant to certain individuals at the hospital, most notably Mr Bellinger, who Ms Tonks copied in when responding to Mr Gordon raising concerns at a staff information session (described in Section 5.2.22).

Assessment Greystone concluded that:

> On the available evidence, it is likely that there has been knowledge and reports of inappropriate and more serious behaviour by Mr Griffin over an extended period of time, and that these may not have been properly dealt with by the [Tasmanian Health Service]. It is possible that proper reporting and management responses may have prevented Mr Griffin from offending and subsequently being charged with criminal offences, and thus protected vulnerable children and young people.[1461]

Mr Gordon received an email from the Integrity Commission's Chief Executive Officer on 21 November 2019, which read:

> … I consider the best way forward is to refer the matter to Ms Morgan-Wicks, with a request that she take further action. This decision is largely based on my belief that Ms Morgan-Wicks is in a better position to deal with the cultural and workplace issues that envelop your complaint – while we try to work with sensitivity, I do not believe that the commission is the best agency to deal with this matter in the existing circumstances.
>
> In referring the matter, I would expect Ms Morgan-Wicks to make sufficient inquiries to satisfy herself as to whether any act of misconduct has occurred and if so, to ensure that misconduct is dealt with in an appropriate way. It is also an opportunity for her to review any relevant policies and procedures. Ms Morgan-Wicks will advise us of any action she takes and I would be happy to pass that on to you.[1462]

When Counsel Assisting asked Mr Gordon whether he was disappointed by the Integrity Commission's determination not to investigate his complaint, Mr Gordon gave this response:

> I was hoping it would, but I did not expect it to because that submission to the Integrity Commission was highly emotive at the time and it was a lot of hearsay without facts, so I did not expect it to be investigated thoroughly but, like I said, the result I wanted I achieved: Kathrine Morgan-Wicks was aware of it.[1463]

Secretary Morgan-Wicks told us that she did not specifically recall receiving this correspondence from the Integrity Commission.[1464] We consider that it is possible that staff within the Office of the Secretary who received the complaint from the Integrity Commission may not have specifically notified the Secretary, given the volume of correspondence that is transacted through her office.[1465]

On 2 December 2019, the Integrity Commission's letter and report was referred to the then Chief People Officer at the Department with a request that she 'review the appropriate systems and provide advice to the Secretary'.[1466] In line with standard practice, the former Chief People Officer allocated the complaint to Mr Bellinger, as then Human Resources Manager, for investigation.[1467] According to the former Chief People Officer, they did this in consultation with another member of the human resources team. We note that the former Chief People Officer had only been in their role for a few weeks at this time but had previously worked in the Department's human resources area.[1468]

We consider it should have been obvious to the human resources team that allocating the complaint to Mr Bellinger—or indeed to anyone within that team—was inappropriate given their direct involvement in the management of some of the complaints about Mr Griffin (which the complainant took specific issue with). Mr Bellinger had been directly involved in responding to various complaints about Mr Griffin's behaviour over the years and played a central role in the hospital's management of more recent staff concerns about how Mr Griffin's conduct had been managed.

The former Chief People Officer told us they had no reason to believe there was any conflict of interest in Mr Bellinger investigating the complaint forwarded by the Integrity Commission and would have expected either the human resources team or Mr Bellinger to have notified them if there was.[1469] The Secretary echoed the former Chief People Officer's view:

> It's my expectation that when employees receive matters that they are working on, so whether it's an investigation or whether it's a transaction or other matter that they need to work with, that they need to evaluate their own conflicts of interest in relation to handling of matters.[1470]

When Counsel Assisting asked the Secretary whether allocating the complaint to Mr Bellinger in these circumstances was a conflict of interest, she replied: 'I believe so, yes'.[1471] Michael Easton, current Chief Executive Officer, Integrity Commission, similarly acknowledged that there was a potential concern that Mr Bellinger had a conflict of interest and should not have undertaken the investigation.[1472] The Health Complaints Commissioner, Richard Connock, also stated to us that 'it should probably have gone to somewhere other than human resources in this circumstance, yes'.[1473] The Department has since clarified that at the time of the referral the Department was not aware of the scale of the concerns in relation to the hospital's human resources team. However, the Department has acknowledged that, in hindsight, the matter should not have gone to the human resources team at the hospital.[1474]

Mr Easton's evidence also discussed the Integrity Commission's own processes for monitoring complaints. He accepted that in November 2019 the monitoring of complaints that were referred to public authorities was less rigorous than he would have liked it to have been.[1475] However, speaking generally, he held the view that it would be

appropriate at times for a public agency to investigate itself where there is an allegation of potential document destruction and cover up within the organisation.[1476]

Counsel Assisting asked Mr Easton about the reasons for referring the matter back to the Department, querying whether community outrage at the circumstances surrounding Mr Griffin's long-time employment in the paediatric ward should have warranted a more independent investigation. Mr Easton explained that enhancing public confidence was a relevant consideration, but community outrage was not. Mr Easton's evidence on this is set out below:

> Q [Counsel Assisting]: What about the need to restore public confidence in the aftermath of a discovery that a paedophile had worked on a paediatric ward at Launceston General Hospital for 18 years? Did that context and the understandable community outrage that followed weigh at all in your decision about whether or not this matter should be referred back to the Department of Health?
>
> A [Mr Easton]: No.
>
> Q: It didn't?
>
> A: No.
>
> Q: But you'd accept that public confidence in independent— I'm not going to phrase it, it's not going to be spot on— but independent scrutiny of allegations of misconduct is one of your objectives under your Act?
>
> A: It is: … 'enhance public confidence, and misconduct by public officers will be appropriately investigated and dealt with'.
>
> Q: And you didn't take that into account? The fact that this in particular might be a matter where the public, in order to have confidence in the system, would have welcomed an independent investigation of Mr Gordon's complaints, you didn't take that consideration into account?
>
> A: No, we do take—where we can enhance public confidence into account all the time. What you were talking about was community outrage; we don't take that into account, but broadly we need to always be conscious of, whatever we are doing, we are enhancing public confidence that is appropriately investigated and dealt with, and 'appropriately' can mean by us or by another agency. That's the key element, and then by doing that we enhance public confidence. We're not responding to community emotion or outrage—not disrespecting that, it's just, that's not a factor, it's how we enhance public confidence that things are appropriately dealt with, is the key thing.[1477]

Mr Easton indicated that a triage team within the Integrity Commission met every three weeks to discuss the monitoring of active referrals.[1478]

Secretary Morgan-Wicks told us that Mr Daniels was not made aware of the Integrity Commission report on the basis that two of the people named in the complaint reported to him.[1479] The fact that most of the executive were implicated in the complaint meant that there was no scrutiny by senior executives (or anyone else, it seems) of the investigation into the complaint, which was ultimately led by human resources staff.

Finding—The Integrity Commission should have ensured Will Gordon's complaint to them was robustly and independently reviewed

Although we accept that there may be instances where it is appropriate to refer a complaint back to a principal officer of a public authority for investigation, this should only occur in circumstances where the referring agency, in this case the Integrity Commission, is satisfied that:

- the public authority tasked with the review has adequate processes in place to ensure complaints are robustly and independently investigated
- the referring agency has adequate processes in place to maintain a close level of oversight and scrutiny over an authority's investigation, to ensure it is robust and independent.

We note that Mr Gordon's complaint to the Integrity Commission did not name human resources staff as subjects of the complaint. However, we consider the Integrity Commission should have been attuned to the risks that could arise in referring the complaint back to the Department, including that it may be investigated by those who had previously been involved with complaints about Mr Griffin's conduct. The Integrity Commission should have set guiding parameters for the Department to avert this, such as specifying that the complaint should not be investigated by those previously connected to the management of complaints involving Mr Griffin.

5.2.28 5 December 2019—Dr Renshaw receives another complaint about Mr Griffin from a staff member

On 5 December 2019, following Dr Renshaw's invitation to staff at the information sessions to share any further concerns related to Mr Griffin with him, a staff member emailed Dr Renshaw about a comment that a patient had made about Mr Griffin.[1480]

The staff member provided the name of the patient but did not nominate a date or timeframe for the comment.

The reporting staff member told Dr Renshaw that the patient said Mr Griffin would often offer to take her home, which she found confusing in the context of him being a nurse. The staff member added:

> Again, this is very much a Jim sort of thing to say about patients and he would often say the same comment to us about disadvantaged children as a kind of hero like gesture … I thought I better mention it to you as it clearly seemed to be confusing to [the patient].[1481]

This information was suggestive of the 'private care arrangement' that Mr Griffin described to Detective Senior Constable Hindle on 31 July 2019 as explanation for a former patient, Penny, staying with him. Dr Renshaw forwarded the staff member's email to Tasmania Police.[1482]

5.2.29 5 December 2019—A panel of hospital staff examine sanitised photos found in Mr Griffin's possession

As outlined above, Dr Renshaw noted in a Minute signed by the Secretary on 5 November 2019 that the Tasmanian Health Service was 'committed to providing open disclosure to the families of any child identified as a victim of Griffin at the LGH'.[1483] In Chapter 6, we discuss a protocol used in South Australian schools where the parents of all children who have had contact with a person charged with a child sex offence are made aware of their child's exposure to that person regardless of whether complaints were raised.

From 5 December 2019, the hospital assisted Tasmania Police to identify the patients who were in the photographs Mr Griffin took at the hospital. Tasmania Police sanitised the images for the purposes of this identification. Tasmania Police believed that the images were taken between 2009 and 2014, although the date that some were taken could not be verified.[1484]

According to Dr Renshaw:

> Approximately 10 photos were received on 5 December 2019 by a small panel … in the presence of Detective Senior Constable [Glenn] Hindle and [another detective sergeant]. The panel was able to identify one victim with certainty and two victims with significant doubt because of the quality of the photograph and the lack of any date references on the pictures.[1485]

This information, provided to us in Dr Renshaw's statement, was at odds with an email he sent to Secretary Morgan-Wicks on 7 August 2020, which makes recommendations to her about four identified patients the hospital should engage in open disclosure.[1486] We note that we have received evidence from Tasmania Police that three children were positively identified and that the panel disputed the identification of one other.[1487] We return to this email in Section 5.2.37. This email also refers to Mr Griffin's care arrangement with Penny.[1488]

5.2.30 12–20 December 2019—The Australian Nursing and Midwifery Federation engages with hospital management

On 12 December 2019, Ms Shepherd wrote to Mr Daniels expressing concern about the accuracy of draft minutes prepared by the hospital relating to the 6 November 2019 meeting that she had attended with Mr Daniels, Ms Bryan and Mr Bellinger. In addition to making corrections to the minutes, the letter from Ms Shepherd reflected the Australian Nursing and Midwifery Federation's ongoing concerns that

hospital management was not offering appropriate information and support to staff. The Australian Nursing and Midwifery Federation expressed concern about the staff sessions Dr Renshaw facilitated, during which Dr Renshaw blamed staff for not making mandatory reports about Mr Griffin. Ms Shepherd stated in her letter:

> … when staff tried to discuss the ward culture, they felt they were promptly shut down by Dr Renshaw. This has resulted in anger and further dissatisfaction with management, making staff feel that the [Tasmanian Health Service] is not serious about implementing any change as a result of these current events. This has further reduced staff's confidence in senior management for developing a culture of support and to make mandatory reports and a shared attempt for positive reflection.[1489]

Ms Shepherd also raised concerns about failures of the hospital to consistently give feedback to members who had submitted a Safety Reporting and Learning System report, making them feel that submitting a report was 'fruitless'.[1490]

Mr Daniels replied to the Australian Nursing and Midwifery Federation on 20 December 2019 defending the management response. Mr Bellinger prepared the draft of this letter, which was intended to reflect the outcome of his review of Mr Griffin's complaints that began in November (described in Section 5.2.25).[1491] Mr Daniels told us that his response to the Federation reflected the knowledge he had at the time and that his knowledge was limited because key information about Mr Griffin's complaint history and conduct had not been made available to him.[1492]

On the question of complaints, the response letter noted:

> There has been one (1) SRLS that we could find relevant to Mr Griffin's behaviour. Whilst the person submitting it did not receive feedback the matter was appropriately addressed with Mr Griffin and any feedback that would have been provided to the person submitting it would have been in generic and confidential terms.
>
> There were a small number of HR files, each of which were appropriately addressed.[1493]

No further information about the 'small number of HR files' was provided in the response letter. Nor was there any mention of the complaints about Mr Griffin recorded in Ms Leonard's file notes and diary entries. Mr Daniels later told us that he was informed that the records reviewed in relation to Mr Griffin 'had not revealed any substantiation for taking any remedial actions, other than a reminder to Mr Griffin from the [Nurse Unit Manager] about ensuring that he continued to be cognisant of maintaining appropriate professional boundaries associated with his role'.[1494] Mr Daniels told us he understood this to be a result of Mr Griffin's social and external sporting activities.[1495]

Mr Daniels' letter referred to the fact that the Australian Nursing and Midwifery Federation had not provided any additional information from employees about

complaints previously lodged that were unaddressed. He also defended Dr Renshaw's behaviour at the staff sessions and the type of support offered by the hospital. The letter read in part: 'I would ask that we now turn our mind to collectively moving forward in a way that rebuilds team values and respect within the Ward'.[1496]

As we have outlined above, we saw no evidence that Mr Daniels took any steps to test or verify the advice he was receiving from human resources staff about Mr Griffin's complaints history.

Secretary Morgan-Wicks said of this period:

> I recall having a general awareness of direct discussions and correspondence that was occurring between the ANMF and the Chief Executive Eric Daniels in relation to Ward 4K staff concerns regarding past complaints handling and their desire for a group debrief/counselling sessions in late 2019, but was assured that these matters were being investigated and managed appropriately at the local level. I was not aware of the true depth of anxiety being expressed by several Ward 4K staff at this time, because if I had I would have directly engaged with the staff to hear their concerns and further test that local management action was appropriate.[1497]

5.2.31 14 December 2019—Mr Gordon has a chance encounter with a journalist

Mr Gordon told us that on 14 December 2019, he had a chance meeting with a journalist at a social function.[1498] He did not name this journalist in his evidence to us. Mr Gordon shared his concerns and frustrations relating to Mr Griffin and Ward 4K with the journalist. The journalist then asked him to draft three questions that the journalist could take to Secretary Morgan-Wicks, which Mr Gordon did. We were not provided with these questions. Mr Gordon told us: 'I was desperate for the public to realise this was happening and for people to take responsibility'.[1499]

Sometime in early 2020, Mr Gordon received a call from an acquaintance who had also spoken to this same journalist. Mr Gordon said of this call:

> She told me that the journalist would not present the questions to the Secretary in order to protect me … As a result of this, I understood that the journalist would not investigate the matter. I felt like the situation was being covered up again.[1500]

5.2.32 3 January 2020—Mr Gordon learns of the outcome of the Australian Nursing and Midwifery Federation's advocacy

On 3 January 2020, Mr Gordon received an email from a union organiser indicating that Mr Daniels and the Tasmanian Health Service were of the view that all complaints against Mr Griffin had been appropriately addressed.[1501] Mr Gordon stated to us:

> This email made me feel as though the ANMF had been brick-walled. … [It] heavily implied that our requests wouldn't be actioned and that there would not be an investigation unless staff had more evidence. As a result of this, I decided to seek external avenues to pursue this matter.[1502]

5.2.33 30 January 2020–COVID-19 is declared a Public Health Emergency of International Concern

On 30 January 2020, the World Health Organization declared the coronavirus (COVID-19) a Public Health Emergency of International Concern.[1503] On 17 March 2020, the Premier of Tasmania announced that the State would take several public health emergency response measures.[1504] The Director of Public Health in Tasmania made a formal declaration of a public health emergency in relation to COVID-19 on 24 March 2020.[1505]

We acknowledge that the COVID-19 pandemic placed significant strain on the health system worldwide, and the Tasmanian health system. This included the rapid establishment of a number of COVID-19 response teams, including the Incident Management Team, Regional Health Emergency Management Teams, the establishment of the Emergency Coordination and Operations Centres, and responses to COVID-19 outbreaks, particularly in North West Regional Hospital and North West Private Hospital.[1506] We acknowledge that the intensity and pressure on health staff directly involved in responding to the pandemic, maintaining core services and engaging in reviews at this time, was significant.

On 25 March 2020, Secretary Morgan-Wicks appointed experienced Secretary delegate Ross Smith to lead and manage all non-COVID aspects of the Department to enable her to focus on the pandemic as the State Health Commander.[1507] Mr Smith provided non-COVID related support until 10 September 2021, at which time he was transferred to the Department of Justice.[1508]

We acknowledge that this public health emergency required significant attention from everyone working within the health system, including Secretary Morgan-Wicks and staff at Launceston General Hospital. We also acknowledge that the pandemic would have placed significant strain on the Department's resources. We consider the hospital's actions from this period on with this context in mind.

5.2.34 15–19 February 2020—Mr Gordon contacts freelance journalist Camille Bianchi

On 15 February 2020, after Mr Gordon's attempt to have his concerns investigated by a journalist in December 2019 had failed, he contacted Camille Bianchi, who he knew to be a freelance journalist, as a 'last resort'.[1509] Ms Bianchi was Mr Gordon's former housemate.[1510]

Mr Gordon and Ms Bianchi spoke on 19 February 2020, when Ms Bianchi asked Mr Gordon if she could report the story. Mr Gordon agreed she could.[1511] Mr Gordon told Ms Bianchi that he would not give an interview because he wanted to protect himself and his family from any repercussions.[1512] Ms Bianchi went on to produce *The Nurse* podcast.

Ms Bianchi reflected to us on Mr Gordon's tip-off as follows:

> I got a tip and then what quickly became apparent was that, or at least it seemed so at the time, that the only avenue in which victim-survivors, including Keelie McMahon who was wonderfully courageous … would have the chance to [tell their story], was through media. They wanted to tell their stories because the Griffin matter wouldn't proceed to court because he had died and that stymied all sorts of different processes and so, began, yeah, a good seven, eight, nine months of trying to work out how to tell that story and even if I could.[1513]

Keelie McMahon, who was abused by Mr Griffin, told us why she decided to take part in *The Nurse* podcast:

> I made the decision to speak to Camille because I wanted to change the way the hospital was dealing with the situation and hold it to account. I was also sick of hearing what a great guy Jim was and thought that telling my story would help other people speak up.[1514]

Mr Gordon's identity as the initial source for the podcast only became known when he gave evidence at our hearings on 27 June 2022. Indeed, Ms Bianchi confirmed that day that *The Nurse* podcast was, in fact, named after Mr Gordon in honour of him as a whistleblower.[1515]

5.2.35 3 March 2020—Mr Gordon engages a lawyer to write to the then Minister for Health, Sarah Courtney

On 3 March 2020, Mr Gordon engaged a private lawyer to prepare a letter to the then Minister for Health, the Honourable Sarah Courtney MP, on his behalf.[1516] At hearings, Mr Gordon described his thinking at the time:

> You know, this isn't a minor thing to be swept under the rug, this is the sexual abuse of children. At what point do we as healthcare workers, and this includes all levels of management, brush aside our ethics and morals to cover this sort of thing up? That's just frigging, like, despicable, it's deplorable. For the sake of our own reputations, our egos, our money, you know, finances or whatever, it's just—I just couldn't let that happen, so I pushed as far as I could to Sarah Courtney so that she knew this was happening and so that she could not say she did not know about it.[1517]

The letter prepared by Mr Gordon's lawyer, dated 3 March 2020, raised two key points, the first of which is outlined below:

> The first and primary concern which is occasioning significant workplace stress and indeed grief is whether the alleged victims of the perpetrator have been contacted with respect to the matter and whether those persons have been offered counselling and assistance with respect to the alleged historical child sexual abuse. My client tells me that this is of significant concern to professional and other staff within the Launceston General Hospital and a matter which is occasioning significant workplace stress itself.[1518]

The letter also documented ongoing staff requests for proper psychological support and suggested that the ability for staff to speak publicly and openly about the matter may assist.[1519]

Mr Gordon received, via his lawyer, an acknowledgment letter from former Minister Courtney sometime in March 2020 (the letter is not dated).[1520] The letter stated in part:

> I have referred your letter to the Secretary of the Department for urgent attention and advice on appropriate action, and I will write to you again following that further advice.[1521]

This suggests that the letter was forwarded to the Office of the Secretary. We note that Secretary Morgan-Wicks has advised us that between 25 March 2020 and 10 September 2021, all matters requiring the approval of the Secretary that did not relate to COVID-19 were delegated to the Secretary delegate, Ross Smith.[1522]

Minister Courtney sent a final letter to Mr Gordon's lawyer sometime after this (that letter was also not dated).[1523] It explained that the information that could be provided to staff was sometimes limited, where answers were unknown or otherwise restricted by the Tasmania Police investigation.[1524] In relation to the treatment of staff complaints about Mr Griffin, Minister Courtney stated:

> The THS has and is addressing concerns arising from this process. I am aware that staff have raised concerns that their previous issues with respect to the individual employee were not addressed. The Department has reviewed the management records available about the individual and repeatedly requested specific information from the concerned employees; all the issues on record that were raised by staff were appropriately addressed at the time.[1525]

The letter goes on to explain that open disclosure processes would be available to any affected patients, when permitted by Tasmania Police.[1526] The letter listed the supports that had been offered by the hospital, including the Employment Assistance Program, the engagement of the counsellor, training sessions on trauma and grief, training sessions relating to sex offences and related behaviour and several in-service sessions with Dr Renshaw and human resources staff.[1527] The letter from Minister Courtney ended:

> I note you suggest that the staff may be encouraged to raise the matter publicly to address some of the psychological impacts of the alleged abuse. I am advised that the THS does not support raising this publicly as it would be unlikely to positively address the psychological impact, and, to the contrary, may very well cause unnecessary distress to the employees and clients.[1528]

Mr Gordon reflected in his statement to us: 'At this point I knew that the THS were not going to release this information publicly and therefore the media was the only avenue to inform the public of what occurred'.[1529]

Secretary Morgan-Wicks told us in a statement that she did not recall 'discussing or communicating with the then Minister for Health, regarding Mr Griffin prior to 14 October 2020'.[1530] We consider Minister Courtney did refer this correspondence to the Office of the Secretary for advice but as all non-COVID-19 matters were delegated to Mr Smith, we accept that Secretary Morgan-Wicks was not personally aware of it.

5.2.36 April–August 2020—The Integrity Commission complaint is followed up

On or about 15 April 2020, the Office of the Secretary followed up with the Department's human resources team about a response to the Integrity Commission complaint.[1531] It seems no response was provided.

On 29 July 2020, the Office of the Secretary received further correspondence from the Integrity Commission requesting an update on enquiries into the matter.[1532] The Office again followed up with the Department's human resources team on 11 August 2020 and on 18 August 2020.[1533] On 20 August 2020, the Office of the Secretary received a draft response to the Integrity Commission, which the Director of the Office of the Secretary reviewed in consultation with the Chief People Officer.[1534]

Mr Bellinger prepared the draft response. He gave evidence that on receiving the complaint from the Chief People Officer he understood his tasks to be preparing a reply, reviewing the allegations and briefing the Chief People Officer on the issue.[1535] Mr Bellinger's draft response stated that complaints that were known to the Tasmanian Health Service about Mr Griffin had 'been investigated and addressed with Mr Griffin' and that the Tasmanian Health Service had 'reviewed all available records and determined that all matters that were raised with the Agency were addressed in a manner that was reasonable in the circumstances that existed at that time'.[1536]

When Counsel Assisting questioned Mr Bellinger about what steps he took to examine the issues raised in the complaint forwarded by the Integrity Commission, Mr Bellinger confirmed that he did not undertake a fresh investigation into the allegations because he understood a review had already occurred through his previous enquiries.[1537] This appeared to be a reference to his own November 2019 review in which he found that previous complaints had been handled appropriately.[1538] At the hearings, Mr Bellinger agreed that his review of the Integrity Commission complaint was a 'desktop review' and did not involve fresh consideration of any complaints or concerns.[1539]

When Counsel Assisting asked Secretary Morgan-Wicks about the level of investigation required to respond to a complaint of misconduct, she replied that it was her expectation that a 'thorough review' would be undertaken, so she could respond 'accurately and truthfully to the Integrity Commission'.[1540]

Mr Easton from the Integrity Commission described Mr Bellinger's desktop review approach as being insufficient, noting:

> It comes back to our expectation, I guess, which is that the matter be investigated and action taken but, as I said earlier, it doesn't necessarily mean everything is investigated but a desktop review is surely not sufficient.[1541]

5.2.37 17 August 2020—Dr Renshaw provides the Secretary with recommendations relating to open disclosure

In the Minute she received on 5 November 2019, Secretary Morgan-Wicks requested further information, when it was appropriate, about the identities of any patients in the images held by Mr Griffin, so she could approve an open disclosure process.[1542]

As noted above, on 5 December 2019, a small panel of Launceston General Hospital staff viewed sanitised photographs in an effort to assist Tasmania Police to identify some of the people in the photographs taken at the hospital.[1543] In one part of his statement to us, Dr Renshaw indicated that three individuals 'could clearly be identified from the photos'.[1544] However, in another part of the same statement he says one individual was identified 'with certainty' and two individuals 'with significant doubt' due to the quality of the photographs and a lack of date references.[1545]

On 17 August 2020, Dr Renshaw sent an email to Secretary Morgan-Wicks and the Director of the Office of the Secretary with the identities of four patients and associated recommendations for how an open disclosure should proceed.[1546] He noted that there was another patient who appeared to have been a 'one-time' admission, but staff could not recall their name and their identity could not be established.[1547]

Open disclosure was recommended for two patients with their parents.[1548] In relation to one patient, who was an adult by that time, Dr Renshaw's email noted:

> Pictures were hard to identify and were clearly made without this patient's awareness; my own impulse is not to offer open disclosure to [the patient] as it may cause anxiety/distress from matters completely outside [their] knowledge. However, if the decision is to provide open disclosure, this would only require open disclosure to the patient.[1549]

This email also referred to Penny and Mr Griffin's care arrangement with her.[1550] It was clear from that correspondence that Dr Renshaw was still at pains to distance the hospital from Mr Griffin's care of Penny, despite her status as a former patient.

Secretary Morgan-Wicks replied to the email asking whether Dr Renshaw had spoken to any of the patients or parents, noting that Mr Daniels had suggested Dr Renshaw may have spoken to one.[1551] We do not have Dr Renshaw's response to this email, or Secretary Morgan-Wicks' decision in relation to Dr Renshaw's recommendations.

Dr Renshaw told us in his statement that open disclosure occurred with one family, on 28 October 2020, which is described in Section 5.2.47. At one point of his statement, he wrote: 'Two other individuals, who at the time of contact were adults or had already provided evidence to Police regarding Griffin, declined open disclosure'.[1552] At another point of his statement, he told us:

> The family of the identified victim was contacted through the Department of Paediatrics and accepted the offer of open disclosure … The remaining two 'possibles' (who were both aged over 18) declined open disclosure.[1553]

5.2.38 10 September 2020—The Secretary responds to the Integrity Commission about its investigation of the complaint

Secretary Morgan-Wicks reviewed Mr Bellinger's draft response to the Integrity Commission and approved it on 10 September 2020, without amendment.[1554] We note that numerous senior officials reviewed and cleared the draft response prior to the Secretary receiving it.[1555] We reference the most pertinent sections below.

The written response provided the following assurances to the Integrity Commission:

> I assure you that we have considered the matters in a timely manner, as they have been raised in a number of forums since the death of Mr Griffin, including a police investigation and … also a coronial investigation which has only recently concluded.
>
> …
>
> The complainant's concern that past complaints relating to Mr Griffin had been raised but not addressed by the Agency has previously been discussed with, and reviewed by, the Tasmanian Health Service (THS) on a number of occasions.[1556]

The reference to reviewing past complaints 'on a number of occasions' appeared to be a reference to Mr Bellinger's sole review in November 2019. The response goes on to say:

> As reflected in [Mr Daniels'] correspondence to the Australian Nursing and Midwifery Federation (ANMF) (Attachment I) 20 December 2019, several matters have previously been raised with the THS and those have been addressed.[1557]

We note that no details of complaints were provided to the Australian Nursing and Midwifery Federation in the letter dated 20 December 2019, which referred to a 'small number of HR files'.

The response to the Integrity Commission identified eight different concerns raised about Mr Griffin over 14 years, which were described as follows:

- 2005: The former Clinical Nurse Consultant of Ward 4K addressed with Mr Griffin his act of kissing a patient on the forehead whilst redirecting them back to their inpatient bed. A copy of the Agency's available records is provided.

- 2008–2009: A series of undated/unsigned notes that are believed to be Ms Leonard's. The relevant contents relate to Mr Griffin providing his phone number to patients and professional boundary issues.
- January 2009: Concerns were raised by a Psychiatric Registrar with respect to Mr Griffin not complying with the pre-determined care plan and providing his personal contact details to the patient. Further file notes of [a Ward 4K staff member] and Mr Sherring are provided and a draft of the proposed correspondence to Mr Griffin. The final correspondence has not been located in the records.
- March 2009: Record of Ms Leonard's meeting with Mr Griffin with respect to a further boundary issue, that being his intent to 'give away' a former patient at her wedding. Mr Griffin ultimately determined with his manager's counsel not to do so.
- April 2013: Mr Griffin was asked not to tend to a patient as a result of 'family issues'.
- March 2017: Provides a record of a meeting between Mr Griffin and his Nurse Unit Manager on 6 March 2017 with respect to a patient who expressed feeling uncomfortable in Mr Griffin's presence.
- An event was lodged in the Safety Reporting & Learning System on 29 August 2017 as referenced in the complaint provided to the Integrity Commission. The matter was provided to Mr Griffin for his reply, his written response was considered, and a decision reached. Mr Griffin was reminded to maintain appropriate relationships with patients and families. It is acknowledged that the complainant should have received a more informed outcome.
- August 2019: [A nurse] raised a concern with respect to Mr Griffin's conduct in July 2018. At this time Mr Griffin was already the subject to other investigations, and the matter was referred to Tasmania Police. Given Mr Griffin's passing, the matter was not put to him by the [Tasmanian Health Service].[1558]

Launceston General Hospital also supplied its records related to these complaints to the Integrity Commission but not an actual review or explanation of its assessments.

Secretary Morgan-Wicks stated in the letter:

> In summary, the Agency has over the course of 14 years had several complaints pertaining to Mr Griffin that can be broadly characterised as professional boundary issues. Each matter that the THS was made aware of has been investigated and addressed with Mr Griffin.[1559]

She also noted in the letter that there were some incomplete records but that there had been 'no information indicating that evidence has been destroyed and the records reflect that there are several issues on file that have been addressed'.[1560] We are unclear how a desktop review could lead to this conclusion.

The letter concluded:

> The THS has reviewed all available records and determined that all of the matters that were raised at the agency were addressed in a manner that was reasonable in the circumstances that existed at the time. The decisions made over the past 15 years were without the benefit of the information that now exists as a result of the Police investigation and the management actions cannot be judged with that in mind.
>
> Further, the THS has repeatedly sought to particularise and identify any complaints that the employees contend were previously raised and not addressed. No such complaints have been identified.[1561]

The letter named Mr Bellinger as having carriage of the investigation in response to the complaint received by the Integrity Commission.[1562]

The list of complaints in the response, although extensive, does not cover all the complaints about Mr Griffin that were known to or discoverable by the hospital. Omitted complaints included:

- a 2002 concern about Mr Griffin hugging patients and engaging in non-care related touching (this was referenced in a file note by Mr Sherring, retrospectively, in 2009)
- a complaint on 5 July 2004 relating, again, to Mr Griffin hugging a patient (we consider this omission curious, given that Mr Bellinger's response to Detective Senior Constable Hindle on 11 October 2019 noted 'a small number of HR files dating back to 2004', which suggests Mr Bellinger's awareness of this complaint)[1563]
- Mr Griffin being counselled for including a former patient in an inappropriate 'email forward' on 8 May 2009, although we note that this may be captured in the reference to Ms Leonard's unsigned and undated notes from 2008–09
- a concern reported to Ms Leonard about Mr Griffin being a 'sleaze' and suggesting he was a risk to children, in November 2012
- concerns reported by a nurse about Mr Griffin's behaviour with teenage girls in November 2015
- a complaint from a student on placement about Mr Griffin's use of pet names and unprofessional behaviour in May 2017
- the complaint reported on 18 July 2019 about Mr Griffin's inappropriate conversations with a patient and their father about medications and his encouragement that a colleague nurse 'taste' a controlled medication before giving it to a patient.

More information about each of these complaints is in Section 4.

Most significantly, the letter to the Integrity Commission does not include Ms Pearn's disclosure to human resources staff in 2011 or 2012, which Mr Bellinger was reminded of on 11 October 2019.

Finding—James Bellinger did not conduct a proper investigation into James Griffin's complaints history and misled the Secretary of the Department and the Integrity Commission

As we have outlined above, Mr Bellinger appeared to undertake a cursory 'review' of complaints relating to Mr Griffin in November 2019. Mr Bellinger's reference to his various 'reviews' was confusing, but what is clear to us is that there was no meaningful review at any stage. Mr Bellinger told us that his November 2019 review was limited to complaints that were addressed with Mr Griffin, which resulted in Ms Pearn's disclosure in 2011 or 2012 being excluded. Further, this review does not appear to have been recorded and was not communicated to anyone else other than through verbal assurances that responses were appropriate. His subsequent reviews in response to the Australian Nursing and Midwifery Federation's concerns and the Integrity Commission relied on this inadequate review.

Deficiencies in Mr Bellinger's 'review' conducted in response to the Integrity Commission referral included the following:

It was inappropriate for Mr Bellinger and other hospital human resources staff to undertake the review. Mr Bellinger had a direct conflict of interest in the matter, given that he and other human resources staff were involved in managing complaints about Mr Griffin. An investigation should have ideally been undertaken by a person entirely independent of the hospital, but most certainly not by its own human resources team.

- The response omitted important information and complaints about Mr Griffin. Why some complaints were omitted and not others is unclear to us and we can find no logic in their selection.
- One omission was particularly concerning, namely the disclosure by Ms Pearn in 2011 or 2012. We consider it likely that this was omitted either because it would jeopardise the reputation of the hospital or because it would reflect badly on Mr Bellinger and/or the human resources team or possibly both.
- Of the listed complaints, there was inadequate context to convey their seriousness. For example, the description of the January 2009 complaint from the Senior Psychiatric Registrar was limited to not following a care plan and providing contact details to a patient, when in fact the Senior Psychiatric

Registrar was so concerned by Mr Griffin's behaviour (noting it was not his first such observation) that he recommended Mr Griffin seek psychological help. This incident also involved Mr Griffin cuddling the same patient.

- This review does not appear to have been documented, aside from listing complaints and records relating to complaints in the letter to the Integrity Commission. A review or investigation of this nature and significance should have been the subject of a comprehensive written report or briefing that outlined all the relevant facts and appended all associated documentation to explain the reasoning behind the conclusion that matters were handled appropriately (at the time or otherwise). It should have been checked by independent parties on its journey up the line to the Secretary. This way, each person reading it could assess its methodology, including its accuracy, quality and thoroughness, as well as ask questions and escalate any concerns arising from it.
- Noting the complaint referenced possible document destruction and failures to respond to complaints, simply reviewing records of complaints put to Mr Griffin was clearly inadequate. The review should have included interviews with Ward 4K staff to investigate whether there were complaints of which they were aware that had not been responded to, or for which records were now missing or altered.

We are unclear what, if any, scrutiny Mr Bellinger's superiors in the human resources team applied to this review, noting they recalled only seeing the final letter to the Integrity Commission. We are of the view that Mr Bellinger was not closely supported or supervised by senior managers in the task of responding to the Integrity Commission, which demonstrated an absence of concern by senior leaders about the seriousness of the complaint. This lack of scrutiny enabled the response prepared by Mr Bellinger to the Integrity Commission to contain inaccurate and misleading information.

There was no evidence of an investigation beyond a 'desktop review'. Given reported limitations in finding certain records and information, evidence should have been sought directly from key staff. We note that human resources staff requested Ms Leonard's records (although their contents do not appear to have been reflected in their entirety), but further steps should have been taken, such as interviewing or seeking statutory declarations from staff, to supplement the records that were available. We accept that Mr Daniels (via the Australian Nursing and Midwifery Federation) and Dr Renshaw (at staff sessions) did ask staff to share any information about unaddressed complaints. We also accept that by this stage staff may not have trusted management or perceived that they could not prove their prior complaints.

In a statement to us, Secretary Morgan-Wicks said that before hearing Mr Bellinger's evidence at our Commission of Inquiry she was not aware that he had been informed, in October 2019, of the complaint that Ms Pearn made about Mr Griffin.[1564] Secretary Morgan-Wicks said that had she been made aware of Ms Pearn's disclosure, she would have immediately started an internal investigation, rather than waiting until October 2020.[1565] She agreed that Mr Bellinger's draft response was misleading to both her and to the Integrity Commission.[1566]

5.2.39 16 September 2020—The Integrity Commission acknowledges the Secretary's letter

On 16 September 2020, the then recently appointed Chief Executive Officer of the Integrity Commission, Mr Easton, replied to Secretary Morgan-Wicks' letter, noting the 'comprehensive information provided' and the outcome of the Department's investigation. Mr Easton's letter stated:

> The information you have provided confirms the ongoing reports of James Griffin's conduct as described in the original complaint, and describes the management actions taken at the time. While it is now difficult to gauge the appropriateness of individual responses, it is clear that a pattern of behaviour was emerging, the end product of which was allegedly serious misconduct and criminal behaviour by Mr Griffin.[1567]
>
> Our original assessment identified the possibility that some staff stopped making reports about Mr Griffin given a perceived failure of management to respond to earlier reports and a fear of losing their jobs if they spoke out. Mr Griffin's apparent presence and personality also contributed to this reluctance to report.[1568]

The letter also identified the 'need to ensure new or rotating managers have accessibility to prior management actions and responses' to ensure 'continuity in the response and identifying patterns of behaviour across time'.[1569]

When Counsel Assisting asked Mr Easton about specific follow-up the Integrity Commission had pursued to ensure the Department was taking appropriate steps to address these issues, he referenced the Integrity Commission providing general education and training to State Service officials about misconduct. He added that Department employees had attended in greater numbers than any other agency.[1570]

Mr Easton conceded that, apart from providing training, 'we haven't undertaken active follow-up on that particular issue with that particular department'.[1571] He described the monitoring process for complaints in November 2019 (at a time when he was not the Chief Executive Officer) as 'less rigorous than they are now'.[1572] He said:

> My predecessor was not as active or desirous of us to be as active in following things up with agencies; it doesn't mean that he didn't think we should, it's just that I've come into the chair and I really think we should, it's a big part of our reason for

> being, is to build our capacity of agencies to deal with misconduct, it's there in the objectives of the Act, and how else are we to do that without understanding what their weak points are and how they are dealing with misconduct?[1573]

Mr Easton explained that the Integrity Commission now has additional resources for monitoring compliance and was 'trying to build some proactive measures' into these processes.[1574] He told us that once a matter is referred to an agency for response, it moves from the Integrity Commission's complaints stream into its compliance stream.[1575] We heard that the Integrity Commission makes contact with a person at the relevant agency 'within three to four weeks after' a matter is referred to them for a response to ensure they have received the referral and are actioning it, in addition to checking whether the Integrity Commission can assist.[1576]

We further heard that the Integrity Commission generally gives an agency 'about six months' to respond, and then a compliance team, led by the Director of Operations and a senior investigator, follow up the matter.[1577] When a response is received from an agency it goes into a 'compliance triage' run by the senior investigator, who determines, according to criteria, whether the Integrity Commission needs to provide more time or assistance to the agency to respond, or whether the Integrity Commission should manage the response themselves.[1578]

Finding—The Integrity Commission's monitoring of the Department's response to Will Gordon's complaint was insufficient and it should have sought further review

Mr Gordon's complaint, which raised serious concerns about potential misconduct, should have been investigated by the Integrity Commission itself or been subjected to more rigorous and active monitoring by the Integrity Commission. Once the Integrity Commission referred Mr Gordon's complaint to the Department on 21 November 2019, there was no further follow-up until 29 July 2020.

We are pleased to note that the Integrity Commission is now more focused on monitoring compliance, but this does not satisfy the concerns we hold about the Integrity Commission's acceptance of the response letter provided by Secretary Morgan-Wicks on 10 September 2020. The response letter revealed systemic problems with the Department's complaints processes, not least because of the sheer number of complaints it outlined in relation to Mr Griffin, but also the letter's assurance (despite the hindsight knowledge of the serious misconduct and criminal behaviour of Mr Griffin) that they had each been dealt with appropriately. The Department's response demonstrated no reflection on systemic errors or the potential improvements that could be made in its responses. The Integrity Commission identified these systemic problems in its response, but they were not referred to the

Health Complaints Commissioner, nor did the Integrity Commission seek any formal reassurances from the Department that they had been actively addressed. Without adequate redress, children remained vulnerable to the same errors occurring again.

Mr Easton described his reaction to the response letter as follows:

> I actually thought it was comprehensive, but I also just had a visceral reaction to, 'I can't believe nobody has picked up that there's been an issue with this person'. That's my fundamental concern with the response, was that, how can there be this many reports—and I believe there's more since what's in this letter—how can somebody not have picked this up? That's what worries me.[1579]

Given the nature of the complaint, we consider that the Integrity Commission should not have concluded that the matter had been resolved, particularly given Mr Easton's own reaction to its contents.

5.2.40 13 October 2020—The first episode of *The Nurse* podcast is released

The first episode of Camille Bianchi's podcast, *The Nurse,* was released on 13 October 2020. The first episode was titled 'Just Jim'. As of May 2022, this episode had been downloaded more than 1.3 million times.[1580]

The podcast initially provided an avenue for victim-survivors of Mr Griffin's abuse to share their experiences. However, it expanded over time as Ms Bianchi received information from more victim-survivors and about incidents involving other abusers, government departments and institutions. The podcast led to more media reports about Mr Griffin and other abuses at Launceston General Hospital, including those we describe in Case study 2, relating to Dr Tim (a pseudonym).[1581]

Recognising the significant attention that *The Nurse* podcast drew to child sexual abuse in institutions (and how this may have impacted on those affected by such abuses), Mr Gordon wrote in a statement to us:

> I want to make it known I am sorry for any hurt or trauma or collateral damage I may have unknowingly inflicted to victims of abuse by fighting for this event to be released to the public, and in my quest to obtain a Commission of Inquiry. I honestly meant no harm.[1582]

Secretary Morgan-Wicks told us at a hearing that she was alarmed to learn, through the podcast, about the extent of Mr Griffin's behaviour and that the hospital had, at various times, questioned him about these behaviours. We note she was aware of at least the eight complaints listed in her response to the Integrity Commission.[1583] Senior executives at the hospital, Ms Bryan and Dr Renshaw, also told us that the podcast exposed them to new information about Mr Griffin's conduct.[1584]

The podcast made reference to what we presume was Ms Pearn's disclosure, as follows:

> Shockingly, in 2010 a survivor of Jim's abuse told the hospital's HR department something was badly wrong. She told them in a formal meeting he had molested her as a child. She told them to protect the children then in his care. She told them 9 years before he was charged and finally taken off the ward.[1585]

We are not clear how Ms Bianchi learned of this disclosure because Ms Pearn was not the source. However, Ms Pearn, recognising that the podcast was gaining widespread media attention, contacted Dr Renshaw to inform him of the disclosure she had made to the hospital.[1586] Dr Renshaw was already aware of Ms Pearn's disclosure at this point, having been advised by Tasmania Police about it a year earlier, on 29 October 2019. Ms Pearn described a brief phone conversation with Dr Renshaw. She told us that Dr Renshaw was 'very dismissive' in his response to her informing him of her disclosure and that she felt 'fobbed off'.[1587] Dr Renshaw told us in hearings that he did not remember this phone call but did not dispute it occurred.[1588]

5.2.41 14 October 2020—The Secretary recommends an immediate review to the Minister for Health

The day after the first episode of *The Nurse* podcast aired, Secretary Morgan-Wicks contacted Minister Courtney, recommending that she initiate an immediate review into 'internal and external conduct reporting mechanisms and the THS [Tasmanian Health Service] complaints handling process relating to unprofessional conduct and sexual misconduct'.[1589]

Minister Courtney responded in writing on 14 October 2020. She asked Secretary Morgan-Wicks to examine and provide advice on a range of issues, past and current, which we quote directly:

a. the current internal reporting mechanisms of the Tasmanian Health Service and the compliance of these mechanisms with Australian Health Practitioner Regulation Agency standards and mandatory reporting obligations under relevant Tasmanian legislation

b. the appropriateness and effectiveness of Tasmanian Health Service complaints handling processes relating to unprofessional conduct and sexual misconduct

c. the effectiveness of interaction between Working with Vulnerable People systems and the Tasmanian Health Service

d. the degree of compliance with the Tasmanian Health Service complaints handling processes

e. the appropriateness of mechanisms to ascertain and act upon systemic behaviour of an employee

f. any further action required by the Tasmanian Health Service to improve the culture, policies and processes relating to these issues.[1590]

Minister Courtney also requested that Secretary Morgan-Wicks consider the management of any complaints and concerns relating to Mr Griffin, including whether any further action or review needed to be undertaken.[1591] Minister Courtney further requested that a 'centralised mechanism be established for current and former staff and patients to come forward and provide information to assist in the examination of the matter'.[1592]

Secretary Morgan-Wicks confirmed that the Department would lead an examination to respond to the issues raised by Minister Courtney. Secretary Morgan-Wicks then set up a review team to start this work.[1593] Secretary Morgan-Wicks wrote to all staff at the Department to inform them of the internal examination.[1594]

Secretary Morgan-Wicks also set up a public disclosure email address for staff and another for public enquiries, along with a dedicated phone line to triage complaints or submissions and advise on available support services.[1595]

5.2.42 15 October 2020—The Secretary attends a meeting with Ward 4K staff

On 15 October 2020, Secretary Morgan-Wicks sat in on the end of a meeting with Ward 4K staff at the hospital, which was facilitated by the Australian Nursing and Midwifery Federation. We received no evidence that any members of the hospital executive attended this meeting. Secretary Morgan-Wicks told us:

> I recall feeling confronted by the depth of feeling and anxiety in the room and the sense of distrust that anything different was going to happen if information was reported. I explained the nature of a protected disclosure and that the review of the information would be entirely separate from the Ward and from LGH and conducted by an experienced and senior team in the South.[1596]

We can understand why staff would have been wary and sceptical, given the way their concerns had been managed in the past.

Mr Gordon recalled Secretary Morgan-Wicks' attendance:

> I challenged Kathrine Morgan-Wicks that she must have known about the issues on the ward and that it should not have come to nurses becoming whistleblowers in order to get the story out to the public. I also said that the hospital should have and still should take responsibility for their abysmal handling of the situation and asked what changes will be made. Kathrine did not answer questions, instead saying words to the effect of 'if I knew about the situation, something would have been followed up on'. This is despite the response I received from the Integrity Commission and the Minister's letter to my lawyer which stated that she had referred my letter to Kathrine Morgan-Wicks.[1597]

As we noted above, Secretary Morgan-Wicks told us that between 25 March 2020 and 10 September 2021, all matters that were not related to COVID-19 were delegated to Secretary delegate Ross Smith.[1598]

Pressure began to mount for a Commission of Inquiry. As Ms Shepherd of the Australian Nursing and Midwifery Federation stated to us:

> Unfortunately, due to the fact that a report to the Integrity Commission was already known about by the Secretary of the Department of Health and the Minister for Health was also aware of members' concerns, members did not have trust in any internal, departmental or Government led investigation, which is why they, along with the ANMF, called for a Commission of Inquiry.[1599]

As we discuss in other chapters of this report, these calls coincided with concerns about civil and redress claims related to child sexual abuse in schools and youth detention.

Secretary Morgan-Wicks attended several more meetings with ward staff in the coming days and weeks. Dr Renshaw and nursing management also attended some of these meetings. Secretary Morgan-Wicks told us that over the course of these meetings it became apparent to her that:

> Ward 4K staff remained traumatised by the death and alleged criminal conduct of Mr Griffin of which they had no awareness, and felt that they had been 'silenced by Management' unable to grieve or openly discuss the matter and that the issue therefore had continued to fester for over a year, causing significant workplace disharmony.[1600]

5.2.43 15–21 October 2020—The hospital hears concerns from patients' families

On 15 October 2020, likely as a result of *The Nurse* podcast, the Director of Improvement, Quality and Patient Safety Service, North and North West at Launceston Hospital informed Dr Renshaw that the hospital feedback line had received four phone calls and an email from concerned families.[1601]

The Director of Improvement sought guidance from Dr Renshaw about how to handle the matter. Mr Daniels was copied into this email. The Director asked Dr Renshaw: 'Can we please have some direction regarding our responses from a complaints perspective and what direction we should be giving potential new victims in regards to contacting police'.[1602] She also sought guidance on whether a public statement would be required.[1603] It is notable to us that even at this stage, Dr Renshaw was seen as the key contact in relation to matters concerning Mr Griffin.

Dr Renshaw responded to this request for advice on 22 October 2020, the same day that an independent review was announced, which we discuss in more detail below. In his response, Dr Renshaw provided the following instructions:

- All patients or community members were to contact the dedicated public enquiries email, which was established on 22 October 2020.
- Staff were to contact the dedicated staff email address.

- The contact details of support services listed on Minister Courtney's media release—1800 RESPECT, Laurel House, Lifeline, the Sexual Assault Support Service and Relationships Australia—should be provided to concerned families.[1604]

Dr Renshaw added that 'there will be the occasional person who may insist on dealing with us directly' and that this should be assessed on a case-by-case basis.[1605] He also asked that a particular family, who were due to be contacted as part of an open disclosure process, be put through to him immediately, should they call.[1606]

We also received evidence that on 21 October 2020, the hospital's response to an in-person contact from a distressed person concerning comments made by her daughter about Mr Griffin was to provide an email address and a consumer feedback form for them to lodge a complaint, notwithstanding the person had clearly requested to speak with someone.[1607] This person was advised to send an email outlining their concern and that they were seeking to speak to someone or receive counselling about the matter.[1608] They were further advised to include this information in the feedback form, which would be received by Dr Renshaw, who was 'managing all enquiries regarding the matter to see what the hospital could assist with'.[1609]

5.2.44 16 October 2020—The Department is advised that the police investigation into Mr Griffin had been closed and Dr Renshaw seeks advice from the Secretary on responding to queries and disclosures

On 16 October 2020, a detective with Tasmania Police emailed Dr Renshaw advising him that the police investigation into Mr Griffin had been formally closed.[1610]

The detective noted that due to media coverage associated with *The Nurse* podcast, police had received 'a number of enquiries regarding complaints against Griffin at the hospital'. The detective queried whether there was a central point of contact at the hospital to which these queries could be directed.[1611] Dr Renshaw immediately forwarded this email to Secretary Morgan-Wicks, the Director of the Office of the Secretary, Mr Daniels and the Director of Improvement, Quality and Patient Safety Service, North and North West.[1612]

The same day, Dr Renshaw emailed Secretary Morgan-Wicks, copying in Mr Daniels, advising her of Tasmania Police's decision to close the investigation into Mr Griffin.[1613] Dr Renshaw also wrote in this email that following the release of the podcast, the hospital had received calls from concerned patients and their families, as well as former staff, with information about Mr Griffin's conduct.[1614] Dr Renshaw's email read in part:

> While most of the feedback constitutes a desire to simply communicate individual experiences with Mr Griffin, there have been at least two where specific allegations are made about incidents on Ward 4K that are either recollected after a period of time or were allegedly reported to hospital staff at the time but for which we can find no record of complaint. I have also had a call from a former staff member …

> who had had significant concerns from her knowledge of Mr Griffin outside the hospital and who reported the matter to her Manager at the time. The Manager took the matter seriously and pursued the matter through HR. There was no documented outcome of this concern.[1615]

As outlined above, the call Dr Renshaw received from a former staff member was the call from Ms Pearn. To our knowledge, this email was the first time that Mr Daniels and Secretary Morgan-Wicks were notified of Ms Pearn's disclosure, albeit in general terms. Mr Daniels told us that he was not aware of the disclosure by Ms Pearn until he gave evidence during our hearings.[1616] Dr Renshaw does not reveal in the email that he was aware of Ms Pearn's disclosure a year earlier, on 29 October 2019, when advised by Tasmania Police.

In the email, Dr Renshaw asked Secretary Morgan-Wicks for an urgent discussion about 'our strategy to address the concerns that will continue to arrive as the podcast continues over the next few weeks'.[1617] The Director of the Office of the Secretary responded by email on behalf of the Secretary, noting that they had attempted to call Dr Renshaw. The Director of the Office of the Secretary provided Dr Renshaw with the relevant email addresses for queries, told him that a central contact point was being established and that advice would be provided in due course.[1618] The Director of the Office of the Secretary stated in their email to Dr Renshaw that allegations of criminal conduct should be directed to Tasmania Police.[1619] They also flagged a desire to speak with Dr Renshaw about the forthcoming open disclosure process. We do not know whether that call took place and, if it did, what was discussed.[1620]

Shortly after, Mr Daniels forwarded an email chain, which included Dr Renshaw's original recommendations relating to open disclosure, to Ms Bryan, Mr Bellinger and the Director of Improvement.

Misconduct finding—Dr Peter Renshaw misled our Commission of Inquiry about his state of knowledge

Throughout Section 5, we have shown that Dr Renshaw withheld important information, particularly in briefings to the Chief Executive and the Secretary, that significantly and adversely affected their ability to make the best possible decisions to address Mr Griffin's conduct and its implications for staff, patients, the hospital and the broader community. That Dr Renshaw's briefings were factually inaccurate also hampered our Inquiry. We relied on accurate documentation and truthful statements to inform and shape our Inquiry, particularly in the lead up to our hearings. Dr Renshaw did not provide this when it was within his power to do so.

There were many instances during our Inquiry where witnesses forgot certain events or were confused by questions. We accept that giving oral evidence, in particular, is daunting and it can be easy to misspeak. We note this here to make explicit our inclination to give witnesses the benefit of the doubt.

We consider that Dr Renshaw falls into a different category. We consider that in view of the totality of his evidence, the evidence of others and relevant documents provided by other agencies, that Dr Renshaw actively sought to mislead our Commission of Inquiry. We describe how he misled us below.

Dr Renshaw misled us about the extent of his knowledge regarding Penny

Through our hearings, we established that Dr Renshaw had knowledge that Penny was a former patient who had been under the care of Mr Griffin. Tasmania Police was concerned about Penny because Mr Griffin was spending time with her outside the hospital setting. Dr Renshaw learned this from Detective Senior Constable Hindle on 31 July 2019, which is evidenced by Ahpra file notes discussing Dr Renshaw's notification of Mr Griffin to Ahpra the following day.

Dr Renshaw did not convey any information to the hospital executive or the Secretary that suggested his awareness, or the full extent of his awareness, of the above information. His advice to the Secretary on 17 August 2020 acknowledged that Tasmania Police was aware of Penny but does not clarify that this concern was known to him (and hence the hospital) as far back as 31 July 2019.

Dr Renshaw did not alert us to Penny in his statement at all, whether directly or indirectly. When we asked whether he knew of Mr Griffin 'having contact with paediatric patients after hours or when off-duty', Dr Renshaw responded: 'I became aware of this allegation from "The Nurse" podcast'.[1621] When we asked whether he knew of Mr Griffin having 'ongoing contact with paediatric patients after they were discharged from hospital', Dr Renshaw again responded: 'I became aware of this allegation from "The Nurse" podcast'.[1622]

These responses were clearly untrue.

Dr Renshaw misled us about the extent of his knowledge regarding Ms Pearn's disclosure

We have made earlier findings regarding Dr Renshaw's failure to escalate his knowledge of Ms Pearn's disclosure to the hospital.

Through our hearings, we established that Dr Renshaw held the following knowledge about Ms Pearn's disclosure:

- On his return from leave, sometime after 18 October 2019, Dr Renshaw heard a 'corridor rumour' about a former staff member reporting their own child sexual abuse by Mr Griffin to their manager and human resources sometime before.
- Tasmania Police confirmed Ms Pearn's disclosure to Dr Renshaw on 29 October 2019.
- Ms Pearn called Dr Renshaw sometime after the release of *The Nurse* podcast about her disclosure, which was reflected in Dr Renshaw's email to the Secretary on 16 October 2020.[1623]

There is no reference to Ms Pearn, or any information that resembles Ms Pearn's circumstances, in Dr Renshaw's statement to us. In our request for statement, we asked Dr Renshaw: 'Did anyone raise a concern about Mr Griffin with you (either formally and informally). If yes, please detail in respect of each concern'. Dr Renshaw listed some matters, which we have reflected earlier in this case study, but made no mention of Ms Pearn's phone call to him.

While we accept that Dr Renshaw may have been receiving many contacts at the time that Ms Pearn called him, we consider that Ms Pearn's call would have stood out to him, given its significance and his prior knowledge from Tasmania Police about her complaint. We consider that Dr Renshaw recognised the significance of Ms Pearn's disclosure to such an extent that he advised the Secretary about it, although without naming her. We do not accept that information he received about Ms Pearn was information that he would have forgotten. His failure to include this information in his statement to us was deliberately misleading.

As we have flagged elsewhere, we found Dr Renshaw to be an unhelpful witness. He was defensive and pedantic. Each of the concessions he made, once confronted by the evidence, had to be extracted from him during hearings. We consider that Dr Renshaw failed to accept responsibility for his failures. He did not demonstrate even a modicum of self-reflection during our hearings. Dr Renshaw's approach to our Inquiry frustrated many affected parties, particularly victim-survivors and their families, who were understandably seeking some acknowledgment, reflection and, indeed, apologies.

Dr Renshaw's omissions and fabrications amount to misleading our Commission of Inquiry. We do not make this finding lightly. Misleading a commission of inquiry undermines public trust and confidence in the process. Such an act by a senior state servant is unethical and unprofessional and brings the State Service into disrepute.

Under section 18 of the *Commissions of Inquiries Act 1995* ('Commissions of Inquiries Act'), we have the power to make a finding of misconduct. Section 3 of the

Commissions of Inquiries Act defines misconduct as 'conduct by a person that could reasonably be considered likely to result in a criminal charge, civil liability, disciplinary proceedings, or other legal proceedings, being brought against that person in respect of the conduct'. Section 10 of the State Service Act outlines circumstances under which a State Service employee may be subject to disciplinary processes. This includes when an employee breaches the State Service Code of Conduct.

Dr Renshaw's conduct in misleading our Commission of Inquiry meets most, if not all, of these provisions and may be considered likely to result in disciplinary proceedings, which meets the definition of misconduct in the Commission of Inquiries Act. We make a finding of misconduct against Dr Renshaw.

5.2.45 20 October 2020—The Secretary is advised of Ms Pearn's identity and media reports on Mr Griffin's offending

On 19 October 2020, after her conversation with Dr Renshaw, Ms Pearn spoke with the former Director of Employee Relations, who had since taken up a role in the Department's Commission of Inquiry Response and Reform team, to continue her efforts to bring the circumstances of her disclosure to the hospital's attention.[1624] Around this time, Ms Pearn also spoke with Minister Courtney about the handling of her disclosure.[1625]

Secretary Morgan-Wicks told us that she first became aware of Ms Pearn's first complaint to the hospital (in 2011 or 2012) on 20 October 2020, when she was informed about Ms Pearn's conversation with the former Director of Employee Relations.[1626] We note that Dr Renshaw did advise her, in general terms, a few days earlier on 16 October 2019.[1627] Secretary Morgan-Wicks therefore became aware of Ms Pearn's disclosure roughly a year after Mr Bellinger and Dr Renshaw had knowledge of it (if we accept Mr Bellinger's evidence that he was not present at the original disclosure, which we do not).

On the same day, 20 October 2020, *The Examiner* newspaper identified the unnamed paediatric nurse in its report of 9 October 2019 as Mr Griffin (refer to Section 5.2.14 for a discussion of the 9 October 2019 report).[1628]

On 21 October 2020, Secretary Morgan-Wicks received a file note of a conversation that Minister Courtney had with Ms Pearn.[1629]

On the same day, Secretary Morgan-Wicks wrote to Minister Courtney recommending an independent investigation into the hospital's response to complaints about Mr Griffin, in addition to the planned internal examination.[1630] Secretary Morgan-Wicks wrote:

> Whilst my examination of this issue continues, I write to confirm that I have received information which raises serious allegations about the proper conduct, strength and adequacy of historical reporting processes relating to the subject of this matter, involving both the [Tasmanian Health Service] and other Government Agencies.

> Given my remit as the Department of Health Head of Agency, I do not hold the powers necessary to conduct an in depth cross-agency systems review. Noting the serious nature of the concerns raised, I am writing to you to request that you consider instituting an independent investigation in relation to this matter so that this information can be independently assessed and examined.
>
> In the interim, I will continue to undertake my examination of the relevant [Tasmanian Health Service] and Department policies and procedures, as confirmed above.[1631]

5.2.46 22 October 2020—The Department announces an independent investigation into the management of complaints about Mr Griffin

The next day, 22 October 2020, the then Premier, the Honourable Peter Gutwein MP, and Minister Courtney announced the Independent Investigation into the Systems of the Tasmanian Health Service and Relevant Government Agencies/Organisations Relating to the Management of Historical Reports of Allegations of Child Sexual Abuse.[1632] As indicated above, the terms of reference of the investigation required examining the circumstances surrounding Mr Griffin's conduct and other related matters.

On 12 and 17 November 2020, Secretary Morgan-Wicks and the Department's Chief People Officer met with staff on Ward 4K to give an update on the Department's internal examination and to provide them with information about the independent investigation.[1633] During these meetings, staff expressed concern that the issues were not being considered by a Commission of Inquiry.[1634]

5.2.47 28 October 2020—Open disclosure with a family occurs

As foreshadowed earlier on 28 October 2020, open disclosure with a family occurred following the discovery of an image of their child among the photos on Mr Griffin's devices. Open disclosure was provided to the family on 28 October 2020 at a meeting involving Dr Renshaw, a 'social worker/counsellor', a Tasmania Police liaison officer and possibly Ms Tonks.[1635] While Dr Renshaw suggested she was present, Ms Tonks did not recall whether she attended the open disclosure meeting.[1636] Dr Renshaw told us: 'I believe that it went well, the family concerned appeared to be very thankful for it'.[1637]

This family contacted us to share their experience of the process. They told us that Dr Renshaw contacted them after their child had been identified in images found in Mr Griffin's possession.[1638]

Although they found the meeting with Dr Renshaw and Tasmania Police to be 'informative and useful', they also felt that the overall process of disclosure, and the lack of follow-up since, was not ideal.[1639] Their dissatisfaction stemmed from the following:

- They found out about the identification of their child via a voicemail message from the hospital, which was received by the patient's mother while at work. This message left her 'feeling sick and … very upset'.[1640]

- They received assurances from Dr Renshaw that, while the hospital had responded to some concerns relating to Mr Griffin over the years (which Dr Renshaw described to them in general terms), these concerns 'were not of a direct sexual nature or of photos being taken'. The family has since queried the accuracy of this characterisation.[1641] They recall that Dr Renshaw described one complaint as being about Mr Griffin 'giving away… a former patient' (likely a reference to the February 2009 complaint) and another complaint as Mr Griffin giving teenage female patients advice about boyfriends (this was likely Mr Gordon's August 2017 complaint).[1642] We consider it unlikely that Dr Renshaw shared the full extent of Mr Griffin's complaints history with this family.
- The family was not offered any counselling and received no follow-up from the hospital or Tasmania Police. They felt 'it should have been offered, we shouldn't have just been left to sort ourselves out'.[1643]

In describing the effect that the revelation of Mr Griffin's conduct towards their child had on their family, family members told us:

> The long-term impact this has had on our family is significant. Our trust in others to care for [our child] is now very limited … I don't want this to happen to other families … they should be able to leave their children on the ward in the care of nursing staff.[1644]

The *Risk Management Open Disclosure Policy* that forms part of the suite of policies and procedures relevant to open disclosure includes an objective to:

> … ensure that persons who have experienced an adverse clinical event will be provided with timely communication and discussion about what has occurred, why the adverse event occurred, and what is being done to prevent it happening again.[1645]

This objective was a live concern for this family:

> We discussed how as parents we really just wanted to know that the hospital had put processes in place for this to *never* happen again and for future complaints to be addressed. Dr Renshaw talked about personal phone use no longer being allowed when on shift.[1646] [Emphasis is the parents'.]

One of the desired outcomes of an open disclosure process is 'Improved patient satisfaction with the process of managing an adverse clinical event'.[1647] The family told us:

> Our family has always been very respectfully treated by the LGH nursing and medical staff and we have nothing but praise for them. We have no doubt that they have saved [our daughter's] life on several occasions.
>
> We do have concerns about how the photo incident was reported to us and the lack of follow up we have since had.[1648]

We note that a 'social worker/counsellor' was present for this discussion, which the family did not recall (they remembered a person taking notes).[1649] The family told us that no support was offered after the open disclosure process for the patient or her parents.[1650]

Finding—Launceston General Hospital should ensure open disclosure processes are trauma-informed

We note the quite different recollections of how this open disclosure process occurred. We consider that an open disclosure process in relation to child sexual abuse should:

- not discuss the substance of the open disclosure in a voicemail message
- define the actions taken to prevent child sexual abuse occurring again and keep affected parties up to date with subsequent reforms
- ensure the patient and family are personally connected with expert sexual abuse counsellors.

5.2.48 November 2020—Angelique Knight contacts Dr Renshaw

Former Ward 4K patient Angelique Knight contacted Dr Renshaw sometime after *The Nurse* podcast was released. She shared a concern with Dr Renshaw about a reference in the podcast relating to her, namely that Mr Griffin wanted to 'give away' a patient at her wedding (described in Section 4.1.10). Ms Knight told us that Dr Renshaw responded to this concern by saying, 'oh that's interesting', without elaborating further.[1651]

Ms Knight told Dr Renshaw that she was worried that some of the images found on Mr Griffin's phone may have been taken of her because Mr Griffin would have had many opportunities to do this while caring for her.[1652] She wanted to see the images but recalled Dr Renshaw telling her that it 'can't happen' and that only one person had been identified from the photographs.[1653] Ms Knight said 'he didn't explain the process that led to this identification'.[1654] She further stated:

> I don't know if James Griffin did take photos of me and that bothers me … I was really annoyed … and it felt like Peter Renshaw was just brushing me off again. I felt like I was nothing and just a number to him.[1655]

On 10 November 2020, Ms Knight wrote to Dr Renshaw to share her shock and disgust about Mr Griffin's conduct. She told him it made her 'utterly sick and angry knowing how inappropriate he was with me … for half my life on 4K and outside of 4K'.[1656] She wrote: 'I feel so disgusting and I have no idea where to go with this I just know this is extremely hard trying to process! Hopefully someone can help!'[1657] Dr Renshaw wrote back expressing some sympathy and providing assurance that the hospital was cooperating

fully with the independent investigation.[1658] He also encouraged Ms Knight to look after herself and reach out to support services, and he provided the contact details of some of these services.

At our hearings, Ms Knight described finding this response lacking:

> … it just seemed very generic to me, like, you know, a very basic email that he's probably sent everybody that sent him an email—that's how it felt anyway … I just felt like a number to him, you know, like it's … not really important, not a big deal, kind of.[1659]

She acknowledged that Dr Renshaw provided information about support services but felt it was not personalised and required her to seek out help herself, rather than the hospital offering support.[1660]

Ms Knight's experience reinforced our view that Launceston General Hospital did not have an adequate process for responding to victim-survivors and related parties about Mr Griffin. The hospital did not provide clear information about what processes the hospital and police had undertaken to identify potential victims and, aside from a list of support service numbers, did not offer counselling. Providing a list of contact details for support services, while useful, is not an adequate response in these circumstances.

5.2.49 November 2020—A Launceston General Hospital staff member is approached by management following their participation in *The Nurse* podcast

A Launceston General Hospital staff member, who had a family member who was abused by Mr Griffin, spoke to Camille Bianchi for *The Nurse* podcast.[1661] The staff member also had a part-time role at the Sexual Assault Forensic Examiner (known as 'SAFE') in relation to sexual assault victims. SAFE sits within the Launceston General Hospital's area of responsibility.

The staff member told us that during a meeting with a Launceston General Hospital manager and the SAFE medical lead, they were told that due to their participation in the podcast and because of their family member's experience, the staff member's objectivity could be questioned, and this might compromise any prosecutions in which they were involved through SAFE. The staff member said they were confused by this information, given that SAFE is a forensic service and their family member's experience would not change the nature of any forensic evidence.

The Launceston General Hospital manager said that when the podcast was released, the SAFE medical lead approached her to discuss whether there was a potential conflict of interest or perceived bias if the staff member was to give evidence in a future sexual assault case.[1662] The manager told us that the medical lead had sought advice from the Director of Public Prosecutions who said that the staff member potentially could have a conflict of interest. The manager told us that the meeting with the staff member was

intended to see how the staff member might feel about this risk if their objectivity was questioned in a prosecution, given they had shared information about their family's experience publicly through the podcast, and to consider the staff member's wellbeing. The manager also told us that, given the concerns expressed by the medical lead, she considered it was appropriate for her to raise the issue with the staff member, and in doing so she did not express any personal views.

The staff member told us that at the time they interpreted the conversation as reprisal for speaking out, but with the benefit of hindsight they acknowledged it also expressed some concern for their mental health.

The manager denied that her comments were a reprisal for the staff member speaking out about their family's experience publicly. While SAFE does not conduct any general screening to determine if employees have experienced sexual assault, the manager explained that the difference in this situation was that the staff member had made their family's experiences public.

We also heard of other occasions when Launceston General Hospital management spoke to staff who had spoken publicly. We recognise that such conversations might have been based on genuine concerns about conflicts of interest or staff wellbeing. We are concerned, however, that such approaches, at least in the absence of a clear explanation of their purpose, risked contributing to a culture where staff felt reluctant to speak up about sexual abuse or feared adverse consequences if they did so publicly.

5.2.50 23 November 2020—The intention to establish a Commission of Inquiry is announced

On 23 November 2020, the then Premier Gutwein announced that a Commission of Inquiry into the Tasmanian Government's responses to child sexual abuse in institutional settings would be established in early 2021.[1663]

5.2.51 15 March 2021—Our Commission of Inquiry is formally established

On 15 March 2021, our Commission of Inquiry was formally established by Order of the Governor of Tasmania.[1664]

5.2.52 September 2021—Legal Services and the Department convene a group of staff to provide information in response to civil claims lodged in relation to Mr Griffin

In September 2021, the former Director of Employee Relations at the Department (who had since moved to the Department's Commission of Inquiry Response and Reform team) and Mr Bellinger joined a group established by Legal Services either within or designed to assist the Department to provide information to the Office of the Solicitor-General in response to civil claims relating to Mr Griffin.[1665] At least one of these civil

claims referenced a disclosure made to the hospital in 2010.[1666] This may have been drawn from the reference to a disclosure reported in *The Nurse* podcast, which we have presumed to be a reference to Ms Pearn's disclosure, although we consider it occurred in 2011 or 2012.

The former Director of Employee Relations recalled discussing Ms Pearn's disclosure with Mr Bellinger in the context of it coming up in one of the civil claims. We understand that they were already aware of Ms Pearn's disclosure through their conversation with Ms Pearn on 19 October 2020.[1667] On their evidence, they were not made directly aware of the possibility of Mr Bellinger's presence at Ms Pearn's initial disclosure; however, we have not been able to confirm this.

The former Director of Employee Relations and Mr Bellinger's exchange revealed that the Department accepted that the meeting Ms Pearn reported having with hospital's human resources staff did in fact occur, despite the hospital having no record of it.[1668] The former Director of Employee Relations told us that in discussions with Mr Bellinger, he mentioned that he often had contact with Stewart Millar in Mr Millar's capacity as a consultant, and that Mr Millar would likely be willing to provide a statement about Ms Pearn's disclosure, relevant to the claim.[1669]

5.2.53 1 October 2021—Mr Bellinger is asked to obtain statements from Mr Millar and Mr Fratangelo regarding Ms Pearn's disclosure

On 1 October 2021, the former Director of Employee Relations emailed Mr Bellinger asking him to obtain statements from Mr Millar and Mr Fratangelo about Ms Pearn's disclosure, noting they could do this themself if he was unable to.[1670] The former Director of Employee Relations wrote: 'No super urgency – it's not required at this stage but may be later' [Emphasis is the former Director's].[1671]

We note it was around this time that, as part of our evidence gathering, we were also making enquiries about Mr Millar's recollections of Ms Pearn's disclosure. We were not aware at that point that Mr Millar had recently given a similar statement to the Department.

We learned from the Solicitor-General, Sarah Kay SC, that the request for a statement from Mr Millar did not come from her office and it only learned that it had been taken on 28 January 2022 when a solicitor from her office had a discussion with a Department employee. This solicitor's file note of the conversation said:

> James Bellinger had contacted [Mr Millar] (the retiree) in late 2021, as they were unsure of details of alleged discussion of former staff member re abuse by Griffin when she was a child. … [The employee] confirmed OSG didn't ask for it [a statutory declaration] to be done, Health did on own volition and [Mr Millar] (had?) offered to make a stat dec as a record.[1672]

Because Ms Pearn's disclosure was made to the hospital's human resources team, it was not appropriate for anyone from that team to be involved in obtaining statements from Mr Fratangelo or Mr Millar.

On 30 October 2021, Mr Bellinger reported to the former Director of Employee Relations that Mr Millar was reviewing his statement and that Mr Fratangelo 'cannot recall [the disclosure] for the life of him'.[1673] Mr Fratangelo was not asked to complete a statutory declaration to this effect.[1674]

We have compared a draft version of Mr Millar's statement, prepared by Mr Bellinger, with the version that was ultimately signed by Mr Millar. The draft unsigned statement included the following content about who attended the meeting when Ms Pearn disclosed Mr Griffin's abuse: 'I believe it was either Gino Fratangelo or James Bellinger'.[1675]

On 3 November 2021, Mr Millar advised Mr Bellinger that he had made 'a couple of small changes' to the statement and forwarded a revised version.[1676] We identified two changes, one of which we do not consider consequential. On 8 November 2021, Mr Millar attended the hospital to sign the statement. In Mr Millar's final statement, signed on 8 November 2021, the content relevant to who attended the meeting when Ms Pearn disclosed Mr Griffin's abuse read: 'I believe it was either Gino Fratangelo or James Bellinger *or both*' [Emphasis ours].[1677]

We consider Mr Millar's edit notable. We also note that this is the evidence that Mr Millar has consistently given, including to us.

Mr Bellinger said he did not share this information from Mr Millar's statement with anyone at the hospital, beyond providing the former Director of Employee Relations a copy of Mr Millar's statement.[1678] We are not clear whether and how this statement was used.

Mr Bellinger gave evidence at our hearings that he only became aware that Mr Millar placed him at the meeting where Ms Pearn's disclosure took place when he was taking Mr Millar's statement.[1679] He admitted that this knowledge did not prompt him to recuse himself from taking the statement due to a conflict of interest.[1680] Mr Bellinger conceded that 'with hindsight somebody else should have taken over that interview process or that witness statement process'.[1681]

When Counsel Assisting asked Mr Bellinger whether the reason he did not take any steps in response to his conflict of interest was because he didn't want any further scrutiny of Ms Pearn's disclosure, Mr Bellinger responded: 'No, it was not that reason'.[1682]

The former Director of Employee Relations told us that it was not their expectation that Mr Bellinger would discuss Mr Millar's recollection with him and draft Mr Millar's statement himself, only that he would request that Mr Millar provide a statement. They said that they only became aware that Mr Bellinger had prepared the statement himself when they received a copy and saw that Mr Millar's name was misspelt.[1683] They acknowledged that they should not have asked Mr Bellinger to obtain a statement from Mr Millar.[1684]

Finding—Launceston General Hospital's human resources team should not have been involved in the request or preparation of a statement from Stewart Millar regarding Kylee Pearn's disclosure

The Department's Commission of Inquiry Response and Reform team (where the former Director of Employee Relations worked at this time) was responsible for providing our Commission of Inquiry with all relevant documentation from the Department, including in relation to Ms Pearn's disclosure.

Because Ms Pearn's disclosure was made to the hospital's human resources team, it should have been clear to the Department's Commission of Inquiry Response and Reform team that the hospital's human resources team should not have been involved in documenting anything connected to Ms Pearn's disclosure, nor gaining statements from other human resources team members.

Furthermore, it was reasonably foreseeable to the Department's Commission of Inquiry Response and Reform team that Mr Bellinger and Mr Millar would be witnesses at our Commission of Inquiry and that there may have been a point of contention in their differing recollections of who was present at Ms Pearn's disclosure, and that greater care to not compromise the evidence before our Inquiry should have been taken.[1685]

Finding—James Bellinger should not have taken the statement from Stewart Millar

We are concerned that Mr Bellinger took the statement from Mr Millar about Ms Pearn's disclosure in 2011 or 2012 given our finding that Mr Bellinger was at the meeting with Ms Pearn when she made the disclosure.

Even on Mr Bellinger's evidence that he was not at the meeting, when asked by the former Director of Employee Relations to obtain a statement from Mr Millar, Mr Bellinger should have flagged his likely conflict of interest and declined to be involved. Mr Bellinger was a member of the human resources team. It was not appropriate for him to have any involvement in Mr Millar's statement. Even on the most favourable interpretation of Mr Bellinger's evidence, at the point Mr Millar named Mr Bellinger as being at the meeting, he should have reported this to his manager and ceased involvement. Mr Bellinger conceded that somebody else should have taken the statement.

We are concerned about Mr Bellinger's decisions regarding Ms Pearn's 2011 or 2012 disclosure, including:

- not alerting anyone within the hospital or Department to Ms Pearn's disclosure when Detective Senior Constable Hindle enquired about it on 11 October 2019, despite his evidence that it would be his usual practice to do so
- not including Ms Pearn's disclosure in any of his various reviews of Mr Griffin's prior complaints history, including the response to the Integrity Commission.

These decisions contributed to our finding that he was present at the 2011 or 2012 meeting.

6 Observations

Despite considering the documents and other evidence relevant to Mr Griffin for some months, we struggle to come to terms with the enormity of the collective failure by a range of institutions—including Launceston General Hospital, Child Safety Services and Tasmania Police—that characterises their responses to the risks Mr Griffin posed. These collective failures enabled a motivated sexual predator to repeatedly groom, harm and abuse vulnerable young patients and other children with whom he had contact. The extent of Mr Griffin's sexual abuse of children and young people is astounding and devastating. We acknowledge that the incidents we are aware of likely reflect only some of Mr Griffin's sexual offending across a range of contexts. We only examined one facet of Mr Griffin's abuse, namely his abuse within an institution. We know of many more victim-survivors and witnesses who decided not to share their experiences with us.

What is clear from the evidence we have laid out in Sections 3 and 4 is that:

- Mr Griffin had a clear modus operandi in often (but not always) targeting particularly vulnerable young girls who, because of their family circumstances, poor mental health or physical illness, were more susceptible to his grooming. While we heard evidence that Mr Griffin could be opportunistic in offending against short-stay patients, it was young people with ongoing chronic conditions whom Mr Griffin most often targeted because their extended stays in hospital created more opportunities for him to groom them and their families, build relationships that could extend beyond the hospital and offend against them.
- Mr Griffin was tactical in his interactions with people who may have detected his abuses or raised the alarm. He groomed colleagues, managers and the families of patients to build their trust and to make them less likely to recognise, report or act on his behaviour. This grooming lowered the guard of some people and made them more inclined to view Mr Griffin's inappropriate behaviours as benign or indicative of a higher level of care and concern for patients.

- When Mr Griffin's charm did not work, particularly with male nursing colleagues who were conscious of the professional conduct expected of male nurses, he revealed glimpses of a more intimidating and hostile side that made people wary to confront him. Mr Griffin's aggressive side was apparent on the few occasions that he was confronted with complaints or resistance from patients and very evident in his abuse of Ms Skeggs. While the revelations about Mr Griffin were a shock to some, they were a confirmation of the suspicions held by others who had encountered or detected his menacing side.
- Much of Mr Griffin's inappropriate behaviour occurred in plain sight, which at times made it less likely to be detected. He groomed, breached professional boundaries with and inappropriately touched children with brazenness. His behaviour was facilitated by his confidence that he could act with impunity—when concerns were raised, the hospital, Tasmania Police and Child Safety Services largely failed to intervene. His unabashed behaviour was also a strategy to reassure people that his conduct was appropriate. In being so open with some of his conduct, those around him often did not recognise his behaviour as abusive (or second guessed their sense that it was) and even participated in assuring others, including patients and their family members, that his behaviour was 'just Jim'.
- Mr Griffin often encouraged relationships between his victims and his family. This had the effect of making the time he spent with his victims less suspect. It also made his victims feel that they had a duty to protect his children from the distress of disclosures about his conduct. This kept them silent. Many victim-survivors that we heard from were careful to ensure the information they provided us would not hurt Mr Griffin's family, who have no doubt suffered considerably. We expect that many others did not provide us with information for this reason.
- The health setting that Mr Griffin operated in gave him unique opportunities to offend. It gave him access to young girls who were often in a frightened and highly vulnerable state. Many of these young girls spent long periods on the ward and initially welcomed his warmth and attentiveness, which informed how their families interpreted Mr Griffin's keen interest in their care. Patients' need for physical care (including for bathing, dressing or other intimate procedures) provided a veneer of legitimacy for his abuses, particularly because chaperone protocols were not strongly embedded and enforced on the ward, and children and young people (and their families) had little information to help them identify what was normal and what was unprofessional practice (although some did come to recognise how Mr Griffin's behaviour differed from that of other nurses).
- The dysfunctional nature of Ward 4K enabled Mr Griffin to offend. He took full advantage of this toxic work culture. Staff were mired in interpersonal conflict for many years, which had the effect of demotivating them, making them less likely

to speak up about their concerns, and allowing management and human resources staff to be sceptical or dismissive of their complaints.

- The systems, policies and processes of the hospital were not adequate to protect children from sexual abuse. The hospital provided inadequate guidance on expected standards of behaviour in child-facing roles, showed lax enforcement and embedding of the chaperone protocol, demonstrated poor complaints-handling processes, showed reluctance to take disciplinary action in the face of escalating noncompliance, and failed to adequately notify and involve senior management and external agencies about the multiple complaints against Mr Griffin. The combination of all these factors contributed to a disclosure as significant as Ms Pearn's in 2011 or 2012 being met with complete inaction.
- Similarly, the failures of Child Safety Services to properly share information and create meaningful opportunities for disclosure meant chances were missed to piece together information that could have revealed Mr Griffin's abuses at a much earlier stage. The response of Child Safety Services to concerns about Ms Skeggs in 2013 did not feel safe or helpful to her; instead, it cast doubt on reported concerns in a rush to close its file. This response may well have been a product of a pressured and overstretched system, but it contributed to allowing Mr Griffin to continue his abuses.
- Following the email it received in 2000 onwards, Tasmania Police similarly failed to act on critical information at various times and to review prior intelligence holdings that would have allowed a more complete assessment of Mr Griffin's modus operandi. Mr Griffin was not given priority as a suspected offender despite significant risks to children. The failure of Tasmania Police to act diligently on intelligence gathered by the Australian Federal Police in 2015 cannot be overstated. While Tasmania Police has rightly reviewed its actions and apologised accordingly, this failing was so egregious as to warrant revisiting by our Inquiry.
- Each organisation—Launceston General Hospital, Tasmania Police and Child Safety Services—should have done more to assess and act on the risks posed by Mr Griffin, acknowledging that the extent of the risk was only fully apparent when the information held by each of these agencies was put together. Mr Griffin had a pattern of abusive behaviour towards children that was stark and undeniable. The failures to share information, particularly between Tasmania Police and Child Safety Services, meant that opportunities to identify this pattern earlier were lost.

The following is clear to us from the evidence presented in Section 5:

- Launceston General Hospital only acted in response to Mr Griffin when forced to do so and as a result of the police investigation prompted by Ms Skeggs' report in 2019. The lack of any pre-existing plans or strategies to manage a crisis of

this nature—that is, employing a paedophile in a paediatric ward for 18 years—combined with the completely dysfunctional dynamics within the hospital, created significant vulnerabilities that were ultimately catastrophic in terms of the hospital's response.

- Leadership of this response was largely absent. However, to the extent that the hospital's leadership was involved in the response, it did not properly acquit its responsibilities.
- Secretary Morgan-Wicks came to our hearings to listen and accept responsibility. She stood out as one of the few senior witnesses to genuinely appreciate the scale of the catastrophe that was the hospital's response to revelations of Mr Griffin's offending and that the task ahead of rebuilding community trust will be enormous. Her willingness to be accountable was as appropriate as it was heartening. It was clear to us that Secretary Morgan-Wicks was not only poorly advised, but also misled.

Several staff from Ward 4K who provided evidence to us showed great vulnerability and courage in honestly admitting what they felt were their own failings to report, record actions or to take greater steps in response to Mr Griffin's conduct. There can be a fine line between self-condemnation, genuine regret and appropriate reflection on what one would do differently if they had their time again. We hope bystanders of Mr Griffin's abuse learn from their experience and work towards safer practices in future. Some of these individuals have done the most—alongside victim-survivors—to draw attention to the systemic failures within the hospital. They have spoken up and spoken out, notwithstanding their own fears of reprisal. We, and the broader Tasmanian community, owe a great debt to them for their fearlessness and tenacity.

What was apparent to us is that the people who most berated themselves for their decisions and actions were those least responsible for Mr Griffin's abuse—victim-survivors. We witnessed the anguish of many victim-survivors who believed that they alone were being abused by Mr Griffin and felt wracked with guilt when the extent of his abuse became known. They expressed to us that they should have raised the alarm. These feelings come from a deep concern for others and for the protection of children, which we greatly admire, but it is not a burden victim-survivors of abuse should have to carry. It is not their responsibility to protect others from their abuser. It is the responsibility of institutions tasked with their care and protection.

Our Commission of Inquiry would not have been possible without the willingness of victim-survivors and their supporters to share their most painful and distressing experiences with us. We know there are many other people who have chosen not to do so, which we respect. We had hoped our hearings would offer a degree of healing and catharsis for many who held unanswered questions or were rightly hoping and expecting some proper acknowledgment of their suffering and their

efforts to bring attention to concerns about Mr Griffin with the hospital. Instead, they—like us—were met with a response from senior executives at the hospital that lacked empathy, insight, reflection and care for them.

We hope this report—alongside our Commission of Inquiry's care and deep admiration for all victim-survivors—nonetheless offers some measure of comfort and closure that can be further reinforced by the recommendations that we discuss in Chapter 15.

Notes

Introduction

1 Order of the Governor of Tasmania made under the *Commissions of Inquiry Act 19.95*, 15 March 2021.

In accordance with the Restricted Publication Order of the Commission of Inquiry dated 30 August 2023 and section 10(3) of the *Commissions of Inquiry Act 1995* (Tas), the Governor has omitted Volume 6, Chapter 14, Case Study 1 because the public interest in the disclosure of that part of the report is significantly outweighed by other relevant considerations, namely the right of any person to a fair trial.

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Case study 2: Response to complaint about Dr Tim (a pseudonym)

137 Statement of Craig Duncan, 8 June 2022, 2 [6].

138 Statement of Craig Duncan, 8 June 2022, 2 [6].

139 The name 'Dr Tim' is a pseudonym; Order of the Commission of Inquiry, restricted publication order, 27 June 2022.

140 Statement of Craig Duncan, 8 June 2022, 1 [5].

141 Statement of Craig Duncan, 8 June 2022, 17–18 [93].

142 Statement of Craig Duncan, 8 June 2022, 10 [46]; Statement of Craig Duncan, 8 June 2022, Annexure CD-004 (Letter from Zoe Duncan, undated); Statement of Craig Duncan, 8 June 2022, Annexure CD-036 (Marked-up 'How to Stay Safe' booklet, undated).

143 Statement of Craig Duncan, 8 June 2022, 2 [7].

144 Statement of Craig Duncan, 8 June 2022, 2 [7].

145 Statement of Craig Duncan, 8 June 2022, 2 [10].

146 Statement of Craig Duncan, 8 June 2022, 2 [10].

147 Statement of Craig Duncan, 8 June 2022, 3 [11].

148 Statement of Craig Duncan, 8 June 2022, 3 [11].

149 Statement of Craig Duncan, 8 June 2022, 3 [12].

150 Statement of Craig Duncan, 8 June 2022, 3 [13].

151 Statement of Craig Duncan, 8 June 2022, 3 [13].

152 Statement of Craig Duncan, 8 June 2022, 3 [14].

153 Statement of Craig Duncan, 8 June 2022, 3 [14].

154 Statement of Craig Duncan, 8 June 2022, 3 [14].

155 Statement of Craig Duncan, 8 June 2022, 3 [14].

156 Statement of Craig Duncan, 8 June 2022, 4 [14].

157 Statement of Craig Duncan, 8 June 2022, 4 [14].

158 Statement of Craig Duncan, 8 June 2022, 4 [17].

159 Statement of Craig Duncan, 8 June 2022, 4 [18].

160 Statement of Craig Duncan, 8 June 2022, 4 [18].

161 Statement of Craig Duncan, 8 June 2022, 4 [18].

162 Statement of Craig Duncan, 8 June 2022, 5 [19].

163 Statement of Peter Renshaw, 20 June 2022, 19 [17], 46 [68.1]; Statement of Peter Renshaw, 20 June 2022, Annexure 19 (File note of Peter Renshaw regarding Zoe Duncan, 29 May 2001 with additional notes).

164 Statement of Peter Renshaw, 20 June 2022, 19 [17.1], 46 [67.1].

165 Statement of Peter Renshaw, 20 June 2022, 47 [69.3]; Statement of Peter Renshaw, 20 June 2022, Annexure 19 (File note of Peter Renshaw regarding Zoe Duncan, 29 May 2001 with additional notes).

166 After Hours Nurse Coordinator, 'Incident Report', 20 May 2001, 1, produced by the Department of Communities in response to a Commission notice to produce.

167 Statement of Peter Renshaw, 20 June 2022, Annexure 19 (File note of Peter Renshaw regarding Zoe Duncan, 29 May 2001 with additional notes).

168 Statement of Peter Renshaw, 20 June 2022, Annexure 19 (File note of Peter Renshaw regarding Zoe Duncan, 29 May 2001 with additional notes).

169 Transcript of Peter Renshaw, 8 September 2022, 3737 [1–7].

170 Transcript of Peter Renshaw, 8 September 2022, 3737 [16–20].

171 Transcript of Peter Renshaw, 8 September 2022, 3739 [39–40].

172 Transcript of Peter Renshaw, 8 September 2022, 3740 [36]–3741 [2].

173 Transcript of Peter Renshaw, 8 September 2022, 3753 [37].

174 Medical Council of Tasmania, 'Investigation Report', 19 March 2003, 3, produced by the Australian Health Practitioner Regulation Agency in response to a Commission notice to produce.

175 Statement of Craig Duncan, 8 June 2022, 5 [19].

176 Statement of Craig Duncan, 8 June 2022, 5 [19].

177 Statement of Craig Duncan, 8 June 2022, 5 [19].

178 Statement of Craig Duncan, 8 June 2022, 5 [20].

179 Statement of Craig Duncan, 8 June 2022, 6 [25].

180 Statement of Craig Duncan, 8 June 2022, 5 [21].

181 Statement of Craig Duncan, 8 June 2022, 5 [21].

182 Statement of Craig Duncan, 8 June 2022, 5 [21].

183 Statement of Craig Duncan, 8 June 2022, 5 [22].

184 Statement of Craig Duncan, 8 June 2022, 5 [22].

185 Statement of Craig Duncan, 8 June 2022, 5 [22].

186 Statement of Craig Duncan, 8 June 2022, 6 [24].

187 Statement of Craig Duncan, 8 June 2022, 6 [24].

188 Statement of Craig Duncan, 8 June 2022, 6 [25].

189 Statement of Craig Duncan, 8 June 2022, 6 [25].

190 Statement of Peter Renshaw, 20 June 2022, 48 [69.8]; Statement of Peter Renshaw, 20 June 2022, Annexure 19 (File note of Peter Renshaw regarding Zoe Duncan, 29 May 2001 with additional notes).

191 Statement of Peter Renshaw, 20 June 2022, Annexure 19 (File note of Peter Renshaw regarding Zoe Duncan, 29 May 2001 with additional notes).

192 Statement of Peter Renshaw, 20 June 2022, Annexure 19 (File note of Peter Renshaw regarding Zoe Duncan, 29 May 2001 with additional notes).

193 Statement of Peter Renshaw, 20 June 2022, Annexure 19 (File note of Peter Renshaw regarding Zoe Duncan, 29 May 2001 with additional notes).

194 Transcript of Peter Renshaw, 8 September 2022, 3745 [16–18].

195 Transcript of Peter Renshaw, 8 September 2022, 3745 [20–23].

196 Transcript of Peter Renshaw, 8 September 2022, 3747 [27–35], 3752 [3–5].

197 Transcript of Peter Renshaw, 8 September 2022, 3747 [37]–3749 [21].

198 Statement of Peter Renshaw, 20 June 2022, Annexure 19 (File note of Peter Renshaw regarding Zoe Duncan, 29 May 2001 with additional notes); Statement of Craig Duncan, 8 June 2022, 6–7 [26].

199 Statement of Craig Duncan, 8 June 2022, 7 [26].

200 Statement of Craig Duncan, 8 June 2022, 7 [26].

201 Statement of Peter Renshaw, 20 June 2022, 48 [69.9]; Statement of Peter Renshaw, 20 June 2022, Annexure 19 (File note of Peter Renshaw regarding Zoe Duncan, 29 May 2001 with additional notes).

202 Transcript of Peter Renshaw, 8 September 2022, 3751 [33]–3752 [1].

203 Statement of Craig Duncan, 8 June 2022, 7 [26]; Statement of Peter Renshaw, 20 June 2022, 48 [69.9]; Statement of Peter Renshaw, 20 June 2022, Annexure 19 (File note of Peter Renshaw regarding Zoe Duncan, 29 May 2001 with additional notes).

204 Transcript of Peter Renshaw, 8 September 2022, 3753 [15–17].

205 Statement of Peter Renshaw, 20 June 2022, 49 [69.10]; Statement of Peter Renshaw, 20 June 2022, Annexure 19 (File note of Peter Renshaw regarding Zoe Duncan, 29 May 2001 with additional notes).

206 Statement of Peter Renshaw, 20 June 2022, 49 [69.10].

207 Transcript of Peter Renshaw, 8 September 2022, 3752 [34–39].

208 Transcript of Peter Renshaw, 8 September 2022, 3752 [34]–3753 [3].

209 Statement of Craig Duncan, 8 June 2022, 7 [26].

210 Statement of Peter Renshaw, 20 June 2022, Annexure 19 (File note of Peter Renshaw regarding Zoe Duncan, 29 May 2001 with additional notes).

211 Transcript of Peter Renshaw, 8 September 2022, 3750 [37–42].

212 Statement of Peter Renshaw, 20 June 2022, 20 [18.3].

213 Peter Renshaw, *Procedural Fairness Response*, 12 July 2023, 2–3.

214 Peter Renshaw, *Procedural Fairness Response*, 12 July 2023, 3.

215 Peter Renshaw, *Procedural Fairness Response*, 12 July 2023, 2–3.

216 Transcript of Claire Lovell, 4 July 2022, 2274 [3–4].

217 Transcript of Peter Renshaw, 8 September 2022, 3742 [14–15], 3743 [30–37], 3745 [20–23] 3746 [30–36], 3747 [34–35].

218 Statement of Craig Duncan, 8 June 2022, 7 [27].

219 Statement of Craig Duncan, 8 June 2022, 7 [27].

220 Statement of Craig Duncan, 8 June 2022, 7 [27].

221 Statement of Craig Duncan, 8 June 2022, 7 [27].

222 Statement of Craig Duncan, 8 June 2022, 7 [27].

223 Statement of Craig Duncan, 8 June 2022, 7 [27].

224 Statement of Peter Renshaw, 20 June 2022, Annexure 19 (File note of Peter Renshaw regarding Zoe Duncan, 29 May 2001 with additional notes).

225 Statement of Peter Renshaw, 20 June 2022, Annexure 19 (File note of Peter Renshaw regarding Zoe Duncan, 29 May 2001 with additional notes).

226 Transcript of Peter Renshaw, 8 September 2022, 3754 [14–16].

227 Statement of Peter Renshaw, 20 June 2022, 49 [69.11].

228 Statement of Peter Renshaw, 20 June 2022, 20 [18.4].

229 Statement of Peter Renshaw, 20 June 2022, 49 [69.11].

230 Transcript of Peter Renshaw, 8 September 2022, 3738 [42]–3739 [8].

231 Transcript of Peter Renshaw, 8 September 2022, 3739 [1–2].

232 Transcript of Peter Renshaw, 8 September 2022, 3752 [11–19].

233 Peter Renshaw, 'File Note – Meeting with Dr Tim', 29 May 2001, 1, produced by the Department of Health in response to a Commission notice to produce.

234 Statement of Peter Renshaw, 20 June 2022, 49 [69.12].

235 Statement of Peter Renshaw, 20 June 2022, 49 [69.12].

236 Statement of Peter Renshaw, 20 June 2022, 20 [18.5].

237 Statement of Peter Renshaw, 20 June 2022, Annexure 19 (File note of Peter Renshaw regarding Zoe Duncan, 29 May 2001 with additional notes); Transcript of Peter Renshaw, 8 September 2022, 3755 [3–8].

238 General Practitioner, Letter to Dr Renshaw, 25 May 2001, produced by the Department of Communities in response to a Commission notice to produce.

239 Statement of Craig Duncan, 8 June 2022, 8 [30].

240 Statement of Peter Renshaw, 20 June 2022, 49 [69.13]; Statement of Peter Renshaw, 20 June 2022, Annexure 19 (File note of Peter Renshaw regarding Zoe Duncan, 29 May 2001 with additional notes).

241 Statement of Peter Renshaw, 20 June 2022, 49 [69.13]; Statement of Peter Renshaw, 20 June 2022, Annexure 19 (File note of Peter Renshaw regarding Zoe Duncan, 29 May 2001 with additional notes).

242 Statement of Peter Renshaw, 20 June 2022, Annexure 19 (File note of Peter Renshaw regarding Zoe Duncan, 29 May 2001 with additional notes).

243 Statement of Peter Renshaw, 20 June 2022, Annexure 19 (File note of Peter Renshaw regarding Zoe Duncan, 29 May 2001 with additional notes).

244 Statement of Peter Renshaw, 20 June 2022, 50 [69.14]; Statement of Peter Renshaw, 20 June 2022, Annexure 19 (File note of Peter Renshaw regarding Zoe Duncan, 29 May 2001 with additional notes).

245 Statement of Peter Renshaw, 20 June 2022, 50 [71.1], 52 [72.4].

246 Peter Renshaw, 'File Note – Meeting with Dr Tim', 29 May 2001, 1, produced by the Department of Health in response to a Commission notice to produce.

247 Peter Renshaw, 'File Note – Meeting with Dr Tim', 29 May 2001, 1, produced by the Department of Health in response to a Commission notice to produce.

248 Peter Renshaw, 'File Note – Meeting with Dr Tim', 29 May 2001, 1, produced by the Department of Health in response to a Commission notice to produce.

249 Peter Renshaw, 'File Note – Meeting with Dr Tim', 29 May 2001, 1, produced by the Department of Health in response to a Commission notice to produce.

250 Transcript of Peter Renshaw, 8 September 2022, 3760 [17–20].

251 Statement of Peter Renshaw, 20 June 2022, 20 [18.5], 50 [69.14]; Statement of Peter Renshaw, 20 June 2022, Annexure 19 (File note of Peter Renshaw regarding Zoe Duncan, 29 May 2001 with additional notes); Statement of Craig Duncan, 8 June 2022, 8 [31].

252 Statement of Peter Renshaw, 20 June 2022, Annexure 19 (File note of Peter Renshaw regarding Zoe Duncan, 29 May 2001 with additional notes); Child and Family Services, 'Initial Enquiry Report', 12 September 2001, 3, produced by the Department of Communities in response to a Commission notice to produce.

253 Child and Family Services, 'Initial Enquiry Report', 12 September 2001, 3, produced by the Department of Communities in response to a Commission notice to produce.

254 Child and Family Services, 'Initial Enquiry Report', 12 September 2001, 3, produced by the Department of Communities in response to a Commission notice to produce.

255 Statement of Peter Renshaw, 20 June 2022, 50 [69.14]; Statement of Peter Renshaw, 20 June 2022, Annexure 19 (File note of Peter Renshaw regarding Zoe Duncan, 29 May 2001 with additional notes).

256 Statement of Peter Renshaw, 20 June 2022, 50 [69.15].

257 Statement of Peter Renshaw, 20 June 2022, Annexure 2 (Protocol for Hospital-Based Medical and Nursing Staff for the Reporting and Management of Cases of Suspected Child Abuse or Neglect, implemented 6 March 1998); Transcript of Elizabeth Stackhouse, 27 June 2022, 1735 [26]–1736 [5].

258 Statement of Peter Renshaw, 20 June 2022, Annexure 2 (Protocol for Hospital-Based Medical and Nursing Staff for the Reporting and Management of Cases of Suspected Child Abuse or Neglect, implemented 6 March 1998).

259 Statement of Peter Renshaw, 20 June 2022, Annexure 2 (Protocol for Hospital-Based Medical and Nursing Staff for the Reporting and Management of Cases of Suspected Child Abuse or Neglect, implemented 6 March 1998).

260 Statement of Peter Renshaw, 20 June 2022, Annexure 2 (Protocol for Hospital-Based Medical and Nursing Staff for the Reporting and Management of Cases of Suspected Child Abuse or Neglect, implemented 6 March 1998).

261 Transcript of Peter Renshaw, 8 September 2022, 3739 [42]–3740 [20].

262 Transcript of Peter Renshaw, 8 September 2022, 3739 [42]–3740 [20].

263 Transcript of Peter Renshaw, 8 September 2022, 3742 [43]–3743 [2].

264 Transcript of Elizabeth Stackhouse, 27 June 2022, 1737 [27–32].

265 Transcript of Elizabeth Stackhouse, 27 June 2022, 1737 [37]–1738 [3].

266 Statement of Peter Renshaw, 20 June 2022, 47 [69.3]; Statement of Peter Renshaw, 20 June 2022, Annexure 19 (File note of Peter Renshaw regarding Zoe Duncan, 29 May 2001 with additional notes).

267 Transcript of Peter Renshaw, 8 September 2022, 3737 [1–7].

268 Peter Renshaw, *Procedural Fairness Response*, 12 July 2023, 2.

269 Peter Renshaw, *Procedural Fairness Response*, 12 July 2023, 2.

270 *Children, Young Persons and Their Families Act 1997* s 14.

271 Transcript of Peter Renshaw, 8 September 2022, 3747 [20–35].

272 Child and Family Services, 'Initial Enquiry Report', 12 September 2001, 10, produced by the Department of Communities in response to a Commission notice to produce; Medical Council of Tasmania, 'Investigation Report', 19 March 2003, 3, produced by the Australian Health Practitioner Regulation Agency in response to a Commission notice to produce.

273 Transcript of Peter Renshaw, 8 September 2022, 3745 [22], [39–42].

274 Transcript of Peter Renshaw, 8 September 2022, 3746 [12–15].

275 Transcript of Peter Renshaw, 8 September 2022, 3752 [34–39].

276 Transcript of Peter Renshaw, 8 September 2022, 3753 [1–3].

277 Statement of Elizabeth Stackhouse, 22 June 2022, 10 [77].

278 Statement of Elizabeth Stackhouse, 22 June 2022, 14 [107].

279 Transcript of Peter Renshaw, 8 September 2022, 3738 [42]–3739 [8].

280 Transcript of Peter Renshaw, 8 September 2022, 3739 [1–2].

281 Statement of Elizabeth Stackhouse, 22 June 2022, 13 [102]; Elizabeth Stackhouse, Letter to Laurel House, 8 May 2002, produced by the Department of Health in response to a Commission notice to produce.

282 Statement of Elizabeth Stackhouse, 22 June 2022, 11 [78], 14 [110].

283 Department of Health and Human Services, 'Examination of Patients by Medical, Nursing and Allied Health Staff (Chaperone Policy)', undated, 3, produced by the Department of Health in response to a Commission notice to produce; Statement of Craig Duncan, 8 June 2022, Annexure CD-011 (Draft Department of Health and Human Services – Launceston General Hospital Policy – Examination of Patients by Medical, Nursing and Allied Health Staff (Chaperone Policy), undated).

284 Department of Health and Human Services, 'Examination of Patients by Medical, Nursing and Allied Health Staff (Chaperone Policy)', June 2002, 1–2, produced by the Commissioner for Children and Young People in response to a Commission notice to produce.

285 Statement of Craig Duncan, 8 June 2022, 9 [37]; Statement of Craig Duncan, 8 June 2022, Annexure CD-003 (Annotated 'Term One Reflection' worksheet by Zoe Duncan, undated).

286 Intake and Assessment Coordinator, Letter to Peter Renshaw, 13 June 2001, 1, produced by the Department of Communities in response to a Commission notice to produce; Intake and Assessment Coordinator, Letter to Anne Duncan, 13 June 2001, 1, produced by the Department of Communities in response to a Commission notice to produce; Statement of Craig Duncan, 8 June 2022, 9 [34]; Statement of Craig Duncan, 8 June 2022, Annexure CD-002 (Letter from Child and Family Services to Anne Duncan, 13 June 2001).

287 Intake and Assessment Coordinator, Letter to Peter Renshaw, 13 June 2001, 1, produced by the Department of Communities in response to a Commission notice to produce.

288 Department of Community and Health Services, 'Procedure to be followed where there is an allegation of maltreatment of a client (who is a child) by an employee of the Agency', June 1997, 1, produced by the Department of Communities in response to a Commission notice to produce.

289 Department of Community and Health Services, 'Procedure to be Followed where there is an Allegation of Maltreatment of a Client (who is a Child) by an Employee of the Agency', June 1997, 5–6, produced by the Department of Communities in response to a Commission notice to produce.

290 Department of Community and Health Services, 'Procedure to be Followed where there is an Allegation of Maltreatment of a Client (who is a Child) by an Employee of the Agency', June 1997, 8–9, produced by the Department of Communities in response to a Commission notice to produce.

291 Department of Community and Health Services, 'Procedure to be Followed where there is an Allegation of Maltreatment of a Client (who is a Child) by an Employee of the Agency', June 1997, 12, produced by the Department of Communities in response to a Commission notice to produce.

292 Allegation of Maltreatment of a Client (who is a Child) by an Employee of the Agency', June 1997, 12–15, produced by the Department of Communities in response to a Commission notice to produce.

293 Statement of Peter Renshaw, 20 June 2022, Annexure 19 (File note of Peter Renshaw regarding Zoe Duncan, 29 May 2001 with additional notes).

294 Statement of Peter Renshaw, 20 June 2022, Annexure 19 (File note of Peter Renshaw regarding Zoe Duncan, 29 May 2001 with additional notes) 3.

295 Statement of Peter Renshaw, 20 June 2022, Annexure 19 (File note of Peter Renshaw regarding Zoe Duncan, 29 May 2001 with additional notes) 3.

296 Statement of Peter Renshaw, 20 June 2022, Annexure 19 (File note of Peter Renshaw regarding Zoe Duncan, 29 May 2001 with additional notes) 3.

297 Request for statement served on Secretary, Department of Communities, 1 June 2022, 8 [20(c)].

298 Statement of Michael Pervan, 4 July 2022, 22 [121].

299 Transcript of Darren Hine, 6 July 2022, 2465 [24–30].

300 Transcript of Claire Lovell, 4 July 2022, 2274 [22–42].

301 Transcript of Claire Lovell, 4 July 2022, 2275 [39–47].

302 Transcript of Claire Lovell, 4 July 2022, 2279 [18–26].

303 Transcript of Claire Lovell, 4 July 2022, 2279 [36–44].

304 Transcript of Claire Lovell, 4 July 2022, 2276 [1–6].

305 *Royal Commission into Institutional Responses to Child Sexual Abuse* (Final Report, December 2017) vol 4, 30–33, 52–55; Statement of Helen Milroy, 28 April 2022, 4 [16–17]; Statement of Michael Salter, 7 April 2022, 8 [30], 15 [58].

306 Statement of Craig Duncan, 8 June 2022, 9 [39].

307 Statement of Craig Duncan, 8 June 2022, 9 [40].

308 Statement of Craig Duncan, 8 June 2022, 9 [41].

309 Statement of Craig Duncan, 8 June 2022, 9 [41].

310 Statement of Craig Duncan, 8 June 2002, 10 [43].

311 Statement of Craig Duncan, 8 June 2022, 10 [43].

312 Psychologist and Rehabilitation Provider, Report to Child and Family Services, 11 July 2001, produced by the Department of Communities in response to a Commission notice to produce; Statement of Craig Duncan, 8 June 2022, 8 [32]; Statement of Craig Duncan, 8 June 2022, Annexure CD-001 (Report by [confidential] Psychologist and Rehabilitation Provider regarding Zoe Duncan, 11 July 2001).

313 General Practitioner, Letter to Child and Family Services, 22 July 2001, produced by the Department of Communities in response to a Commission notice to produce.

314 Child and Family Services, 'Initial Enquiry Report', 12 September 2001, 6, produced by the Department of Communities in response to a Commission notice to produce.

315 Child and Family Services, 'Initial Enquiry Report',1. September 200 1. 6, produced by the Department of Communities in response to a Commission notice to produce.

316 Child and Family Services, 'Initial Enquiry Report', 12 September 2001, 6, produced by the Department of Communities in response to a Commission notice to produce.

317 Child and Family Services, 'Initial Enquiry Report', 12 September 2001, 4–10, produced by the Department of Communities in response to a Commission notice to produce; Statement of Craig Duncan, 8 June 2022, 10 [48].

318 Child and Family Services, 'Initial Enquiry Report', 12 September 2001, 5, produced by the Department of Communities in response to a Commission notice to produce.

319 Child and Family Services, 'Initial Enquiry Report', 12 September 2001, 7, produced by the Department of Communities in response to a Commission notice to produce.

320 Child and Family Services, 'Initial Enquiry Report', 12 September 2001, 8, produced by the Department of Communities in response to a Commission notice to produce.

321 Child and Family Services, 'Initial Enquiry Report', 12 September 2001, 8–9, produced by the Department of Communities in response to a Commission notice to produce.

322 Child and Family Services, 'Initial Enquiry Report', 12 September 2001, 9, produced by the Department of Communities in response to a Commission notice to produce.

323 Child and Family Services, 'Initial Enquiry Report', 12 September 2001, 9, produced by the Department of Communities in response to a Commission notice to produce.

324 Child and Family Services, 'Initial Enquiry Report', 12 September 2001, 10, produced by the Department of Communities in response to a Commission notice to produce.

325 These people included Zoe's parents, Dr Renshaw, Zoe's General Practitioner, Zoe's psychologist, Zoe's school teachers and Laurel House. Child and Family Services, 'Initial Enquiry Report', 12 September 2001, 10, produced by the Department of Communities in response to a Commission notice to produce.

326 Child and Family Services, 'Initial Enquiry Report', 12 September 2001, 10, produced by the Department of Communities in response to a Commission notice to produce.

327 Child and Family Services, 'Initial Enquiry Report', 12 September 2001, 10, produced by the Department of Communities in response to a Commission notice to produce.

328 Child and Family Services, 'Initial Enquiry Report', 12 September 2001, 10, produced by the Department of Communities in response to a Commission notice to produce.

329 Child and Family Services, 'Initial Enquiry Report', 12 September 2001, 10, produced by the Department of Communities in response to a Commission notice to produce.

330 Child and Family Services, 'Initial Enquiry Report', 12 September 2001, 11, produced by the Department of Communities in response to a Commission notice to produce.

331 Statement of Craig Duncan, 8 June 2022, 4 [16].

332 Statement of Craig Duncan, 8 June 2022, 12 [57].

333 Child and Family Services, 'Initial Enquiry Report', 12 September 2001, 11, produced by the Department of Communities in response to a Commission notice to produce.

334 Child and Family Services, 'Initial Enquiry Report', 12 September 2001, 11, produced by the Department of Communities in response to a Commission notice to produce.

335 Child and Family Services, 'Initial Enquiry Report', 12 September 2001, 11, produced by the Department of Communities in response to a Commission notice to produce.

336 Child and Family Services, Initial Enquiry Report, 12 September 2001, 2–10, produced by the Department of Communities in response to a Commission notice to produce.

337 Transcript of Claire Lovell, 4 July 2022, 2279 [3–12].

338 Transcript of Claire Lovell, 4 July 2022, 2278 [21–38].

339 Statement of Craig Duncan, 8 June 2022, 12 [57]; Child and Family Services, 'Initial Enquiry Report', 12 September 2001, 5, produced by the Department of Communities in response to a Commission notice to produce.

340 Statement of Craig Duncan, 8 June 2022, 13 [61].

341 Transcript of Darren Hine, 6 July 2022, 2467 [6–17].

342 Statement of Michael Salter, 7 April 2022, 9 [31–32].

343 Transcript of Claire Lovell, 4 July 2022, 2281 [7–17].

344 Transcript of Claire Lovell, 4 July 2022, 2281 [30–42].

345 Statement of Michael Pervan, 4 July 2022, 23 [125].

346 Statement of Michael Pervan, 4 July 2022, 23 [125], 24 [131].

347 Statement of Michael Pervan, 4 July 2022, 23 [129].

348 Transcript of Claire Lovell, 4 July 2022, 2278 [3–4].

349 Transcript of Peter Renshaw, 8 September 2022, 3763 [5–11].

350 Transcript of Peter Renshaw, 8 September 2022, 3764 [6–31].

351 Transcript of Peter Renshaw, 9 September 2022, 3844 [6–19].

352 Statement of Craig Duncan, 8 June 2022, 11 [49].

353 Statement of Craig Duncan, 8 June 2022, 11 [50].

354 Statement of Darren Hine, 14 June 2022, Annexure DH-38 (Subject Report by Detective Sergeant, 12 October 2001); Statement of Craig Duncan, 8 June 2022, 13 [62]; Statement of Craig Duncan, 8 June 2022, Annexure CD-005 (Letter from [confidential] to Craig and Anne Duncan regarding 'Zoe Duncan – Criminal injuries compensation application', 25 February 2003).

355 Transcript of Darren Hine, 6 July 2022, 2465 [13–15], [21–22].

356 Statement of Darren Hine, 14 June 2022, Annexure DH-38 (Subject Report by Detective Sergeant, 12 October 2001).

357 Statement of Darren Hine, 14 June 2022, Annexure DH-38 (Subject Report by Detective Sergeant, 12 October 2001); Statement of Craig Duncan, 8 June 2022, 11 [52]; Statement of Craig Duncan, 8 June 2022, Annexure CD-005 (Letter from [confidential] to Craig and Anne Duncan regarding 'Zoe Duncan – Criminal injuries compensation application', 25 February 2003).

358 Statement of Darren Hine, 14 June 2022, Annexure DH-38 (Subject Report by Detective Sergeant, 12 October 2001); Statement of Craig Duncan, 8 June 2022, 11 [51]; Statement of Craig Duncan, 8 June 2022, Annexure CD-005 (Letter from [confidential] to Craig and Anne Duncan regarding 'Zoe Duncan – Criminal injuries compensation application', 25 February 2003).

359 Statement of Darren Hine, 14 June 2022, Annexure DH-38 (Subject Report by Detective Sergeant, 12 October 2001).

360 Statement of Darren Hine, 14 June 2022, Annexure DH-38 (Subject Report by Detective Sergeant, 12 October 2001).

361 Statement of Darren Hine, 14 June 2022, Annexure DH-38 (Subject Report by Detective Sergeant, 12 October 2001).

362 Statement of Darren Hine, 14 June 2022, Annexure DH-38 (Subject Report by Detective Sergeant, 12 October 2001).

363 Statement of Darren Hine, 14 June 2022, Annexure DH-38 (Subject Report by Detective Sergeant, 12 October 2001); Statement of Craig Duncan, 8 June 2022, Annexure CD-005 (Letter from [confidential] to Craig and Anne Duncan regarding 'Zoe Duncan – Criminal injuries compensation application', 25 February 2003).

364 Transcript of Darren Hine, 6 July 2022, 2468 [8–32].

365 Transcript of Darren Hine, 6 July 2022, 2467 [34–47]; Statement of Darren Hine, 14 June 2022, 100 [458].

366 Transcript of Darren Hine, 6 July 2022, 2466 [15–44].

367 Transcript of Darren Hine, 6 July 2022, 2467 [19–32].

368 Statement of Darren Hine, 14 June 2022, Annexure DLH-38 (Subject Report by Detective Sergeant, 12 October 2001).

369 Transcript of Darren Hine, 6 July 2022, 2468 [34]–2469 [7].

370 Statement of Craig Duncan, 8 June 2022, 23 [119].

371 Statement of Craig Duncan, 8 June 2022, 13 [66].

372 Statement of Craig Duncan, 8 June 2022, 23 [120]; Statement of Craig Duncan, 8 June 2022, Annexure CD-006 (Document titled 'Issues relating to Sexual Assault – Zoe Duncan', undated); Statement of Craig Duncan, 8 June 2022, Annexure CD-008 (Notes of meeting held Henty House, 14 November 2001); Statement of Craig Duncan, 8 June 2022, Annexure CD-023 (Email chain between Craig and Anne Duncan and Child Youth and Family Support, subject 'Copy of Report re Zoe Duncan and the LGH Case; Protocols (Past and Present) Regarding Mandatory Reporting by Health Workers; Protocol under which Case Worker Operated', 15 November 2015).

373 Statement of Craig Duncan, 8 June 2022, 23 [120]; Statement of Craig Duncan, 8 June 2022, Annexure CD-023 (Email chain between Craig and Anne Duncan and Child Youth and Family Support, subject 'Copy of Report re Zoe Duncan and the LGH Case; Protocols (Past and Present) Regarding Mandatory Reporting by Health Workers; Protocol under which Case Worker Operated', 15 November 2015).

374 Statement of Craig Duncan, 8 June 2022, 24 [122]; Statement of Craig Duncan, 8 June 2022, Annexure CD-024 (Letter from Anne and Craig Duncan to Commissioner for Children, 11 December 2001).

375 Statement of Craig Duncan, 8 June 2022, 24 [124].

376 Statement of Craig Duncan, 8 June 2022, 24 [124]; Case file, Zoe Duncan, 23 December 2005, produced by the Commissioner for Children and Young People in response to a Commission notice to produce.

377 Statement of Craig Duncan, 8 June 2022, 24 [125].

378 Statement of Craig Duncan, 8 June 2022, 24 [126]; Statement of Craig Duncan, 8 June 2022, Annexure CD-026 (Pages of Child and Family Services 'Initial Enquiry Report' provided to Anne and Craig Duncan, 12 September 2001); Statement of Craig Duncan, 8 June 2022, Annexure CD-027 (Department of Health and Human Services – Launceston General Hospital Policy – Protocol for Public Hospital Staff: Reporting and Management of Cases of Suspected Child Abuse or Neglect, implemented April 2002).

379 Statement of Peter Renshaw, 20 June 2022, 46 [67.1].

380 Statement of Craig Duncan, 8 June 2022, 15 [75].

381 Statement of Craig Duncan, 8 June 2022, 15 [75]; Statement of Craig Duncan, 8 June 2022, Annexure CD-009 (Letter from [confidential], Co-ordinator / Counsellor, Laurel House to Elizabeth Stackhouse, Chief Executive Officer Launceston General Hospital, 2 May 2002).

382 Statement of Craig Duncan, 8 June 2022, 15 [76]; Statement of Craig Duncan, 8 June 2022, Annexure CD-011 (Draft Department of Health and Human Services – Launceston General Hospital Policy – Examination of Patients by Medical, Nursing and Allied Health Staff (Chaperone Policy), undated); Statement of Craig Duncan, 8 June 2022, Annexure CD-010 (Letter from Elizabeth Stackhouse, Chief Executive Officer Launceston General Hospital to [confidential], Co-ordinator / Counsellor, Laurel House, 8 May 2002).

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384 Statement of Craig Duncan, 8 June 2022, 16 [79].

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Case study 3: James Griffin

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665 Statement of Sonja Leonard, 21 June 2022, Annexure SL-21 (Email from Luigino Fratangelo to Sonja Leonard and draft letter) 2.

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673 Letter from Tasmania Police Detective Inspector to Acting Commander Northern District, 'Griffin, James (Jim) Geoffrey (18/08/1950) – Investigative Review', 26 October 2020, produced by Tasmania Police in response to a Commission notice to produce.

674 Transcript of Claire Lovell, 4 July 2022, 2287 [46]–2288 [3].

675 Letter from Tasmania Police Detective Inspector to Acting Commander Northern District, 'Griffin, James (Jim) Geoffrey (18/08/1950) – Investigative Review', 26 October 2020, produced by Tasmania Police in response to a Commission notice to produce.

676 Transcript of Tiffany Skeggs, 30 June 2022, 2032 [33–39].

677 Transcript of Tiffany Skeggs, 30 June 2022, 2032 [1–4].

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684 Transcript of Claire Lovell, 4 July 2022, 2289 [40–42].

685 Letter from Tasmania Police Detective Inspector to Deputy Commissioner J Higgins, 'Griffin, James (Jim) Geoffrey – Investigative Review', 18 November 2020, produced by Tasmania Police in response to a Commission notice to produce.

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688 Tasmania Police, *Revised Interim Report into the Review of Police Investigations Relating to James Griffin* (Report, 23 December 2020), produced by Tasmania Police in response to a Commission notice to produce.

689 Tasmania Police, *Revised Interim Report into the Review of Police Investigations Relating to James Griffin* (Report, 23 December 2020), produced by Tasmania Police in response to a Commission notice to produce.

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691 Transcript of Claire Lovell, 4 July 2022, 2287 [46]–2288 [3].

692 Child Protection Services, Notification Report [redacted], produced by the Tasmanian Government in response to a Commission notice to produce.

693 Transcript of Claire Lovell, 4 July 2022, 2290 [8–30].

694 Transcript of Claire Lovell, 4 July 2022, 2291 [17–19].

695 Transcript of Claire Lovell, 4 July 2022, 2291 [19–21].

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699 Statement of Tiffany Skeggs, 23 June 2022, 24 [95].

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701 Statement of a Ward 4K staff member, 21 June 2022, [55].

702 Statement of a Ward 4K staff member, 21 June 2022, [55].

703 Transcript of Sonja Leonard, 29 June 2022, 2009 [40]–2010 [4].

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707 Letter from Tasmania Police Detective Inspector to Deputy Commissioner J Higgins, 'Griffin, James (Jim) Geoffrey – Investigative Review', 18 November 2020, produced by Tasmania Police in response to a Commission notice to produce.

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715 Letter from Tasmania Police Detective Inspector to Acting Commander Northern District, 'Griffin, James (Jim) Geoffrey (18/08/1950) – Investigative Review', 26 October 2020, produced by Tasmania Police in response to a Commission notice to produce.

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731 Letter from Tasmania Police Commander to Michael Easton, 'Outcome of Investigation into Alleged Misconduct by a Designated Public Officer', 1 July 2021.

732 Letter from Tasmania Police Detective Inspector to Deputy Commissioner J Higgins, 'Griffin, James (Jim) Geoffrey – Investigative Review', 18 November 2020, produced by Tasmania Police in response to a Commission notice to produce.

733 Letter from Tasmania Police Detective Inspector to Deputy Commissioner J Higgins, 'Griffin, James (Jim) Geoffrey – Investigative Review', 18 November 2020, produced by Tasmania Police in response to a Commission notice to produce.

734 Transcript of Darren Hine, 6 July 2022, 2453 [35–47].

735 Transcript of Darren Hine, 6 July 2022, 2453 [35–47].

736 Statement of Sonja Leonard, 21 June 2022, Annexure SL-15 (Handwritten note) 1.

737 Statement of Sonja Leonard, 21 June 2022, Annexure SL-15 (Handwritten note) 1.

738 Statement of Sonja Leonard, 21 June 2022, Annexure SL-15 (Handwritten note) 1.

739 Statement of Sonja Leonard, 21 June 2022, Annexure SL-15 (Handwritten calendar note for 4 November 2015) 1.

740 Statement of Sonja Leonard, 21 June 2022, [137].

741 Statement of Sonja Leonard, 21 June 2022, [138].

742 Statement of Sonja Leonard, 21 June 2022, Annexure SL-15 (Handwritten calendar note for 4 November 2015) 1.

743 Statement of Sonja Leonard, 21 June 2022, [137].

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746 Statement of Sonja Leonard, 21 June 2022, [140].

747 Statement of Sonja Leonard, 21 June 2022, [140].

748 Statement of Sonja Leonard, 21 June 2022, [141].

749 Statement of Sonja Leonard, 21 June 2022, [143].

750 Statement of Sonja Leonard, 21 June 2022, [144].

751 Statement of Janette Tonks, 10 June 2022, 11–12 [32].

752 Statement of James Bellinger, 10 June 2022, 42 [47].

753 Statement of James Bellinger, 1 June 2022, 42 [47].

754 Statement of James Bellinger, 10 June 2022, 42 [47].

755 Statement of Michael Sherring, 10 June 2022, 26 [75].

756 Statement of Michael Sherring, 10 June 2022, 26 [75].

757 Statement of Michael Sherring, 10 June 2022, 26 [75]; Statement of Michael Sherring, 10 June 2022, Annexure 22 (Letter from Sonja Leonard to James Griffin, 6 March 2017).

758 Statement of Sonja Leonard, 21 June 2022, Annexure SL-16 (Letter from Sonja Leonard to James Griffin) 1.

759 Statement of Michael Sherring, 10 June 2022, Annexure 22 (Letter from Sonja Leonard to James Griffin, 6 March 2017).

760 Statement of Sonja Leonard, 21 June 2022, Annexure SL-16 (Letter from Sonja Leonard to James Griffin) 2.

761 Transcript of Sonja Leonard, 29 June 2022, 2005 [47]–2006 [2].

762 Statement of Sonja Leonard, 21 June 2022, Annexure SL-16 (Letter from Sonja Leonard to James Griffin) 2.

763 Transcript of Sonja Leonard, 29 June 2022, 2006 [16–23].

764 Transcript of Sonja Leonard, 29 June 2022, 2006 [36–37].

765 Statement of Sonja Leonard, 21 June 2022, Annexure SL-17 (Email to Michael Sherring) 1.

766 Statement of Michael Sherring, 10 June 2022, 26.

767 Statement of Michael Sherring, 10 June 2022, 26.

768 Statement of Sonja Leonard, 21 June 2022, Annexure SL-17 (Email to Michael Sherring) 1.

769 Statement of Sonja Leonard, 21 June 2022, Annexure SL-18 (Email from Michael Sherring to Sonja Leonard) 1.

770 Statement of Sonja Leonard, 21 June 2022, Annexure SL-18 (Email from Michael Sherring to Sonja Leonard) 1.

771 Statement of Sonja Leonard, 21 June 2022, Annexure SL-18 (Email from Michael Sherring to Sonja Leonard) 1.

772 Statement of Michael Sherring, 10 June 2022, 32 [94(g)]; Michael Sherring, Procedural Fairness Response, 15 May 2023, 7.

773 Statement of Will Gordon, 30 March 2022, 3 [9].

774 Statement of Will Gordon, 30 March 2022, 3 [9].

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777 Statement of Will Gordon, 30 March 2022, 3 [9].

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779 Statement of Will Gordon, 30 March 2022, 3 [10].

780 Statement of Will Gordon, 30 March 2022, 3 [11].

781 Transcript of Will Gordon, 27 June 2022, 1750 [36–32].

782 Transcript of Sonja Leonard, 28 June 2022, 2006 [43]–2007 [2].

783 Statement of Will Gordon, 30 March 2022, 3 [14].

784 Transcript of Mathew Harvey, 28 June 2022, 1834 [40–42].

785 Transcript of Sonja Leonard, 29 June 2022, 2007 [4–15].

786 Statement of Sonja Leonard, 21 June 2022, Annexure SL-30 (Email from Sonja Leonard to Mathew Harvey, 28 August 2017) 1.

787 Statement of Mathew Harvey, 17 August 2022, 20 [97].

788 Statement of Sonja Leonard, 21 June 2022, [192].

789 Transcript of Mathew Harvey, 28 June 2022, 1833 [7–8].

790 Statement of Sonja Leonard, 21 June 2022, 25 [192].

791 Statement of Sonja Leonard, 21 June 2022, 25 [195]; Statement of Mathew Harvey, 28 June 2022, attaching the 'Safety Event Management Form (Safety Event ID 52489)', produced by the Tasmanian Government in response to a Commission notice to produce.

792 Statement of Sonja Leonard, 21 June 2022, 25 [195].

793 Statement of Mathew Harvey, 17 August 2022, [25].

794 Statement of Mathew Harvey, 17 August 2022, [25].

795 Statement of Sonja Leonard, 21 June 2022, [193]; Statement of Sonja Leonard, 21 June 2022, Annexure SL-32 (Email from Sonja Leonard to James Griffin and attached letter).

796 Statement of Sonja Leonard, 21 June 2022, Annexure SL-32 (Email from Sonja Leonard to James Griffin and attached letter) 1.

797 Transcript of Mathew Harvey, 28 June 2022, 1826 [35–39].

798 Transcript of Mathew Harvey, 28 June 2022, 1827 [10–12].

799 Statement of Sonja Leonard, 21 June 2022, Annexure SL-32 (Email from Sonja Leonard to James Griffin and attached letter) 1.

800 Statement of Sonja Leonard, 21 June 2022, Annexure SL-32 (Email from Sonja Leonard to James Griffin and attached letter) 1.

801 Transcript of Will Gordon, 27 June 2022, 1754 [45]–1755 [7].

802 Statement of Sonja Leonard, 21 June 2022, [194].

803 Statement of Sonja Leonard, 21 June 2022, Annexure SL-33 (Email from Sonja Leonard to Mathew Harvey with attached letter from James Griffin, 11 September 2017) 1.

804 Statement of Sonja Leonard, 21 June 2022, Annexure SL-33 (Email from Sonja Leonard to Mathew Harvey with attached letter from James Griffin, 11 September 2017) 1.

805 Statement of Sonja Leonard, 21 June 2022, [200].

806 Statement of Mathew Harvey, 17 June 2022, 9 [35].

807 Statement of Mathew Harvey, 17 June 2022, 9 [35].

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810 Statement of James Bellinger, 10 June 2022, 21 [23].

811 Statement of Mathew Harvey, 17 June 2022, [30].

812 Statement of Sonja Leonard, 21 June 2022, 26 [201].

813 Statement of Mathew Harvey, 24 March 2023, 2 [8–11].

814 Statement of Sonja Leonard, 21 June 2022, Annexure SL-34 (Email from Sonja Leonard to James Griffin attaching letter, 11 September 2017) 2.

815 Statement of Sonja Leonard, 21 June 2022, Annexure SL-34 (Email from Sonja Leonard to James Griffin attaching letter, 11 September 2017) 2.

816 Transcript of Sonja Leonard, 29 June 2022, 2004 [45–47].

817 Statement of Sonja Leonard, 21 June 2022, [180].

818 Transcript of Sonja Leonard, 29 June 2022, 2004 [36–37].

819 Statement of Sonja Leonard, 21 June 2022, Annexure SL-25 (Handwritten notes regarding James Griffin) 1.

820 Transcript of Mathew Harvey, 28 June 2022, 1844 [11–13].

821 Statement of Mathew Harvey, 17 June 2022, [30].

822 Transcript of Mathew Harvey, 28 June 2022, 1828 [40]–1829 [32]; Statement of Mathew Harvey, 24 March 2023, 2 [13]–4 [19].

823 Transcript of Mathew Harvey, 28 June 2022, 1834 [10–18].

824 Transcript of Mathew Harvey, 28 June 2022, 1839 [11–14].

825 Transcript of Sonja Leonard, 29 June 2022, 2007 [26]–2008 [7].

826 Transcript of Janette Tonks, 30 June 2022, 2057 [37–39].

827 Transcript of Janette Tonks, 30 June 2022, 2048 [38–47].

828 Transcript of Janette Tonks, 30 June 2022, 2057 [43–46].

829 Transcript of Janette Tonks, 30 June 2022, 2057 [43]–2058 [5].

830 Transcript of Janette Tonks, 30 June 2022, 2058 [7–13].

831 Transcript of Janette Tonks, 30 June 2022, 2058 [17–21].

832 Transcript of Janette Tonks, 30 June 2022, 2053 [22–26].

833 Transcript of Mathew Harvey, 28 June 2022, 1844 [22–24].

834 Transcript of Mathew Harvey, 28 June 2022, 1844 [26]–1845 [27].

835 Transcript of Mathew Harvey, 28 June 2022, 1830 [9–27].

836 Transcript of Mathew Harvey, 28 June 2022, 1831 [36]–1832 [6].

837 Transcript of Mathew Harvey, 28 June 2022, 1839 [41]–1940 [6].

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841 Transcript of James Bellinger, 28 June 2022, 1873 [7–24].

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843 Transcript of James Bellinger, 28 June 2022, 1867 [1–26].

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845 Statement of Will Gordon, 27 June 2022, 4 [16].

846 Statement of Will Gordon, 27 June 2022, 6 [25].

847 Statement of Will Gordon, 27 June 2022, 19 [85].

848 Statement of Will Gordon, 30 March 2022, 10 [45].

849 Statement of Kathrine Morgan-Wicks, 22 August 2022, 25 [157–158].

850 Statement of Jacqueline Allen, 15 August 2022, 27 [150].

851 Statement of Jacqueline Allen, 15 August 2022, 27 [150].

852 Statement of Barry Nicholson, 18 August 2022, 11 [88].

853 Transcript of James Bellinger, 28 June 2022, 1871 [40–44].

854 Statement of Kathrine Morgan-Wicks, 22 August 2022, 25 [160].

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856 Transcript of Michael Sherring, 29 June 2022, 1972 [28–34], 1973 [8–11].

857 Transcript of James Bellinger, 28 June 2022, 1872 [4–6].

858 Transcript of Sonja Leonard, 29 June 2022, 2008 [9–25].

859 Transcript of Sonja Leonard, 29 June 2022, 2009 [3–6].

860 Transcript of Sonja Leonard, 29 June 2022, 2008 [21–25].

861 Statement of Barry Nicholson, 18 August 2022, 11 [88].

862 Statement of Annette Whitemore, 20 June 2022, 4 [19].

863 Statement of Will Gordon, 27 June 2022, 4 [19].

864 Tasmania Health Organisation North, Performance Development Agreement signed by James Griffin and Sonja Leonard, 25 May 2018.

865 Tasmania Health Organisation North, Performance Development Agreement signed by James Griffin and Sonja Leonard, 25 May 2018.

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867 Statement of Sonja Leonard, 21 June 2022, Annexure SL-22 (Email from Matthew Harvey to James Bellinger and former Director of Employee Relations forwarding further emails, 7 August 2019) 1.

868 Statement of Sonja Leonard, 21 June 2022, Annexure SL-22 (Email from Matthew Harvey to James Bellinger and former Director of Employee Relations forwarding further emails, 7 August 2019) 1.

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870 Statement of Sonja Leonard, 21 June 2022, Annexure SL-22 (Email from Matthew Harvey to James Bellinger and former Director of Employee Relations forwarding further emails, 7 August 2019) 1.

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872 Statement of Sonja Leonard, 21 June 2022, [151].

873 Statement of Sonja Leonard, 21 June 2022, [151].

874 Statement of Sonja Leonard, 21 June 2022, [152].

875 Statement of Sonja Leonard, 21 June 2022, Annexure SL-22 (Email from Matthew Harvey to James Bellinger and former Director of Employee Relations forwarding further emails, 7 August 2019) 1.

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877 Statement of Sonja Leonard, 21 June 2022, [154].

878 Email from a nurse to Peter Renshaw, 5 December 2019, produced by Peter Renshaw in response to a Commission notice to produce.

879 Email from Peter Renshaw to Glenn Hindle, 13 August 2019, produced by the Tasmanian Government in response to a Commission notice to produce.

880 For example, Statement of Maria Unwin, 22 June 2022, 6 [23]; Statement of 'Angela', 3 May 2022, 4 [25]; Witness Statement of Kylee Pearn, 8 November 2021, 5 [17]; Transcript of Kylee Pearn, 28 June 2022, 1793 [36–43], 1794 [7–19].

881 Transcript of Kathrine Morgan-Wicks, 5 July 2022, 2376 [6–11].

882 Transcript of Emily Shepherd, 29 June 2022, 1940 [24–28].

883 Statement of Emily Shepherd, 23 June 2022, 11 [56–57].

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885 Statement of Maria Unwin, 22 June 2022, 5 [21].

886 Transcript of Will Gordon, 27 June 2022, 1746 [22–32].

887 Anonymous Statement, 20 June 2022, 7 [37].

888 Statement of Will Gordon, 30 March 2022, 2 [8].

889 Statement of Will Gordon, 30 March 2022, 15 [73].

890 Transcript of Sonja Leonard, 29 June 2022, 1985 [15–18].

891 Transcript of Sonja Leonard, 29 June 2022, 1988 [16–18].

892 Transcript of Sonja Leonard, 29 June 2022, 1984 [20–33].

893 Statement of Sonja Leonard, 21 June 2022, [180].

894 Statement of Maria Unwin, 22 June 2022, 4 [15].

895 Statement of James Bellinger, 10 June 2022, Appendix 8 (Tasmanian Health Service Protocol – Complaint or Concern about Health Professional Conduct) 4.

896 Transcript of Annette Whitemore, 29 June 2022, 1905 [24–36].

897 Transcript of Will Gordon, 27 June 2022, 1762 [20–23].

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899 Statement of a Ward 4K staff member, 21 June 2022, 5 [25].

900 Transcript of Helen Bryan, 30 June 2022, 2087 [32]–2088 [4].

901 Transcript of Helen Bryan, 30 June 2022, 2082 [1–9], 2086 [36–41], 2087 [19–22].

902 Statement of Maria Unwin, 22 June 2022, 3 [9].

903 Statement of Maria Unwin, 22 June 2022, 3 [9].

904 Statement of Maria Unwin, 22 June 2022, 4 [13].

905 Statement of Maria Unwin, 22 June 2022, 3 [9].

906 Statement of a Ward 4K staff member, 21 June 2022, [46].

907 Statement of a Ward 4K staff member, 21 June 2022, [67].

908 Statement of a Ward 4K staff member, 21 June 2022, [45].

909 Statement of a Ward 4K staff member, 21 June 2022, [47].

910 Statement of a Ward 4K staff member, 21 June 2022, [66].

911 Statement of a Ward 4K staff member, 21 June 2022, [49].

912 Statement of a Ward 4K staff member, 21 June 2022, [49].

913 Statement of Will Gordon, 27 June 2022, 2 [5].

914 Statement of Will Gordon, 27 June 2022, 5 [22].

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916 Statement of Will Gordon, 27 June 2022, 6 [24].

917 Anonymous Statement, 20 June 2022, 2 [10].

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919 Anonymous Statement, 20 June 2022, 3 [12].
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921 Anonymous Statement, 21 June 2022, 2 [7].
922 Anonymous Statement, 21 June 2022, 2 [8].
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925 Anonymous Statement, 21 June 2022, 4 [20].
926 Anonymous Statement, 21 June 2022, 5 [21–22].
927 Anonymous Statement, 21 June 2022, 3 [15].
928 Anonymous Statement, 21 June 2022, 3 [13].
929 Anonymous Statement, 21 June 2022, 3 [16].
930 Anonymous Statement, 21 June 2022, 7 [31].
931 Anonymous Statement, 2 March 2022, 4 [16].
932 Anonymous Statement, 2 March 2022, 4 [17].
933 Anonymous Statement, 2 March 2022, 5 [19–20].
934 Anonymous session, 6 October 2021.
935 Anonymous session, 6 October 2021.
936 Statement of a Nurse Unit Manager, 22 June 2022, 4 [35, 38].
937 Statement of a Nurse Unit Manager, 22 June 2022, 4 [40].
938 Statement of a Nurse Unit Manager, 22 June 2022, 4 [41].
939 Statement of a Nurse Unit Manager, 22 June 2022, 4 [42].
940 Statement of Sonja Leonard, 21 June 2022, [156].
941 Statement of Sonja Leonard, 21 June 2022, [157].
942 Statement of Sonja Leonard, 21 June 2022, [171].
943 Statement of Angelique Knight, 2 June 2022, 2 [8].
944 Statement of Angelique Knight, 2 June 2022, 2 [11].
945 Statement of Angelique Knight, 2 June 2022, 2 [11].
946 Statement of Angelique Knight, 2 June 2022, 3 [11].
947 Statement of Angelique Knight, 2 June 2022, 4 [18].
948 Submission 38 Angelique Knight, 5.
949 Submission 38 Angelique Knight, 3.
950 Submission 38 Angelique Knight, 3.
951 Submission 38 Angelique Knight, 3.
952 Submission 38 Angelique Knight, 3.
953 Submission 38 Angelique Knight, 4.
954 Submission 38 Angelique Knight, 4.
955 Submission 38 Angelique Knight, 4.
956 Submission 38 Angelique Knight, 4.
957 Statement of Angelique Knight, 2 June 2022, Annexure AK-001 (Statutory Declaration, Angelique Knight, 25 May 2021).
958 Statement of Kirsty Neilley, 29 March 2022, 2 [5].
959 Statement of Kirsty Neilley, 29 March 2022, 2 [7].
960 Statement of Kirsty Neilley, 29 March 2022, 2 [7].
961 Statement of Kirsty Neilley, 29 March 2022, 2 [9].
962 Statement of Kirsty Neilley, 29 March 2022, 2 [8].

963 Statement of Kirsty Neilley, 29 March 2022, 2 [8].
964 Statement of Kirsty Neilley, 29 March 2022, 2 [8].
965 Statement of Kirsty Neilley, 29 March 2022, 2 [10].
966 Statement of Kirsty Neilley, 29 March 2022, 2 [10].
967 Statement of Kirsty Neilley, 29 March 2022, 3 [11].
968 Statement of Kirsty Neilley, 29 March 2022, 3 [13].
969 Statement of Kirsty Neilley, 29 March 2022, 3 [13].
970 Statement of Kirsty Neilley, 29 March 2022, 3 [13].
971 Statement of Kirsty Neilley, 29 March 2022, 3 [14].
972 Statement of Kirsty Neilley, 29 March 2022, 3 [14].
973 Statement of Kirsty Neilley, 29 March 2022, 4 [15].
974 Statement of Kirsty Neilley, 29 March 2022, 5 [21].
975 Statement of Kirsty Neilley, 29 March 2022, 5 [21].
976 Statement of Kirsty Neilley, 29 March 2022, 5 [23].
977 Statement of Kirsty Neilley, 29 March 2022, 6 [25].
978 Statement of Kirsty Neilley, 29 March 2022, 6 [25].
979 Statement of Kirsty Neilley, 29 March 2022, 6 [25].
980 Statement of Kirsty Neilley, 29 March 2022, 6 [27].
981 Statement of Kirsty Neilley, 29 March 2022, 6 [27].
982 The names 'Angela' and 'Lilian' are pseudonyms; Order of the Commission of Inquiry, restricted publication order, 30 August 2023.
983 Statement of 'Angela', 3 May 2022, 3 [16].
984 Statement of 'Angela', 3 May 2022, 3 [16].
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986 Statement of 'Angela', 3 May 2022, 3 [20].
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991 Submission 118 Anonymous, 1 [3].
992 Submission 118 Anonymous, 1 [4].
993 Submission 118 Anonymous, 2 [5].
994 Submission 118 Anonymous, 2 [7].
995 Submission 118 Anonymous, 2 [9].
996 Submission 118 Anonymous, 2 [10].
997 Submission 135 Anonymous, 1.
998 Submission 135 Anonymous, 1.
999 Information received anonymously, 21 July 2022.
1000 Information received anonymously, 21 July 2022.
1001 Submission 113 Anonymous, 2 [11].
1002 Submission 113 Anonymous, 2 [13].
1003 Submission 113 Anonymous, 2 [13].
1004 Submission 113 Anonymous, 2 [14].
1005 Submission 113 Anonymous, 2 [15].
1006 Submission 113 Anonymous, 2 [16].

1007 Submission 113 Anonymous, 1 [4]–2[9].
1008 Submission 134 Anonymous, 2 [2.2.1].
1009 Submission 134 Anonymous, 2 [2.2.2].
1010 Submission 134 Anonymous, 2 [2.2.3].
1011 Submission 134 Anonymous, 2 [2.2.4].
1012 Submission 134 Anonymous, 2 [2.2.2].
1013 Submission 134 Anonymous, 3 [2.2.5.1].
1014 Submission 134 Anonymous, 3 [2.2.5.2].
1015 Submission 134 Anonymous, 3 [2.2.5.2].
1016 Submission 134 Anonymous, 4 [3.2].
1017 Submission 134 Anonymous, 4 [3.2.4].
1018 Submission 134 Anonymous, 4 [3.2.4].
1019 Submission 120 Anonymous, 1 [2]–2 [6].
1020 Submission 117 Anonymous, 1 [4].
1021 Submission 117 Anonymous, 1 [4].
1022 Submission 117 Anonymous, 1 [5–6].
1023 Submission 116 Anonymous, 2 [7].
1024 Submission 115 Anonymous, 1 [2], [5].
1025 Submission 115 Anonymous, 2 [6].
1026 Submission 115 Anonymous, 2 [8].
1027 Submission 115 Anonymous, 2 [9].
1028 Submission 115 Anonymous, 2 [9].
1029 Submission 115 Anonymous, 2 [10].
1030 Submission 115 Anonymous, 2 [10].
1031 Submission 115 Anonymous, 2 [12–13].
1032 Submission 115 Anonymous, 2 [14].
1033 Submission 115 Anonymous, 3 [15].
1034 Submission 115 Anonymous, 3 [16].
1035 Submission 115 Anonymous, 3 [17].
1036 Submission 115 Anonymous, 3 [20].
1037 Submission 115 Anonymous, 4 [22–24].
1038 Submission 114 Anonymous, 2 [6].
1039 Submission 114 Anonymous, 1 [4].
1040 Submission 114 Anonymous, 1 [5].
1041 Submission 114 Anonymous, 1 [6].
1042 Submission 114 Anonymous, 2 [6].
1043 Submission 114 Anonymous, 2 [7].
1044 Submission 114 Anonymous, 2 [11–13.].
1045 Submission 33 Anonymous, 1.
1046 Anonymous Statement, 1 June 2022, 1 [4].
1047 Anonymous Statement, 1 June 2022, 2 [6].
1048 Anonymous Statement, 1 June 2022, 2 [7].
1049 Confidential Statement, 1 June 2022, 2 [7].
1050 Confidential Statement, 1 June 2022, 2 [8].
1051 Email from the Health Practitioner to the Commission in response to a Request for Statement, 20 June 2022, 1.

1052 Transcript of Sonja Leonard, 29 June 2022, 2018 [36–41].

1053 Transcript of Sonja Leonard, 29 June 2022, 2018 [45]–2019 [6].

1054 Statement of Sonja Leonard, 21 June 2022, [256].

1055 *State Service Act 2000* s 9(3).

1056 Statement of Helen Bryan, 10 June 2022, [47].

1057 Statement of Helen Bryan, 10 June 2022, [48].

1058 Statement of Eric Daniels, 15 June 2022, 17 [35]; Statement of Helen Bryan, 10 June 2022, 16.

1059 Statement of Erwin Loh, 24 June 2022, 8 [43].

1060 Transcript of Janette Tonks, 30 June 2022, 2055 [13–18].

1061 Transcript of Eric Daniels, 30 June 2022, 2109 [16–19].

1062 Eric Daniels, *Procedural Fairness Response*, 12 July 2023, 17; Statutory Declaration of Eric Daniels, 12 July 2023, [17].

1063 Transcript of Helen Bryan, 30 June 2022, 2082 [47]–2083 [4].

1064 Statement of Matthew Hardy, 27 June 2022, 31 [198].

1065 Statement of Matthew Hardy, 27 June 2022, 33 [219].

1066 Transcript of Sonja Leonard, 29 June 2022, 2006 [20–41].

1067 Transcript of Helen Bryan, 30 June 2022, 2081 [41–47], 2082 [11–15].

1068 *Criminal Code Act 1924* s 105A as amended by the *Criminal Code and Related Legislation Amendment (Child Abuse) Act 2019* s 7.

1069 *Children, Young Persons and Their Families Act 1997* s 13.

1070 *Children, Young Persons and Their Families Act 1997* s 14(2). Other prescribed persons for the purposes of mandatory reporting under s 14(2) include a medical practitioner, a registered nurse or enrolled nurse, a person registered under the Health Practitioner Regulation National Law (Tasmania) in the midwifery profession, a person registered under the Health Practitioner Regulation National Law (Tasmania) in the dental profession as a dentist, dental therapist, dental hygienist or oral health therapist, a person registered under the Health Practitioner Regulation National Law (Tasmania) in the psychology profession, or a police officer. Refer to Children, Young Persons and Their Families Act 1997 s 14(1).

1071 *Nursing Act 1995* s 55.

1072 *Health Practitioner Regulation National Law Act 2009 (Qld)* sch 1, ss 141, 141A, as adopted by the *Health Practitioner Regulation National Law (Tasmania) Act 2020* s 4.

1073 *Health Practitioner Regulation National Law Act 2009 (Qld)* s 144(c*).*

1074 *Registration to Work with Vulnerable People Act 2013* s 53A.

1075 *Registration to Work with Vulnerable People Regulations 2014* r 5A.

1076 Letter from Tasmania Police Detective Inspector to Deputy Commissioner J Higgins, 'Griffin, James (Jim) Geoffrey – Investigative Review', 18 November 2020, produced by Tasmania Police in response to a Commission notice to produce.

1077 Statement of Tiffany Skeggs, 23 June 2022, 25 [99].

1078 Statement of Tiffany Skeggs, 23 June 2022, 25 [100].

1079 Statement of Tiffany Skeggs, 23 June 2022, 25 [100].

1080 Statement of Tiffany Skeggs, 23 June 2022, 26 [105].

1081 Statement of Tiffany Skeggs, 23 June 2022, 26 [22].

1082 Statement of Sonja Leonard, 21 June 2022, [64].

1083 Statement of Sonja Leonard, 21 June 2022, [96].

1084 Statement of Sonja Leonard, 21 June 2022, [97].

1085 Statement of Sonja Leonard, 21 June 2022, [98].

1086 Transcript of Sonja Leonard, 29 June 2022, 2011 [6–8].

1087 Transcript of Sonja Leonard, 29 June 2022, 2012 [4–21].

1088 Transcript of Sonja Leonard, 29 June 2022, 2011 [23–30].

1089 Statement of Sonja Leonard, 21 June 2022, [64].

1090 Transcript of Sonja Leonard, 29 June 2022, 2011 [10–26].

1091 Transcript of Sonja Leonard, 29 June 2022, 2013 [2–12].

1092 Statement of Janette Tonks, 10 June 2022, 9 [29].

1093 Janette Tonks, *Procedural Fairness Response*, 3 April 2022, 11.

1094 Tasmania Police, 'Investigative review – James Geoffrey Griffin', undated, produced by Tasmania Police in response to a Commission notice to produce.

1095 Tasmania Police, 'Investigative review – James Geoffrey Griffin', undated, produced by Tasmania Police in response to a Commission notice to produce.

1096 Tasmania Police, 'Investigative review – James Geoffrey Griffin', undated, produced by Tasmania Police in response to a Commission notice to produce.

1097 Tasmania Police, 'Investigative review – James Geoffrey Griffin', undated, produced by Tasmania Police in response to a Commission notice to produce.

1098 Tasmania Police, 'Investigative review – James Geoffrey Griffin', undated, produced by Tasmania Police in response to a Commission notice to produce.

1099 Tasmania Police, 'Investigative review – James Geoffrey Griffin', undated, produced by Tasmania Police in response to a Commission notice to produce.

1100 Statement of Tiffany Skeggs, 23 June 2022, 1 [5].

1101 Statement of Tiffany Skeggs, 23 June 2022, 2 [6].

1102 Statement of Tiffany Skeggs, 23 June 2022, 2 [8].

1103 Statement of Tiffany Skeggs, 23 June 2022, 2 [9].

1104 Tasmania Police, 'Investigative review – James Geoffrey Griffin', undated, produced by Tasmania Police in response to a Commission notice to produce.

1105 Tasmania Police, 'Investigative review – James Geoffrey Griffin', undated, produced by Tasmania Police in response to a Commission notice to produce.

1106 Statement of Tiffany Skeggs, 23 June 2022, 43 [185].

1107 Transcript of Erwin Loh, 4 July 2022, 2250 [29]–2251 [4].

1108 Notice to produce to State of Tasmania, 4 August 2021, 4 [8(b)]; Letter from Solicitor General of Tasmania to Commission of Inquiry, 'Commission of Inquiry into the Tasmanian Government's Responses to Child Sexual Abuse in Institutional Settings', 25 March 2022, 4 [11].

1109 Transcript of Helen Bryan, 30 June 2022, 2089 [30–36].

1110 Transcript of Helen Bryan, 30 June 2022, 2089 [37–44].

1111 Transcript of Helen Bryan, 30 June 2022, 2082 [47]–2083 [4].

1112 Transcript of Helen Bryan, 30 June 2022, 2090 [41]–2091 [1].

1113 Helen Bryan, *Procedural Fairness Response*, 28 June 2023, [12].

1114 Transcript of Peter Renshaw, 9 September 2022, 3831 [12–15].

1115 Transcript of Peter Renshaw, 9 September 2022, 3831 [17–21].

1116 Transcript of Eric Daniels, 30 June 2022, 2115 [5–8].

1117 Transcript of Eric Daniels, 30 June 2022, 2116 [10].

1118 Transcript of Eric Daniels, 30 June 2022, 2116 [7–18].

1119 Eric Daniels, *Procedural Fairness Response*, 12 July 2023, 14–16; Statutory Declaration of Eric Daniels, 12 July 2023, [12–17].

1120 Statement of Helen Bryan, 10 June 2022, 19.

1121 Transcript of Helen Bryan, 30 June 2022, 2089 [17–22]; Statement of Helen Bryan, 12 June 2022, 19.

1122 Transcript of Helen Bryan, 30 June 2022, 2088 [6–45].

1123 Transcript of Helen Bryan, 30 June 2022, 2089 [4–9].

1124 Transcript of Helen Bryan, 30 June 2022, 2089 [11–15].

1125 Transcript of Peter Renshaw, 9 September 2022, 3845 [3–14].

1126 Statement of Elizabeth Stackhouse, 22 June 2022, 2, [7], 5 [33].

1127 Statement of Stephen Ayre, 24 June 2022, 3 [18].

1128 Statement of John Kirwan, 21 August 2022, 4 [20–22].

1129 Statement of Eric Daniels, 15 June 2022, 4 [6.1]; Transcript of James Bellinger, 28 June 2022, 1864 [7–13]; Transcript of Mathew Harvey, 28 June 2022, 1824 [6–12], 1824 [32–43].

1130 Statement of Elizabeth Stackhouse, 22 June 2022, 5 [30].

1131 Statement of Stephen Ayre, 24 June 2022, 3 [17].

1132 Statement of John Kirwan, 21 August 2022, 4 [15].

1133 Statement of Eric Daniels, 15 June 2022, 4 [6.2].

1134 Transcript of Eric Daniels, 30 June 2022, 2108 [47], 2109 [1–14].

1135 Transcript of Eric Daniels, 30 June 2022, 2110 [9–24].

1136 Transcript of Eric Daniels, 30 June 2022, 2110 [26–28].

1137 Transcript of Eric Daniels, 30 June 2022, 2111 [4–24].

1138 The name 'Penny' is a pseudonym; Order of the Commission of Inquiry, restricted publication order, 4 July 2022; Statement of Glenn Hindle, 9 November 2022, 2 [4].

1139 Statement of Glenn Hindle, 9 November 2022, 5 [16].

1140 Statement of Glenn Hindle, 9 November 2022, 5 [16].

1141 Statement of Glenn Hindle, 9 November 2022, 3 [10].

1142 Statement of Glenn Hindle, 9 November 2022, 3 [10].

1143 Statement of Glenn Hindle, 9 November 2022, 4 [12]; Statement of Glenn Hindle, 9 November 2022, Annexure 1 (Occurrence enquiry log report, 2 August 2019).

1144 Statement of Glenn Hindle, 9 November 2022, 4 [12].

1145 Statement of Glenn Hindle, 9 November 2022, 4 [12].

1146 Statement of Glenn Hindle, 9 November 2022, 4 [14].

1147 Statement of Glenn Hindle, 9 November 2022, 2 [4].

1148 Statement of Glenn Hindle, 9 November 2022, 2 [6].

1149 Statement of Peter Renshaw, 20 June 2022, [41.1].

1150 Statement of Peter Renshaw, 20 June 2022, 19 [16.1].

1151 Transcript of Helen Bryan, 30 June 2022, 2083 [6–11], [39–41].

1152 Transcript of Helen Bryan, 30 June 2022, 2083 [41–43]; Transcript of Janette Tonks, 30 June 2022, 2063 [30–35].

1153 Transcript of Janette Tonks, 30 June 2022, 2065 [34–37].

1154 Transcript of Janette Tonks, 30 June 2022, 2066 [39–44].

1155 Transcript of Helen Bryan, 30 June 2022, 2084 [3–14].

1156 Transcript of Janette Tonks, 30 June 2022, 2066 [12]; Transcript of Helen Bryan, 30 June 2022, 2084 [20].

1157 Transcript of Helen Bryan, 30 June 2022, 2084 [21–23].

1158 Transcript of Janette Tonks, 30 June 2022, 2064 [8–10].

1159 Transcript of Janette Tonks, 30 June 2022, 2064 [13–14].

1160 Transcript of Janette Tonks, 30 June 2022, 2064 [13–23].

1161 Statement of Peter Renshaw, 20 June 2022, [35.1].

1162 Transcript of Janette Tonks, 30 June 2022, 2064 [26].

1163 Transcript of Janette Tonks, 30 June 2022, 2064 [39–41].

1164 Transcript of Glenn Hindle, 6 July 2022, 2442 [22–28].

1165 Transcript of Janette Tonks, 30 June 2022, 2065 [6–14].

1166 Statement of Sonja Leonard, 21 June 2022, [238–239].

1167 Statement of Peter Renshaw, 20 June 2022, [42(e)].

1168 Statement of Peter Renshaw, 20 June 2022, [16], [63].

1169 Statement of Peter Renshaw, 20 June 2022, [42(c)], [52.3.9].

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1171 Transcript of Peter Renshaw, 9 September 2022, 3827 [42]–3828 [1].

1172 Statement of Peter Renshaw, 20 June 2022, [16], [42(a)].

1173 Statement of Peter Renshaw, 20 June 2022, [41.1], [42.6(f)].

1174 Email from Mathew Harvey to former Director of Employee Relations, James Bellinger and another, 'Re: Registration to Work with Vulnerable People Act 2013 – Immediate Suspension Notification to Named Employer – Griffin', 31 July 2019 3:18pm, produced by the Tasmanian Government in response to a Commission notice to produce.

1175 Email from Mathew Harvey to former Director of Employee Relations, James Bellinger and another, 'Re: Registration to Work with Vulnerable People Act 2013 – Immediate Suspension Notification to Named Employer – Griffin', 31 July 2019 3:18pm, produced by the Tasmanian Government in response to a Commission notice to produce.

1176 Tasmania Police, 'Investigative review – James Geoffrey Griffin', undated, produced by Tasmania Police in response to a Commission notice to produce.

1177 Email from Mathew Harvey to former Director of Employee Relations, James Bellinger and another, 'Re: Registration to Work with Vulnerable People Act 2013 – Immediate Suspension Notification to Named Employer – Griffin', 31 July 2019 3:18pm, produced by the Tasmanian Government in response to a Commission notice to produce.

1178 Transcript of Peter Renshaw, 8 September 2022, 3777 [21–25], [44–47].

1179 Transcript of Detective Hindle, 6 July 2022, 2441, [29–34].

1180 Transcript of Detective Hindle, 6 July 2022, 2439, [23–47].

1181 Transcript of Detective Hindle, 6 July 2022, 2441 [39–47].

1182 Statement of Sarah Kay, 1 February 2023, 1 [4].

1183 Statement of Sarah Kay, 1 February 2023, 1–2 [4].

1184 Statement of Sarah Kay, 1 February 2023, 2 [4].

1185 Mathew Harvey, *Procedural Fairness Response*, 24 March 2023, 6 [26].

1186 Statement of Glenn Hindle, 9 November 2022, 2 [4].

1187 Statement of Glenn Hindle, 9 November 2022, 2 [6].

1188 Statement of Glenn Hindle, 9 November 2022, 2 [6].

1189 Transcript of Peter Renshaw, 8 September 2022, 3778 [35–47].

1190 Transcript of Peter Renshaw, 8 September 2022, 3779 [34–36].

1191 Statement of Peter Renshaw, 20 June 2022, [42.1].

1192 Dot points for the Secretary, 'Notification of Action Taken under Work with Vulnerable People Act 2013', 31 July 2019, produced by Peter Renshaw in response to a Commission notice to produce.

1193 Dot points for the Secretary, 'Notification of Action Taken under Work with Vulnerable People Act 2013', 31 July 2019, produced by Peter Renshaw in response to a Commission notice to produce.

1194 Transcript of Helen Bryan, 30 June 2022, 2092 [38–47].

1195 Statement of a staff member in the Quality Patient Safety Service North, 3 June 2022, 10 [24], 17 [58].

1196 Statement of a staff member in the Quality Patient Safety Service North, 3 June 2022, 10 [24], 17 [58].

1197 Dot points for the Secretary, 'Notification of Action Taken under Work with Vulnerable People Act 2013', 31 July 2019, produced by Peter Renshaw in response to a Commission notice to produce.

1198 Transcript of Peter Renshaw, 8 September 2022, 3788 [7–8].

1199 Transcript of Peter Renshaw, 8 September 2022, 3788 [9–11].

1200 Transcript of Peter Renshaw, 8 September 2022, 3788 [20–23].

1201 Dot points for the Secretary, 'Notification of Action Taken under Work with Vulnerable People Act 2013', 31 July 2019, produced by Peter Renshaw in response to a Commission notice to produce.

1202 Australian Health Practitioner Regulation Agency, 'File note – Telephone Call', 1 August 2019, 1, produced by the Australian Health Practitioner Regulation Agency in response to a Commission notice to produce.

1203 Transcript of Peter Renshaw, 8 September 2022, 3778 [35–47].

1204 Australian Health Practitioner Regulation Agency, 'File Note – Telephone Call RN James Griffin', 1 August 2019, produced by Australian Health Practitioner Regulation Agency in response to a Commission notice to produce.

1205 Australian Health Practitioner Regulation Agency, 'File Note – Telephone Call Re: Griffin James', 5 August 2019, produced by Australian Health Practitioner Regulation Agency in response to a Commission notice to produce.

1206 Tasmania Police, *Procedural Fairness Response*, 23 March 2023, 8.

1207 Australian Commission on Safety and Quality in Health Care, National Safety and Quality Health Service Standards (2nd ed, 2017) 74.

1208 Transcript of Janette Tonks, 30 June 2022, 2065 [6–14]; Statement of Annette Whitemore, 20 June 2022, 2 [11]; Statement of Will Gordon, 30 March 2022, 6 [26].

1209 Janette Tonks, *Procedural Fairness Response*, 3 April 2023, 13.

1210 Statement of Annette Whitemore, 20 June 2022, 3 [12].

1211 Statement of Will Gordon, 30 March 2022, 6 [28].

1212 Statement of Will Gordon, 30 March 2022, 6 [29].

1213 Transcript of Janette Tonks, 30 June 2022, 2070 [21–25].

1214 Janette Tonks, *Procedural Fairness Response*, 3 April 2023, 13.

1215 Statement of Sonja Leonard, 21 June 2022, 30 [238]; Transcript of Sonja Leonard, 29 June 2022, 2014 [15–16].

1216 Statement of Sonja Leonard, 21 June 2022, 30 [238].

1217 Statement of Sonja Leonard, 21 June 2022, 32 [253].

1218 Statement of Kate Brady, 4 July 2022, 9 [30].

1219 Statement of Peter Renshaw, 20 June 2022, [53.1].

1220 Minute to Secretary, 'Employment Direction No. 4 – Suspension of Mr James Griffin', 5 August 2019; Letter from Michael Pervan to James Griffin, 'Suspension from Duties with Pay—Intention to Investigate', 5 August 2019.

1221 Statement of Matthew Hardy, 27 June 2022, 32 [203–205].

1222 Email from Glenn Hindle to Peter Renshaw, 'James GRIFFEN', 7 August 2019 7:30am, produced by Peter Renshaw in response to a Commission notice to produce.

1223 Email from Glenn Hindle to Peter Renshaw, 'James GRIFFEN', 7 August 2019 7:30am, produced by Peter Renshaw in response to a Commission notice to produce.

1224 Email from Glenn Hindle to Peter Renshaw, 'James GRIFFEN', 7 August 2019 7:30am, produced by Peter Renshaw in response to a Commission notice to produce.

1225 Statement of Mathew Hardy, 27 June 2022, 32 [203–205].

1226 Statement of Mathew Hardy, 27 June 2022, 32 [209–211].

1227 Tasmanian Health Service, Employee Exit Form for James Griffin, dated 8 August 2019.

1228 Statement of Mathew Harvey, 18 August 2022, [109].

1229 Statement of Mathew Harvey, 18 August 2022, [109].

1230 Minute to Secretary Michael Pervan, 'Resignation – Mr James Griffin', 14 August 2019, produced by the Tasmanian Government in response to a Commission notice to produce.

1231 Minute to Secretary Michael Pervan, 'Resignation – Mr James Griffin', 14 August 2019, produced by the Tasmanian Government in response to a Commission notice to produce.

1232 Minute to the Secretary Michael Pervan, 'Resignation – Mr James Griffin', 14 August 2019, produced by the Tasmanian Government in response to a Commission notice to produce.

1233 Statement of Mathew Harvey, 18 August 2022, [72].

1234 Transcript of Eric Daniels, 30 June 2022, 2015 [42]–2106 [15].

1235 Statement of Peter Renshaw, 20 June 2022, [53.1].

1236 *Child and Youth Safe Organisations Act 2023 s* 35(3*).*

1237 Letter from Tasmania Police Detective Inspector to Acting Commander Northern District, 'Griffin, James (Jim) Geoffrey (18/08/1950) – Investigative Review', 26 October 2020, produced by Tasmania Police in response to a Commission notice to produce.

1238 Letter from Tasmania Police Detective Inspector to Acting Commander Northern District, 'Griffin, James (Jim) Geoffrey (18/08/1950) – Investigative Review', 26 October 2020, produced by Tasmania Police in response to a Commission notice to produce.

1239 Letter from Tasmania Police Detective Inspector to Acting Commander Northern District, 'Griffin, James (Jim) Geoffrey (18/08/1950) – Investigative Review', 26 October 2020, produced by Tasmania Police in response to a Commission notice to produce.

1240 Letter from Tasmania Police Detective Inspector to Acting Commander Northern District, 'Griffin, James (Jim) Geoffrey (18/08/1950) – Investigative Review', 26 October 2020, produced by Tasmania Police in response to a Commission notice to produce.

1241 Transcript of Glenn Hindle, 6 July 2022, 2443 [6–10].

1242 Tasmania Police, 'Investigative review – James Geoffrey Griffin', undated, produced by Tasmania Police in response to a Commission notice to produce.

1243 Statement of Mathew Harvey, 18 August 2022, [113].

1244 Statement of Peter Renshaw, 20 June 2022, [52.1].

1245 Letter from Tasmania Police Detective Inspector to Acting Commander Northern District, 'Griffin, James (Jim) Geoffrey (18/08/1950) – Investigative Review', 26 October 2020, produced by Tasmania Police in response to a Commission notice to produce.

1246 Letter from Tasmania Police Detective Inspector to Acting Commander Northern District, 'Griffin, James (Jim) Geoffrey (18/08/1950) – Investigative Review', 26 October 2020, produced by Tasmania Police in response to a Commission notice to produce.

1247 Transcript of Glenn Hindle, 6 July 2022, 2443 [10–22], 2444 [1–4].

1248 Tasmania Police, 'Investigative review – James Geoffrey Griffin', undated, produced by Tasmania Police in response to a Commission notice to produce.

1249 Statement of Kathrine Morgan-Wicks, 22 June 2022, 3 [13].

1250 Statement of Kathrine Morgan-Wicks, 22 June 2022, 3 [13].

1251 Sarah Aquilina, 'Man Faces Child Sex Charges', *The Examiner* (Launceston, 9 October 2019).

1252 Transcript of James Bellinger, 8 September 2022, 3700 [13–16].

1253 Transcript of James Bellinger, 8 September 2022, 3700 [26–44].

1254 Transcript of James Bellinger, 8 September 2022, 3701 [17].

1255 Transcript of James Bellinger, 8 September 2022, 3701 [23–32].

1256 Email from James Bellinger to Glenn Hindle, 'J Griffin', 11 October 2019 11:32am, produced by the Tasmanian Government in response to a Commission notice to produce.

1257 Transcript of James Bellinger, 8 September 2022, 3701 [7].

1258 Transcript of Sonja Leonard, 29 June 2022, 2013 [25–42].

1259 Transcript of James Bellinger, 8 September 2022, 3701 [39], [42].

1260 Transcript of James Bellinger, 8 September 2022, 3701 [27–42].

1261 Transcript of James Bellinger, 8 September 3712 [13–23].

1262 Transcript of James Bellinger, 8 September 2022, 3702 [21–35].

1263 Statement of Kathrine Morgan-Wicks, 22 June 2022, 3 [15]; Statement of Kathrine Morgan-Wicks, 22 June 2022, Annexure 1 (Minute to Secretary, 14 October 2019).

1264 Statement of Kathrine Morgan-Wicks, 22 June 2022, Annexure 1 (Minute to Secretary, 14 October 2019).

1265 Statement of Kathrine Morgan-Wicks, 22 June 2022, Annexure 1 (Minute to Secretary, 14 October 2019).

1266 Statement of Kathrine Morgan-Wicks, 22 June 2022, Annexure 1 (Minute to Secretary, 14 October 2019).

1267 Statement of Kathrine Morgan-Wicks, 22 June 2022, Annexure 1 (Minute to Secretary, 14 October 2019).

1268 Statement of Kathrine Morgan-Wicks, 22 June 2022, Annexure 1 (Minute to Secretary, 14 October 2019).

1269 Letter from Tasmania Police Detective Inspector to Deputy Commissioner J Higgins, 'Griffin, James (Jim) Geoffrey – Investigative Review', 18 November 2020, produced by Tasmania Police in response to a Commission notice to produce.

1270 Letter from Tasmania Police Detective Inspector to Deputy Commissioner J Higgins, 'Griffin, James (Jim) Geoffrey – Investigative Review', 18 November 2020, produced by Tasmania Police in response to a Commission notice to produce.

1271 Transcript of James Bellinger, 8 September 2022, 3704 [9–13].

1272 Transcript of James Bellinger, 8 September 2022, 3704 [19].

1273 Email from James Bellinger to Glenn Hindle, 'J Griffin', 11 October 2019 11:32am, produced by the Tasmanian Government in response to a Commission notice to produce.

1274 Statement of Kathrine Morgan-Wicks, 30 June 2022, 4 [26]; Transcript of Eric Daniels, 30 June 2022, 2107 [47]–2108 [9].

1275 Transcript of Eric Daniels, 30 June 2022, 2107 [25–38].

1276 Transcript of Eric Daniels, 30 June 2022, 2107 [47]–2108 [9].

1277 Email from Peter Renshaw to Kathrine Morgan-Wicks, Director of the Office of the Secretary and Eric Daniels, 'Open Disclosure CONFIDENTIAL', 16 October 2020 11:46am.

1278 Statement of Kathrine Morgan-Wicks, 30 June 2022, 5 [32].

1279 Tasmania Police, 'Investigative review – James Geoffrey Griffin', undated, produced by Tasmania Police in response to a Commission notice to produce.

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1281 *Inquest into the Death of James Geoffrey Griffin* (Magistrates Court of Tasmania, Coroner's Division, Coroner Cooper, 18 May 2020) 4 <https://www.magistratescourt.tas.gov.au/__data/assets/pdf_file/0004/589531/Griffin,-James-Geoffrey-web.pdf>.

1282 Statement of Sonja Leonard, 21 June 2022, [241].

1283 Statement of Sonja Leonard, 21 June 2022, [241].

1284 Statement of Sonja Leonard, 21 June 2022, [242].

1285 Statement of Sonja Leonard, 21 June 2022, [242].

1286 Statement of Helen Bryan, 10 June 2022, [56].

1287 Helen Bryan, *Procedural Fairness Response*, 28 June 2023, [9–11].

1288 Statement of Peter Renshaw, 20 June 2022, [61].

1289 Statement of Will Gordon, 30 March 2022, Annexure WG-003 (Email from Sonja Leonard to Staff, 21 October 2019).

1290 Statement of Will Gordon, 30 March 2022, 7 [34].

1291 Statement of Will Gordon, 30 March 2022, 7 [35].

1292 Statement of Will Gordon, 30 March 2022, 8 [34].

1293 Statement of Will Gordon, 30 March 2022, 7 [34].

1294 Statement of Annette Whitemore, 20 June 2022, 5 [25].

1295 Statement of Annette Whitemore, 20 June 2022, 5 [26].

1296 Statement of Sonja Leonard, 21 June 2022, [244].

1297 Transcript of Sonja Leonard, 29 July 2022, 2018 [9–12].

1298 Statement of Peter Renshaw, 20 June 2022, [43(g)].

1299 Statement of Kate Brady, 4 July 2022, 10 [35].

1300 Statement of Peter Gordon, 23 June 2022, 16 [52]; Statement of Debora Picone, 21 June 2022, 25 [100].

1301 Statement of Will Gordon, 27 June 2022, 6 [25].

1302 Transcript of Will Gordon, 27 June 2022, [5–14].

1303 Transcript of Annette Whitemore, 29 June 2022, 1904 [31–40].

1304 Statement of Will Gordon, 30 March 2022, 8 [37].

1305 Statement of Keelie McMahon, 9 May 2022, 4 [22]; Statement of Angelique Knight, 2 June 2022, 3 [12].

1306 Transcript of Peter Renshaw, 8 September 2022, 3780 [16–22], 3795 [16–20].

1307 Transcript of Peter Renshaw, 8 September 2022, 3780 [16–26].

1308 Transcript of Peter Renshaw, 8 September 2022, 3780 [42], 3781 [20–21].

1309 Transcript of Peter Renshaw, 8 September 2022, 3793 [19–21].

1310 Transcript of Peter Renshaw, 8 September 2022, 3783 [30–34].

1311 Department of Health, *Procedural Fairness Response*, 28 April 2023, Annexure D (Response table) 40 [99].

1312 Transcript of Peter Renshaw, 8 September 2022, 3794 [33–34].

1313 Transcript of Peter Renshaw, 8 September 2022, 3784 [19–22]; Peter Renshaw, Procedural Fairness Response, 12 July 2023, 5.

1314 Transcript of Peter Renshaw, 8 September 2022, 3796 [31–36].

1315 Statement of Kathrine Morgan-Wicks, 22 June 2022, 3 [19]; Transcript of Kathrine Morgan-Wicks, 9 September 2022, 3855 [17–26].

1316 Statement of Kathrine Morgan-Wicks, 22 June 2022, 3 [19].

1317 Statement of Kathrine Morgan-Wicks, 22 June 2022, 3 [19].

1318 Statement of Kathrine Morgan-Wicks, 22 June 2022, 4 [20].

1319 Statement of Kathrine Morgan-Wicks, 22 June 2022, 6 [35]; Statement of Kathrine Morgan-Wicks, 22 June 2022, Annexure 4 (Email from Director of the Office of the Secretary to Kathrine Morgan-Wicks, 2 November 2020) 1.

1320 Statement of Will Gordon, 30 March 2022, 8 [38].

1321 Statement of Will Gordon, 20 March 2022, 8 [38].

1322 Transcript of Emily Shepherd, 29 June 2022, 1937 [26–33].

1323 Statement of Emily Shepherd, 23 June 2022, 7 [37–38].

1324 Statement of Emily Shepherd, 23 June 2022, Annexure ES-4 (Letter from Emily Shepherd to Sonja Leonard, 28 October 2019).

1325 Statement of Will Gordon, 30 March 2022, 8 [39].

1326 Statement of Will Gordon, 30 March 2022, 8 [39].

1327 Statement of Will Gordon, 30 March 2022, 8 [39].

1328 Statement of Will Gordon, 30 March 2022, 8 [39].

1329 Statement of Emily Shepherd, 23 June 2022, Annexure ES-4 (Letter from Emily Shepherd to Sonja Leonard, 28 October 2019).

1330 Transcript of Peter Renshaw, 8 September 2022, 3789 [42–47].

1331 Peter Renshaw, *Procedural Fairness Response*, 12 July 2023, 5.

1332 Statement of Peter Renshaw, 20 June 2022, [54.2].

1333 Email from Glenn Hindle to Peter Renshaw, 'RE: JG Incident Report – 18 July 2019', 29 October 2019 2:23pm, produced by the Tasmanian Government in response to a Commission notice to produce; Statement of Glenn Hindle, 15 August 2022, 2 [8].

1334 Statement of Glenn Hindle, 15 August 2022, 2 [8].

1335 Transcript of Peter Renshaw, 9 September 2022, 3801 [12–18].

1336 Statement of Janette Tonks, 10 June 2022, 15 [67], 17 [73].

1337 Statement of Peter Renshaw, 20 June 2022, [63].

1338 Statement of Peter Renshaw, 20 June 2022, [63].

1339 Statement of Peter Renshaw, 20 June 2022, [61.1].

1340 Statement of Janette Tonks, 10 June 2022, 15–16 [67].

1341 Transcript of Annette Whitemore, 29 June 2022, 1908 [32–35].

1342 Janette Tonks, *Procedural Fairness Response*, 3 April 2023, 15.

1343 Statement of Helen Bryan, 10 June 2022, [58].

1344 Statement of Peter Renshaw, 20 June 2022, [63.2].

1345 Statement of Peter Renshaw, 20 June 2022, [63.3].

1346 Email from Will Gordon to Peter Renshaw, 12 November 2019 3:29pm, produced by Peter Renshaw in response to a Commission notice to produce.

1347 Email from Will Gordon to Peter Renshaw, 12 November 2019 3:29pm, produced by Peter Renshaw in response to a Commission notice to produce.

1348 Email from Will Gordon to Peter Renshaw, 12 November 2019 3:29pm, produced by Peter Renshaw in response to a Commission notice to produce.

1349 Email from Peter Renshaw to James Bellinger, Eric Daniels and Helen Bryan (forwarding Will Gordon's email) 12 November 2019 4:31pm, produced by Peter Renshaw in response to a Commission notice to produce.

1350 Email from James Bellinger to Peter Renshaw, Eric Daniels and Helen Bryan, 12 November 2019 4:52pm, produced by Peter Renshaw in response to a Commission notice to produce.

1351 Email from James Bellinger to Peter Renshaw, Eric Daniels and Helen Bryan, 12 November 2019 4:52pm, produced by Peter Renshaw in response to a Commission notice to produce.

1352 Email from James Bellinger to Peter Renshaw, Eric Daniels and Helen Bryan, 12 November 2019 4:52pm, produced by Peter Renshaw in response to a Commission notice to produce.

1353 Transcript of Will Gordon, 27 June 2022, 1762 [4–12].

1354 Transcript of Will Gordon, 27 June 2022,1762 [17–19].

1355 Transcript of Will Gordon, 27 June 2022,1762 [24–30].

1356 Transcript of Will Gordon, 27 June 2022,1762 [39–44].

1357 Transcript of Will Gordon, 27 June 2022,1762 [16–23].

1358 Transcript of Janette Tonks, 30 June 2022, 2074 [28–29].

1359 Email from Ward 4K staff member to Peter Renshaw, 13 November 2019 3:16pm, produced by the Tasmanian Government in response to a Commission notice to produce.

1360 Email from Ward 4K staff member to Peter Renshaw, 13 November 2019 3:16pm, produced by the Tasmanian Government in response to a Commission notice to produce.

1361 Email from Peter Renshaw to a Ward 4K staff member 14 November 2019 2:25pm, produced by Peter Renshaw in response to a Commission notice to produce.

1362 Email from Peter Renshaw to a Ward 4K staff member, 14 November 2019 2:25pm, produced by Peter Renshaw in response to a Commission notice to produce.

1363 Statement of Will Gordon, 8 March 2022, 10 [46].

1364 Letter from former Chief Executive Officer, Integrity Commission to Kathrine Morgan-Wicks, 'Referral of complaint from the Integrity Commission', 21 November 2019, 1, 3.

1365 Statutory Declaration of Eric Daniels, 12 July 2023, [23].

1366 Transcript of Eric Daniels, 30 June 2022, 2113 [19–26].

1367 Transcript of Eric Daniels, 30 June 2022, 2125 [39–41].

1368 Transcript of Peter Renshaw, 8 September 2022, 3805 [7–19].

1369 Minute to Secretary, 'Potential Legal Issue – Launceston General Hospital (LGH) in relation to ex-employee James Griffin', 5 November 2019.

1370 Minute to Secretary, 'Potential Legal Issue – Launceston General Hospital (LGH) in relation to ex-employee James Griffin', 5 November 2019.

1371 Peter Renshaw, *Procedural Fairness Response*, 12 July 2023, 4.

1372 Peter Renshaw, *Procedural Fairness Response*, 12 July 2023, 4.

1373 Peter Renshaw, *Procedural Fairness Response*, 12 July 2023, 4.

1374 Minute to Secretary, 'Potential Legal Issue – Launceston General Hospital (LGH) in relation to ex-employee James Griffin', 5 November 2019.

1375 Transcript of Peter Renshaw, 8 September 2022, 3789 [42–47].

1376 Peter Renshaw, *Procedural Fairness Response*, 12 July 2023, 5.

1377 Transcript of Peter Renshaw, 8 September 2022, 3789 [42–47].

1378 Transcript of James Bellinger, 28 June 2022, 1867 [1–26].

1379 Transcript of Peter Renshaw, 8 September 2022, 3789 [22–26].

1380 Transcript of Peter Renshaw, 9 September 2022, 3810 [20–47].

1381 Minute to Secretary, 'Potential Legal Issue – Launceston General Hospital (LGH) in relation to ex-employee James Griffin', 5 November 2019.

1382 Minute to Secretary, 'Potential Legal Issue – Launceston General Hospital (LGH) in relation to ex-employee James Griffin', 5 November 2019.

1383 Transcript of Peter Renshaw, 9 September 2022, 3819 [26–29].

1384 Minute to Secretary, 'Potential Legal Issue – Launceston General Hospital (LGH) in relation to ex-employee James Griffin', 5 November 2019.

1385 Minute to Secretary, 'Potential Legal Issue – Launceston General Hospital (LGH) in relation to ex-employee James Griffin', 5 November 2019.

1386 Minute to Secretary, 'Potential Legal Issue – Launceston General Hospital (LGH) in relation to ex-employee James Griffin', 5 November 2019.

1387 Transcript of Peter Renshaw, 9 September 2022, 3805 [25–26].

1388 Minute to Secretary, 'Potential Legal Issue – Launceston General Hospital (LGH) in relation to ex-employee James Griffin', 5 November 2019.

1389 Minute to Secretary, 'Potential Legal Issue – Launceston General Hospital (LGH) in relation to ex-employee James Griffin', 5 November 2019.

1390 Transcript of Eric Daniels, 30 June 2022, 2113 [28–35].

1391 Transcript of Peter Renshaw, 9 September 2022, 3803 [20–38].

1392 Transcript of Kathrine Morgan-Wicks, 9 September 2022, 3855 [2–20].

1393 Transcript of Kathrine Morgan-Wicks, 9 September 2022, 3857 [25–30].

1394 Statement of Kathrine Morgan-Wicks, 22 June 2022, 15 [88].

1395 Statement of Kathrine Morgan-Wicks, 22 June 2022, 15 [87–88].

1396 Transcript of Kathrine Morgan-Wicks, 9 September 2022, 3854 [39–44].

1397 Statement of Kathrine Morgan-Wicks, 30 June 2022, 5 [32].

1398 Transcript of Kathrine Morgan-Wicks, 9 September 2022, 3856 [39–41].

1399 Transcript of Peter Renshaw, 8 September 2022, 3793 [43–47], 3794 [3–8]; Peter Renshaw, *Procedural Fairness Response*, 12 July 2023, 4.

1400 Transcript of Peter Renshaw, 8 September 2022, 3794 [7–8].

1401 Peter Renshaw, *Procedural Fairness Response*, 12 July 2023, 5–6.

1402 Transcript of Peter Renshaw, 9 September 2022, 3819 [47]–2820 [5].

1403 Transcript of Peter Renshaw, 8 September 2022, 3792 [35–42].

1404 Statement of Emily Shepherd, 23 June 2022, 7 [39].

1405 Statement of Emily Shepherd, 23 June 2022, Annexure ES-5 (Letter to Emily Shepherd from Eric Daniels, 31 October 2019).

1406 Statement of Emily Shepherd, 23 June 2022, Annexure ES-5 (Letter to Emily Shepherd from Eric Daniels, 31 October 2019).

1407 Statement of Emily Shepherd, 23 June 2022, Annexure ES-5 (Letter to Emily Shepherd from Eric Daniels, 31 October 2019).

1408 Statement of Emily Shepherd, 23 June 2022, 7 [39].

1409 Statement of Emily Shepherd, 23 June 2022, 8 [44].

1410 Statement of Emily Shepherd, 23 June 2022, 8 [45].

1411 Statement of Emily Shepherd, 23 June 2022, 8 [45].

1412 Statement of Emily Shepherd, 23 June 2022, 9 [46].

1413 Statement of Emily Shepherd, 23 June 2022, 1 [55].

1414 Transcript of Eric Daniels, 30 June 2022, 2113 [1–17].

1415 Transcript of James Bellinger, 28 June 2022, 1879 [23–27]; Transcript of James Bellinger, 8 September 2022, 3708 [15–25].

1416 Statement of Kathrine Morgan-Wicks, 22 June 2022, 18 [109].

1417 Transcript of James Bellinger, 28 June 2022, 1879 [29–35].

1418 Transcript of James Bellinger, 28 June 2022, 1876 [19–22].

1419 Transcript of James Bellinger, 28 June 2022, 1877 [36]–1878 [3].

1420 Transcript of James Bellinger, 8 September 2022, 3708 [43–45].

1421 Transcript of James Bellinger, 8 September 2022, 3710 [19–26].

1422 Transcript of James Bellinger, 8 September 3710 [20–33], 3709 [8–10].

1423 Transcript of James Bellinger, 8 September 3715 [36–41].

1424 Statement of Kathrine Morgan-Wicks, 22 June 2022, 18 [109].

1425 Transcript of Peter Renshaw 9 September 2022, 3829 [4]–3830 [14].

1426 Statement of Will Gordon, 30 March 2022, 3 [14].

1427 Statement of Will Gordon, 30 March 2022, Annexure WG-006 (Chain of emails between Janette Tonks and Will Gordon).

1428 Statement of Will Gordon, 30 March 2022, Annexure WG-006 (Chain of emails between Janette Tonks and Will Gordon).

1429 Statement of Will Gordon, 30 March 2022, Annexure WG-006 (Chain of emails between Janette Tonks and Will Gordon).

1430 Statement of Will Gordon, 30 March 2022, Annexure WG-006 (Chain of emails between Janette Tonks and Will Gordon).

1431 Statement of Will Gordon, 30 March 2022, Annexure WG-006 (Chain of emails between Janette Tonks and Will Gordon).

1432 Statement of Will Gordon, 30 March 2022, Annexure WG-006 (Chain of emails between Janette Tonks and Will Gordon).

1433 Statement of Will Gordon, 30 March 2022, 1 [68].

1434 Statement of Will Gordon, 30 March 2022, 1 [68].

1435 Statement of a staff member in the Quality Patient Safety Service North, 3 June 2022, 11 [27].

1436 Statement of a staff member in the Quality Patient Safety Service North, 3 June 2022, 11 [27].

1437 Statement of a staff member in the Quality Patient Safety Service North, 3 June 2022, 9 [22].

1438 Statement of a staff member in the Quality Patient Safety Service North, 3 June 2022, 10 [24]; 17 [58].

1439 Statement of a staff member in the Quality Patient Safety Service North, 3 June 2022, 17 [58].

1440 Statement of a staff member in the Quality Patient Safety Service North, 3 June 2022, 17 [59].

1441 Transcript of Will Gordon, 27 June 2022, 1752 [41]–1753 [46].

1442 Transcript of Will Gordon, 27 June 2022, 1763 [34–40].

1443 Letter from former Chief Executive Officer, Integrity Commission to Kathrine Morgan-Wicks, 'Referral of complaint from the Integrity Commission', 21 November 2019.

1444 Letter from former Chief Executive Officer, Integrity Commission to Kathrine Morgan-Wicks, 'Referral of complaint from the Integrity Commission', 21 November 2019.

1445 Letter from former Chief Executive Officer, Integrity Commission to Kathrine Morgan-Wicks, 'Referral of complaint from the Integrity Commission', 21 November 2019.

1446 Letter from former Chief Executive Officer, Integrity Commission to Kathrine Morgan-Wicks, 'Referral of complaint from the Integrity Commission', 21 November 2019.

1447 Letter from former Chief Executive Officer, Integrity Commission to Kathrine Morgan-Wicks, 'Referral of complaint from the Integrity Commission', 21 November 2019.

1448 Letter from former Chief Executive Officer, Integrity Commission to Kathrine Morgan-Wicks, 'Referral of complaint from the Integrity Commission', 21 November 2019.

1449 Letter from former Chief Executive Officer, Integrity Commission to Kathrine Morgan-Wicks, 'Referral of complaint from the Integrity Commission', 21 November 2019.

1450 *Integrity Commission Act 2009* s 35.

1451 Assessment Greystone report, attached to Letter from former Chief Executive Officer, Integrity Commission to Kathrine Morgan-Wicks, 'Referral of complaint from the Integrity Commission', 21 November 2019, 1

1452 Assessment Greystone report, attached to Letter from former Chief Executive Officer, Integrity Commission to Kathrine Morgan-Wicks, 'Referral of complaint from the Integrity Commission', 21 November 2019, 2

1453 Assessment Greystone report, attached to Letter from former Chief Executive Officer, Integrity Commission to Kathrine Morgan-Wicks, 'Referral of complaint from the Integrity Commission', 21 November 2019, 1. Refer also to *State Service Act 2000* s 9(1), (4).

1454 Assessment Greystone report, attached to Letter from former Chief Executive Officer, Integrity Commission to Kathrine Morgan-Wicks, 'Referral of complaint from the Integrity Commission', 21 November 2019, 2.

1455 Assessment Greystone report, attached to Letter from former Chief Executive Officer, Integrity Commission to Kathrine Morgan-Wicks, 'Referral of complaint from the Integrity Commission', 21 November 2019, 4–7.

1456 Assessment Greystone report, attached to Letter from former Chief Executive Officer, Integrity Commission to Kathrine Morgan-Wicks, 'Referral of complaint from the Integrity Commission', 21 November 2019, 5.

1457 Assessment Greystone report, attached to Letter from former Chief Executive Officer, Integrity Commission to Kathrine Morgan-Wicks, 'Referral of complaint from the Integrity Commission', 21 November 2019, 5.

1458 Assessment Greystone report, attached to Letter from former Chief Executive Officer, Integrity Commission to Kathrine Morgan-Wicks, 'Referral of complaint from the Integrity Commission', 21 November 2019, 6.

1459 Assessment Greystone report, attached to Letter from former Chief Executive Officer, Integrity Commission to Kathrine Morgan-Wicks, 'Referral of complaint from the Integrity Commission', 21 November 2019, 6.

1460 Assessment Greystone report, attached to Letter from former Chief Executive Officer, Integrity Commission to Kathrine Morgan-Wicks, 'Referral of complaint from the Integrity Commission', 21 November 2019, 6.

1461 Assessment Greystone report, attached to Letter from former Chief Executive Officer, Integrity Commission to Kathrine Morgan-Wicks, 'Referral of complaint from the Integrity Commission', 21 November 2019, 9.

1462 Statement of Will Gordon, 30 March 2022, Annexure 7 (Letter from the former Chief Executive Officer, Integrity Commission to Will Gordon, 21 November 2019); Submission 102 Will Gordon

1463 Transcript of Will Gordon, 27 June 2022, 1764 [15–20].

1464 Statement of Kathrine Morgan-Wicks, 30 June 2022, 2 [10].

1465 Statement of Kathrine Morgan-Wicks, 30 June 2022, 2 [10].

1466 Statement of Kathrine Morgan-Wicks, 30 June 2022, 3 [12]; Statement of the former Chief People Officer, 28 November 2022, 7 [30]; Transcript of Kathrine Morgan-Wicks, 9 September 2022, 3865 [42–47].

1467 Statement of the former Chief People Officer, 28 November 2022, 7 [31–32]; Transcript of James Bellinger, 28 June 2022, 1879 [14–19].

1468 Statement of the former Chief People Officer, 28 November 2022, 1 [1(i)], 7 [34–35].

1469 Statement of the former Chief People Officer, 28 November 2022, 7 [39–40].

1470 Transcript of Kathrine Morgan-Wicks, 9 September 2022, 3866 [42–47].

1471 Transcript of Kathrine Morgan-Wicks, 9 September 2022, 3867 [35–38].

1472 Transcript of Michael Easton, 30 June 2022, 2154 [2–20].

1473 Transcript of Richard Connock, 4 July 2022, 2198 [19–21].

1474 Department of Health, *Procedural Fairness Response*, 28 April 2023, Annexure D (Response table) 43 [107].

1475 Transcript of Michael Easton, 30 June 2022, 2135 [1–10].

1476 Transcript of Michael Easton, 30 June 2022, 2138 [47]–2139 [4].

1477 Transcript of Michael Easton, 30 June 2022, 2148 [35]–2149 [27].

1478 Transcript of Michael Easton, 30 June 2022, 2151 [33–46].

1479 Statement of Kathrine Morgan-Wicks, 30 June 2022, [23].

1480 Email from Staff member, Launceston General Hospital to Peter Renshaw, '4K', 5 December 2019 6:11pm, produced by Peter Renshaw in response to a Commission notice to produce.

1481 Email from Staff member, Launceston General Hospital to Peter Renshaw, '4K', 5 December 2019 6:11pm, produced by Peter Renshaw in response to a Commission notice to produce.

1482 Statement of Peter Renshaw, 20 June 2022, [43.2].

1483 Statement of Peter Renshaw, 20 June 2022, [55.1].

1484 Letter from Tasmania Police Detective Inspector to Deputy Commissioner J Higgins, 'Griffin, James (Jim) Geoffrey – Investigative Review', 18 November 2020, produced by Tasmania Police in response to a Commission notice to produce.

1485 Statement of Peter Renshaw, 20 June 2022, [56.1].

1486 Email from Peter Renshaw to Kathrine Morgan-Wicks (Director of the Office of the Secretary copied in), 'Open Disclosure CONFIDENTIAL', 17 August 2020 1:55pm.

1487 Letter from Tasmania Police Detective Inspector to Deputy Commissioner J Higgins, 'Griffin, James (Jim) Geoffrey – Investigative Review', 18 November 2020, produced by Tasmania Police in response to a Commission notice to produce.

1488 Email from Peter Renshaw to Kathrine Morgan-Wicks (Director of the Office of the Secretary copied in), 'Open Disclosure CONFIDENTIAL', 17 August 2020 1:55pm.

1489 Letter from Emily Shepherd to Eric Daniels, 'Re: Launceston General Hospital ward 4K', 12 December 2019.

1490 Letter from Emily Shepherd to Eric Daniels, 'Re: Launceston General Hospital ward 4K', 12 December 2019.

1491 Transcript of James Bellinger, 8 September 3709 [23–30].

1492 Eric Daniels, *Procedural Fairness Responses*, 12 July 2023, 23 and 16 August 2023, 3–8.

1493 Letter from Eric Daniels to Emily Shepherd, 20 December 2019.

1494 Statutory Declaration of Eric Daniels, 12 July 2023, [18–20].

1495 Statutory Declaration of Eric Daniels, 12 July 2023, [20].

1496 Letter from Eric Daniels to Emily Shepherd, 20 December 2019.

1497 Statement of Kathrine Morgan-Wicks, 22 June 2022, 9 [51e].

1498 Statement of Will Gordon, 30 June 2022, 11 [52].

1499 Statement of Will Gordon, 30 June 2022, 11 [52].

1500 Statement of Will Gordon, 30 June 2022, 11 [53].

1501 Statement of Will Gordon, 30 June 2022, 11 [54].

1502 Statement of Will Gordon, 30 June 2022, 11 [54].

1503 'COVID-19 Public Health Emergency of International Concern Global Research and Innovation Forum', World Health Organisation (Web Page, 12 February 2020) <https://www.who.int/publications/m/item/covid-19-public-health-emergency-of-international-concern-(pheic)-global-research-and-innovation-forum>.

1504 Peter Gutwein, 'Ministerial Statement COVID-19 Response Measures' (Media Release, 17 March 2020) <https://www.premier.tas.gov.au/releases/ministerial_statement_covid-19_response_measures>.

1505 Director of Public Health, 'Public Health' (Declaration of Public Health Emergency – COVID-19), Tasmanian Government Gazette, No 21955, 24 March 2020, 147. <https://www.gazette.tas.gov.au/editions/2020/march_2020/21955_-_Special_24_March_2020.pdf>

1506 Department of Health, *Procedural Fairness Response*, 28 April 2023, Annexure D (Response table) 44—46 [111].

1507 Statement of Kathrine Morgan-Wicks, 24 May 2022, 8 [61]; Statement of Kathrine Morgan Wicks, 22 June 2022, 1 [5].

1508 Statement of Kathrine Morgan-Wicks, 24 May 2022, 8 [61]; Statement of Kathrine Morgan Wicks, 22 June 2022, 1 [5].

1509 Statement of Will Gordon, 30 June 2022, 1 [56].

1510 Transcript of Will Gordon, 27 June 2022, 1766 [12–13].

1511 Statement of Will Gordon, 30 June 2022, 11 [55].

1512 Statement of Will Gordon, 30 June 2022, 11 [54].

1513 Transcript of Camille Bianchi, 5 May 2022, 444 [9–91].

1514 Statement of Keelie McMahon, 9 May 2022, [38].

1515 @CamilleBianchi (Camille Bianchi) (Twitter, 27 June 2022, 5:09pm AEST) <https://twitter.com/camillebianchi/status/1541317874450501632?s=46&t=M4BfbtR56Bj2FHhvNmLk-A>.

1516 Statement of Will Gordon, 30 June 2022, 12 [57].

1517 Transcript of Will Gordon, 27 June 2022, 1765 [26–36].

1518 Statement of Will Gordon, 30 June 2022, Annexure WG-009 (Letter from a Solicitor to Sarah Courtney, 3 March 2020).

1519 Statement of Will Gordon, 30 June 2022, Annexure WG-009 (Letter from a Solicitor to Sarah Courtney, 3 March 2020).

1520 Statement of Will Gordon, 30 June 2022, Annexure WG-010 (Letter from Sarah Courtney to a Solicitor, undated).

1521 Statement of Will Gordon, 30 June 2022, Annexure WG-010 (Letter from Sarah Courtney to a Solicitor, undated).

1522 Statement of Kathrine Morgan-Wicks, 13 April 2023, 6 [30–32].

1523 Statement of Will Gordon, 30 June 2022, Annexure WG-011 (Letter from Sarah Courtney to a Solicitor, undated).

1524 Statement of Will Gordon, 30 June 2022, Annexure WG-011 (Letter from Sarah Courtney to a Solicitor, undated).

1525 Statement of Will Gordon, 30 June 2022, Annexure WG-011 (Letter from Sarah Courtney to a Solicitor, undated).

1526 Statement of Will Gordon, 30 June 2022, Annexure WG-011 (Letter from Sarah Courtney to a Solicitor, undated).

1527 Statement of Will Gordon, 30 June 2022, Annexure WG-011 (Letter from Sarah Courtney to a Solicitor, undated).

1528 Statement of Will Gordon, 30 June 2022, Annexure WG-011 (Letter from Sarah Courtney to a Solicitor, undated).

1529 Statement of Will Gordon, 30 June 2022, 12 [61].

1530 Statement of Kathrine Morgan-Wicks, 22 June 2022, 13 [71].

1531 Statement of Kathrine Morgan-Wicks, 30 June 2022, 3 [16].

1532 Statement of Kathrine Morgan-Wicks, 30 June 2022, 3 [17]; Statement of Kathrine Morgan-Wicks, 30 June 2022, Annexure 62 (Letter from Integrity Commission to Kathrine Morgan-Wicks, 29 July 2020).

1533 Statement of Kathrine Morgan-Wicks, 30 June 2022, 3 [18].

1534 Statement of Kathrine Morgan-Wicks, 30 June 2022, 3–4 [20–21].

1535 Transcript of James Bellinger, 28 June 2022, 1879 [42–44].

1536 Letter from Kathrine Morgan-Wicks to former Chief Executive Officer, Integrity Commission, 'Matter MM19/0172', 10 September 2020.

1537 Transcript of James Bellinger, 28 June 2022, 1880 [3–13].

1538 Transcript of James Bellinger, 28 June 2022, 1879 [21–31].

1539 Transcript of James Bellinger, 28 June 2022, 1880 [25–30], 1883 [16–19].

1540 Transcript of Kathrine Morgan-Wicks, 9 September 2022, 3869 [31–35].

1541 Transcript of Michael Easton, 30 June 2022, 2154 [47]–2155 [4].

1542 Minute to Secretary, 'Potential Legal Issue – Launceston General Hospital (LGH) in relation to ex-employee James Griffin', 5 November 2019.

1543 Statement of Peter Renshaw, 20 June 2022, [56.1].

1544 Statement of Peter Renshaw, 20 June 2022, [55.1].

1545 Statement of Peter Renshaw, 20 June 2022, [56.1].

1546 Email from Peter Renshaw to Kathrine Morgan-Wicks and Director of the Office of the Secretary, 'Open Disclosure CONFIDENTIAL', 17 August 2020.

1547 Email from Peter Renshaw to Kathrine Morgan-Wicks and Director of the Office of the Secretary, 'Open Disclosure CONFIDENTIAL', 17 August 2020.

1548 Email from Peter Renshaw to Kathrine Morgan-Wicks and Director of the Office of the Secretary, 'Open Disclosure CONFIDENTIAL', 17 August 2020.

1549 Email from Peter Renshaw to Kathrine Morgan-Wicks and Director of the Office of the Secretary, 'Open Disclosure CONFIDENTIAL', 17 August 2020.

1550 Email from Peter Renshaw to Kathrine Morgan-Wicks and Director of the Office of the Secretary, 'Open Disclosure CONFIDENTIAL', 17 August 2020.

1551 Email from Kathrine Morgan-Wicks to Peter Renshaw, 'RE: Open Disclosure CONFIDENTIAL', 17 August 2020 2:39pm.

1552 Statement of Peter Renshaw, 20 June 2022, [55].

1553 Statement of Peter Renshaw, 20 June 2022, [56].

1554 Statement of Kathrine Morgan-Wicks, 30 June 2022, 4 [22].

1555 Department of Health, *Procedural Fairness Response*, 28 April 2023, Annexure D (Response table) 49 [117].

1556 Letter from Kathrine Morgan-Wicks to Michael Easton, 'Matter MM19/0172', 10 September 2020.

1557 Letter from Kathrine Morgan-Wicks to Michael Easton, 'Matter MM19/0172', 10 September 2020.

1558 Letter from Kathrine Morgan-Wicks to Michael Easton, 'Matter MM19/0172', 10 September 2020.

1559 Letter from Kathrine Morgan-Wicks to Michael Easton, 'Matter MM19/0172', 10 September 2020.

1560 Letter from Kathrine Morgan-Wicks to Michael Easton, 'Matter MM19/0172', 10 September 2020.

1561 Letter from Kathrine Morgan-Wicks to Michael Easton, 'Matter MM19/0172', 10 September 2020.

1562 Letter from Kathrine Morgan-Wicks to Michael Easton, 'Matter MM19/0172', 10 September 2020.

1563 Email from James Bellinger to Glenn Hindle, 'J Griffin', 11 October 2019 11:32am produced by the Tasmanian Government in response to a Commission notice to produce.

1564 Statement of Kathrine Morgan-Wicks, 30 June 2022, 5 [27].

1565 Transcript of Kathrine Morgan-Wicks, 9 September 2022, 3873 [7–18].

1566 Transcript of Kathrine Morgan-Wicks, 9 September 2022, 3872 [45–47].

1567 Letter from Michael Easton to Kathrine Morgan-Wicks, 'Information report received on Assessment Greystone', 16 September 2020.

1568 Letter from Michael Easton to Kathrine Morgan-Wicks, 'Information report received on Assessment Greystone', 16 September 2020.

1569 Letter from Michael Easton to Kathrine Morgan-Wicks, 'Information report received on Assessment Greystone', 16 September 2020.

1570 Transcript of Michael Easton, 30 June 2022, 2156 [21–29].

1571 Transcript of Michael Easton, 30 June 2022, 2156 [36–38].

1572 Transcript of Michael Easton, 30 June 2022, 2135 [10].

1573 Transcript of Michael Easton, 30 June 2022, 2134 [38–46].

1574 Transcript of Michael Easton, 30 June 2022, 2134 [25–27].

1575 Transcript of Michael Easton, 30 June 2022, 2133 [32–39].

1576 Transcript of Michael Easton, 30 June 2022, 2133 [41–47].

1577 Transcript of Michael Easton, 30 June 2022, 2134 [4–11].

1578 Transcript of Michael Easton, 30 June 2022, 2134 [13–21].

1579 Transcript of Michael Easton, 30 June 2022, 2156 [5–11].

1580 Transcript of Camille Bianchi and Emily Baker, 5 May 2022, 445 [3–5].

1581 Statement of Kathrine Morgan-Wicks, 22 June 2022, 9 [52], [72]. Refer also to Emily Baker, 'Family Alleges Launceston General Hospital Doctor Raped Their Daughter Decades Ago', ABC News (online, 6 April 2021) <https://www.abc.net.au/news/2021-04-06/family-alleges-hospital-rape-of-daughter/100048880>.

1582 Statement of Will Gordon, 30 March 2022, 16 [78].

1583 Statement of Kathrine Morgan-Wicks, 22 June 2022, 9 [52].

1584 Statement of Helen Bryan, 10 June 2022, [48(b)]; Statement of Peter Renshaw, 20 June 2022, [38].

1585 'Just Jim', The Nurse (Camille Bianchi, 13 October 2020).

1586 Transcript of Kylee Pearn, 28 June 2022, 1794 [2–5].

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Commission of Inquiry into the Tasmanian Government's Responses to Child Sexual Abuse in Institutional Settings

Who was looking after me? Prioritising the safety of Tasmanian children

Volume 6: Children in health services
Book 2

August 2023

Commission of Inquiry into the Tasmanian Government's Responses to Child Sexual Abuse in Institutional Settings Report

Volume 6
Children in health services (Book 2)

The Honourable Marcia Neave AO
President and Commissioner

Professor Leah Bromfield
Commissioner

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Commissioner

August 2023

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15 The way forward: Children in health services

1 Introduction

Health services have a duty of care to patients, which extends to keeping them safe from sexual abuse while they are under care. The National Safety and Quality Health Service Standards require that health services protect the public from harm and provide quality health care to all patients. The National Principles for Child Safe Organisations, which have now been substantially adopted in the *Child and Youth Safe Organisations Act 2023* ('Child and Youth Safe Organisations Act'), set out the expectations of organisations to create cultures that foster child safety and wellbeing. The *Children, Young Persons and Their Families Act 1997* ('Children, Young Persons and Their Families Act') and the *Health Practitioner Regulation National Law Act 2009* (Qld) ('National Law') require that sexual misconduct by health practitioners be reported, including to the Australian Health Practitioner Regulation Agency ('Ahpra').[1]

There is limited research into the prevalence of sexual abuse in health services. However, we know from the available evidence that abusers who are also health workers will exploit their often unquestioned, intimate access to young patients, and that children and young people's vulnerability to abuse is heightened when they are sick, injured or otherwise unwell.

This volume makes a much-needed contribution to the research on child sexual abuse in health services. We learned that abusers use tactical strategies to avoid detection when offending in health services. They leverage the trust and deference that many of us afford health workers, take advantage of the assumption that sexual abuse cannot

The co-chairs of the Community Recovery Initiative made eight recommendations directed at improving management, leadership and culture; improving communication with staff and the media; and increasing staff training.

Secretary Morgan-Wicks told us that she accepted the recommendations of the Community Recovery Initiative, which she believes are consistent with, and able to be implemented through, the recommendations of the Child Safe Governance Review.[22] The co-chairs of the Community Recovery Initiative stated an intention to liaise with the Department to monitor progress of actions towards the implementation of their recommendations.[23]

2.1.3 Child Safe Organisation Project

Other Department-initiated reforms are relevant to our Commission of Inquiry. In particular, the Child Safe Organisation Project was set up primarily to implement the National Principles for Child Safe Organisations and associated Child Safe Standards, as recommended by the National Royal Commission and endorsed by the former Council of Australian Governments in February 2019.[24]

The objective of the Child Safe Organisation Project was to ensure the Department has a strong, common understanding of child safety and wellbeing, that children's voices are heard, and that children and their families are involved in decisions affecting them.[25]

Key elements of the Child Safe Organisation Project were to develop a framework for child safety and wellbeing, set up an independent panel for child safety and wellbeing, and establish a new Child Safety and Wellbeing Service within the Department.

The Child Safe Organisation Project finished in December 2022. The Child Safety and Wellbeing Service now leads implementation of the Department's work to improve child safety and wellbeing.[26] We understand that child safeguarding officers located at Tasmania's four public major hospitals are also supporting implementation of the Department's *Child Safety and Wellbeing Framework*, including providing education on mandatory reporting and identifying grooming and professional boundary breaches.[27] We have been advised that these roles have been successfully filled in each region.[28]

We note that Tasmanian health services will be subject to legislative requirements to embed the Child and Youth Safe Standards (which are based on the National Principles for Child Safe Organisations) and will also be subject to a Reportable Conduct Scheme to enable oversight of how investigations of reportable allegations (which includes child sexual abuse and sexual misconduct) are conducted.[29] For further discussion on these schemes, refer to Chapter 18.

2.2 A policy framework and implementation plan

Although substantial reform work is underway across the Department, we consider this would be strengthened by clarifying:

- how the reforms will work together to provide a system-wide response to child sexual abuse in health services
- how the reforms are being prioritised
- expected timeframes for implementation.

To this end, we recommend that the Department develops and communicates a policy framework and implementation plan for reforms to improve responses to child sexual abuse in health services, against which it will be accountable to the community. This plan should explain how reforms—including departmental reforms, those recommended by the Child Safe Governance Review, Community Recovery Initiative and our Commission of Inquiry—fit together to ensure the safety of children in health settings. Publishing the policy framework and implementation plan will provide a greater degree of transparency and accountability around the Department's implementation of reforms.

In February 2023, Secretary Morgan-Wicks provided a written update on the Department's reform work. She told us that an implementation plan had been prepared and included the recommendations of the Child Safe Governance Review and Community Recovery Initiative.[30] She said the plan covers implementing the recommendations not only within Launceston General Hospital but also across the Department.[31] She also told us that several of the recommendations have already been 'completed'.[32]

We are pleased that the Department has started implementation planning in relation to the recommendations of the Child Safe Governance Review and Community Recovery Initiative. However, given the number and complexity of recommendations to be implemented (and, as we note above, the fact that some may take time to become fully embedded), we consider the Department and the community would benefit from a policy framework and implementation plan that outlines:

- the purpose and need for the reforms
- the role, responsibilities and interactions of bodies the Department has set up as part of the reforms
- how the reforms work together to provide a system-wide response to child sexual abuse in health services
- how the reforms are being prioritised for implementation and who is responsible for their implementation
- the expected timeframes for implementation.

We asked the co-chairs of the Child Safe Governance Review about the features they considered important in a monitoring and oversight function relating to health services. Adjunct Professors Picone and Crawshaw advised us that, in their view, the following skills and capabilities are needed:

- independence (actual and perceived)
- strong understanding of public sector management, health service administration and subject-specific knowledge relevant to recommendations
- good access to engage with individuals responsible for implementation and scope to offer objective guidance and advice
- sound reporting methodology, which includes monitoring of front-line staff experiences of the implementation of recommendations
- a long enough period of oversight to cover the reform agenda.[33]

We acknowledge that the policy framework and implementation plan may need to evolve over time because of changes in implementation dependencies and unexpected challenges, but we consider that, at the outset, the policy framework and implementation plan should contain the elements set out in the following recommendation.

Recommendation 15.1

The Department of Health should develop and communicate a policy framework and implementation plan for reforms to improve responses to child sexual abuse in health services. The policy and implementation plan should:

a. set out the purpose and need for the reforms

b. set out the role, responsibilities and interactions of bodies the Department has set up as part of the reforms

c. explain how reforms, including departmental reforms and those recommended by the Child Safe Governance Review, Community Recovery Initiative and this Commission of Inquiry, will work together to respond to child sexual abuse in health services

d. outline how the reforms are being prioritised for implementation and who is responsible for their implementation

e. set out the expected timeframes for implementation

f. be published on the Department's website.

3 Creating strong foundations to protect children

In this section, we make recommendations aimed at creating child safe cultures across Tasmanian health services including:

- establishing the National Principles for Child Safe Organisations as a mandatory requirement for accrediting health services against the National Safety and Quality Health Service Standards
- creating a child safe culture in Tasmanian health services
- empowering children to influence how health care is delivered
- creating safe physical environments for children
- ensuring the development and implementation of key child safe policies that are publicly accessible and create a shared understanding of the rights of children and expectations of staff conduct
- improving professional development for staff about child sexual abuse and related matters such as grooming and professional boundaries.

3.1 Implementing the National Principles for Child Safe Organisations

Health services that prioritise child safety share key organisational characteristics. These characteristics are reflected in the expectations of the National Principles for Child Safe Organisations ('National Principles') and include good culture, competent leadership, the empowerment of children and young people, safe physical environments, appropriate policies and targeted professional development. Although these principles are reflected in Tasmania's Child and Youth Safe Standards, we refer to the National Principles in this chapter because health services must be accredited nationally.

The Tasmanian Government and the Department should continue to work to implement the expectations of the National Principles in Tasmanian health services. The National Principles should also be a mandatory requirement for accrediting health services against the National Safety and Quality Health Service Standards.

3.1.1 National Safety and Quality Health Service Standards

The National Safety and Quality Health Service Standards ('National Standards') are the starting point for determining what is required for a hospital (or any health service) to be safe for patients. The National Standards are a consistent statement on the level of care consumers can expect from health services across Australia.[34]

The primary aims of the National Standards are to 'protect the public from harm and to improve the quality of health service delivery'.[35] All public and private hospitals, as well as other health services, are assessed for compliance with the National Standards as part of their accreditation under the Australian Health Service Safety and Quality Accreditation Scheme.[36]

While the National Standards make no express reference to child safety, the Standards most relevant to child safety are the Clinical Governance Standard and the Partnering with Consumers Standard.[37] Aspects of these Standards are discussed throughout this section.

3.1.2 Launceston General Hospital's accreditation against the National Standards

The last organisation-wide assessment of Launceston General Hospital against some of the National Standards occurred in 2022.[38] As of July 2023, the Australian Commission on Safety and Quality in Health Care's website indicates that the Launceston General Hospital is accredited, with an assessment against the National Standards 'to be completed by 12/12/2022'.[39]

One of the co-chairs of the Child Safe Governance Review, Adjunct Professor Debora Picone, also gave evidence to us in her capacity as Chief Executive Officer, Australian Commission on Safety and Quality in Health Care. She told us that in June 2022, the Tasmanian Health Service North Region, which includes Launceston General Hospital, underwent assessment during the week of 4 April 2022.[40] The assessment covered three of the eight Standards—the Partnering with Consumers Standard, the Preventing and Controlling Infection Standard and the Comprehensive Care Standard.[41] Independent assessors were also specifically asked to review the hospital's systems for incident reporting, complaints handling, risk management and open disclosure.[42] The assessors found the systems in place at the hospital 'were effective, were being used appropriately, and were being monitored'.[43]

3.1.3 Integrating the National Principles into the National Standards

While the National Standards apply to services provided to all patients, including children and young people, they do not specifically address issues of child safety.[44] Adjunct Professor Picone told us that aspects of the National Principles are reflected in the National Standards, particularly in the Clinical Governance Standard and Partnering with Consumers Standard.[45] Although it is not currently mandatory, there is an expectation that health services will implement systems to keep children safe and manage risks to children as part of complying with the National Standards.[46]

Adjunct Professor Picone told us that it would be possible, and indeed preferable, to embed the National Principles into the National Standards, making the National

Principles mandatory for all accredited health services.[47] She noted that the Australian Commission on Safety and Quality in Health Care has not previously had enough information about the failures of child safety systems in health services to warrant this.[48]

The Tasmanian Government has recently made efforts to implement the expectations of the National Principles, including within the Department (as evidenced in the new *Child Safety and Wellbeing Framework* referred to above and discussed below).[49] The enactment of the Child and Youth Safe Organisations Act will also legislate that health services providing care to children and young people must adopt the National Principles in the form of the Child and Youth Safe Standards, and implement a Reportable Conduct Scheme.[50]

However, in our view, the expectations of the National Principles should be reflected explicitly within mandatory requirements for accreditation against the National Standards under the Australian Health Service Safety and Quality Accreditation Scheme. This will highlight the core importance of child safety to broader concepts of patient safety, provide another safeguard for children and young people, and allow implementation of the National Principles to be assessed at least once every three years by a body that is familiar with the operating environments of health services.

We anticipate the Australian Commission on Safety and Quality in Health Care will engage and share information with the Independent Regulator of the Child and Youth Safe Standards and Reportable Conduct Scheme in Tasmania, as well as with the Tasmanian Health Complaints Commissioner, Ahpra and the National Health Practitioner Boards ('National Boards'), about the compliance of health services and health practitioners with the National Principles.

The need to ensure compliance with principles and standards of child safety extends beyond health services to health departments as system administrators for state-based public health systems and regulators of the private health sector.[51] Secretary Morgan-Wicks told us that the Department had not previously identified child sexual abuse in public health services as a specific strategic risk; instead, risk assessments tended to form part of patient safety and clinical decision-making processes in individual health services.[52] Secretary Morgan-Wicks identified areas in the Department that provide direct service delivery to children and young people, or that have access to the personal information of children and young people, as posing the greatest risk of child sexual abuse.[53] These areas included Women's and Children's Services, and Child and Adolescent Mental Health Services.[54]

Secretary Morgan-Wicks acknowledged that it was a 'critical oversight' that there was not a broader focus on managing the risks of child sexual abuse in public health services and indicated that the occurrence of child sexual abuse had now been added to the Department's Strategic Risk Register and approved by the Health Executive.[55] Secretary Morgan-Wicks told us that the Department's Child Safe Organisation Project was managing work to address this risk.[56]

The case studies discussed in Chapter 14 highlight the risk of child sexual abuse in health services and demonstrate that these services need to have systems in place to prevent such abuse occurring, and to respond appropriately when it does occur. The Tasmanian Government should advocate for the Australian Commission on Safety and Quality in Health Care to formally integrate the expectations of the National Principles into the National Standards.

Recommendation 15.2

1. The Tasmanian Government and Department of Health should continue to implement the National Principles for Child Safe Organisations across all health services.
2. The Tasmanian Government should advocate at a national level for compliance with the National Principles for Child Safe Organisations to be a mandatory requirement for accrediting health services against the National Safety and Quality Health Service Standards under the Australian Health Service Safety and Quality Accreditation Scheme.

3.2 Protecting children through a child safe culture

In this section, we recommend that the Department takes steps to embed a child safe culture in health services.

As noted in other chapters of our report, an organisation's 'culture' refers to the assumptions, values, beliefs and norms that distinguish appropriate from inappropriate behaviours in an organisation, and how those assumptions, values, beliefs and norms translate into practice, including staff conduct.[57]

Professor Ben Mathews, Research Professor, School of Law, Queensland University of Technology, told us that in Australia and other countries such as the United States it has been found that institutions with strong leadership and a positive culture have higher prospects of early recognition, reporting and appropriate responses to child sexual abuse.[58]

In Chapter 13, we outlined previous reviews that had identified common themes related to a poor organisational culture across Tasmanian health services including:

- ineffective governance arrangements and a lack of clarity about roles and responsibilities among health service staff
- an absence of scrutiny over staff conduct and decision making, and a lack of accountability for senior managers and executives

- organisational cultures characterised by poor leadership and poor behaviour, including misconduct by State Service employees in relation to conflicts of interest, underperformance and mistreatment of other staff
- failures to report misconduct due to fear of retribution
- instability because of changes in organisational and governance structures.

In the health context, the National Standards explicitly require that the governing body of a health service 'provides leadership to develop a culture of safety and quality improvement, and satisfies itself that this culture exists within the organisation'.[59] The Australian Commission on Safety and Quality in Health Care defines a safety culture as:

> A commitment to safety that permeates all levels of an organisation, from the clinical workforce to executive management. Features commonly include acknowledgement of the high-risk, error-prone nature of an organisation's activities; a blame-free environment in which individuals are able to report errors or near misses without fear of reprimand or punishment; an expectation of collaboration across all areas and levels of an organisation to seek solutions to vulnerabilities; and a willingness of the organisation to direct resources to deal with safety concerns.[60]

We consider that this requirement of leadership to support a safety culture should extend to ensuring safety and quality processes protect children and young people who are under a health service's care. Given our findings, achieving this outcome will require cultural change, at least within Launceston General Hospital and possibly across the Department.

Professor Erwin Loh, Group Chief Medical Officer and Group General Manager, Clinical Governance, St Vincent's Health Australia, told us: 'Culture change management is probably the hardest thing to do in any organisation, no matter what the profession or industry'.[61] As an expert in facilitating such change within health services, he offered the following reflections:

- Organisations need to have broad strategies for encouraging staff to speak up and not be afraid to 'challenge the status quo'. Organisations cannot rely on single initiatives alone.[62]
- Senior leadership must model the desired behaviours. The leadership should welcome criticism and feedback from staff and patients, ensuring those who have spoken up feel appreciated, listened to and that their concerns have been acted on.[63]
- Middle management (such as nurse unit managers and heads of medical units) must also be engaged in creating a safety culture.[64]

3.2.1 Cultural improvement initiatives

Secretary Morgan-Wicks recognised that organisational change is 'one of the most significant challenges' facing the Department.[65] She told us of several measures being implemented across the Department and at hospitals that are directed at improving organisational culture. These include:

- the Speaking up for Safety program being implemented at Royal Hobart Hospital, which is designed to build 'a culture of safety and reliability' in the hospital by encouraging all staff to speak up if they experience or observe concerning actions or behaviour[66]
- the One Health Cultural Improvement Program, which the Department began working on in January 2022.[67]

Professor Loh explained that the Speaking up for Safety program is based on the Vanderbilt Promoting Professional Accountability model ('Vanderbilt model') that is used widely in the United States and in some Australian hospitals.[68]

Professor Loh gave evidence of a similar program he is responsible for administering in St Vincent's Health Australia, known as the Ethos Program. Like Speaking up for Safety, this is a peer-based early intervention program designed to recognise staff who demonstrate positive behaviours, remove barriers from speaking up about concerns that affect patient or staff safety, and allow for a quick, fair and transparent response 'to all staff', including those making a complaint and those with concerning behaviours.[69]

Under the Ethos Program, staff are trained on how to 'speak up' effectively and can use an online messaging system to submit feedback for recognition (to acknowledge positive behaviour) or reflection (to offer feedback for improvement).[70] This feedback is delivered by a trained Ethos Messenger, who is generally a peer of the staff member, via an informal conversation.[71] The program allows for anonymous reports; however, Professor Loh told us that, in his experience, most people using the program are happy to be identified.[72] The Ethos Program supplements other practices at the hospital, including raising a concern directly with a colleague.[73]

Trained staff triage reports received through the Ethos messaging system across four levels, depending on the seriousness of the incident.[74] Less serious behaviour would not necessarily be formally reported. While Speaking up for Safety and the Ethos Program have a similar intent, a key difference is that the Ethos Program includes an option for positive recognition, whereas Speaking up for Safety facilitates only feedback in response to negative interactions.[75]

We consider a staff reporting system that applies to all staff, volunteers, contractors and sub-contractors in a hospital is a valuable initiative for creating a culture that enables giving and receiving of feedback.

We note, however, that professional boundary breaches towards a child by a staff member, whether they are an employee, volunteer, contractor or sub-contractor, should always be formally reported, responded to and recorded in centralised records for future reference.

Secretary Morgan-Wicks told us that the Department's One Health Cultural Improvement Program is based on a 'cultural baseline' of information drawn from staff interviews; an academic literature review relating to health care and organisational culture; departmental surveys and reviews; and data relating to workers compensation, State Service Code of Conduct investigations and workplace safety reports.[76] In May 2022, Secretary Morgan-Wicks told us that work had begun under the program to:

- develop and embed departmental values that signal acceptable behaviours, and what to do if these are not upheld
- build leadership and management skills, including around communication and how to respond to complaints or grievances
- improve induction procedures for new employees to help them better understand values and desired behaviours
- improve complaints and disciplinary policies and processes.[77]

When Secretary Morgan-Wicks gave evidence at our hearings in September 2022 she advised that the Department was putting the finishing touches on the program.[78]

The Child Safe Governance Review made several recommendations to improve the culture at Launceston General Hospital.[79] These included recommendations to:

- set up a specific advisory group at the hospital with diverse membership[80]
- improve communication with staff about progress against cultural improvement plans[81]
- clarify the expectations of executive and management through performance agreements[82]
- develop a culture improvement strategy[83]
- monitor staff feedback through annual surveys on patient safety culture.[84]

As noted above, the Tasmanian Government has accepted all the recommendations set out in the Child Safe Governance Review.[85]

In a written update provided to our Commission of Inquiry in February 2023, Secretary Morgan-Wicks stated that senior leadership at Hospitals North, which includes Launceston General Hospital, is implementing an accountability and culture framework called Excellence Together.[86]

3.2.2 Our observations

We welcome the focus of the Tasmanian Government and the Department on addressing organisational culture to address child safety concerns. We consider that these reforms should be guided by a set of principles, which we set out in the following recommendation. We also consider that progress reports to the Child Sexual Abuse Reform Implementation Monitor (Recommendation 22.1) should demonstrate how these principles have been translated into policy and practice.

Initiatives designed to support cultural change should be informed by a range of sources and be the subject of regular review and evaluation against pre-established criteria to ascertain whether they are achieving desired outcomes.

Recommendation 15.3

The Department of Health should ensure its cultural improvement program embeds a safety culture in health services by:

a. requiring clear organisational values be observed across all levels of health services, including in relation to staff conduct

b. establishing strong governance arrangements to address staff practices that place children at risk of abuse, and complementing established patient safety governance structures

c. ensuring all levels of management demonstrate a commitment to a safety culture, including by addressing poor staff conduct

d. clarifying roles and responsibilities among staff when there is a suspicion that child sexual abuse has occurred or that safety policies are not observed

e. ensuring there are processes that hold senior managers and executives accountable to respond appropriately to the conduct of their staff, including through performance agreements and role descriptions

f. establishing measures of a strong organisational culture that indicate an organisation

    i. welcomes concerns about staff and sees them as an opportunity to improve safety for staff and patients

    ii. empowers staff to feel safe and supported to raise concerns about colleagues with their leaders and gives them confidence in the ability of leaders to respond to concerns and take disciplinary actions (including termination) where appropriate

iii. ensures staff are clear about the process for raising concerns, how these concerns will be addressed and what feedback they can expect to receive

g. providing progress reports to the Child Sexual Abuse Reform Implementation Monitor to demonstrate how these principles have been translated into policy and practice (Recommendation 22.1).

Recommendation 15.4

1. The Department of Health should consider integrating features of the St Vincent's Health Australia's Ethos Program into its cultural improvement program.
2. The Department of Health should ensure, in adopting its cultural improvement program, professional boundary breaches by staff towards a child are always formally reported, responded to and recorded in centralised records for future reference.

3.3 Embedding child safety as a priority for leadership

The National Principles state an expectation that 'child safety and wellbeing is embedded in organisational leadership, governance and culture'.[87] As Professor Mathews says:

> To succeed in preventing child sexual abuse requires a genuine commitment by the institution or organisation to children's rights to safety. If the leadership in an organisation does not possess this quality, it is near impossible to prevent instances of child sexual abuse.[88]

3.3.1 Problems of leadership and accountability

In Chapter 14, Case study 3, relating to James Griffin we make several findings about the failures of leadership in Launceston General Hospital. These included findings that:

- Launceston General Hospital leadership collectively failed to address a toxic culture in Ward 4K that enabled James Griffin's offending to continue and prevented his conduct being reported.
- Leadership at Launceston General Hospital collectively failed to provide appropriate supervision and proactive oversight, which is a systemic problem.
- Leadership at Launceston General Hospital was dysfunctional, and this compromised its collective response to revelations about James Griffin.
- Launceston General Hospital did not have clear accountabilities for child safety.

Several senior executive staff at Launceston General Hospital told us that responsibility for child safety was not part of senior executive roles and that they were not subject to any performance measures, indicators or financial outcomes in relation to safeguarding children.[89]

3.3.2 The need for accountability

Dr Samantha Crompvoets, Director, Australian Human Rights Commission and sociologist with expertise in organisational culture, was frank in her evidence to our Commission of Inquiry about the limits of incremental organisational change in response to a crisis. She noted that there may be times, due to the nature and significance of particular events, when a 'complete reset' of the organisation will be required from the ground up.[90] Dr Crompvoets said that leadership accountability is essential to achieving change within an organisation.[91] She spoke about the importance of 'tangible' accountability, which requires a specific person to be responsible for a particular recommendation or action.[92] Dr Crompvoets noted that accountability should not be a 'tick and flick' exercise, but built into a leader's key performance indicators.[93]

Will Gordon, the Launceston General Hospital nurse who blew the whistle on the management of complaints about Mr Griffin, told us that nothing would change at the hospital 'unless management at every hierarchical level … changes'.[94] Another staff member said that the hospital needed 'to be flushed from the top down' and that '[n]ew staff should be put in all senior positions'.[95] The co-chairs of the Community Recovery Initiative described 'strong feelings' among those they consulted that senior leaders who gave evidence at our Commission of Inquiry 'be seen to be made accountable and be seen to be removed and not allowed just "to retire"'.[96] The co-chairs went on to say:

> To not meet this criterion will, in our view, lead to the risk of an overall failure assessment of restorative trust actions from those we heard from and, more generally, for those whom [the Department] seeks to restore a trusting relationship.[97]

At our hearings, Secretary Morgan-Wicks also acknowledged that it was time Launceston General Hospital had a 'complete reset'.[98]

3.3.3 Recent reforms

The Department has developed the *Child Safety and Wellbeing Framework* as part of its Child Safe Organisation Project. This framework, publicly released in September 2022, has the objective of establishing 'a systemic approach to enhance the way the Department of Health works with vulnerable people, specifically children and young people'.[99] It:

- ensures structures, systems and processes are in place to mandate and foster a child safe organisation and child safe culture[100]
- establishes the National Principles as key priorities to be embedded into the Department's child safe approach[101]

- applies to the entire Department, as well as organisations funded by the Department[102]
- details the responsibility and requirements to be met by all people engaged by the Department in protecting the health, safety, welfare and wellbeing of children and young people.[103]

Secretary Morgan-Wicks told us that the framework is an important step in ensuring a Department-wide commitment to child safe practices and reporting of suspected child sexual abuse.[104]

The Tasmanian Government has also committed to clarifying expectations and improving accountability for child safety through Head of Agency performance agreements.[105] Jenny Gale, Secretary, Department of Premier and Cabinet and Head of the State Service, told us on the final day of our hearings:

> Every Head of Agency's performance agreement with the Premier will commit them to identify and take action within their own department and across the service that will keep children safer. This commitment applies regardless of whether that agency engages directly in child-related work.[106]

We would expect such performance measures to also filter down into the responsibilities of other management teams in health services.

Adjunct Professors Picone and Crawshaw advised us in July 2023 that Secretary Morgan-Wicks had issued a directive to all staff under section 34 of the *State Service Act 2000* ('State Service Act') in respect of their child safeguarding responsibilities as employees of the Department of Health, and is updating all statements of duties to include the following:

> Champion a child-safe culture that upholds the National Principles for Child Safe Organisations. The Department is committed to the safety, well-being, and empowerment of all children and young people, and expects all employees to actively participate in and contribute to our rights-based approach to care, including meeting all mandatory reporting obligations.[107]

The Child Safe Governance Review also made several recommendations for ensuring accountability of leadership through improved governance, organisational structure, clearer roles and accountabilities, and professional development. Although many of these recommendations relate to Launceston General Hospital, they are relevant to other health services across Tasmania. Key recommendations of the Child Safe Governance Review include:

- ensuring collective and individual commitment to child safety through the Secretary, executive and clinical leadership of Launceston General Hospital implementing the *Child Safety and Wellbeing Framework*, signing a statement of commitment and undertaking an annual review of child safety and wellbeing status, confirmed by a publicly reported attestation statement[108]

- changes to the organisational structure and executive titles at Launceston General Hospital, including splitting the role of Chief Executive Hospitals North/North West and advertising for a new Chief Executive Hospitals North[109]
- more frequent meetings between various management and governance groups in Hospitals North, including at least a quarterly discussion on culture improvement initiatives and the implementation of the Child Safe Organisation Framework, which, under the Child and Youth Safe Organisations Act, comprises the Child and Youth Safe Standards and Reportable Conduct Scheme at Launceston General Hospital[110]
- various changes to role responsibilities and added performance measures relating to child safety, culture, workplace and patient safety for executives and senior managers, supported by annual performance reviews.[111]

On accepting the interim recommendations of the Child Safe Governance Review in September 2022, the Premier announced more changes to support leadership renewal at Launceston General Hospital and the Department, including changes to existing positions and the creation of new positions.[112] The announcement stated that some key members of Launceston General Hospital's executive team had either moved to another leadership role, were acting in their current role or were 'on a period of extended leave' before their impending retirement.[113]

3.3.4 Our observations

Health leaders need to be equipped and empowered to embed the expectations of the National Principles and related reforms in the day-to-day work and practice of staff working in health services. Various activities will aid their endeavours, including culture-improvement initiatives, refreshed policies and practices, and relevant professional development, for which we make recommendations elsewhere in this chapter.

Health leaders (and State Service staff) are subject to annual performance reviews. We consider that health leaders should have accountability measures for child safety in their performance agreements and that they should receive regular feedback on their performance against these measures.

The Australian Commission on Safety and Quality and Health Care's *User Guide for Acute and Community Health Service Organisations that Provide Care for Children* ('User Guide') suggests mechanisms through which health services should adopt the Charter on the Rights of Children and Young People in Healthcare Services in Australia (discussed below), including:

- allocating responsibility for the implementation of the Charter to a senior individual or committee
- building the requirements of the Charter into the organisation's safety and quality systems, and processes of care for children

- displaying the Charter in areas within the organisation frequented by children, such as paediatric units or play areas
- providing accessible copies of the Charter in formats that meet community needs, especially for those with limited capacity to read and comprehend complex written text
- providing education about the Charter to new members of the workforce responsible for providing care for children
- using the Charter as the basis for discussions between clinicians and children about care planning and treatment
- using play-based techniques when appropriate
- adding specific questions relating to the Charter to consumer experience surveys.[114]

We consider some of these mechanisms could be used to support a commitment to child safety across health services. We also recommend that the Department have appropriate processes in place to ensure leaders have the knowledge, skills, aptitude and core capability requirements to effectively manage people and to lead a child safe organisation.

Recommendation 15.5

The Department of Health should make health leadership accountable for embedding child safety as a priority, including by:

a. ensuring that all relevant health leaders have an obligation to act consistently with the National Principles for Child Safe Organisations (reflected in Tasmania's Child and Youth Safe Standards) in their role descriptions and performance agreements, with compliance with this obligation to be reviewed annually

b. ensuring that the role descriptions and performance agreements of all staff providing services to children require them to protect child safety, with compliance with this obligation to be considered as part of annual performance reviews.

Recommendation 15.6

The Department of Health, to support health services become child safe organisations, should ensure:

a. child safety, including safety from abuse in health services, is overseen by the governance and leadership structures established through the cultural improvement program

b. child safety is built into the safety and quality systems of health services

c. staff responsible for providing care to children have the knowledge and skills to respond to child safety concerns in line with the expectations of a child safe organisation and relevant health service policies, including being equipped to identify and respond to indicators of child sexual abuse

d. staff act consistently with the National Principles for Child Safe Organisations (reflected in Tasmania's Child and Youth Safe Standards) when performing their work, including in discussions between health practitioners, health workers and children about care planning and treatment.

3.4 Empowering children, families and carers

Children's views about their health care are important and should inform health services' policies and practices. In this section, we consider the barriers that children and their families and carers may face in identifying inappropriate behaviour by health workers and in raising concerns with health services, particularly in a hospital setting. We also consider how children can and should influence health services' policies and practices more generally. We make recommendations that will help to:

- facilitate engagement with children about safe health care
- address concerns about children's perceptions of safety in hospitals, including by creating a safe physical environment
- ensure consistent information is provided to children and their families and carers about patient rights, what they can expect of staff, and ways to provide feedback.

3.4.1 Empowering children and young people through meaningful engagement and participation

Principle 2 of the National Principles states, in part, an expectation that organisations ensure children and young people participate in decisions affecting them.[115] In health services, this means that children and young people should have the opportunity

to inform decisions about their individual health care, and be consulted about the development, implementation and evaluation of health services' policies and strategies that are relevant to their care and safety.[116]

The Australian Commission on Safety and Quality in Health Care's User Guide states that health services can involve children and young people (as well as their families) in the development, implementation and evaluation of relevant policies and strategies through a governance structure that, among other things:

- effectively engages children and their families and carers
- has representation from children and their families and carers
- includes mechanisms to maximise engagement with children
- includes the views of children and their families when planning new facilities or redesigning existing ones.[117]

The National Standards also require health services to 'seek regular feedback from patients, carers and families about their experiences and outcomes of care' and to 'use this information to improve safety and quality systems'.[118]

At our hearings in September 2022, we asked Secretary Morgan-Wicks about how the voices and views of children were informing the Department's work. She indicated that the Department had engaged the Commissioner for Children and Young People and Child Wise, a child safeguarding consulting organisation, to provide expert advice on the best ways to ensure children's perspectives were reflected in the *Child Safety and Wellbeing Framework* and new policies and procedures.[119] In November 2022, Secretary Morgan-Wicks wrote to our Commission of Inquiry to tell us that the Department had worked with the Commissioner for Children and Young People to consult with children on a new name for the paediatric ward (previously known as Ward 4K) at Launceston General Hospital.[120] In a progress update provided to our Inquiry in February 2023, Secretary Morgan-Wicks wrote:

> The consultation process with children to engage them initially on child safeguarding themes is progressing and will also include consultation on renaming the children's wards across the State. The Department of Health will implement an ongoing engagement mechanism from the initial consultation process. Engagement with children will also feed into the development of child safe behaviours and further consideration of child-friendly complaint mechanisms.[121]

In June 2023, it was announced that paediatric wards across Tasmania's major hospitals will soon be known as the 'Wombat Ward', based on consultative processes with young Tasmanians aged 8 to 18 years through workshops at the Royal Hobart Hospital, Launceston General Hospital and the North West Regional Hospital in April 2023.[122] We were advised that these workshops also canvassed broader discussion of children's experiences of health services, including what was working well and what could be improved.[123]

We welcome this engagement, but consulting children and young people on the renaming of a hospital ward is a small step. While we are encouraged by some broader discussions about children and young people's experiences of health services, we would like to see the Department's engagement with children and young people continue to expand as reforms are further planned and implemented.

In December 2022, the Child Safe Governance Review reported that children and young people who are treated at Launceston General Hospital do not have a pathway for reporting concerns about their safety, other than raising these concerns 'in person' with a staff member.[124] The review made two recommendations relevant to this issue:

- the Department of Health [develops] an online form for children and young people to report concerns about their safety (in real time)[125]
- children and young people who are provided with health care within the Tasmanian Health Service be provided with the opportunity to complete a survey of their patient experience.[126]

Again, these steps are commendable. But we consider that the Department should go further to proactively empower children and young people to meaningfully participate in decision making on matters that affect them, including their safety. The Department could do this by setting up ways to engage with children and young people regularly and meaningfully.

The relationship between children and young people feeling heard and feeling safe was something identified through our commissioned research into safety in government run organisations.[127] Associate Professor Tim Moore, Deputy Director, Institute of Child Protection Studies, Australian Catholic University, who was one of the researchers we commissioned, told us:

> Children and young people want to play a part in their own protection and, in building alliances with adults to develop strategies to meet their safety needs, they can build confidence, awareness and an ability to turn to adults if they are being harmed … 'participatory' strategies need to empower individual children and young people through child-friendly and proactive means as well as through collective activities such as youth advisory groups.[128]

Liana Buchanan, Principal Commissioner, Commission for Children and Young People (Victoria), similarly stated that:

> Efforts to empower children in organisations are critical. An organisation can have perfect policies, processes and systems but if children do not feel that they will be listened to if they speak up, and that they will be believed and action taken, the policies and systems will be of little value.[129]

Victoria's Commission for Children and Young People has developed a guide for organisations working with children and young people.[130] The guide recognises that everyone benefits when children and young people's participation is done well,

outlining principles to support the meaningful participation of children and young people in decision making.[131] The Commission for Children and Young People's guide also includes specific advice for involving children and young people of different ages.[132]

The Office of the Advocate for Children and Young People in New South Wales has developed a comprehensive guide for setting up a children and young people's advisory group.[133] The purpose of such an advisory group is to facilitate the voices of children and young people on a range of issues relevant to service delivery.[134] An advisory group is a way to gather feedback, test ideas and ensure policies and practices best reflect the unique needs of children and young people.[135] Participation in an advisory group can build children and young people's trust and confidence in an organisation, improve the experience of children and young people within that organisation, and enhance the knowledge of an organisation's leaders about child safety.[136]

Establishing a dedicated health services young people's advisory group in Tasmania will help facilitate the contribution of young people in creating safer health services and will complement measures the Department is already implementing.

The types of issues that the health services young people's advisory group could contribute to, using developmentally appropriate methods, include:

- policies and practices that relate to providing health care to children and young people (for example, expected standards of staff behaviour, use of chaperones (or accompanying persons/observers) and processes for getting informed consent, or how to make a complaint)
- induction materials for staff in child-facing roles
- the design, interpretation and response to surveying children and young people cared for in Tasmanian health services recommended by the Child Safe Governance Review[137]
- initiatives to improve the experience of health care for groups with particular needs (for example, Aboriginal and other culturally diverse children, gender diverse young people and those with disability or mental illness, or those who identify as LGBTQIA+)
- analysing complaints data and advising on how to avoid future complaints
- implementing initiatives under the Child Safe Organisation Project
- built environment projects or upgrades to facilities that will affect younger patients
- contributing to recruitment processes for senior roles focused on child safety.

It is important that the health services young people's advisory group is adequately funded and that the role and functions of the group, including the scope of its authority, are clear from the outset. Without this support and role clarity, participants may feel the group is tokenistic or hollow, creating understandable cynicism and distrust that only serve to damage an organisation.

It would be beneficial for senior leaders within the Department and its agencies, as well as statutory role holders—such as the Health Complaints Commissioner, Ahpra, the National Boards and the Commissioner for Children and Young People—to regularly engage with the health services young people's advisory group. This engagement could include making themselves available for questions and discussion.

We acknowledge that setting up a health services young people's advisory group may mean that only a small number of children and young people are consulted. It is therefore important that the Department also pursues other strategies to engage children and young people of all ages. These strategies may include consultations, surveys, youth forums and events, staff communications and social media.[138] One strategy, for example, could involve extending the role of hospital-based child safeguarding officers to include engaging and empowering children and young people through regular visits to hospital wards and providing information to them in appropriate formats. It is imperative that the Department identifies age-appropriate ways to engage with all children and young people on questions of patient safety.[139] The health services young people's advisory group would be well placed to advise on these strategies.

Recommendation 15.7

1. The Department of Health should establish a health services young people's advisory group. The advisory group should:
    a. have a clear purpose and objectives
    b. be guided by clear terms of reference developed in consultation with children and young people
    c. comprise young people with significant lived experience of health services, including young people of different ages, from diverse backgrounds and with different care needs
    d. enable young people to contribute to decision making in a safe and meaningful way about issues that affect them
    e. allow young people to have a say in departmental strategies, policies, procedures and protocols that affect them
    f. be adequately funded and resourced.
2. Summaries of the health services young people's advisory group meetings should be prepared and distributed to all senior executive teams in the Department.

3. The Department should report on the activities of the health services young people's advisory group and on other engagement with children and young people through its annual report.
4. The Department should undertake other age-appropriate engagement with children to ensure as many children and young people as possible can take part in shaping health services.

3.4.2 Children and young people's perception of safety in hospitals

Our commissioned research showed that children often feel unsafe and disempowered during hospital stays. Some reported feeling unsafe because they were given little information about their treatment or because medical staff dismissed their opinions.[140] Associate Professor Moore said:

> Children continue to report that they feel disrespected, their needs and wishes disregarded and their ability to influence change as limited. While we see children as having less value to adults and their views and needs as secondary to those of adults, children are vulnerable.[141]

Speaking of their experience receiving care at a hospital, one young person explained how not being believed affects how safe and well young people feel:

> Socially, often, children aren't believed when they say something. Their opinions aren't valued as much because they're children, because they're young.
> A lack of life experience. I also think because I was unwell mentally, physically.
> But regardless, if I'm unwell, I should still be treated with compassionate decency.
> To treat somebody in that state in such [a] dehumanising and most humiliating way, it just makes you feel worse. It makes you not want to commit to getting better.
> I makes you feel like you're hopeless.[142]

This young person went on to describe how raising concerns did not resolve their negative situation at the hospital and left them feeling their issues were not taken seriously. They said that for children to feel safe in institutions like hospitals it is essential that they are believed and listened to.[143]

Some people, including children and young people, are not aware of their rights when receiving health care.[144] Angelique Knight, a former Ward 4K patient, told us: 'You are so vulnerable while you are in hospital because you are completely reliant on someone else doing everything for you'.[145] She said: 'Patients should be told about how they can make complaints. There could be signs up on the wall or a pamphlet could be placed in your hospital pack'.[146] This sense of disempowerment can also extend to parents and carers of child patients. For example, Angela (a pseudonym) described the challenge she faced when she raised concerns about vaginal cream being used for her young daughter, who has cerebral palsy and needs support to communicate.[147] Angela said she raised her concerns but felt staff dismissed them and that she was unaware of any action being taken.[148]

It can be difficult for children, families and carers to identify improper conduct when receiving health care or medical treatment. Some witnesses only came to understand the behaviour of Mr Griffin as inappropriate once they were adults. For example, Kirsty Neilly, another former Ward 4K patient, reflected on an incident where Mr Griffin had carried her from the ward shower back to her room, wrapped only in a towel: 'I now think that Jim carrying me from the shower like that is weird. I shouldn't have been so casual about it'.[149]

To further complicate matters, children and young people and their families and carers can sometimes understandably perceive inappropriate and unprofessional behaviours as the actions of dedicated and caring health workers. Kim (a pseudonym) told us that when she attended Launceston General Hospital with her daughter Paula (a pseudonym), Mr Griffin was a familiar face at a time she was feeling scared.[150] She described perceiving Mr Griffin's interest in her daughter and his 'touchy-feely' nature as him being friendly and caring.[151]

Sonja Leonard, former Nurse Unit Manager, Ward 4K, Launceston General Hospital, commented that children and parents often reacted positively to Mr Griffin's boundary breaches, such as hugging child patients, and that staff witnessing the behaviour 'did not respond negatively'.[152]

3.4.3 Rights when receiving health care

Health services have a critical role to play in promoting patients' rights, expected standards of staff behaviour and complaints pathways.

The National Standards Partnering with Consumers Standard requires that 'leaders of a health service organisation develop, implement and maintain systems to partner with consumers' in relation to 'the planning design, delivery, measurement and evaluation of care'.[153]

Under the National Standards, health services must adopt a charter of rights that is consistent with the *Australian Charter of Healthcare Rights* and ensure this local charter is accessible to patients, carers, families and other consumers.[154] The *Australian Charter of Healthcare Rights* describes what patients, families and carers should expect when receiving health care. It says that an individual has the right to:

- provide feedback or make a complaint without it affecting the way they are treated
- have concerns addressed in a transparent and timely way
- share their experience and take part in improving the quality of care and health services.[155]

The *Charter on the Rights of Children and Young People in Healthcare Services in Australia* also sets out 11 rights that 'aim to ensure that children and young people receive health care that is both appropriate and acceptable to them and to their families'.[156]

These include the rights of children and young people to:

- express their views, and to be heard and taken seriously
- participate in decision making and, as appropriate to their capabilities, to make decisions about their care
- be kept safe from all forms of harm.[157]

Secretary Morgan-Wicks told us that the information given to patients, including children and young people, varies across Tasmanian public health services.[158] Information is sometimes provided through the following publications:

- *Australian Charter of Health Care Rights*, including the consumer booklet *Understanding My Healthcare Rights* (published by the Australian Commission on Safety and Quality in Health Care)
- *Young People's Healthcare Rights* (published by Children's Healthcare Australasia)
- *The Rights of Every Child in Healthcare* (also published by Children's Healthcare Australasia).[159]

Secretary Morgan-Wicks also told us that the practices of different health services relevant to informing patients about their rights will align as part of the Department's ongoing reform work.[160]

In our view, the Department should ensure all health services provide consistent information to young patients and their families and carers about rights, safety and care. This information should be delivered in accessible and age-appropriate language and formats. Health workers should also receive professional development on these issues. Again, child safeguarding officers in Tasmania's four major public hospitals could help provide such information to health consumers and staff.

Recommendation 15.8

1. The Department of Health should ensure consistent information is provided to patients, including suitable age-appropriate resources for children and young people and their families and carers, across its health services. These resources should include information on:
    a. requirements and expectations of a child safe organisation
    b. patient rights when receiving health care, including the rights of children and young people

c. expected standards of behaviour for health service staff

d. processes for raising concerns and making complaints internally and externally

e. roles of health regulatory bodies in receiving complaints.

2. This information should be provided in formats that meet community needs, especially for those with less capacity to comprehend complex written text.

3.4.4 Creating a safe physical environment

The National Principles state an expectation that an organisation's physical environment must promote the safety and wellbeing of children and young people while minimising the opportunity for them to be harmed.[161] The National Standards require health services to maximise safety and quality of care for patients through the design of the health service's environment and by ensuring buildings, equipment, utilities, devices and other infrastructure are fit for purpose.[162]

In this section, we discuss physical factors that can affect the safety of children and young people in health services. We also summarise what we heard about recent efforts to improve the physical environment of Launceston General Hospital.

We make recommendations to ensure children and young people's sense of safety is monitored to inform improvements in the physical environment of health services, and that these safety considerations extend to the needs of children and young people with diverse needs and backgrounds (for example, those who are Aboriginal, come from culturally diverse backgrounds, have disability or mental illness or identify as LGBTQIA+).

3.4.5 Physical factors affecting the safety of children and young people

In our commissioned research into children's perceptions of safety, several young people said that they did not feel safe in hospitals because of their physical characteristics. These young people described:

- hospitals as 'creepy' and 'sterile'[163]
- their hospital room as dark and not having a window—'I didn't feel like I could flourish in an area like that'[164]
- feeling uncomfortable 'being in a room with strangers'[165]
- hospitals not being welcoming spaces for Aboriginal children and young people.[166]

Catherine Turnbull, Chief Child Protection Officer, SA Health, Department for Health and Wellbeing, told us about a range of physical factors that make children and young people vulnerable to abuse and harm in hospital settings. These include children and young people being kept in individual rooms that are not closely monitored by staff or CCTV, and health workers examining children and young people without a chaperone present (such as a parent, carer or other staff member).[167]

Others who shared their experiences made observations about the physical environment of Launceston General Hospital at the time of their admission and how they felt unsafe, isolated, out of view of others, or that staff could easily be alone with patients.[168]

This evidence illustrates why health services should not assume that the 'busyness' of a hospital ward, emergency department or other health service negates the risk of abuse of children and young people.

3.4.6 Efforts to improve physical safety at Launceston General Hospital

One of the Department's new Child Safety and Wellbeing Principles in its *Child Safety and Wellbeing Framework* focuses on providing safe health care environments (including physical and online environments), and ensuring health services that contract third-party providers have 'procurement policies that ensure the safety of children and young people'.[169]

Launceston General Hospital's paediatric ward has recently undergone an extensive redevelopment as part of broader upgrades to the hospital's Women's and Children's Services precinct.[170] This redevelopment was completed in November 2022.

Secretary Morgan-Wicks described the redevelopment as adding a 34-bed children's ward and a paediatric outpatient clinic incorporating allied health.[171] Secretary Morgan-Wicks also described that the new ward offers more single rooms with bathrooms, is divided into two age-appropriate pods for younger patients and adolescents, and meets Australian building standards.[172] Other features include a playroom, playground and outdoor courtyards.[173]

Secretary Morgan-Wicks said the redevelopment has resulted in 'improved observation of patients by staff' and provided 'room for an adult support person to stay with a child patient throughout the admission, promoting safety, advocacy and comfort for everyone'.[174] She said that in addition to providing 'a brand new, contemporary and safer layout', the redevelopment has also 'helped to trigger significant staff conversations in relation to brand new models of safer care in their new environment'.[175] Commissioner Benjamin visited the redeveloped paediatric ward on 14 March 2023.

We welcome these improvements and view them as a good start, but not an end point, for improving child safety.

The Department should seek feedback on how to ensure health spaces designed for children feel safe and welcoming. The Child Safe Governance Review recommended that children and young people be provided with the opportunity to complete a survey on their patient experience.[176] This survey should include questions about children and young people's perception of safety, including physical safety, in the hospital. Responses should inform ongoing monitoring, evaluation and improvements to the hospital's physical environment. Data obtained from this and other surveys such as the Patient Safety Culture Survey, Child Safe Organisation Survey and People Matter Survey may also inform improvements. We would like the Department to work to ensure the physical environments of all its health services are safe for children and young people. Again, the child safeguarding officers at each of Tasmania's four major public hospitals could play a role in this work.

We understand that the Department has embedded Aboriginal health liaison officers at its major hospitals. We have not, however, seen evidence of any work to ensure the paediatric ward, Launceston General Hospital or other Tasmanian health services are culturally safe spaces for Aboriginal children and young people.[177] In our view, the Department should actively consider actions in this regard.

The Department should work with relevant stakeholders to consider diverse and varied needs and backgrounds of children and young people using health services, including those who are Aboriginal, come from culturally diverse backgrounds, have disability or mental illness or identify as LGBTQIA+.

Recommendation 15.9

The Department of Health should require its health services to undertake regular and ongoing monitoring of children and young people's sense of safety in health services to inform continuous improvements to child safety, including in the safety of the physical environment.

Recommendation 15.10

The Department of Health should work with relevant stakeholders to consider the needs and backgrounds of children and young people using health services, including Aboriginal children, children from culturally diverse backgrounds, children with disability, children with mental illness and children who identify as LGBTQIA+. The Department should consult with Aboriginal communities on how it can provide culturally safe spaces for Aboriginal children across its health services.

3.5 Policies, procedures and protocols on child safety

Policies, procedures and protocols play a key role in supporting health services to reduce the risk of child sexual abuse and to appropriately respond to concerns when they arise. As our case studies in Chapter 14 show, informally assessing or responding to concerns about staff conduct with children and young people does not keep them safe. Well-drafted, targeted and up-to-date policies, procedures and protocols on child safety enable child safety to be embedded in practice and for any concerns to be quickly raised by staff and appropriately addressed by the health service.

In this section, we recommend a review and consolidation of the Department's existing policies to identify gaps in safeguarding children. Once consolidated and revised, these policies should be regularly reviewed so they reflect best practice and provide accurate, up-to-date information to staff, who rely on them to effectively perform their roles and fulfil their responsibilities. We also identify key policies in relation to child safety—such as those that explain external reporting obligations, professional conduct and chaperoning—that need revising or drafting and should be prioritised in the review of policies and procedures.

3.5.1 The importance of child safety policies

The National Principles recognise the importance of policies to safeguard children.[178] The Australian Commission on Safety and Quality in Health Care's User Guide provides that 'policies, procedures and protocols should include processes for identifying children at risk of harm from health care'.[179] The User Guide suggests several strategies to protect children's safety and privacy, including minimising non-essential exposure of children to people not authorised to provide their care, detailing requirements for mandatory reporting and balancing the promotion of children's rights to use electronic devices with the risks posed by these devices.[180]

3.5.2 Current policies and procedures

The Department has 'numerous' policies, procedures and protocols in place to reduce the risk of child sexual abuse.[181] These include those relating to pre-employment, clinical practice, behavioural standards, identifying child sexual abuse, consumer complaints, complaints and incident handling, external reporting, targeted supports, and records and information management.[182]

These policies, procedures and protocols are available to staff through the Department's Strategic Document Management System, which is accessible via the intranet.[183] Changes to key policies, procedures and protocols are communicated to staff through a communications platform called 'Reach', as well as through email, updated hardcopies and at staff meetings.[184]

Secretary Morgan-Wicks told us that staff are made aware of the location of policies, procedures and protocols when they start in their role. She said it was her expectation that managers would draw key policies, procedures and protocols to the attention of staff and encourage them to familiarise themselves with those that are relevant to their role.[185] Secretary Morgan-Wicks also stated that volunteers are expected to comply with departmental policies, procedures and protocols.[186]

We received some evidence that the technology used to access policies needed improvement. For example, Sue McBeath, Nursing and Midwifery Director, Women's, Adolescent and Children's Services, Tasmanian Health Service South, told us the intranet site used by staff relies on outdated technology, which contributes to 'confusion and delays' in accessing relevant information.[187]

Our examination of departmental policies, procedures and protocols revealed that many were past their review date or only applicable to particular regions, areas or services. Further, many focused primarily on the risk of familial abuse of children and young people, rather than the risk of child sexual abuse being perpetrated by a health worker. There did not appear to be any policies, procedures or protocols developed specifically in response to the National Royal Commission's recommendations.[188]

Launceston General Hospital used several overarching policies and information guides covering the care of children and young people including:

- *A Manual for Working with Vulnerable Children and Their Families*[189]
- *Child Safety Practice Framework*[190]
- *Reporting Concerns About the Safety and Wellbeing of Children and Young People*[191]
- *Charter on the Rights of Children and Young People in Healthcare Services in Australia*.[192]

Again, most of these resources focused on the risk of familial abuse of children and young people rather than the risk of child sexual abuse in health settings. The Child Safe Governance Review also noted that Launceston General Hospital had been inconsistent in implementing and following statewide policies and frameworks.[193]

Ms Turnbull told us that SA Health has developed several policies, guidelines and directives that specifically address the safeguarding of children and young people in the health system, including the *Child Safe Environments (Child Protection) Policy Directive* and the *Responding to Suspected or Alleged Offences Against a Child or Young Person Occurring at a SA Health Facility or Service Policy Guideline which are available online*.[194]

In contrast with the Tasmanian Department's policies, procedures and protocols discussed above, SA Health's policies are clearly targeted at preventing and responding to child safety concerns in a health service context.

3.5.3 Efforts to improve child safety policies

Secretary Morgan-Wicks told us that one of the Department's recent initiatives has been to review and align its policies, procedures and protocols.[195] She described this process as 'time-consuming' and requiring 'significant change management to align disparate regional practices into a consistent and statewide protocol that is accepted by all health professional and support staff groups'.[196] She also said that the COVID-19 pandemic had slowed progression of this initiative.[197]

One of the Department's Child Safety and Wellbeing Principles in its *Child Safety and Wellbeing Framework* is '[a]ccessible and inclusive child safety and wellbeing policies'.[198] The framework foreshadows the development of several policies, protocols and guidelines relating to child safety, including:

- a child safety and wellbeing policy
- a protocol for interacting safely with children and young people
- a policy for safeguarding children and young people
- a protocol for safeguarding children and young people.[199]

The *Child Safety and Wellbeing Framework* is accompanied by practice guidance titled *Recognising the Signs of Harm to Children and Young People* and practice guidance titled *Disclosures of Harm to Children and Young People*.[200]

3.5.4 Our observations

We agree that child safeguarding policies should apply to health services statewide.

We also agree that the Department's review of policies should include specific policies for safeguarding children in health services. We discuss specific policies below.

The Department should ensure it complies with the requirements set out in Action 1.7 of the National Standards when conducting its review of policies, including to:

- set out, review and maintain the currency and effectiveness of policies, procedures and protocols
- monitor and take action to improve adherence to policies, procedures and protocols
- review compliance with legislation, regulation and jurisdictional requirements.[201]

It is also our view that children and young people be involved in the development and testing of existing and new policies that affect them, through the health services young people's advisory group we recommend above and other empowerment and engagement strategies (refer to Recommendation 15.7).

We consider that the Department should make its child safety policies and guidelines publicly available on its website, so they are easily accessible to staff, patients, families and consumers. This will promote transparency, consistency and accountability in approaches to child safety across the Department and its services. It will also assist children, young people and their parents and carers to understand how to raise a concern, and what process to expect in response. We also consider there is a potential role for child safeguarding officers in ensuring children and young people and their families and carers are aware of these policies, what they say and where to find them.

Recommendation 15.11

1. The Department of Health should review and consolidate its policies, procedures and protocols. This review should prioritise identifying gaps in relation to safeguarding children and should inform the development and implementation of consistent statewide policies, procedures and protocols on child safety.
2. The Department's safeguarding policies should include implementing the National Principles for Child Safe Organisations and other recommended policy changes (namely, policies on reporting obligations, professional conduct and providing a chaperone (Recommendations 15.12, 15.13 and 15.14)).
3. The Department should undertake regular scheduled reviews of its policies, procedures and protocols for child safety to ensure they continue to reflect best practice and organisational changes.
4. The Department should publish its policies, procedures and protocols for child safety on its website to promote transparency and ensure accessibility to staff, patients and their families.

3.5.5 Mandatory and other reporting policies

Doctors, nurses, midwives and departmental employees and volunteers are all prescribed mandatory reporters under the Children, Young Persons and Their Families Act.[202] Mandatory reporters must report to Child Safety Services when 'in carrying out official duties or in the course of [their] work' they believe, or suspect 'on reasonable grounds' or know that 'a child has been or is being abused'.[203]

Employers and staff who are registered in a health profession under the National Law are also obliged to make mandatory notifications to Ahpra and the National Boards in circumstances including when they form a 'reasonable belief' that a health practitioner has engaged in sexual misconduct in connection with the practice of a health profession.[204]

In Chapter 14, we find that Launceston General Hospital had no clear system, procedures or process in place to report complaints about Mr Griffin to external agencies, such as Tasmania Police, Child Safety Services, the Registrar of the Registration to Work with Vulnerable People Scheme or Ahpra. Consequently, ward staff, nurse unit managers, senior management and members of the executive were not aware of their distinct roles and responsibilities for reporting. Many staff members were also not aware that they could independently make reports to external agencies on a mandatory or voluntary basis.

The *Tasmanian Health Service Protocol – Complaint or Concern about Health Professional Conduct* ('Complaints Protocol'), which came into effect in November 2020 and applies to all Tasmanian Health Service staff, sets out how staff should report complaints or concerns about colleagues.[205]

The Child Safe Governance Review recommended that the Complaints Protocol focus on practical guidance for staff in managing and responding to risks of child sexual abuse.[206] The Complaints Protocol states:

> In the case of reporting an offence complaint, this should be undertaken through the relevant Executive/Medico-Legal Advisor (South) through Human Resources. Mandatory reporting of a registered health professional, as represented by the organisation, must be sanctioned formally (in writing) and in accordance with line delegations.[207]

We have two concerns about this approach.

First, although it is reasonable—for the purpose of keeping management informed of concerns or to avoid multiple staff making a report about the same incident—that an organisation has a process in place for reporting child safety concerns through senior personnel, a staff member cannot be precluded from making a mandatory report themselves, and this should be made explicit in the Complaints Protocol. Put another way, there should be no suggestion in the Complaints Protocol that a staff member's reporting of a health worker must be authorised according to line delegations. Under the Children, Young Persons and Their Families Act, it is a defence to a charge of failing to make a mandatory report if a person can prove that they 'honestly and reasonably believed' another person had already made a report.[208] It is not a defence that they did not make the report because they were not given approval to do so by their manager or an executive at their organisation.

Second, a protocol that relies on senior personnel to make a mandatory report must be supported by a transparent reporting process against which senior personnel will be held accountable. It also requires that health service executive members be aware of their reporting obligations and requirements.

We heard evidence that some health service executive members at Launceston General Hospital were not aware of the Strong Families, Safe Kids Advice and Referral Line—the first point of contact for reporting child safety and wellbeing concerns, including making mandatory reports under the Children, Young Persons and Their Families Act.[209]

In our view, the Complaints Protocol should provide more guidance on external reporting obligations, including about voluntary pathways for reporting and support for staff.

Adjunct Professors Picone and Crawshaw advised us that, as of July 2023, a draft complaints management framework had been developed by the Department and has been subject to some initial consultation. This initial feedback is being incorporated before a broader round of consultation, which will involve consumer engagement.[210]

Recommendation 15.12

1. The Department of Health should ensure there are up-to-date policies on mandatory and voluntary reporting obligations, including for concerns about staff conduct, and that these are effectively communicated to staff. These policies must not require that reporting be formally authorised.
2. The Department's review of the *Tasmanian Health Service Protocol – Complaint or Concern about Health Professional Conduct* and associated documents should include:
    a. a description of external reporting requirements in relation to child safety, including voluntary reporting pathways, and reporting to Tasmania Police, Child Safety Services, the Registrar of the Registration to Work with Vulnerable People Scheme, the Independent Regulator under the *Child and Youth Safe Organisations Act 2023* and the Australian Health Practitioner Regulation Agency
    b. guidance on when it is appropriate to acquit mandatory reporting obligations by reporting concerns to a superior (for example, to avoid multiple notifications). This should make clear that a person is always entitled to make a notification to an external agency if they wish to do so
    c. a list of internal contacts for staff who have questions about child safety concerns and their reporting obligations.

3.5.6 Developing and implementing a professional conduct policy

The National Royal Commission identified an increased risk of institutional child sexual abuse when expectations of conduct between children and staff are not clear or consistently enforced.[211] This clarity and consistency can be achieved by implementing a professional conduct policy for staff (including employees, volunteers, contractors and sub-contractors). The Australian Commission on Safety and Quality in Health Care's User Guide states that creating a 'code of conduct that establishes clear expectations for appropriate behaviour with children' is one strategy for building a child safe culture in health services.[212]

The National Royal Commission recommended that a code of conduct contain clear descriptions of acceptable and unacceptable behaviour towards children, articulate the process to be followed in response to breaches of the code, be signed and acknowledged by all staff, and be broadly publicised, including to children and their families.[213]

Neither the Department nor Launceston General Hospital appear to have had a professional conduct policy beyond the State Service Code of Conduct in place during the period under examination by our Commission of Inquiry.

We recommend that the Department develops and implements a professional conduct policy for staff including employees, volunteers, contractors and sub-contractors who have contact with children and young people. The policy should reflect the content recommended by the National Royal Commission and include information about what constitutes a boundary violation or grooming behaviour. The policy should give examples of behaviours that are inappropriate in clinical and a non-clinical contexts, such as being overly or unnecessarily familiar with children, making inappropriate comments to children, engaging with children through online social networks, and having inappropriate and unnecessary contact with children outside the professional relationship. The policy should also address the challenges of maintaining these expectations of staff when they live in small communities, and outline realistic ways in which these expectations can be met. The policy should also state that a breach of the professional conduct policy may amount to a breach of the State Service Code of Conduct and result in disciplinary action (refer to our discussion and recommendations in Chapter 20).

Given the diversity of staff working in the Department and across its services, the professional conduct policy may need to differentiate between general expectations relevant to all staff and expectations that are specific to particular staff—for example, clinical staff, some of whom will be registered health practitioners under the National Law. The latter are subject to other professional codes and guidelines developed by their respective National Boards.

Recommendation 15.13

1. The Department of Health, in developing a professional conduct policy (Recommendation 20.2), should ensure:
    a. there is a separate professional conduct policy for staff who have contact with children and young people in health services
    b. the professional conduct policy for health services, in addition to the matters set out in Recommendation 20.2
        i. specifies expectations outlined in other relevant Department of Health policies and procedures
        ii. refers to other professional obligations of registered health practitioners, including those developed by the Australian Health Practitioner Regulation Agency and the National Boards
        iii. reflects the specific risks that arise in health services, particularly the sometimes intimate and invasive nature of health services, and the significant trust and power afforded by patients and the broader community to those providing health services
    c. the professional conduct policy for health services spells out expected standards of behaviour for volunteers, contractors and sub-contractors
    d. the Department uses appropriate mechanisms to ensure compliance by volunteers, contractors and sub-contractors with the professional conduct policy for health services.
2. The professional conduct policy for health services should be reinforced through professional development requirements (Recommendation 15.15).

3.5.7 The importance of chaperone policies

Chaperone (or Accompanying persons/Observer) policies are designed to ensure children and young people have another person (be that a parent, guardian or another health practitioner) present when any intimate examinations are undertaken on them (for example, an unclothed examination).

Adjunct Professor Picone of the Australian Commission on Safety and Quality in Health Care emphasised the importance of chaperone policies in health services:

> Now, as far as clinical practice is concerned it is essential if you're doing intimate procedures, particularly on children, and also in my view older cognitively impaired people or people that may have an intellectual or some other disability, you must have two people there: that's the end of it.[214]

The *Tasmanian Health Service Statewide Chaperone Protocol for Intimate Examinations* ('Chaperone Protocol') (effective from September 2016) states that all patients 'must be offered the presence of a chaperone during any intimate examination and/or treatment', with 'consideration for higher risk patients', who include 'children and adolescents—in addition to the parents'.[215]

The Chaperone Protocol provides guidance on documenting the request for, and use of a chaperone, obtaining consent from the patient to the examination and the presence of a chaperone, the role of the chaperone, and sexual misconduct by a health practitioner in connection with their profession.[216]

We find in Chapter 14, Case study 2, relating to Dr Tim (a pseudonym) that Launceston General Hospital should have formalised, implemented and enforced a chaperone policy as soon as practicable after Zoe Duncan's May 2001 disclosure, and not waited until June 2002 to do so.[217] We heard evidence to suggest that staff at Launceston General Hospital are still not aware of the Chaperone Protocol.[218]

The Child Safe Governance Review observed that, apart from the Chaperone Protocol, there were no other policies, procedures or guidelines in the Department or Tasmanian Health Service covering the accompanying of children and young people (or other vulnerable people) when accessing health services.[219]

The Child Safe Governance Review recommended that the Chaperone Protocol be broadened to include all examinations (not just intimate examinations) of vulnerable or at-risk patients, including children and young people, and that the information pack the hospital provides to patients on admission be updated to include the offer of the presence of an extra staff member during examinations or episodes of care where no family member or carer can be present.[220]

In our view, children and young people, and other vulnerable patients, should be offered a chaperone for all examinations and treatments. The risk for abuse is not confined to examinations or treatments of an intimate nature.

Recommendation 15.14

The Department of Health's chaperone (or Accompanying Person/Observer) policy should be updated to require the presence of an extra staff member during examinations or episodes of care where no family member or carer can be present.

3.6 Professional development for health service staff

Many people (including employees, volunteers and contractors) who work with children and young people in health services are in a unique position to identify and respond to child safety concerns because they develop a rapport with children and young people as part of the care relationship. However, to run a child safe health service, staff must know how to recognise the indicators of child sexual abuse, respond to disclosures and comply with relevant reporting requirements. As Professor Mathews from the Queensland University of Technology School of Law told us:

> Education and training are the cornerstone of any effort by an institution to embed the capacity and skills to properly recognise child sexual abuse.[221]

Policies, procedures and protocols relating to child safety must be supported by comprehensive induction and ongoing professional development programs that equip staff to see the practices and behaviours of others through a child safety lens.[222] The National Principles (Principle 7) state the expectation that staff and volunteers are 'equipped with the knowledge, skills and awareness to keep children and young people safe through ongoing education and training'.[223]

This section summarises what we heard about professional development relevant to child safety in the Department and Launceston General Hospital, and how it should be improved. We recommend that the Department identifies minimum requirements for professional development on child safety for different levels of staff, including leadership.

3.6.1 Professional development at Launceston General Hospital

We observed a lack of awareness about the risks to child safety at Launceston General Hospital. This lack of awareness was apparent among paediatric ward staff, middle management, human resources staff and executives. Staff at the hospital did not have specific training on, or an understanding of, grooming behaviours and professional boundary breaches. They didn't know where to go with concerns or how to fulfil reporting requirements.

At our hearings, Eric Daniels, former Chief Executive, Hospitals North/North West, acknowledged a 'significant failure' to provide professional development to all staff (from frontline staff through to senior management), particularly for identifying grooming behaviours.[224] Mr Daniels told us that additional training has since been developed in relation to child safety.[225]

Secretary Morgan-Wicks told us that while there are mandatory training requirements for departmental staff, they are not specific to identifying, reporting or responding to child sexual abuse, or to trauma-informed practice.[226] Secretary Morgan-Wicks advised that staff training needs are assessed by managers and officials at the local level, and that the focus on child safety depends on the type of service provided.[227]

Michael Sherring, Clinical Nurse Educator, Women's and Children's Services, Department of Health provided the details of mandatory and voluntary training sessions organised for staff in Women's and Children's Services at Launceston General Hospital, including Ward 4K staff, during the period examined by our Commission of Inquiry. These sessions covered topics such as Child Safety Services, vulnerable children, the effects of child abuse, the child safety liaison officer role and trauma-informed care.[228]

Mr Sherring advised that orientation packs for new staff (including support and administrative staff) have always included information about child safety, mandatory reporting and professional boundaries.[229] However, we saw no evidence of any training or resources provided to staff specifically covering the risk of child sexual abuse perpetrated by a staff member at the hospital. Also of note is that the findings of the National Royal Commission did not prompt the hospital to provide any training to its staff on child sexual abuse in institutional settings.[230]

Other evidence confirmed that limited professional development on recognising and responding to child sexual abuse was provided to the staff, management and executive at Launceston General Hospital before the revelations of Mr Griffin's offending in 2019.[231]

We accept Mr Sherring's evidence that he arranged training for staff on professional boundaries, but we consider that training could be strengthened. Emily Shepherd, Branch Secretary, Australian Nursing and Midwifery Federation (Tasmanian Branch), met with Ward 4K members on 24 October 2019 after Mr Griffin's death.[232] In her statement to us, she wrote that 'members reported minimal, if any, education and training on mandatory reporting obligations or grooming behaviours'.[233]

Ms Shepherd said that it was clear to her that 'there was confusion, lack of clarity, and there was a myriad of different reporting systems'.[234] Ms Shepherd also observed that, beyond raising concerns with their nurse unit manager or nursing director, Ward 4K members were not clear on the processes for escalating their concerns.[235]

We recommend that the Department ensures there are up-to-date policies on mandatory and voluntary reporting obligations, including for concerns about staff conduct (refer to Recommendation 15.12).

However, policies alone are not enough—staff must also receive regular professional development that reinforces their reporting obligations and provides the opportunity to clarify these obligations.

3.6.2 Professional development for human resources staff

Human resources staff in health services have a central role in responding to complaints and concerns about staff and, by extension, in managing risks connected to child sexual abuse. They are often the first port of call for a staff member or manager who is unsure about how to respond to concerns or complaints about the behaviour of a colleague.

We were extremely concerned about the clear lack of understanding among human resources staff at Launceston General Hospital about child safety issues, including risks of child sexual abuse, grooming and professional boundary breaches perpetrated by staff members. Mathew Harvey, former Human Resources Consultant, Department of Health told us that, to the best of his knowledge, prior to the allegations concerning Mr Griffin becoming more broadly known in 2019, neither he nor anyone else in the human resources department had received any professional development in relation to identifying child sexual abuse or grooming behaviours.[236] This lack of training was confirmed by other human resources staff.[237]

It is our view that human resources staff must have sufficient knowledge to recognise potential risks to child safety and to provide advice and direction to staff on how to respond to and navigate these risks, as well as associated concerns such as staff animosity and disagreements that may arise when a complaint is made.

Knowledge relevant to child safety and abuse is particularly important when managers and staff have a close working, or even personal, relationship with the staff member against whom a complaint is made. This relationship, in the absence of a trained response to child safety risks, can compromise objectivity and create difficult dynamics in a workplace. To ensure accurate advice and appropriate referrals, it is critical that human resources staff understand child sexual abuse risks, know their reporting and notification requirements, and are familiar with all relevant hospital policies, procedures and protocols related to child safety.

3.6.3 Recent professional development on child safety

Secretary Morgan-Wicks acknowledged an absence of department-wide training in child safety.[238] However, we understand that since revelations about Mr Griffin's offending in 2019, some steps have been taken to improve professional development opportunities for staff on child safety matters. For example, following feedback from a staff member, Launceston General Hospital arranged education sessions for Ward 4K staff on abuser profiles, tactics and strategies with respect to grooming behaviour. An external organisation delivered this training in February and March 2020.[239] As far as we are aware, this was one-off training provided only to Ward 4K staff.

Secretary Morgan-Wicks told us that in May 2022, mandatory child safety training had also been developed as part of the Department's Child Safe Organisation Project.[240] We understand from the Child Safe Governance Review that this training is being delivered across the Department and Tasmanian Health Service.[241] Secretary Morgan-Wicks reported that key areas of focus for the training include the National Principles, indicators of abuse and grooming behaviours, mandatory reporting, and trauma-informed approaches to receiving reports or complaints about child safety.[242]

In a written update provided to our Commission of Inquiry in February 2023, Secretary Morgan-Wicks told us that the Australian Childhood Foundation's 'Foundations of Safeguarding Children and Young People' course was made available to departmental staff in November 2022.[243] Secretary Morgan-Wicks also reported that 'short online sessions' on mandatory reporting, professional boundaries, grooming and lodging child safeguarding concerns in the Safety Reporting and Learning System had been developed and would be available 'over coming months'.[244]

The Child Safe Governance Review made numerous recommendations for staff professional development across Launceston General Hospital and the Department. Key recommendations included that:

- a capability review be conducted for any necessary training and upskilling of statewide human resources staff[245]
- a full-time child safety liaison officer role and a dedicated child safe unit be established to support reporting and training in child safety at Launceston General Hospital and to provide expert advice to staff[246]
- the content and frequency of mandatory training for all Launceston General Hospital staff be reviewed as soon as possible to streamline, and ensure an optimum environment for, implementing mandatory child safety training.[247]

The Child Safe Governance Review's recommendations are consistent with a more general recommendation made by the co-chairs of the Community Recovery Initiative that all staff 'undergo training in their responsibility to prevent and report incidents of child sexual abuse and more generally in the principles and pillars of the Launceston General Hospital safety culture'.[248] The co-chairs of the Child Safe Governance Review advised us that, as of July 2023, more than 15,500 staff have undertaken mandatory child safety training.[249] We were told the Department is mindful that undertaking such training may be difficult for staff with their own personal experiences of abuse, which has contributed to the development of a confidential Safety Plan tool. This tool can be used by affected staff with their line manager to ensure they receive sufficient support to undertake their work duties safely.[250]

3.6.4 Improving professional development on child safety

The ability of staff to view the clinical practice of their colleagues through a child safety lens is a key part of ensuring child sexual abuse and inappropriate behaviours, including grooming and professional boundary violations, are identified and acted on early.

Many management and executive staff who made statements to our Commission of Inquiry said that professional development on child safety was a way to improve the health system's response to allegations of child sexual abuse and would help restore community confidence in Launceston General Hospital.[251] We consider that substantial

professional development is required across all levels of staff at Launceston General Hospital and the Department on a range of matters concerning child safety.

Professional development in relation to children and young people should be designed for all health workers, not just those who are specially trained to deliver health care to children.[252] It should also extend to a health service's executive and human resources personnel so they can understand the risks of abuse to children and young people, identify staff training needs to address these risks, and ensure managers are well supported to respond to and manage complaints about staff conduct.

However, over-reliance on professional development to address child safety concerns must be avoided. An ability to identify and respond effectively to child abuse must also be coupled with a preparedness to act.

The executive and senior managers who appeared at our hearings were well into long careers in the health sector. While employers have a responsibility to provide professional development opportunities to staff on a broad range of matters, including child safety, individuals also have a responsibility to be attuned to the types of risks that may arise within their workplace. This extends to applying good judgment and common sense to situations and to escalating concerns up the chain or to external agencies (as the case may be). This is particularly important in paediatric wards where frontline staff would more routinely be confronted with disclosures or evidence of child abuse that has taken place elsewhere, including the family home.

In our view, the work already underway by the Department and the implementation of the Child Safe Governance Review's recommendations are appropriate to address concerns about the lack of professional development on child safety and must be given time to succeed. We consider that child safeguarding officers at Tasmania's major public hospitals are well placed to help plan and deliver training to staff on child safety issues in health services.

We consider the professional development requirements for staff in relation to child safety should be subject to public reporting. This would be one way to assure the community that a particular standard of knowledge and capability has been reached across the workforce. Periodic evaluations also enable assessment of whether existing professional development requirements and opportunities continue to align with best practice and, importantly, whether the desired uplift in workforce capability has been achieved and maintained over time.

3.6.5 Enhancing leadership skills

Above we discuss the importance of leadership in establishing a child safe culture. Professor Loh, from St Vincent's Health Australia, described the importance of management training for health practitioners moving from clinical practice into senior executive roles. For doctors, this may be training through the Royal Australasian College

of Medical Administrators, and for nurses and other health practitioners, training through the Australasian College of Health Service Management.[253] In evidence during our hearings, Adjunct Professor Picone indicated that either an undergraduate or postgraduate degree in management was required, at a minimum.[254] Ms Turnbull, from SA Health, agreed, adding that those making the transition to management should also receive ongoing mentoring and supervision.[255]

Ms McBeath, who at one point held the role of Director of Nursing at Launceston General Hospital, told our Inquiry about the challenges some nursing staff face when transitioning from a clinical to a managerial or leadership role:

> I believe that one of the many challenges for particularly Nurse Unit Managers is the broadness of their responsibility and the lack of support and preparation for them as they transition from a clinical to a managerial and leadership role. Investment in leadership development and manager support would provide much needed opportunities which may assist managers in identifying and responding appropriately to complex issues such as the issues under review in this investigation.[256]

The Child Safe Governance Review considered the professional development needs of leaders, including managers. It noted that a key component of the Department's One Health Cultural Improvement Program is 'consistent and effective leadership and management development and training across the Department and Tasmanian Health Service'.[257] The Child Safe Governance Review noted that the Department was participating in a range of leadership and management development activities and developing two more management and leadership programs for staff, one with the University of Tasmania.[258]

The Child Safe Governance Review recommended that leadership and management training be prioritised for frontline and middle managers at Launceston General Hospital, and that the Department's leadership and management training 'retain a multi-disciplinary focus rather than a siloed approach involving different professional cohorts'.[259]

In a written update provided to our Commission of Inquiry in February 2023, Secretary Morgan-Wicks identified two professional development programs the Department is delivering: the Aspire Leadership Program and the Elevate Management Program.[260] She told us that the Aspire Leadership Program is a specialised program designed to 'identify and support our senior leaders' and was piloted with 18 participants from different health services and professional areas between August and December 2022.[261] A second cohort of 20 participants began the program in February 2023.[262] Secretary Morgan-Wicks stated that the Elevate Management Program is designed to develop management skills in staff across areas such as governance, risk, problem solving, communication, people management and project delivery and execution.[263]

In July 2023, we were advised by Adjunct Professors Picone and Crawshaw that the One Health Culture Elevate Management Development Program had commenced, which is specifically designed for the Department and is:

> … designed to upskill managers in the non-clinical aspects of their roles and focuses on development in the areas of planning, delegating, financial and people management, governance, performance management, communication and human resources.[264]

While we welcome the Department's recent efforts at improving the professional development of those in leadership roles, organisations such as Launceston General Hospital and the Department must have leaders and managers who are committed to prioritising children's and staff safety and wellbeing over the long term. In the context of our findings in Chapter 14, Case study 3, relating to James Griffin, leaders must have the capacity to effect organisational change, the curiosity to ask questions to understand problems, and an aptitude for developing and implementing reforms. Managers must also be supported to confidently perform their roles and responsibilities through appropriate professional development and ongoing supervision and mentoring. Because their roles and responsibilities include managing and responding to complaints about staff conduct and any associated conflict in an open and transparent way, their training must focus on helping them to discharge these responsibilities well. Ideally, staff applying for senior leadership and management roles in the Department and at Launceston General Hospital should have leadership and management qualifications or training at the time of appointment. At a minimum, the organisation should support them to undertake this training and obtain these qualifications when new to the role. New and emerging leaders, such as those being promoted from clinical practice into people management roles, should be provided with professional development to help them navigate this transition.

Professor Mathews commented on the need for external governance to be in place to ensure institutions and their leaders have a genuine commitment to child safety. Such governance may include requirements for leaders to hold certain qualifications or undertake professional development related to child sexual abuse, and for leaders to prove its workforce meets a standard of education.[265]

3.6.6 Our observations

In addition to the Department's recent professional development initiatives, we consider that the Department should monitor the effectiveness of these initiatives. Outcomes-based measures of effectiveness could include consumer and staff feedback on the knowledge and skills of staff and leadership, including through consumer and staff surveys.

Recommendation 15.15

1. The Department of Health should identify minimum requirements for professional development on child safety for different levels of staff, including staff, volunteers and contractors, as well as leadership. Professional development should cover, at a minimum:
    a. understanding child sexual abuse (including grooming and boundary breaches)
    b. the requirements and expectations of a child safe organisation
    c. mandatory and voluntary reporting obligations, including the role and function of Tasmania Police, Child Safety Services, the Registrar of the Registration to Work with Vulnerable People Scheme, the Independent Regulator under the *Child and Youth Safe Organisations Act 2023* and the Australian Health Practitioner Regulation Agency
    d. relevant child safeguarding policies and procedures.
2. The Department should have appropriate processes in place to ensure leaders have the knowledge, skills, aptitude and core capability requirements to effectively manage people and to lead a child safe organisation.
3. The Department should develop outcomes-based measures of the effectiveness of child safety professional development initiatives for all categories of staff, volunteers, and contractors, including management, leadership, human resources, and professional and non-professional staff.
4. These outcomes-based measures should be reviewed annually and the results used to inform further professional development initiatives and leadership selection.

4 Improving responses to child sexual abuse

The National Principles aim to prevent the likelihood of child sexual abuse occurring in institutions. However, the National Principles require that organisations have robust systems in place to respond to child safety concerns where they arise. Principle 6 states that processes to respond to complaints and concerns should be 'child focused'.[266] Robust complaints management and investigations systems are also requirements of the National Standards.[267]

The National Royal Commission noted that responses to complaints of child sexual abuse encompass a range of actions that institutions should take. These actions include:

- identifying complaints—child or adult survivors who report possible child sexual abuse should be taken seriously
- assessing risk—potential safety issues for victims and other parties should be identified and action taken to ensure their safety (including for the subject of the complaint where necessary)
- reporting—all relevant bodies and institutions should be informed of the complaint, including, for example, the police, the Registrar of the Registration to Work with Vulnerable People Scheme, the Strong Families, Safe Kids Advice and Referral Line and any relevant professional oversight body
- communicating and providing support—institutions may need to communicate with all affected parties and must assess the need for, and be able to provide, support for those involved, including complainants, parents, employees and other affected children
- investigating—this process should begin after a complaint is received and risk assessment completed; some actions, such as ensuring the integrity of a location as soon as possible after a complaint is received, can be crucial to an investigation
- maintaining records—institutions should maintain relevant records, including of investigation processes
- completing a root cause analysis—where required, institutions should review the circumstances of the complaint to identify possible systemic factors that may have contributed to the incident
- monitoring and reviewing—institutions must have policies and procedures to help continually improve the 'protection of children for whom the institution has responsibility'.[268]

The case studies in Chapter 14 show that Launceston General Hospital and the Department more broadly did not have a robust complaints management framework in place for responding to child safeguarding concerns. In Case study 3, we make findings that:

- Launceston General Hospital failed to manage the risks posed by James Griffin.
- Launceston General Hospital did not have a robust system for managing complaints involving child safety.
- Launceston General Hospital failed to consider the cumulative effect of complaints about James Griffin.
- Launceston General Hospital had no clear system, procedures or process in place to report complaints about James Griffin to external agencies.

- The response of Launceston General Hospital to complaints about James Griffin suggested it was ultimately not concerned about his conduct.

The case studies in Chapter 14 have also exposed a disciplinary system that is not tailored to addressing high-risk, sensitive complaints involving children's safety. In the health service context, we saw a highly conservative approach to initiating disciplinary proceedings.

In Chapter 6, we recommend that a Child-Related Incident Management Directorate be established. This directorate would support agencies to meet the requirements outlined by the National Royal Commission in relation to child safety concerns and complaints about staff conduct. The Directorate would also receive, assess, investigate, coordinate and oversee responses to allegations of child sexual abuse against staff. The Directorate's management of such misconduct matters, including procedures for an investigation and the recommendations made at the end of an investigation, would be controlled by the State Service's disciplinary system. We discuss the failings of the State Service disciplinary system extensively in Chapter 20.

In this section, we make recommendations to improve the Department's complaints and disciplinary processes in line with the directorate we recommend in Chapter 6.

4.1 Complaints

This section considers the systems and processes required to effectively respond to complaints in a health service and outlines the reforms currently underway to strengthen the complaints and disciplinary processes at Launceston General Hospital and across the Department. We discuss the specific problems we identified at Launceston General Hospital, so the Department and the hospital can focus on addressing these problems when implementing reforms. We recommend a series of principles to shape reforms to complaints processes.

4.1.1 Best practice approaches to complaints about child sexual abuse

It is important to use a consistent and transparent process in responding to all complaints about health workers. Complaints that may initially seem minor or trivial can hold vital information or reveal more concerning behaviour on further investigation. Complaints about professional boundary breaches, for example, often point to more serious misconduct.[269]

Complaints can also be an important sign that something is not working as intended in the health system and that clearer policies, changed practices or improved staff training and development are necessary. Professor Loh told us that research into doctors consistently shows that the more complaints that are made about a doctor, the more likely their patients will experience adverse clinical events and outcomes.[270]

In the context of child sexual abuse, complaints that a health worker is overly familiar with young patients, has made inappropriate comments in the presence of young patients or has contact with young patients outside the clinical setting, may indicate grooming, which is a serious precursor of other forms of child sexual abuse. We consider that the Department should adopt the widest possible interpretation of what defines a child safety complaint, and therefore what may or may not constitute child sexual abuse. Kathryn Fordyce, Chief Executive Officer, Laurel House, told us:

> Low reporting thresholds are important in protecting children from child sexual abuse. If minor issues are identified, corrected and dealt with constantly and consistently, this deters perpetrators of child sexual abuse from committing child sexual abuse because they are aware that the system will be able to identify them … If we reaffirm that reporting is for the purpose of protecting children from child sexual abuse rather than prosecuting offenders, the process will be more effective.[271]

Adjunct Professor Picone told us that an effective complaints management system is underpinned by health services encouraging all staff to bring concerns to management at the earliest opportunity.[272] She said that health services should record all incidents, including 'near-misses or complaints', which can act as a public health tool in providing 'intelligence' to inform system improvements.[273]

Adjunct Professor Picone also made clear that child sexual abuse complaints should be treated as 'extremely serious' and require a 'thorough' response from senior management.[274] She laid out the following best practice approach to child sexual abuse complaints:

- the matter is immediately escalated to the appropriate senior manager
- the senior manager immediately reports the matter to the police
- the senior manager takes an immediate administrative decision regarding the duties of the alleged offender, including whether they are to be suspended
- the senior manager initiates an open disclosure process with the victim and their family.[275]

Adjunct Professor Picone emphasised that it is not the role of senior management to determine whether an alleged abuser has engaged in child sexual abuse; rather, part of their role is to notify the police of the allegation as soon as possible.[276] We would add that a senior manager must act on the basis that the allegation is true, ensure the risks to child safety as a result of the allegation are addressed and gather organisational information on any previous conduct of concern relating to child safety or professional boundary breaches that might relevant to an investigation and/or assessment of child safety risks. They will also need to ensure all mandatory external reporting requirements are met and appropriate records made.[277]

4.1.2 Current complaints processes

Secretary Morgan-Wicks described the following key features of the Department's complaints system:

- Complaints about child sexual abuse in health settings can come through several channels including online enquiries, consumer feedback, public interest disclosures, referrals to human resources staff, reports made on the Department's Safety Reporting and Learning System, notifications of suspensions of registration to work with vulnerable people or other mandatory accreditation, self-disclosures, unions and media reports.[278]
- On admission, health services give patients, families and carers information about how to raise concerns or to make complaints.[279]
- Supports provided to parties involved in complaints about child sexual abuse are managed on a case-by-case basis, with consideration given to who the most appropriate person is to make contact with a complainant and the way to make contact (in person, by phone, by email or by letter).[280] Other supports offered to affected parties may include the Employee Assistance Program or referrals to external support services and providing a contact person at the Department.[281]

Secretary Morgan-Wicks conceded that the Department's complaints process departed from best practice in the following ways:

- The various avenues for receiving complaints mean that the approach to 'recording, reviewing, investigating and reporting is varied and uncoordinated'.[282]
- There is no consistent governance and oversight of complaints. The person responsible for the complaint depends on how the complaint is received.[283]
- Complaints can be referred to the area that is the subject of the complaint, creating potential conflicts of interest and concerns about confidentiality.[284]
- There is no 'regular, structured analysis, reporting and monitoring of complaints data' due to the disparate ways complaints are managed. This means information on 'trends and systemic issues' is not available to the governance committee to inform decision making.[285]

The evidence we received about how poorly Launceston General Hospital responded to complaints about health practitioners reinforces our view that all complaints about staff conduct towards children should be independently managed through a dedicated unit, such as a Health Services Child-Related Incident Management Directorate. Before outlining the desirable features of such a unit, we describe some reforms in relation to child safety complaints recently announced by the Department.

4.1.3 Efforts towards ensuring a stronger, safer child safety complaints system

In her statement of 22 June 2022, Secretary Morgan-Wicks advised us that she was establishing a complaints management oversight unit ('Statewide Complaints Oversight Unit') in the Office of the Secretary.[286] She said the unit will be responsible for recording and tracking the progress of complaints in a document management system, assessing complaints against previous complaints, and allocating the complaint to an appropriate business unit for action after identifying any potential conflicts of interest.[287] She said the unit will be supported by internal trauma-informed investigators to assist with employee misconduct matters.[288]

As noted above, in November 2020 a Complaints Protocol was introduced across the Tasmanian Health Service. The Complaints Protocol distinguishes between complaints that are 'minor' and able to be 'immediately resolved', and those considered 'serious'.[289]

Under the Complaints Protocol, complaints from consumers are considered more serious where they give rise to a possible legal claim, are a 'public relations risk', may require an external peer review or a root cause analysis investigation, or are subject to open disclosure.[290] In such instances, the relevant executive must be notified—in the case of Launceston General Hospital, this is the Executive Director of Medical Services.[291] Complaints about staff conduct are also considered serious if they give rise to potentially significant misconduct under the State Service Act.[292] The responsibility for deciding whether a matter is minor or serious sits with the relevant manager.[293] We are concerned that the focus of the Complaints Protocol is managing reputational risk and public perception, rather than the harm or risk of harm to patients. We recommend below that the Department's complaints policy prioritises risks of harm to children.

We understand that the Child Safety and Wellbeing Service has been established to receive and triage at least some child safety complaints. The new Child Safety and Wellbeing Service sits with the Deputy Secretary, Community, Mental Health and Wellbeing.[294] The Child Safe Governance Review reported that the Child Safety and Wellbeing Service would receive and triage all concerns and complaints about child safety and make determinations about referrals to other entities (including the Statewide Complaints Oversight Unit, Ahpra and the National Boards), departmental human resources, child safeguarding officers in hospitals, the Strong Families, Safe Kids Advice and Referral Line or the police.[295] We are uncertain about the proposed relationship between the Child Safety and Wellbeing Service and the Statewide Complaints Oversight Unit.

The Child Safe Governance Review also made a broad range of recommendations for managing complaints, the most relevant of which can be summarised as follows:

- The Statewide Complaints Oversight Unit should develop clear and consistent forms, policies and practices for complaints, and the Tasmanian Health Service should review its complaints management framework.[296]

- The Department's Safety Reporting and Learning System should be the single point for recording complaints and concerns.[297]
- There should be increased monitoring, auditing and public reporting of incidents logged in the Safety Reporting and Learning System.[298]
- The Complaints Protocol (described above) should be reframed to include a focus on providing practical guidance in responding to concerns about staff, and a concise document summarising patient safety reporting obligations based on the different categories of staff should be developed.[299]

The Secretary has accepted these recommendations.

Secretary Morgan-Wicks gave evidence that she is establishing an independent statewide Child Safety and Wellbeing Panel. The purpose of the panel will be to oversee the monitoring and investigation of child safeguarding concerns in the Department. The Child Safety and Wellbeing Panel will comprise experts in child safeguarding and health systems.[300] Its specific functions will include:

- reviewing and assessing all serious child safeguarding events referred by the Secretary (including completing a root cause analysis)
- conducting research and providing advice or evaluations on evidence-based approaches to safeguarding
- advising on improvements based on lessons from serious safeguarding incidents.[301]

The Department has since appointed several individuals to serve on the Child Safety and Wellbeing Panel, including two consumer representatives.[302]

4.1.4 Principles to guide the implementation of reforms

Our evidence pointed to specific weaknesses and shortcomings in complaints handling in the Tasmanian health system. From this we have developed principles that we consider should drive reforms to the Department's complaints management system. This is in addition to the need we identify above that the complaints process should have clear escalation processes, internal and external reporting requirements within specific timeframes, and address immediate risks to children's safety. These principles are that:

- Complaints processes should be well understood, trusted and accessible to staff, patients and others.
- There should be appropriate scrutiny and oversight of how complaints about child safety are escalated to senior staff, managed and recorded.
- Complaints about child safety should be recorded comprehensively and stored securely in incident management (Safety Reporting and Learning System) and human resources systems.

- Complaints about unprofessional conduct and boundary violations with child patients should be recognised as a patient safety issue and treated as serious.
- Complaints data should support decision making and inform system improvements.
- There should be appropriate communication and supports provided to those making complaints or affected by the alleged conduct, including through open disclosure processes.

Except for appropriate communication and supports (which we discuss below), we discuss each of these principles, and the evidence that gave rise to them, in turn.

4.1.5 Complaints processes should be well understood, trusted and accessible

Our case studies in Chapter 14 reveal shortcomings in Launceston General Hospital's complaints management processes. Chapter 14, Case study 3, relating to James Griffin most clearly illustrates the lack of clarity and inconsistency in managing complaints, which were received, recorded and responded to in a variety of ways and with no clear process. This was, in large part, because of:

- a failure to recognise boundary violations towards child patients as a potential child safety concern
- the absence of clear, organisation-wide directives on how child safety concerns should be managed
- the significant discretion given to staff in responding to complaints of this nature.

We heard that line managers were often the first port of call for any child safety complaints, with the occasional involvement of the human resources team.[303] Ms Shepherd, from the Australian Nursing and Midwifery Federation, told us that the Tasmanian health system is hierarchical and therefore staff are likely to report any concerns to a manager or senior staff member.[304] Secretary Morgan-Wicks made a similar observation, noting a tendency for health workers to report suspected misconduct by another health worker to a direct line manager such as a nurse unit manager.[305]

The absence of a transparent and user-friendly complaints process also meant that patients were not supported and empowered to report concerns. Chapter 14, Case study 3, relating to James Griffin outlined that attempts made by Ward 4K patients to raise concerns about Mr Griffin's conduct were often dismissed or downplayed by senior and frontline staff. We also heard that patients were not aware they could report a concern to external agencies.

It is vital that any complaints framework is clear, simple to use, consistently applied, accessible and transparent.

4.1.6 Internal and external scrutiny and oversight

The absence of a transparent and consistent complaints framework at Launceston General Hospital meant that line managers, some of whom were relatively junior in the overall hospital hierarchy, carried significant responsibilities for assessing and resolving serious complaints. Most of the complaints made about Mr Griffin were reported to his nurse unit manager at the time, who sometimes (but not always) sought advice and assistance from human resources staff. We heard that the human resources team may or may not be notified, depending on the nature of the complaint and how it was made.

Very few complaints filtered up to senior nursing management. This reflects the significant power and responsibility placed on local managers to designate a matter as 'minor' and manage it informally. Perverse incentives may motivate managers to resolve complaints informally; for example, they may be worried about how such complaints reflect on their own performance. The lack of formality in responding to complaints creates many problems.

As we saw across our case studies, an informal approach to complaints management contributed to failures or delays in notifying or involving external agencies such as the Registrar of the Registration to Work with Vulnerable People Scheme, Child Safety Services, Tasmania Police and professional regulators. The involvement of these agencies would likely have made the risks posed by particular staff more apparent and empowered agencies to take protective measures. External oversight by these agencies would have also facilitated some scrutiny of the hospital's response.

Line managers should not be unilaterally responsible for determining complaints connected to child safety. Information about 'minor' complaints, as defined in the Complaints Protocol, should also not be held exclusively by line managers in file notes or diary entries. There should be one system for capturing all complaints, no matter how minor.

4.1.7 Recording and storing information about complaints

The purpose of the Safety Reporting and Learning System is to record reports of all safety concerns in clinical settings, including any complaints of child sexual abuse.[306]

Nursing staff and managers who gave evidence to our Commission of Inquiry seemed to believe that the Safety Reporting and Learning System was primarily for recording clinical events (for example, medication errors), rather than concerns about staff conduct towards a patient.[307]

Human resources staff also gave evidence to our Inquiry that the Safety Reporting and Learning System was not designed to capture child safety concerns, which were instead addressed through local managers.[308] Mr Harvey noted that human resources staff never see most reports in this system.[309]

Adjunct Professor Picone told us that although systems such as the Safety Reporting and Learning System are more frequently used to record clinical incidents, they should also be used to record non-clinical incidents—for example, complaints about abuse or suspected abuse.[310]

At our hearings, Adjunct Professor Picone confirmed that she had examined the Department's Safety Reporting and Learning System and that, while records can be altered, and frequently are altered from what is first recorded, there is a clear record of such alterations, and the original entry is not destroyed.[311] Adjunct Professor Picone described the system as 'probably the best in the country' in this regard.[312]

Ms Turnbull, from SA Health, told us there is often confusion about what is a human resources issue and what is a clinical issue, and that it is important that staff understand that a complaint about child safety must be recorded in a hospital's incident management system and its human resources system.[313] Ms Turnbull indicated that in South Australia, which uses the same incident management system as Tasmania (but called the Safety Learning System), there is a specific notification section that deals with child sexual abuse complaints.[314]

We understand that a new Child Safety Module has been specifically developed to 'facilitate the reporting of child safety incidents and issues' in Tasmania's Safety Reporting and Learning System. This new model is supported by training and 'how to' guides for staff.[315] Complaints made under this module are sent directly to the Child Safety and Wellbeing Service to be risk assessed and referred for follow-up and ongoing management with appropriate respect for confidentiality.[316] Individuals who made the relevant report are advised of the actions taken, and outcomes of the safeguarding concern.[317] Adjunct Professors Picone and Crawshaw advised us in July 2023 that while the module was relatively new, reporting to date has been stronger in the Northern region of Tasmania compared to other areas, and that the Child Safety and Wellbeing Service would continue to promote awareness and reporting across the State.[318] A new complaints reporting dashboard has also been created, which is consistent across all three Tasmanian regions.[319]

We consider that in addition to recording concerns or complaints about child safety in the Safety Reporting and Learning System, complaints involving staff should also be recorded in a health service's human resources system to ensure they are accessible to those who require such information to inform decision making about staff management, including disciplinary action.

4.1.8 Recognising complaints about child sexual abuse as a patient safety issue

Launceston General Hospital's Quality and Patient Safety Unit is dedicated to managing and resolving complaints.[320] Despite the central role that the Quality and Patient Safety Unit apparently holds in managing complaints, we received little evidence that those making or responding to complaints about child safety concerns dealt directly with this unit.

Dr Peter Renshaw, former Executive Director of Medical Services, Launceston General Hospital, described the Quality and Patient Safety Unit (and its various iterations over the years) as being the area that records 'complaints or grievances made by either staff, patients or family members of patients at the LGH'.[321] He described the unit allocating complaints and clinical incidents to a senior clinician or manager in the affected area, who would oversee an investigation and determine the appropriate response.[322] He said that the Quality and Patient Safety Unit was responsible for ensuring that a response to the complaint was provided within 28 days and 'evaluated the quality of the complaint responses through audit of complainant experience'.[323]

A former nurse within the Quality and Patient Safety Unit at Launceston General Hospital told us that the service coordinates patient safety programs, quality improvement, and risk and incident management.[324] The nurse said that the Quality and Patient Safety Unit is not directly tasked with investigations into staff performance or other human resources matters but that these issues are sometimes uncovered in the unit's reviews of patient safety events, and are then referred to the relevant manager or director, or to the human resources department.[325]

The nurse told us that the Quality and Patient Safety Unit held safety event meetings attended by relevant staff from the unit and by the Executive Director of Medical Services (who, until recently, was Dr Renshaw).[326] The purpose of these meetings was to review serious incidents and discuss investigation processes and improvement opportunities.[327] Following the public release of *The Nurse* podcast, the matter of Mr Griffin was apparently discussed at a serious safety event meeting.[328] The Quality and Patient Safety Unit also sought advice from Dr Renshaw on how to respond when queries from concerned families related to Mr Griffin were raised with the hospital.[329]

Other than this meeting, the Quality and Patient Safety Unit does not appear to have been involved in any of the complaints about Mr Griffin. Again, this suggests that child safety governance arrangements at the hospital have primarily focused on clinical risks, with risks to child safety posed by staff boundary breaches considered a matter for the human resources team. It is important that organisational and governance arrangements in health services recognise that the risk a staff member poses to the safety of children is a serious patient safety issue and not simply a staffing problem to be managed locally.

4.1.9 Complaints data should support decision making and inform system improvements

One of the main problems we noted across all our case studies was that complaints about child sexual abuse or boundary breaches tended to be considered as isolated incidents and did not prompt reviews of child safeguarding systems more broadly. Rarely were complaints routinely escalated to the Secretary to contemplate disciplinary action. This represents many missed opportunities to learn from mistakes and to work to prevent future misconduct.

As previous reviews have revealed, there is a defensive culture within the Tasmanian Health Service. Richard Connock, Health Complaints Commissioner, described how he had 'encountered a somewhat protective and adversarial attitude' within the Tasmanian Health Service in responding to complaints, and had 'routinely encouraged the [Tasmanian Health Service] to be more open with complainants'.[330]

Mr Connock told us that complaints can take an extremely long time to arrive at his office and often seemed to be 'waylaid in the "legal department" for long periods'.[331] We agree with Mr Connock that the Department could do more to recognise the value of complaints across the organisation and, in doing so, apply principles promoting open disclosure by admitting mistakes and identifying opportunities to implement improvements.[332]

While the Department has started work to improve its complaints management processes for child safety concerns, there is not a clearly defined and publicised pathway for escalating, managing and investigating complaints across the Department and within its health services. The governance and review arrangements underpinning such complaints processes are also unclear. We acknowledge that this work is underway, but we consider that the Department must ultimately clarify the complaints pathway along with the roles and responsibilities of the various bodies involved in responses to child safety concerns. We consider that this information could be conveyed through an information diagram showing the complaint escalation, management and investigation pathways for child safety issues in the Department and associated governance and review arrangements. The diagram should be included in the complaints escalation, management and investigation policy that we recommend below, and be made available to health service users and the public.

Recommendation 15.16

1. The Department of Health should have a specific policy on responding to complaints and concerns about staff conduct. The policy should establish a complaints escalation, management and investigation process that is informed by the following principles:
    a. Complaints processes should be well-understood, trusted and accessible to staff, patients and others.
    b. Complaints processes should have clear escalation processes, internal and external reporting requirements within specific timeframes, and address immediate risks to children's safety.
    c. There should be appropriate scrutiny and oversight of how complaints about child safety are escalated to senior staff, managed and recorded.

d. Complaints about child safety should be recorded comprehensively and stored securely in incident management (such as the Safety Reporting and Learning System) and human resources systems.

e. Complaints about unprofessional conduct and boundary breaches with child patients should be recognised as indicating a patient safety issue and treated as serious.

f. Complaints data should support decision making and inform system improvements.

g. There should be appropriate communication and supports provided to those making complaints or affected by the alleged conduct, including through open disclosure processes (Recommendation 15.18).

2. The policy should include a diagram showing the complaints escalation, management and investigation pathways for child safety concerns and associated governance and review arrangements. It should also outline the roles and responsibilities of the various bodies involved in responding to child safety concerns.

3. This policy and diagram should be available to health service users and the public.

4.2 Staff disciplinary processes

Despite being one of the largest public sector agencies, the number of preliminary assessments and Employment Direction No. 5—Breach of Code of Conduct investigations conducted by the Department of Health between 2000 and February 2023 were the lowest across all three child-facing agencies we examined.[333] We describe the data we received from the Department relating to disciplinary processes taken against its staff in greater detail in Appendix H.

In this section, we discuss disciplinary processes and make recommendations for a reformed disciplinary process for child safety concerns and staff behaviour towards children, managed by a Health Services Child-Related Incident Management Directorate. This is consistent with recommendations we make for a new Child-Related Incident Management Directorate in Chapter 6.

4.2.1 Receiving complaints and concerns about child safety and staff conduct

Irrespective of where a complaint or concern about child safety is raised, it should be reported to a central body, which should be staffed by people with child safeguarding

expertise who can assess and triage complaints and concerns. We consider this function should be rolled into the Health Services Child-Related Incident Management Directorate we recommend below. We have been told the intention is for the Child Safety and Wellbeing Service to 'work closely' with the Statewide Complaints Oversight Unit.[334]

4.2.2 Incident Management Directorate

In Chapter 6 on our recommendations for the way forward for children in schools, we describe the findings of the 2014 South Australian *Report of the Independent Education Inquiry* led by the Honourable Bruce Debelle AO KC (and often referred to as 'the Debelle Report'). The South Australian Government commissioned this Inquiry in response to the handling of an incident of child sexual abuse at a local school.[335] While this report was prepared with education settings in mind, it provides useful guidance to all organisations on how to respond effectively to complaints and incidents of child sexual abuse, including health services.

As part of implementing the Debelle Report, investigations into child sexual abuse in South Australian schools are now managed by a specialised Incident Management Directorate.[336] The South Australian Education Department has published guidelines that outline in some detail the steps to take after receiving a complaint of sexual misconduct against a staff member.[337] There is also a clear procedure for public disclosure processes when a staff member has been charged with child sexual abuse offences.

The Department should draw on insight from the Debelle Report when establishing the Health Services Child-Related Incident Management Directorate and associated policies on mandatory and voluntary reporting obligations, open disclosure processes and a critical incident response plan (refer to Recommendations 15.12, 15.18 and 15.19).

We recognise that there may be features of the health service environment that call for a tailored approach in responding to and investigating complaints. An understanding of the health care context (and sometimes specialised clinical knowledge) may be required to consider and investigate complaints of child sexual abuse effectively, particularly where conduct occurs under the guise of a medical procedure or nursing care. For this reason, we do not specifically recommend that complaints about grooming, child sexual abuse and other related harms to children in health services be considered by the Child-Related Incident Management Directorate that we recommend be set up in Chapter 6. Rather, we consider the Tasmanian Government should consider the most appropriate model for managing complaints of this nature against health workers. This could occur by the Tasmanian Government electing to partner with the Child-Related Incident Management Directorate and ensuring the Directorate has access to specialist skills and knowledge relating to complaints in a health services context when required. Alternatively, the Tasmanian Government may decide a separate Health Services Child-Related Incident Management Directorate is needed. If this is the case,

it should be structured and operate consistently with the approach we recommend for the Child-Related Incident Management Directorate, including having three arms of responsibility—for incident report management (including complaints and case management), investigations, and misconduct and disciplinary advice respectively. We briefly summarise these functions below, but further detail can be found in Chapter 6.

We recommend an incident report management arm, which would assess and triage the complaint or concern and determine how it should be managed, including whether a formal investigation is necessary. Any conflicts of interest that may arise in this process should be promptly identified, documented and dealt with. This arm of the Directorate should also:

- ensure compliance with the policy on responding to concerns and complaints about child safety issues and staff conduct
- ensure staff have made appropriate notifications to agencies including Ahpra and the National Boards, Tasmania Police, Child Safety Services and the Registrar of the Registration to Work with Vulnerable People Scheme and the Independent Regulator of the Reportable Conduct Scheme, and act as liaison for these agencies regarding the complaint (such liaison must include seeking confirmation with agencies about whether and when the Department can initiate an investigation without compromising parallel criminal or regulatory investigations)
- ensure other agencies involved in a complaint about staff behaviour towards children (such as the new Commission for Children and Young People, the Health Complaints Commissioner or the Integrity Commission) receive any information they need to acquit their functions
- provide support and guidance, including through fit-for-purpose case management, to the relevant health service about: how any potential risks to patients can be managed while a complaint or concern is investigated; what information should be provided to different audiences (staff, patients and their families and the community) and when; ensuring affected children and young people (and their families and carers) are updated on the status of any complaint, receive appropriate support and can continue to safely receive the health care they need
- ensure all records about the complaint (and the staff member) are comprehensive, accurate and stored in incident management (such as the Safety Reporting and Learning System) and human resources systems.

Rather than human resources staff, the investigations arm of the Directorate should conduct or oversee investigations where sexual misconduct and professional boundary breaches related to children are alleged. Although the human resources team will not have a role in managing and investigating such matters, as noted above, we consider that human resources staff should be familiar with child safety policies so they can

ensure any child safety concerns are appropriately responded to and referred when they arise.

Investigations of complaints should be undertaken by independent investigators who are trained and skilled in child development, child sexual abuse and trauma-related behaviours, and in interviewing vulnerable witnesses. Wherever possible, investigators should have knowledge and experience of the health services context.

Investigations should include the following processes:

- Complainants, their families and key witnesses should be invited to provide evidence or information if they choose to do so. If a decision is made to not contact a complainant or key witness, this should be explained and justified to the decision-maker (Head of Agency).
- Investigators should have access to the specialised and independent clinical knowledge or expert opinion required if a staff member argues that the behaviour subject to a complaint was legitimate clinical care.
- Once started, investigations should be undertaken promptly, and a clear and evidence-based report provided to legally trained adjudicators, who should then make recommendations to the relevant decision-maker (Head of Agency).

We consider some form of investigation should occur even if a staff member leaves the State Service. This investigation would need to determine the full extent of any possible open disclosure or mandatory reporting obligations and identify any necessary system improvements.

The misconduct and disciplinary advice arm should comprise staff who are trained to weigh evidence and assess compliance with procedural fairness requirements. Where a breach of the professional conduct policy, the State Service Code of Conduct or another associated departmental policy is found, this should be outlined in an investigation report provided to the Head of Agency, alongside any advice and recommendations.

Recommendation 15.17

1. The Department of Health should establish a separate Health Services Child-Related Incident Management Directorate or partner with the Child-Related Incident Management Directorate (Recommendation 6.6) to respond to allegations of child sexual abuse and related conduct by staff, breaches of the State Service Code of Conduct and professional conduct policies, and reportable conduct (as defined by the *Child and Youth Safe Organisations Act 2023*) in health services.

2. If the Department partners with the Child-Related Incident Management Directorate, it should ensure the directorate has access to specialised advice to inform investigations against health services staff, particularly where allegations have arisen in the context of provision of health care.
3. If the Department establishes a new Health Services Child-Related Incident Management Directorate, it should mirror the functions and manner of operation reflected in the Child-Related Incident Management Directorate, including having three distinct roles and skill sets covering incident response management, investigations, and misconduct and disciplinary advice.

4.3 Communicating with and supporting victim-survivors

A key element of an organisation's response to child sexual abuse is communicating with and supporting victim-survivors, their families and carers, and others affected by the abuse.

4.3.1 An effective open disclosure process

Under the National Standards, health services must implement a framework of open disclosure with patients, family members and carers in relation to critical incidents that occur in their health service and result in harm to a patient.[338]

An open disclosure process involves an honest discussion with a patient or carer 'about an incident that resulted in harm to the patient while receiving health care'.[339]

Adjunct Professor Picone told us that the key elements of an open disclosure process are:

a. an apology or expression of regret, which should include the words 'I am sorry' or 'we are sorry'
b. a factual explanation of what happened
c. an opportunity for the patient, their family and carers to relay their experience
d. a discussion of the potential consequences of the adverse event
e. an explanation of the steps being taken to manage the event and prevent recurrence.[340]

Adjunct Professor Picone also told us that the principles of open disclosure can be applied at the broader community level. In such circumstances, the principles are:

a. being open and honest about the fact that an incident has occurred
b. admitting fault for the error or set of circumstances as appropriate
c. making a very genuine apology to the affected persons and community

d. identifying what has been learnt from the error

e. advising the community about what is being done or will be done to address the problem

f. demonstrating to the community that the organisation is following through with its promises.[341]

We discuss how open disclosure can be applied at the community level in more detail below (refer to Section 5).

Adjunct Professor Picone said a health service cannot promise an incident will never happen again, but the community needs to see that it is working to resolve issues and is taking steps to prevent recurrence.[342]

The Debelle Report discussed the concept of 'responsible disclosure' for schools managing child sexual abuse allegations. It described responsible disclosure as providing factual information, at an appropriate time, to the various people who have been or may be affected by an event.[343] It notes that providing information after a critical incident or other crisis helps parents (in particular) to maintain their confidence in the institution. Such confidence can be 'greatly undermined' if important information is instead learned through the media.[344]

There was little evidence that the response of Launceston General Hospital to victim-survivors or potential victim-survivors of Mr Griffin's abuse followed best practice. Conversely, there was much evidence that the hospital attempted to manage the revelations of Mr Griffin's offending by restricting communication and the information provided to victim-survivors, former patients, and their families and carers.

Many of the elements of open disclosure (listed above) were missing from Launceston General Hospital's response to the community in 2019, 2020 and thereafter. It was only at our hearings that Mr Daniels, former Chief Executive of Hospitals North/North West, showed some empathy and understanding for the scale of suffering that had occurred at the hospital.[345]

Secretary Morgan-Wicks issued a public apology to victim-survivors, validating a widespread feeling that the Department and Launceston General Hospital had not reckoned with the scale of suffering:

> I am personally horrified by the lack of empathy, humanity and often a lack of trauma-informed approach by the Department and the Tasmanian Health Service to such devastating accounts of abuse from the victim-survivors who have shown immense courage to come forward.[346]

We consider that supports such as counselling should always be offered to patients and their families and carers as part of the open disclosure process.[347] People looking for support should be personally assisted to access this support rather than just provided

with information about how to seek support themselves (that is, they should be provided with a warm referral to a service).

Recommendation 15.18

The Department of Health should ensure open disclosure processes for patients who experience child sexual abuse in health services and their families and carers that:

a. create a safe, trauma-informed pathway for victim-survivors, or others affected by an event, to receive clear and personalised information in response to their questions or concerns

b. facilitate appropriate notifications including to Tasmania Police, Child Safety Services, the Registrar of the Registration to Work with Vulnerable People Scheme, the Independent Regulator under the *Child and Youth Safe Organisations Act 2023* and the Australian Health Practitioner Regulation Agency

c. make appropriate supports available to affected people, including victim-survivors, their immediate family and carers, where abuse is connected to the Department's health services, including warm referrals, with the person's consent, to trained and experienced child sexual abuse counsellors.

4.4 Developing and implementing a critical incident response plan

Child sexual abuse in an institution can trigger a trauma event felt by many.[348] The implications of this are discussed in Section 5. The sexual abuse of a child in a health service, particularly by a staff member who has worked in the service for a long time, can also be described as a critical incident for the purposes of workplace policies, procedures and protocols.

It is not uncommon for institutions to be unprepared and unsure about what to do when a critical incident occurs in the workplace.[349] Dr Kate Brady, Research Fellow, Community Resilience, Melbourne School of Population and Global Health, University of Melbourne, told us that those tasked with managing recovery following a critical incident may not be trained in crisis management and often do not have the skill set required to respond appropriately.[350] Dr Peter Rob Gordon OAM, a clinical psychologist specialising in trauma, emergencies and disasters, explained that a disturbing, tense and threatening event will place a person in a state of 'high arousal'.[351] When those responding to a critical incident enter a 'high arousal state' it can limit their ability to look at what has occurred systematically and morally, resulting in poor decision making.[352] He said that

those tasked with responding may focus on strategies to limit liability, such as forbidding or inhibiting communication outside the institution, and not acknowledging what has happened or not apologising to those involved.[353]

The behaviours described by Dr Gordon were apparent in Launceston General Hospital's response to revelations about Mr Griffin. It is our view that the sheer scale of events connected to Mr Griffin overwhelmed the hospital's executive and management. We heard that managers did not feel equipped or supported to respond to these events. While some senior staff, such as Dr Renshaw, had previously confronted matters of child sexual abuse in their careers (for example, in response to Dr Tim), for most staff it was the first time they had to respond to such a crisis. Helen Bryan, former Executive Director of Nursing, Tasmanian Health Service North, told us that, while she did not agree that there was a lack of urgency from senior management in response to this critical incident, 'this was an incident or allegations that none of us had ever had to manage, experience, and we were navigating through an area that we were not familiar with'.[354] Sonja Leonard, former Nurse Unit Manager, Ward 4K, Launceston General Hospital similarly reflected that 'we were all in very uncharted waters and didn't have any knowledge, or experience, or training in how to deal with this'.[355]

In response to a question from Counsel Assisting our Inquiry about whether management could have done more to ensure greater transparency in the hospital's response, Janette Tonks, former Nursing and Midwifery Director, Women's and Children's Services, Launceston General Hospital said the following:

> Yes … but I also need to acknowledge that we were navigating an issue that—that most of us had never travelled before. We also had been traumatised and significantly affected by the events that had occurred. I think that everything we did was in good faith, we did what we thought at the time was in the best interest of the staff, as well as maintaining the police request about their investigation.
>
> It was extremely difficult to know what was the right thing and what was the wrong thing; there isn't actually a rule book around how you navigate through this particular type of issue.[356]

We heard expert evidence that poor responses to critical incidents can be averted by developing a clear and considered critical incident response plan that leaders can refer to in unprecedented or unanticipated situations. Dr Gordon told us that while health services may have policies, procedures and protocols in place to guide responses to critical incidents such as natural disasters, they are less likely to have explicit policies designed to promote recovery following human-caused traumatic events (that is, intentional acts at the hands of humans such as deliberate negligence or criminal offending) including child sexual abuse by a member of staff.[357] However, he indicated that policies that respond to these types of events can be developed.

In Chapter 14, Case study 3, relating to James Griffin, we find the lack of a coordinated and transparent response by Launceston General Hospital increased feelings of mistrust among hospital staff. Neither the Department nor Launceston General Hospital appear to have had a critical incident response plan in place at the time that Mr Griffin's offending became widely known. However, Mr Daniels indicated that the hospital had started work on critical incident stress management processes for staff and the community in response to the Hillcrest School tragedy, which occurred in December 2021.[358] Mr Daniels indicated that critical incident stress management processes could also apply in circumstances such as those involving Mr Griffin.[359]

In February 2023, Secretary Morgan-Wicks told us that a department-wide 'Critical Incident Response Protocol' would be developed as part of the *One Health Culture Strategy 2022–2027*.[360] She said that the Critical Incident Response Protocol 'will align with the [Department's] overarching Health and Wellbeing program to provide guidance on what support is available, how it is arranged and monitored'.[361]

In our view, the Critical Incident Response Protocol should go further, acknowledging that it is currently under development.[362] Dr Brady told us that a critical incident response plan should draw on Australia's nationally endorsed principles for disaster recovery, which promote community care through psychological first aid.[363] The principles were developed by the Social Recovery Reference Group Australia and are available on the Australian Institute for Disaster Resilience's website.[364] They are: understanding the context; recognising the complexity; use community-led approaches; coordinate all approaches; communicate effectively; and recognise and build capacity.[365]

Dr Brady also highlighted the importance of good communication after collective trauma events, which typically requires regularly communicating with those affected about what is known, what is not known, what is being done and what people can do to help.[366]

Dr Gordon told us it is crucial that those responding to critical incidents seek assistance from people who are external to the institution and its associated organisations to support clear thinking and to form appropriate responses.[367]

Those responsible for responding to critical incidents in health services should have clear policies, procedures and protocols to support their decision making. These policies, procedures and protocols should outline the key steps to take in communicating with and supporting those affected by the incident.[368] We consider that other Tasmanian Government departments should also review whether they have appropriate policies, procedures and protocols in place.

Recommendation 15.19

The Department of Health should develop and implement a critical incident response plan for human-caused traumatic events where numerous staff and patients are affected, including serious child-related incidents. The response plan should:

a. identify who is responsible for leading the response to a critical incident and set out the applicable reporting arrangements

b. identify the steps to responding to a human-caused traumatic event (including incidents relating to child safety)

c. provide for external assistance from experts with training and expertise in crisis management

d. be based on best practice responses to traumatic events

e. provide for early communication of information about the event

f. provide psychological first aid to affected people

g. provide extra support from skilled psychologists on an 'as needed' basis to affected people

h. provide for information about other support services that can assist affected people

i. facilitate communication and support among affected people as a means of social support

j. provide for critical incident debriefing run by a neutral and trained expert where appropriate

k. provide for a review of the Department's response to the critical incident

l. provide for an evaluation of any actions to be implemented as part of the Department's response to the critical incident

m. provide for any lessons from a review or an evaluation of the Department's response to the critical incident, to be shared with the Secretaries Board to further inform responses to critical incidents across the whole of government.

5 Restoring trust

The Launceston community has been profoundly affected by child sexual abuse at Launceston General Hospital and how that abuse was managed. These impacts are manifest in submissions, witness testimony, sessions with a Commissioner and consultations.

There has been a significant and long-term loss of trust in health workers among some in the Launceston community, with some parents avoiding taking their children to Launceston General Hospital and some victim-survivors refusing health care because they feel unsafe in health services. Where victim-survivors have sought health care at Launceston General Hospital, many described the feelings associated with their past experiences of abuse being reactivated, which hospital staff were often not well equipped to mitigate. This is a significant public health concern.

A lack of consistent and transparent information from a health service about what is being done in the wake of child sexual abuse revelations can serve to create an information vacuum. In the case of Mr Griffin, insufficient communication by Launceston General Hospital—with victim-survivors, their families and carers, former patients, staff and the broader community—led to various theories and rumours, some of which were well founded and others that we have not been able to substantiate. More generally, the hospital's approach invited suspicion that it was, above all, trying to protect its reputation.

As already noted, Dr Brady told us that child sexual abuse (particularly on this scale) can become a collective trauma event requiring a response that promotes community care and the restoration of trust using principles of disaster recovery.[369] While it is always best to adopt this approach as quickly as possible after an event, experts assured us that it is never too late to start responding in ways that help a community to heal and regain trust.

Shortly after our first week of hearings relevant to Launceston General Hospital in June 2022, the Department took steps to address some of the issues that emerged from these hearings. These steps included conducting the Child Safe Governance Review and the Community Recovery Initiative. On 8 November 2022, the Tasmanian Parliament apologised to all victim-survivors of child sexual abuse in Tasmanian Government institutions, including those connected with Launceston General Hospital.[370] These responses reflect a start, rather than an acquittal, of what is required to re-establish trust and goodwill in the Northern Tasmanian community.

The public release of our final report, which includes a range of information that has not yet been made public, may have a further unsettling effect on the community and will require a thoughtful and nuanced response from the hospital and the Department. There is a long road ahead.

In this section, we provide a summary of the evidence we heard from victim-survivors, their families and hospital staff about the loss of trust they have experienced following Launceston General Hospital's response to child sexual abuse, particularly the response to the 2019 revelations about Mr Griffin's offending.

We then consider the response of the hospital and the Department to this loss of trust and some of the Department's efforts towards restoring community trust in Launceston General Hospital and public health services more generally.

We recommend that Launceston General Hospital and Tasmania Police assist victim-survivors of child sexual abuse at the hospital on an ongoing basis.

5.1 The loss of trust

This section describes some of what we heard from victim-survivors, their families and supporters about the effects on them of alleged abuse at Launceston General Hospital, including how these events have impacted their overall trust in health services. We also describe some of what we heard about the psychological toll on staff at Launceston General Hospital following the hospital's manifestly deficient approach to responding to disclosures of abuse.

5.1.1 Victim-survivors' loss of trust in the health system and particularly Launceston General Hospital

Several witnesses described to us the trust that they placed in health workers to care for their children. For example, Kim (a pseudonym), whose daughter Paula (a pseudonym), was nursed by Mr Griffin at Launceston General Hospital, told us: 'We trusted the doctors and nurses, we trusted our children to LGH when they were at their most vulnerable'.[371]

Those whose trust has been undermined described an ongoing wariness and, at times, fear about seeking health care, particularly for their children.[372]

Several victim-survivors who experienced Mr Griffin's abuse also told us that their abuse had made them reluctant to seek health care for themselves or their children. One person who had experienced abuse by Mr Griffin said: 'I still feel uncomfortable going to LGH and hospitals in general because of what happened'.[373] Another victim-survivor said: 'Ever since the abuse, I have avoided hospitals and where I have required admission, I have discharged myself shortly after admission. I feel panic when I go near hospitals'.[374] Keelie McMahon, who also experienced abuse by Mr Griffin outside of the hospital, said: 'I shouldn't be putting my children's health on the line purely because I can't step foot in that hospital'.[375]

Michelle Nicholson, a community health social worker, suggested that the reluctance to access health services, as described by some of the witnesses to our Inquiry, is widespread. She told us that it was not uncommon for her clients to avoid seeking health care due to their past experiences.[376]

The effects of breaches of trust by health workers can also extend to other care arrangements. One family that participated in Launceston General Hospital's open disclosure process after their child (who has a disability) was identified in photographs found in Mr Griffin's possession, said:

> The long-term impact this has had on our family is significant. Our trust in others to care for [our child] is now very limited. We cannot bring ourselves to arrange overnight respite in supported accommodation facilities, even though we have been advised by other parents that the care is very good.[377]

We heard that mistrust in Launceston General Hospital has also resulted in people seeking care outside the region. Angela (a pseudonym) told us that she prefers to travel to Hobart to seek health care for her daughter (who has cerebral palsy) after receiving no response from Launceston General Hospital to a complaint she made about the care her daughter was receiving from nurses on Ward 4K, including Mr Griffin.[378] Angelique Knight, a former Ward 4K patient, told us that she, too, attends another hospital whenever possible. She said 'sometimes because of the complexities of my condition they send me to LGH. I dread going there every time'.[379]

Another victim-survivor who experienced abuse by Mr Griffin described going to significant lengths to avoid Tasmanian health services when her children need care. She said: 'When my children have had medical issues and a choice has existed around their treatment, I have made the decision to take them out of the state for treatment'.[380]

We heard from several witnesses that they avoid Launceston General Hospital because being there triggers the trauma of their abuse or otherwise makes them feel unsafe.[381]

One victim-survivor of Mr Griffin stated: 'My son was in hospital recently. I wanted to stay with him but felt unsafe being by myself. Hospital staff did not let my partner stay with me. This response failed to cater to my needs associated with the trauma of the abuse'.[382]

The Child Safe Governance Review reported that '[s]ome survivors perceived staff interactions with them, albeit well intentioned, as making them feel treated as "victims" in a notorious case of serial child abuse rather than as members of the community attending for health care'.[383]

While acknowledging these experiences and the importance of providing trauma-informed care to victim-survivors, Ms Nicholson advocated for individual hospital staff to not be left navigating responses to intergenerational trauma caused by sexual abuse. She said:

> … by and large the vast majority of health workers are doing the best they can in difficult and challenging understaffed circumstances where they are not provided with the necessary trauma informed care training … While on the surface it may look like people are failing to do their duty of care to survivors of historical trauma and children, I believe it is mainly not individuals but a flawed system that is the problem.[384]

The report of the Child Safe Governance Review, reflecting the views of the Lived Experience Expert Reference Group, states that any patient may have experienced prior trauma and therefore all patients should enjoy a level of care and sensitivity based on that assumption. We recommend in Chapter 19 that the Tasmanian Government should develop a whole of government approach to professional development in responding to trauma within government and government funded agencies that provide services to children, as well as statutory bodies that have contact with child sexual abuse victim-survivors (refer to Recommendation 19.2).

5.1.2 Loss of trust among Launceston General Hospital staff

Former and current Launceston General Hospital staff spoke to us about how the mismanagement of allegations of child sexual abuse at the hospital had affected them.

Maria Unwin, a former Ward 4K nurse, recalled that when she joined Launceston General Hospital in 1993, a colleague told her that a nurse had been caught in the act of sexually abusing a child on the ward during night shift. Ms Unwin stated:

> It was clear that when I started at the hospital some staff were still traumatised by this incident and how it had been handled. When it was discussed you could sense a level of fear from the people who were talking about it … When I heard the allegations I was shocked and felt sick. I was always shocked that even [when] someone was caught in the act of child sexual abuse they would only be moved on and that it would be covered up. I would never have expected this to be happening at the hospital in the 1990s.[385]

Kylee Pearn, a former hospital employee, told us that when Mr Griffin was allowed to remain on Ward 4K after she disclosed to human resources staff, in 2011 or 2012, that he had sexually abused her as a child, she 'couldn't cope'.[386] She left her social work role at the hospital and moved to a new role in a school.[387]

Annette Whitemore, a former Ward 4K nurse told us that the hospital's response to allegations against Mr Griffin contributed to her resigning from Ward 4K.[388]

We also heard that some staff were reluctant to seek health care from Launceston General Hospital because of the hospital's failure to effectively respond to allegations of sexual abuse against young patients.[389]

5.2 Launceston General Hospital's response to loss of trust

As outlined in Chapter 14, Case study 3, Launceston General Hospital offered open disclosure to some patients who were identified in photographs found in Mr Griffin's possession. The one family that took part in the open disclosure process expressed concerns about how this process was conducted, in particular:

- hearing about Mr Griffin's offending through a voice message left on their phone while they were at work
- whether they were told the truth that previous concerns raised with the hospital about Mr Griffin were not of a sexual nature
- not being offered counselling or follow-up support from Tasmania Police or the hospital.

The absence of clear communication from the hospital about the photographs found in Mr Griffin's possession has also left some former patients, and their families, wondering if the patients may have been in the cache of images seized by Tasmania Police.

As discussed in Chapter 14, Case study 3, after hearing details of Mr Griffin's offending on *The Nurse* podcast, Ms Knight recalled asking the hospital whether any of the photos found were of her and whether she could see them.[390] The hospital told her that only one patient had been identified from the photos.[391] Ms Knight said that the hospital 'did not explain the process that led to this identification or explain why I couldn't see [the photos] myself'.[392] She went on to explain:

> I don't know if James Griffin did take photos of me and that bothers me. He had plenty of opportunity. I showered in front of him. I was naked in his presence. If there were photos of me on his phone I would have been able to identify myself. I was really annoyed by all of this and it felt like [the hospital] was just brushing me off again. I felt like I was nothing and just a number …[393]

As becomes clear in Chapter 14, Case study 3, beyond the existence of the photographs, the hospital's executive was denying, internally and externally, that there was any connection between Mr Griffin's offending and hospital patients. This denial continued until our hearings when the extent of complaints against Mr Griffin and the experiences of former patients became more broadly known.[394]

Dr Renshaw, who was involved in the response to revelations about Mr Griffin, told us that he had turned his mind to communicating more broadly with potential victims, however:

> I considered the logistics of doing a mail-out to the families of every paediatric patient of the LGH over the previous 15 or so years were well beyond the resources available within the LGH. It was also a factor that there were periods when Griffin was not working at the LGH. I did consider approaching patients and their families who had been inpatients for longer than a specified period of time (for example, over a week or over a month) as being more likely to have been victims of Griffin. However, there was also the potential with such a blanket approach to cause unnecessary distress and anxiety to families whose children had no contact at all with Griffin during their hospital stay.[395]

As set out in Chapter 14, Case study 3, we also heard that some victim-survivors who contacted the hospital were given generic lists of phone numbers for psychological support.[396] While such resources can be useful, simply providing contact details for support services is not an appropriate response from an institution that has a duty to protect patients from harm.

We invited the leadership of Launceston General Hospital to reflect on what could be done to restore the trust of victim-survivors and staff of the hospital. Unfortunately, the responses we received suggested that restoring trust had not been the subject of any deep thought or reflection. Where suggestions were made, they tended to be superficial.[397]

It was clear to us that the hospital's leadership lacked a meaningful understanding of the impact that Mr Griffin's offending has had on victim-survivors, staff and the broader community, and that the leadership has failed to grasp the extent of the work required to restore trust. The hospital's leadership provided no evidence to suggest any insight that acknowledging the extent of Mr Griffin's offending, and providing information about how such offending continued for many years, are essential to restoring trust. We hope that our Commission of Inquiry and final report will provide some of these answers.

We accept that, due to poor records, failed memories, the absence of any witnesses and the reality that the full extent of Mr Griffin's abuse is unlikely to ever be known, Launceston General Hospital will not be able to answer every question and reassure every individual. However, the hospital has an obligation to do what it can to provide some clarity and closure to those who remain distressed or concerned about the implications of Mr Griffin's offending.

Launceston General Hospital's response to victim-survivors, their families and carers, staff and the broader community must not be a bureaucratic exercise. The hospital must consider the needs of known and as yet unknown victim-survivors and, as we recommend above (refer to Recommendation 15.18), make appropriate supports available to affected people including victim-survivors and their immediate family and carers, including warm referrals to trained and experienced child sexual abuse counsellors.

We consider that Launceston General Hospital and Tasmania Police have an ongoing obligation to help identify victim-survivors of Mr Griffin when requests emerge, or, if this is not feasible, to clearly explain why. We are aware that other jurisdictions are using advances in technology to identify victim-survivors in child sexual exploitation material.[398]

We also consider that any communications with the broader community following an incident, such as the potential sexual abuse of patients by a staff member at a hospital, should be informed by the principles of open disclosure applied at the community level, which we have outlined earlier (refer to Section 4.3).

Recommendation 15.20

1. The Department of Health, Launceston General Hospital and Tasmania Police should make clear that they will continue to assist, on an ongoing basis, known and as yet unknown victim-survivors of child sexual abuse by James Griffin related to the hospital and should nominate a contact person for people who have enquiries.
2. Assistance should include:
    a. outlining what is known about Mr Griffin's offending at the hospital
    b. taking steps to ascertain whether a person is or may be a victim-survivor of Mr Griffin's offending or clearly explaining why this cannot be done.
3. The Department and Launceston General Hospital's communications with known and as yet unknown victim-survivors of Mr Griffin and their families and carers and the broader community should be informed by the principles of open disclosure.
4. Launceston General Hospital should ensure victim-survivors and their families and carers who do not receive individual open disclosure (Recommendation 15.18) still receive a warm referral to trained child sexual abuse counsellors if desired.

6 The work of oversight agencies

In Chapter 13, we provided a brief overview of key agencies that oversee aspects of Tasmania's health system, including health practitioners and health services. These agencies include Ahpra, the National Boards and the Health Complaints Commissioner. A core role of these agencies is ensuring the safety of children and young people who receive health care.

In this section, we discuss the role of each agency and make observations about how these agencies might be made more effective in helping to protect the safety of children. In relation to Ahpra and the National Boards, we highlight a general lack of community awareness of their roles and functions. We consider that the recommendations we make above will address concerns about ensuring consistent information is provided to patients, including age-appropriate resources for children and young people and their families and carers (Recommendation 15.8), ensuring there are up-to-date policies on mandatory and voluntary reporting obligations, including for concerns about staff conduct (Recommendation 15.12), developing of a professional conduct policy for staff who have contact with children and young people in health services (Recommendation 15.13) and strengthening professional development around child safety for different levels of staff (Recommendation 15.15).

In relation to the Health Complaints Commissioner, we highlight problems in its ability to fully perform its role and functions, and identify possible areas of improvement. We do not make recommendations about these improvements because we consider the new Commission for Children and Young People that we recommend be established (refer to Chapter 18) will be the peak oversight body responding to concerns about children and young people. We do, however, recommend a review of the Health Complaints Act to consider some of the problems we discuss.

6.1 Ahpra and the National Boards

Ahpra is the agency that administers the National Registration and Accreditation Scheme for health practitioners in Australia. It also provides administrative support to 15 National Boards, which carry out a range of functions for overseeing health practitioners registered across 16 health professions under the National Law.

6.1.1 Codes of conduct

Staff who are registered under one of the health professions recognised by the National Law must follow codes of conduct established by their respective National Board. These codes offer guidance on the expected standards of conduct for registered health practitioners that apply to health practitioners when they are delivering care and to their behaviour outside the workplace.[399] These codes require that health practitioners maintain professional boundaries with patients.[400]

Codes and guidelines that have been approved by the National Boards are admissible in disciplinary proceedings under the National Law. They can be used as evidence of what constitutes appropriate professional conduct or practice for a particular health profession.[401]

6.1.2 Notifications to Ahpra and the National Boards

The National Law provides for notifications to be made to Ahpra and the National Boards where the health, conduct or performance of a registered health practitioner poses a risk to the public.[402]

Registered health practitioners and their employers are mandated under the National Law to report a registered health practitioner if they form a reasonable belief that the practitioner has engaged in 'notifiable conduct'.[403] Notifiable conduct includes 'engaging in sexual misconduct in connection with the practice of a health profession'.[404] Examples of sexual misconduct include sexual activity with a current patient, making sexual remarks, touching patients in a sexual way, touching a patient in an intimate area without clinical indication and engaging in sexual behaviour in front of a patient.[405]

A health practitioner who forms a reasonable belief that another health practitioner has engaged in notifiable conduct and does not make a mandatory notification may be subject to regulatory action.[406]

In addition to mandatory notifications, any entity or person, including patients or members of the public, can make a voluntary notification about a health practitioner.[407] Voluntary notifications can be made to Ahpra and the National Boards on several grounds, including that the practitioner is or may not be a suitable person to hold registration in a health profession because they are not, for example, a fit and proper person to be registered in the profession.[408] A notification may also be about concerns that a practitioner's conduct is unprofessional, unlawful or below acceptable standards.[409]

6.1.3 Managing notifications involving sexual misconduct

Ahpra refers notifications about health practitioners to the National Boards.[410] The National Boards are empowered to take a range of steps in response to a notification, including:

- taking immediate action to stop a health practitioner from practising
- launching an investigation
- imposing registration conditions
- directing the practitioner to attend a health or performance assessment.[411]

Where there is enough evidence for a National Board to form a reasonable belief that child sexual abuse has occurred, the National Board will refer the matter to a responsible tribunal under the National Law.[412] In Tasmania, this tribunal is the Tasmanian Civil and Administrative Tribunal.[413] After considering a matter, the tribunal may make a range of orders, including cautioning or reprimanding a practitioner, imposing conditions on their registration, imposing a fine, or suspending or cancelling the practitioner's registration.[414]

A strength of the National Registration and Accreditation Scheme is that it hosts a single database of all notifications and complaints made about registered health practitioners in Australia.[415] The national database records all notifications about registered health practitioners since the National Law began, irrespective of whether the notification was made to a National Board or to another health complaints entity (such as the Tasmanian Health Complaints Commissioner).[416] The database helps in assessing future complaints about registered health practitioners by enabling patterns of behaviour that have not otherwise resulted in disciplinary action to be identified—for example, repeated concerns about boundary violations.[417]

It is important for health services to have clear systems and processes in place that inform and guide staff about reporting to Ahpra and the National Boards.

6.1.4 Awareness of Ahpra and the National Boards

Despite Ahpra and the National Board's role in managing notifications about health practitioners, we identified through our Inquiry that staff, former patients and the community are not aware of their regulatory functions, nor of their ability and, in some cases, obligation, to make notifications to Ahpra and the National Boards under the National Law. In Chapter 14, Case study 3, relating to James Griffin, we find that Launceston General Hospital had no clear system, procedures or process in place to report complaints about James Griffin to external agencies.

In relation to staff at Launceston General Hospital, Ms Unwin told us that although she was aware of the obligation to report suspected abuse including mandatory reporting under child safety legislation, she had 'always been led to believe that evidence was required to make a complaint'.[418] She said it was not until 2020 that she became aware that she could have made a complaint to the former Tasmanian Nursing Board or Ahpra about Mr Griffin based on her concerns alone.[419]

Similarly, another former Ward 4K nurse, Annette Whitemore, said: 'We all knew we were mandatory reporters, and I don't think we were deliberately not told this, but until 2019 when all this happened … I never knew I could go straight to Ahpra'.[420] Will Gordon, Ward 4K nurse, told us that most nurses on Ward 4K did not realise they could report their colleagues to Ahpra.[421] He said: 'We just didn't know, we weren't told about it, there was no education about that sort of complaint process'.[422]

Dr Renshaw agreed that 'it was clear' staff at Launceston General Hospital were not aware of their mandatory reporting obligations under the National Law.[423] He confirmed that prior to the public revelation of events involving Mr Griffin, there was no training provided to staff about the National Law.[424]

In a statement to us, Matthew Hardy, National Director, Notifications, Ahpra, said:

> Information in relation to a health practitioner's mandatory notification obligations is widely available for health practitioners, and I would expect that registered health practitioners take reasonable steps to undertake self-directed learning to stay current with changes in their profession. Specifically, I would expect that health practitioners and students undertake a degree of training by employers or other entities, with that education supplemented by self-directed learning, including in relation to mandatory notification obligations established by their respective National Board or otherwise as published on Ahpra's website. National Boards mandate participation in annual Continuing Professional Development to facilitate this ongoing professional learning and development process.[425]

In relation to awareness of Ahpra and the National Boards among patients and the community, Ms Knight, a former Ward 4K patient, told us: 'I have never heard of the Australian Health Practitioner Regulation [Agency], even though I've spent so much of my life in hospitals'.[426] Another witness and victim-survivor said

she ‘wasn’t aware of the existence of Ahpra as an independent body’ and, in their experience, ‘people generally aren’t aware of Ahpra like they are with the Ombudsman, Teachers Registration Board or the Integrity Commission’.[427] They said that had they known about Ahpra, they would have contacted the agency about Mr Griffin at the earliest opportunity.[428]

Secretary Morgan-Wicks described the Department’s promotion of Ahpra and the National Boards’ notification processes to patients as ‘limited’, adding that information is ‘more likely’ to be provided once a complaint is received.[429]

Mr Hardy told us that it was his expectation that ‘health consumers and the general public are aware of the existence of health professional regulation in Australia and that there are mechanisms by which complaints can be made’.[430] He said health consumers and the public can access Ahpra and the National Boards’ websites, which provide information on ‘accreditation, registration and notification systems’.[431]

We consider that more must be done to raise awareness about the role of Ahpra and the National Boards among health workers, patients and the broader community. Mr Hardy agreed that although Ahpra does not have a legislated educative role, as a model regulator, the organisation does have ‘an obligation to make sure that our practitioners are educated, that we engage with employers of those practitioners and that the community is aware of who we are and what we do’.[432]

Our Commission of Inquiry’s mandate does not extend to making recommendations to Ahpra or the National Boards. However, we hope that they increase their educational activities, particularly in relation to the ability of any member of the public to report concerns about the conduct of health practitioners.

The Department should ensure staff who are registered health practitioners are aware of their obligations under the National Law. This can be achieved through professional development and by implementing policies that outline what staff should do when they have concerns about a colleague who is a registered health practitioner. We make recommendations above about ensuring there are up-to-date policies on mandatory and voluntary reporting obligations, including for concerns about staff conduct, as well as strengthened professional development on child safety for different levels of staff (refer to Recommendations 15.12 and 15.15).

The Department can also play a role in increasing patient awareness of their rights to make a notification about a health practitioner to Ahpra and the National Boards by including this information in any documentation they produce about patients’ rights and expectations. We make a recommendation above about ensuring consistent information is provided to patients, including age-appropriate resources for children and young people and their families (refer to Recommendation 15.8).

6.2 Health Complaints Commissioner

In Chapter 13, we briefly discuss the role of the Health Complaints Commissioner under the Health Complaints Act. Richard Connock is the current Health Complaints Commissioner. Mr Connock is also the Tasmanian Ombudsman.

Mr Connock leads the Office of the Ombudsman and Health Complaints Commissioner. Together, these offices cover six separate jurisdictions—those of the Parliamentary Ombudsman, the Health Complaints Commissioner, the Energy Ombudsman, Right to Information, the Official Visitors Programs and the Custodial Inspectorate. Mr Connock referred to his Right to Information role as a 'de-facto' role.[433]

The relevant key functions of the Health Complaints Commissioner are:

- receiving, assessing and resolving complaints about Tasmanian health service providers in the public and private sectors
- inquiring into and reporting on matters related to health service providers and health services at the discretion of the Health Complaints Commissioner or at the direction of the Minister for Health.[434]

6.2.1 Complaints involving children and young people

The Health Complaints Commissioner can receive complaints from a parent or guardian of a child under 14 years of age, a person appointed by a child who is aged 14 years or older, or the child directly in circumstances where the Health Complaints Commissioner agrees the child is capable of lodging a complaint.[435]

Matters to note about the Health Complaints Commissioner's management of complaints involving children and young people and child sexual abuse include:

- Complaints are initially referred to Tasmania Police given the behaviour is potentially criminal in nature.[436]
- Complaints involving a health worker who is not registered under the National Law are considered and investigated by the Health Complaints Commissioner, but the Commissioner does not yet have any powers to impose sanctions on that worker.[437]
- Complaints about a health practitioner registered under the National Law are referred to Ahpra and the National Boards (discussed above).[438]
- The Health Complaints Commissioner has a memorandum of understanding with Ahpra that requires complaints to be managed collaboratively. Where a complaint relates to a registered health practitioner and the health service they work in, the complaint can be separated, with the Health Complaints Commissioner investigating the aspects of the complaint relating to the health service to identify broader systemic issues and Ahpra investigating the aspects relating to the individual practitioner.[439]

While we do not consider that the Health Complaints Commissioner should be the first port of call whenever there is a complaint of child sexual abuse within a health service, the Health Complaints Commissioner plays a unique and important role in identifying systemic risks to child safety within health care settings, particularly in relation to health services that do not do enough to address poor or unprofessional staff conduct.

6.2.2 Strengthening the role of the Health Complaints Commissioner

The Health Complaints Commissioner also has an important role in informing and empowering consumers, including children and young people, with respect to their health care rights and the options available to them when they are dissatisfied with or have concerns about their health care. The community should be aware of this role and benefit from these options.

However, the Health Complaints Commissioner faces barriers in effectively performing its legislative functions including a lack of public awareness about the Health Complaints Commissioner's role and inadequate funding.

6.2.3 The Health Complaints Commissioner's response to child sexual abuse in health services

Complaints made to the Health Complaints Commissioner cover a broad spectrum of issues, which vary in nature and degree of seriousness.[440] Mr Connock told us that although his office does not specifically monitor risks in relation to child sexual abuse, it is vigilant in responding to enquiries and complaints involving vulnerable groups and people.[441] He also told us his office had not received any complaints about child sexual abuse in health services throughout the period our Commission of Inquiry is examining (that is, since 2000).[442] However, his office has received complaints about the alleged sexual abuse of vulnerable adults in health services (refer to the Health Complaints Commissioner's report into Ward 1E, which is summarised in Chapter 13).[443]

While the Health Complaints Commissioner would not ordinarily be the first point of contact for those affected by child sexual abuse (in a way that the police or Child Safety Services may be), the absence of any complaints about child sexual abuse is surprising, particularly given how enduring the complaints and concerns were about Mr Griffin and Launceston General Hospital's response.

Mr Connock acknowledged that not receiving complaints about these matters means his office does not have insight into the extent of systemic issues relevant to child safety.[444] He said the absence of complaints connected to child sexual abuse may be because of:

- a lack of awareness among health service users and the community in general of the role of the Health Complaints Commissioner and the Ombudsman, as well as the ability to make notifications to Ahpra and the National Boards

- the Health Complaints Act and *Ombudsman Act 1978* being unable to guarantee anonymity in relation to complaints
- reluctance to make complaints due to fear of reprisals.[445]

6.2.4 Funding the Health Complaints Commissioner

Mr Connock told us that most of his office's resources are dedicated to complaints handling, conciliation and resolution.[446] Data shows that the number of complaints the Health Complaints Commissioner receives has increased considerably since 2019–20. Most recently, in 2021–22, the Health Complaints Commissioner received 769 complaints, up from 440 complaints in 2020–21.[447] These figures do not include enquiries made or notifications received from Ahpra and the National Boards, which accounted for another 541 contacts in 2021–22 and 625 contacts in 2020–21.[448]

Mr Connock told us that the health complaints jurisdiction had historically been underfunded.[449] A review of the Health Complaints Act, completed in 2003, identified funding as a key issue affecting the health complaints jurisdiction. The review concluded that 'the Commissioner's office had been under-resourced since it was first established'.[450] Underfunding is also referenced across several of the Health Complaints Commissioner's annual reports.[451]

Mr Connock also described to us the effects of having very few staff:

> In the past, low staff numbers in the Health Complaints jurisdiction had not only an adverse impact on the time taken to resolve complaints but also, with a necessary focus on complaint resolution, resulted in an inability to perform other functions prescribed under the [Health Complaints] Act. These include things such as: education on health rights; building complaint resolution capacity in providers; auditing improvements to health services and conducting own motion investigations.[452]

All these functions—education on health rights, building health services' capacity in relation to complaints handling, auditing and investigations—are important to ensuring health services protect consumers, including children.

Mr Connock told us that a lack of funding is a key barrier to his office's ability to improve complaints handling procedures in Tasmanian health services.[453] While his office provides feedback to health services about how complaints might be better handled in the course of day-to-day management of health complaints, Mr Connock explained that he has not been able to exercise his broader functions in educating health services on how to manage complaints internally because 'we've got so many complaints; we're really just dealing with those'.[454] Mr Connock also indicated that there have been occasions when he would have undertaken more substantive investigations but did not have the funding and staff available to do so.[455]

Mr Connock told us that the Office of the Ombudsman began receiving extra three-year funding in 2021 to be spread across all six jurisdictions of the Office of the Ombudsman and Health Complaints Commissioner identified above. This was the first increase to funding the Office of the Ombudsman and Health Complaints Commissioner had received since 2014 (apart from dedicated funding for the Right to Information jurisdiction in 2019).[456]

Mr Connock said he was 'hopeful' but 'hesitant' to say that the increased funding, which was significant, would enable the Office of the Health Complaints Commissioner to adequately perform its legislated functions. He noted that the increased funding will 'certainly be a vast improvement' but '[the Office] will just have to see how we go' because an increase of this scale had not occurred before.[457] He did, however, indicate that the funding would 'make a meaningful change' to the performance of functions across all jurisdictions, including the health complaints jurisdiction.[458]

6.2.5 Appointing a separate Health Complaints Commissioner

The Health Complaints Act permits a person who holds the position of Ombudsman to also be appointed to the position of Health Complaints Commissioner.[459] Mr Connock was appointed to the role of Ombudsman and Health Complaints Commissioner in July 2014. He told us that, since the Office of the Health Complaints Commissioner was established in 1997, both appointments have always been held by the same appointee.[460]

The 2003 review of the Health Complaints Act identified distinct advantages in amalgamating review bodies. These advantages included the ability to offer the community the same range of review services present in larger jurisdictions, as well as cost savings associated with salaries, shared premises and shared administrative and infrastructure support.[461]

Since the review, the Ombudsman's roles have greatly increased. Mr Connock said that with responsibilities for six jurisdictions, he only dedicates about one day a week to the performance of the Health Complaints Commissioner role.[462] All other Australian states (although not territories) have appointed a separate Health Complaints Commissioner (or Director, as is the case in Western Australia).[463]

Mr Connock also referred to the potential for conflicts of interest to arise when the Ombudsman is investigating the administrative actions of the Health Complaints Commissioner. He said:

> There have been issues recently in the past with potential conflict of interest because, as Ombudsman, Health Complaints Commissioner comes within my jurisdiction, so we have had complaints against the Health Complaints Commissioner. We've managed that, it's not been— there has not been a problem, but the perception is there and the capacity for conflict.[464]

6.2.6 Code of conduct for unregistered health workers

Health services often employ registered and unregistered health workers. The conduct of registered health practitioners is subject to Ahpra and National Board oversight. A National Board must refer registered health practitioners located in Tasmania to the Tasmanian Civil and Administrative Tribunal where it reasonably believes the practitioner has behaved in a way that constitutes professional misconduct.[465] Our case studies primarily focused on nurses and doctors who are registered in this way.

There is currently no similar professional misconduct process for health workers in Tasmania who are not registered under the National Law.

Health workers who are not registered under the National Law include counsellors, social workers, massage therapists, dietitians, speech pathologists, naturopaths, alternative therapists, personal care attendants and pharmacy assistants.[466] People in these roles often have contact, including close physical contact, with children and enjoy significant community trust. These factors can increase the risks of child sexual abuse.

A complaint can be made to the Health Complaints Commissioner about a health worker who is not registered under the National Law. The Commissioner may investigate and make recommendations in relation to such a complaint, but the Commissioner does not have any disciplinary powers to impose sanctions on the worker.[467] Unregistered health workers who are employed in the State Service are subject to Employment Direction processes (discussed in Chapter 20) or may also face consequences associated with losing, or not obtaining, their registration to work with vulnerable people, including children. However, the Health Complaints Commissioner has no ability to ensure these processes are followed.[468] Because unregistered health workers are not overseen by Ahpra or any National Board, there is a regulatory gap for this group.

In June 2013, at a meeting of the Commonwealth Parliamentary Standing Committee on Health, Australia's health ministers agreed in principle to establish the National Code of Conduct for Unregistered Health Care Workers ('the Code').[469] Drafting the Code was also agreed at a meeting of the former Council of Australian Governments' Health Council in 2015.[470] Each Australian state and territory is responsible for giving effect to the Code.[471] Regimes have been introduced in New South Wales, Queensland, South Australia and Victoria.[472] The Tasmanian Parliament passed amendments to the Health Complaints Act to implement the Code in 2018, but no date has been set for them to begin.[473] The Health Complaints Commissioner will be responsible for administering the Code in Tasmania.[474]

The Code outlines minimum standards of conduct and practice for unregistered health workers who provide a health service.[475] Implementation of the Code in Tasmania will allow the Health Complaints Commissioner to act against unregistered health workers who fail to comply with the standards of conduct and practice set out in the Code. The Health

Complaints Commissioner will have powers to make public warning statements and publish prohibition orders in relation to unregistered health workers who have breached the Code and who pose a risk to public health and safety, including to children.[476]

Mr Connock told us that the administration of the Code will be different from the work his office currently undertakes.[477] He described the Health Complaints Commissioner becoming 'in effect, the equivalent of Ahpra for unregistered practitioners' and that investigations 'required to justify the making of prohibition orders and public statements will be more in the nature of a prosecution than an investigation'.[478] In his 2021–22 annual report, Mr Connock observed that any complaints related to the Code 'would mean an added strain on resources that are already stretched' and require 'extensive modifications to our case management system to accommodate workflows related to the administration of the Code'.[479]

6.2.7 Review of the Health Complaints Act

At the time of establishing the Health Complaints Commissioner in 1997, the role was modelled on health complaints entities in Victoria and Queensland.[480] These entities focused heavily on resolving and conciliating complaints.[481] Mr Connock told us that, as a result, the Health Complaints Commissioner in Tasmania has traditionally dedicated most of its time to conciliating rather than investigating complaints.[482]

The role of health complaints entities in other Australian jurisdictions has since evolved to become 'more of a watchdog' body.[483] The Health Complaints Act has not, however, been reviewed or updated to reflect this more contemporary role, nor has it been substantially reviewed since the National Registration and Accreditation Scheme began in 2010.

When the Health Complaints Act first began, it contained a provision requiring the Health Complaints Commissioner to review the Act three years after its commencement and at five-year intervals thereafter.[484] This provision was repealed by the *Justice and Related Legislation (Miscellaneous Amendments) Act 2006*.[485]

Mr Connock told us that the Health Complaints Act had only been the subject of one legislative review, which, as noted above, was published in 2003.[486] This review resulted in 35 recommendations, including in relation to the early resolution of complaints, the Commissioner's powers of investigations, the appointment of a separate Health Complaints Commissioner, increased responsiveness to the needs of the community and resource allocation. Most of the report's recommendations were incorporated into the *Health Complaints Amendment Act 2005*.[487]

6.2.8 Our observations

In our view, it is unsatisfactory that the Health Complaints Commissioner appears unable to perform its legislated functions appropriately due to a lack of funding and resources.

Given what has emerged about Launceston General Hospital's inability to respond to and manage complaints from health service users and staff in relation to child sexual abuse, there is an urgent need to resource the Health Complaints Commissioner to provide education to the community about its role and to undertake capacity-building work in health services about internal complaints management processes. The Health Complaints Commissioner must also be equipped to undertake investigations when needed. Ensuring health services are safe and trusted is an important contribution to public health objectives and will contribute to keeping children safe from harm.

The current time dedicated to performing the role of the Health Complaints Commissioner (estimated by Mr Connock as the equivalent of one day a week) is inadequate and should be increased.[488] Performing the role with such little time cannot ensure sufficient oversight of the health complaints jurisdiction or the effective acquittal of the Health Complaints Commissioner's legislated functions so far as they relate to complaints connected to child sexual abuse.

The potential for conflicts of interest to arise between the Ombudsman and the Health Complaints Commissioner in circumstances where the Ombudsman is investigating the administrative actions of the Health Complaints Commissioner is also an issue that must be addressed to ensure the community can have confidence in the exercise of functions with respect to each role. A Health Complaints Commissioner who is separate from the Ombudsman should be appointed.

A need for more funding also arises from the expected implementation of the *Code of Conduct for Unregistered Health Care Workers*. Implementing the Code would be a significant step to address a current gap in oversight by improving responses to the conduct of health workers who pose a risk to children and young people and who are not currently captured by existing regulatory schemes. However, implementing the Code will result in more responsibilities for the Health Complaints Commissioner and an added strain on already stretched resources. The Tasmanian Government must ensure the Health Complaints Commissioner has the resources to implement and administer the Code.

In our view, the issues we raise would be best addressed through a comprehensive review of the Health Complaints Act and the role of the Health Complaints Commissioner. We understand the Health Complaints Commissioner secured funding for a consultant to complete a review of the Act by the end of the previous financial year (2022–23).[489] This review may prove a useful first step towards modernising the Act.

We consider that with the introduction of the new Commission for Children and Young People (refer to Chapter 18) and the implementation of the Reportable Conduct Scheme

under the Child and Youth Safe Organisations Act (also discussed in Chapter 18), most concerns about child sexual abuse and related matters in health services will be within the jurisdiction of the new Commission for Children and Young People. We view this new Commission as the primary oversight body for the safety of children and young people in Tasmania. We also consider professional regulation of unregistered health workers a priority because they are a cohort that often provides services to children.

Recommendation 15.21

The Tasmanian Government should ensure a review of the *Health Complaints Act 1995* is completed and considers the role of the Health Complaints Commissioner in relation to:

a. addressing systemic issues within health services related to child safety

b. incorporating the administration, monitoring and oversight of the Code of Conduct for Unregistered Health Care Workers

c. coordinating with the role of the new Commission for Children and Young People (Recommendation 18.6), and the Independent Regulator under the *Child and Youth Safe Organisations Act 2023*.

7 Conclusion

The case studies our Commission of Inquiry considered make clear the enormous suffering caused to victim-survivors, their families and staff, as well as the far-reaching adverse impacts on the broader community and the health system overall, when health services fail to:

- appreciate the risks of abuse to children and young people
- prioritise the safety and wellbeing of children and young people
- respond appropriately to risks and disclosures of harm.

The recommendations we outline in this chapter, and the reforms the Department has recently adopted, represent the beginning, not the end, of the Department's efforts to safeguard children and young people in health services. Keeping children and young people safe is not a one-off endeavour, but a process of continuous improvement that must be informed by children and young people, victim-survivors, independent experts and health workers, including those who have worked tirelessly to advocate for children's safety. Current and future leaders and senior managers at the Department and Launceston General Hospital must be up to this task.

We wish to emphasise that all Tasmanian health services, not just Launceston General Hospital, should reflect on their own child safe practices and closely consider the findings and recommendations in this volume. The issues identified at Launceston General Hospital can, and no doubt do, occur in other health services. We would like all health services to benefit from implementing our recommendations.

We once again recognise the hard-working people in Tasmania's health services, the great majority of whom always seek to act in the best interests of children and young people and ensure their safety. We again express our profound appreciation to the many victim-survivors, their families, current and former staff, advocates and others who contributed to our Commission of Inquiry. We acknowledge your suffering and pay tribute to your efforts to bring incidents of abuse, and the broader matters at Launceston General Hospital, to the public's attention, motivated by a desire for justice and to ensure other children and young people do not have to experience the same trauma. We also recognise former patients and their families and carers who have experienced abuse at Launceston General Hospital or in other Tasmanian health services, and those who may have chosen, for a range of reasons, not to come forward.

The commitment of many who spoke with us about improving the safety of all children and young people in health services was palpable. We trust that this will translate into meaningful and long overdue change in Tasmanian health services.

Notes

1 As adopted by the *Health Practitioner Registration National Law Act (Tasmania) 2010* s 4.

2 Letter from Kathrine Morgan-Wicks to Commission of Inquiry, 17 December 2022, 1; Letter from Kathrine Morgan-Wicks to Commission of Inquiry, 10 February 2023, 2.

3 'Child Safe Organisation Project', *Department of Health* (Web Page) <https://www.health.tas.gov.au/health-topics/child-and-youth-health/child-safety-and-wellbeing/child-safe-organisation-project>.

4 Debora Picone and Karen Crawshaw, *Independent Child Safe Governance Review of the Launceston General Hospital and Human Resources* (Report, December 2022) 7.

5 Jeremy Rockliff and Kathrine Morgan-Wicks, 'Child Safe Governance Review of the Launceston General Hospital and Human Resources' (Media Release, 3 July 2022) <https://www.premier.tas.gov.au/site_resources_2015/additional_releases/child_safe_governance_review_of_the_launceston_general_hospital_and_human_resources>.

6 For the full terms of reference, refer to Debora Picone and Karen Crawshaw, *Independent Child Safe Governance Review of the Launceston General Hospital and Human Resources* (Report, December 2022) 23–24.

7 Debora Picone and Karen Crawshaw, *Independent Child Safe Governance Review of the Launceston General Hospital and Human Resources* (Report, December 2022) 27 [2.47].

8 Debora Picone and Karen Crawshaw, *Independent Child Safe Governance Review of the Launceston General Hospital and Human Resources* (Report, December 2022) 27 [2.48].

9 Letter from Kathrine Morgan-Wicks to Commission of Inquiry, 14 December 2022, 2.

10 We understand that the Chief Executive, who was appointed in December 2022, resigned from the position in or around April 2023. Refer to Charmaine Manuel, 'Jen Duncan Departs as Hospitals North Chief Executive', *The Examiner* (online, 22 April 2023) <https://www.examiner.com.au/story/8168233/departing-hospital-north-boss-to-ensure-a-smooth-transition/>.

11 Letter from Kathrine Morgan-Wicks to Commission of Inquiry, 14 December 2022, 2.

12 Letter from Debora Picone and Karen Crawshaw to Commission of Inquiry, 'Submission from the Independent Oversight Group on the implementation of the recommendations arising from the Independent Child Safe Governance review of the Launceston General Hospital and Human Resources', 6 July 2023, 2.

13 Letter from Debora Picone and Karen Crawshaw to Commission of Inquiry, 'Submission from the Independent Oversight Group on the implementation of the recommendations arising from the Independent Child Safe Governance review of the Launceston General Hospital and Human Resources', 6 July 2023, 2.

14 Letter from Debora Picone and Karen Crawshaw to Commission of Inquiry, 'Submission from the Independent Oversight Group on the implementation of the recommendations arising from the Independent Child Safe Governance review of the Launceston General Hospital and Human Resources', 6 July 2023, 2.

15 Letter from Debora Picone and Karen Crawshaw to Commission of Inquiry, 'Submission from the Independent Oversight Group on the implementation of the recommendations arising from the Independent Child Safe Governance review of the Launceston General Hospital and Human Resources', 6 July 2023, 6.

16 Letter from Debora Picone and Karen Crawshaw to Commission of Inquiry, 'Submission from the Independent Oversight Group on the implementation of the recommendations arising from the Independent Child Safe Governance review of the Launceston General Hospital and Human Resources', 6 July 2023, 1.

17 Letter from Debora Picone and Karen Crawshaw to Commission of Inquiry, 'Submission from the Independent Oversight Group on the implementation of the recommendations arising from the Independent Child Safe Governance review of the Launceston General Hospital and Human Resources', 6 July 2023, 1.

18 Letter from Debora Picone and Karen Crawshaw to Commission of Inquiry, 'Submission from the Independent Oversight Group on the implementation of the recommendations arising from the Independent Child Safe Governance review of the Launceston General Hospital and Human Resources', 6 July 2023, 2.

19 Letter from Debora Picone and Karen Crawshaw to Commission of Inquiry, 'Submission from the Independent Oversight Group on the implementation of the recommendations arising from the Independent Child Safe Governance review of the Launceston General Hospital and Human Resources', 6 July 2023, 3.

20 Elizabeth Daly and Malcolm White, *Launceston General Hospital Community Recovery Initiative Co-Chairs' Report* (Report, 16 November 2022) 6.

21 Elizabeth Daly and Malcolm White, *Launceston General Hospital Community Recovery Initiative Co-Chairs' Report* (Report, 16 November 2022) 7.

22 Letter from Kathrine Morgan-Wicks to Commission of Inquiry, 17 December 2022, 1.

23 Elizabeth Daly and Malcolm White, *Launceston General Hospital Community Recovery Initiative Co-Chairs' Report* (Report, December 2022) 16.

24 Statement of Kathrine Morgan-Wicks, 24 May 2022, 9 [64(e)], 56 [474]; Statement of Kathrine Morgan-Wicks, 22 June 2022, 16 [92]. The National Principles for Child Safe Organisations and the Child Safe Standards are discussed in more detail in Chapter 18.

25 Statement of Kathrine Morgan-Wicks, 22 June 2022, 16 [94].

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Commission of Inquiry into the Tasmanian Government's Responses to Child Sexual Abuse in Institutional Settings

Who was looking after me? Prioritising the safety of Tasmanian children

Volume 7: The justice system and victim-survivors

August 2023

Commission of Inquiry into the Tasmanian Government's Responses to Child Sexual Abuse in Institutional Settings Report

Volume 7
The justice system and victim-survivors

The Honourable Marcia Neave AO
President and Commissioner

Professor Leah Bromfield
Commissioner

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Commissioner

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CHAPTER 17
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Introduction to Volume 7

In this volume—Volume 7—we look specifically at the role the criminal and civil justice systems, including redress schemes, play in responding to child sexual abuse. We examine how these systems might better serve victim-survivors of child sexual abuse in government institutions. The two chapters in this volume discuss the criminal and civil systems in turn. We note that while the former is focused on holding individual perpetrators to account and the latter has a broader focus on institutional accountability, they are not mutually exclusive options for victim-survivors seeking recourse for child sexual abuse.

In Chapter 16, we consider recent reforms to criminal justice responses to child sexual abuse in institutional settings and what further reforms are needed. While the criminal justice system is an important mechanism for holding perpetrators of child sexual abuse to account, it is an adversarial system. It is not always equipped to respond to the complex and sensitive issues that arise for victim-survivors of child sexual abuse. However, there are many ways the system's limitations can be alleviated. For this reason, we make recommendations directed at:

- police specialisation
- training and professional development for the Office of the Director of Public Prosecutions
- improving the law (noting significant and welcome change has already been achieved)
- improving rules of evidence and court procedures
- improved monitoring of the performance of the justice system in relation to child sexual abuse.

In Chapter 17, we assess the effectiveness of the three main pathways available in Tasmania to victim-survivors seeking recompense from the State for the sexual abuse they suffered as children. These pathways are the National Redress Scheme, civil litigation and victims of crime compensation. Relevant to our assessment of these pathways is a consideration of the accessibility of information and records the Government and its institutions hold. In this chapter, we also consider the importance to victim-survivors of receiving a personal apology for the sexual abuse perpetrated against them in government institutions. We make recommendations to ensure:

- redress options are available to victim-survivors into the future
- Government lawyers take a trauma-informed approach to managing settlement processes in child sexual abuse cases

- victim-survivors of child sexual abuse in institutional contexts can access their records
- rights for victim-survivors of child sexual abuse are increased under the *Victims of Crime Assistance Act 1976*
- victim-survivors receive an apology from the Government if they request one.

16 Criminal justice responses

A note on language

In other chapters of our report, we generally use the terms victim-survivor and perpetrator or abuser. However, in this chapter, we also use the terms complainant, accused person, alleged offender and offender because they have particular meanings in the criminal justice system. A reference to victim-survivors is a reference to child and adult victim-survivors, unless otherwise specified.

We use the terms Director of Public Prosecutions ('DPP') and Office of the Director of Public Prosecutions ('ODPP') to distinguish between the individual officeholder and the office.

We also use the terms 'police officer' when referring to a 'sworn' police officer and 'member' or 'members' to capture police officers as well as staff who work for police but are not police officers.

1 Introduction

This chapter focuses on criminal justice responses to child sexual abuse in institutional settings and considers whether reform is needed.

Where child sexual abuse occurs and is reported to police, the criminal justice system may apply. Victim-survivor perceptions of how people in that system respond to complaints can influence whether they disclose the abuse. And the assumptions, practices and structures in the system may affect whether victim-survivors who do make reports to police will have their reports taken seriously and investigated. The criminal justice system provides one of the few ways to hold perpetrators to account and is an important means of disrupting future offending by these abusers.

The National Royal Commission released a standalone report on the criminal justice system in August 2017. The report noted that the criminal justice system is often seen as ineffective in responding to sexual violence, including child sexual abuse.[1] The National Royal Commission made 85 recommendations for criminal justice reform. Tasmanian criminal justice agencies have implemented many of these recommendations, including to introduce a Witness Intermediary Scheme pilot and new provisions in the *Evidence Act 2001* ('Evidence Act') to make it easier for children to give evidence. We commend the Tasmanian Government for making these significant reforms.

During our Inquiry's consultations, sessions with a Commissioner and hearings, we heard from victim-survivors of institutional child sexual abuse about their experiences with the criminal justice system. While some people who spoke to us described sensitive responses, others described practices and behaviour that they felt had exacerbated their trauma. Some of these criticisms came from victim-survivors who had been complainants in child sexual abuse cases prior to recent reforms to the criminal justice system. Other criticisms were made by people with a more recent experience of the criminal justice system, some of whose concerns had not been addressed by the changes.

As part of our Inquiry, we have considered the extent to which legal and procedural reforms made in Tasmania during the past decade or so, including those based on the National Royal Commission's recommendations, have improved the way the criminal justice system deals with child sexual abuse. As we explain in this chapter, the fact that some people continue to describe the criminal justice system as insensitive and traumatic suggests that more needs to be done.

Of course, some principles that underpin the system may render its processes difficult for victim-survivors, irrespective of reform. These include the right of the accused person to remain silent, procedural requirements designed to ensure a fair trial, and the nature of the adversarial system, which requires the evidence of victim-survivors to be tested. A consistent concern that victim-survivors of child sexual abuse express is that, while the accused person has the right to remain silent, the victim-survivor is often subjected to

extensive, vigorous, personal and at times degrading cross-examination. Victim-survivors are often retraumatised by the telling and retelling of their story while preparing for trial and through cross-examination, and by the consequences of an acquittal.[2] Acquittal is often claimed to constitute 'exoneration' of an accused person, whereas it is, in fact, a finding that the offence has not been proved beyond reasonable doubt.

We sympathise with these critiques of the criminal justice system as they relate to child sexual abuse, but—given our terms of reference—we do not address the broader criminal justice system in this chapter. Instead, we focus on reforms that will help victim-survivors in that system. For some victim-survivors, a redress or civil claim may be preferred or may be more appropriate than relying on the criminal justice system. We discuss redress and civil systems in Chapter 17.

We acknowledge that legal and procedural reforms alone will not necessarily improve the criminal justice experience of victim-survivors of child sexual abuse. As long ago as 1998, a Tasmanian task force on sexual assault and rape observed that:

> Law reform is capable of modifying practices and making the process more tolerable for victims. The law can also have an educative effect in terms of attitudinal change in the community. However, it is important to be clear sighted about the impact of changes to legislation without corresponding changes to awareness of the issues within the legal system and in the wider community. Until educational and attitudinal change strategies modify community belief systems, perpetrators will continue to break the law without fear of penalty and victims will continue to lack credibility in the courts and have little confidence in the justice system.[3]

These observations are particularly relevant for crimes involving child sexual abuse in institutions that the community trusts to care for children. Such behaviour was often ignored until the National Royal Commission made its shocking findings about the prevalence of institutional child sexual abuse and the failures of institutions and governments to prevent or respond to such abuse. Our Inquiry has shown that child sexual abuse in institutions is not solely historical.

In this chapter, we explain police and prosecution responses to child sexual abuse cases and highlight areas where we consider more reform is needed. Our recommendations in this chapter consider the fact that Tasmania is a small jurisdiction with limited resources.

Although our Inquiry focuses on child sexual abuse in institutional settings, our recommendations will naturally have an impact on child sexual abuse that occurs in other contexts.

2 Overview of the criminal justice system

This section summarises the key stages in the Tasmanian criminal justice system as they relate to child sexual abuse offence cases. The chapter includes more detail on each stage when it is discussed in relation to a recommendation.

The criminal justice process starts when an offence is reported to, or detected by, police. Police then decide whether to investigate the offence. If they do investigate, they are then responsible for conducting that investigation. In the case of child sexual abuse offences, the investigation typically involves interviewing the accused person, the complainant and any other witnesses. If police gather enough supporting evidence, they may arrest and charge the accused person.

In child sexual abuse offence cases, police typically receive advice from the ODPP about whether an accused person should be charged with an offence. Pre-charging advice that recommends charges not proceed reflects the prosecutor's judgment that there is no reasonable prospect of conviction and not their judgment about whether the alleged behaviour occurred.[4] The willingness or ability of a complainant to give evidence at trial can often be a key consideration when making this recommendation.

Child sexual abuse offence cases are generally heard in the Supreme Court. The ODPP prosecutes these cases. The ODPP also prosecutes some indecent assault matters in the Magistrates Court where the accused person elects to have the matter dealt with summarily (under section 72 of the *Justices Act 1959*). During the hearing of an indecent assault charge in the Magistrates Court, the accused person may be committed to the Supreme Court in certain circumstances, including if a magistrate considers that the charge should be dealt with in the Supreme Court.[5] The ODPP also prosecutes summary child exploitation material offences under the *Classification (Publications, Films and Computer Games) Enforcement Act 1995* ('Classification (Publications, Films and Computer Games) Enforcement Act') in the Magistrates Court.

A victim-survivor may be asked to help prosecute the case, which will normally involve giving evidence about what they experienced. The ODPP provides a Witness Assistance Service to support victim-survivors in giving evidence and understanding the court process.

If an accused person pleads not guilty to a child sexual abuse offence, a trial will be held in the Supreme Court before a judge and jury (or in some cases in the Magistrates Court before a magistrate). Tasmania recently introduced legislation to allow for judge-alone criminal trials, which began on 8 June 2022.[6] At the trial, the Crown (represented by a prosecutor from the ODPP) represents the State and a defence lawyer generally represents the accused person.

When a case is heard before a judge and jury, the judge will decide what evidence the jury can hear. The judge will direct the jury about the legal principles it must apply in deciding whether the accused person is guilty or not guilty. If the jury finds the accused person guilty, the judge decides the sentence. If the jury finds the accused person not guilty, the accused person is acquitted of the offence(s) with which they were charged. Although the Attorney-General can appeal against an acquittal on a question of law in some circumstances, this occurs rarely.[7]

When a person pleads guilty or is found guilty, the court has a sentencing hearing. Again, both the Crown and the defence lawyer will make submissions to the trial judge. Facts that are in dispute may result in another hearing.

A victim-survivor may choose to make a victim impact statement, which they can read out at the sentencing hearing or have read out by the prosecutor. At the end of the sentencing hearing, the judge summarises the facts or makes findings of fact, imposes a sentence and outlines the reasons for the sentence. In Tasmania, the maximum sentence that can be imposed for a child sexual abuse offence is 21 years' imprisonment.[8]

A person who has been sentenced can appeal to the Court of Criminal Appeal (a division of the Supreme Court) against the conviction, against the sentence imposed or against both the conviction and sentence. The Crown can appeal against a 'not guilty' decision on a question of law or fact, or against a verdict (with the Court's permission) in cases tried by a single judge, or against a sentence in all cases.[9]

3 Police responses

Police are often the first point of contact with the criminal justice system for victim-survivors. Sometimes police will be the first to receive a disclosure of child sexual abuse. How police respond is often highly influential in determining how a victim-survivor views the criminal justice system and their willingness to seek a criminal justice response.[10]

Police decisions, including whether and to what extent to investigate a reported crime, are also critical in determining how a matter proceeds. Police failure to prioritise and act on a report of child sexual abuse can have an enormous impact on the quality of evidence they find.

In this section, we outline recent changes Tasmania Police has made to improve the way it deals with child sexual abuse cases. We go on to discuss opportunities for reforms relating to:

- establishing specialist police units
- building trust with particular communities
- improving professional development

- making reporting easier
- conducting effective investigations
- implementing complaints and oversight mechanisms.

Opportunities to improve police coordination and information sharing with other agencies are discussed in Chapter 19 and Chapter 21.

Police can play an important role in disrupting child sexual exploitation and abuse, particularly for vulnerable children such as those in out of home care. We discuss disruptive policing in out of home care in Chapter 9.

3.1 Recent police reforms and initiatives

Tasmania Police told us that it has significantly changed its policies and procedures for investigating child sexual abuse in the past two years. This section outlines those changes.

The National Royal Commission explored issues on how police can:

- encourage reporting
- conduct effective investigations and interviews
- maintain trust and continuity with victim-survivors
- ensure appropriate charging decisions.[11]

The National Royal Commission made several recommendations relating to police, including Tasmania Police.

Tasmania Police has accepted most of these recommendations. Of those it has accepted all are completed or in progress, though some are part of ongoing capacity building and workforce development.[12] Tasmania Police's primary response to the recommendations has been to make extensive changes to the section on sex crimes in the *Tasmania Police Manual*. The manual now offers clearer guidance to police officers on how they should respond to, and investigate, complaints of sexual assault and abuse.[13]

Tasmania Police informed us that it began an internal review on 30 November 2020 to examine police interactions relating to James Griffin.[14] This review found deficiencies, including interagency coordination, information sharing, legislative barriers and investigative shortcomings.[15] We discuss this review in the James Griffin case study (refer to Chapter 14). In summary, the review found that:

- Following a report about Mr Griffin in 2011, there was no record that the police investigator searched the police intelligence system, which would have revealed a report about Mr Griffin from 2009.[16]
- Following a report about Mr Griffin in 2013, there was no record that the police investigator searched the police intelligence system, which would have revealed the previous two reports.[17]
- There were deficiencies in the management of information received by Tasmania Police from the Australian Federal Police in 2015 relating to Mr Griffin's sexual offending and possession of child exploitation material.[18] This matter has been the subject of a Professional Standards investigation, and the police officers involved have been disciplined.[19]

On the public release of the findings of its review on 21 February 2021, Tasmania Police committed to setting up a specialist investigative and policy team to focus on improving police procedures for child sexual abuse cases.[20]

Darren Hine AO APM, former Commissioner, Tasmania Police, told us that the recommendations from the review have led to significant change in the way police respond to child sexual abuse.[21] He stated that Tasmania Police has sought to improve information sharing between agencies by creating the Tasmania Police *Initial Investigation and Notification of Child Sexual Abuse Guidelines*. It has also entered various memorandums of understanding, including the 2021 *Keeping Children Safe Memorandum of Understanding* between the Children Safety Service (in the former Department of Communities) and Tasmania Police (in the Department of Police, Fire and Emergency Management), to ensure prompt and efficient information sharing.[22]

The *Initial Investigation and Notification of Child Sexual Abuse Guidelines*, which came into force on 23 July 2021, guides the response of police officers when they receive a report of child sexual abuse. The guidelines include information about how to manage forensic evidence, notifications and referrals. They also outline the minimum requirements of police officers prior to them filing a report of child sexual abuse, which are to:

- contact the reporting person
- make every effort to establish the victim's identity (if unknown) and to assess and investigate the report
- conduct a thorough examination of Tasmania Police databases
- request cross-agency and interstate checks to see whether intelligence held outside Tasmania may assist the investigation

- provide contact details of the investigating police officer to the victim-survivor and/or parent, guardian or, where appropriate, other support person
- have a supervisor confirm that the above actions have been taken.[23]

On 26 February 2021, the Tasmanian Government launched its Historic Complaints Review Process within Tasmania Police.[24] This review concluded in January 2022. The Child Sexual Abuse Joint Review Team, a multi-agency team, sought to identify potential perpetrators of child sexual abuse where there may be unlinked reports or references across agencies relating to a person.[25]

The Tasmanian Government is also setting up two multidisciplinary centres to co-locate family and sexual violence support services and specialist police investigators.[26] Pilot programs are to start in Launceston and Hobart.[27] Media reports suggested the pilot programs would start in mid-2023.[28] We discuss multidisciplinary ('Arch') centres in Chapter 21. In this chapter—Chapter 16—we focus on the relationship between multidisciplinary centres and police specialisation, which we discuss in Section 3.2.2.

3.2 Opportunities for other police reforms

3.2.1 What we heard about police

The criminal justice system only works if victim-survivors feel comfortable coming forward and making a complaint to police. It is vital that police are seen as a trusted avenue to seek help. They must communicate to victim-survivors with respect and ensure victim-survivors feel supported.

In submissions, consultations, sessions with a Commissioner and hearings, victim-survivors reported varied experiences with police. The experience of a victim-survivor not only affects them (and possibly others affected by the matter they are reporting) but might also influence the decision of others (such as family or friends) to report crimes.

Some victim-survivors described positive experiences with police. One victim-survivor of child sexual abuse told us that the police officer investigating her case had gone 'above and beyond' to make sure the investigation was thorough and timely and that she felt supported.[29] Leah Sallese, a victim-survivor, told us that the police officer investigating her case was 'amazing' and 'treated me with respect, care and kindness'.[30] She said:

> I don't know if everyone has the same experience with Tasmania Police, but I feel lucky to have had the right detectives there to bat for me. My positive experience with the police was a key reason I ended up pursuing criminal justice.[31]

Tiffany Skeggs, a victim-survivor, described the investigating police officer in her case as 'professional and at the same time genuinely caring'.[32] Alex (a pseudonym), another victim-survivor, also told us that the detective on his case had been very supportive.[33]

In contrast, some victim-survivors told us about negative experiences. Mark Southern, a victim-survivor, told us that when he reported sexual abuse to police in 2003, they took his statement and then he 'didn't hear back from them in 10 years'.[34] Mr Southern said police left him 'in the dark' and did not offer him any support while he was waiting for a response.[35]

Faye (a pseudonym) said that when, in about 2006, she spoke to police about the first time she was sexually abused, the person taking the statement said, 'Oh, is that all it was?'[36] She said that this has really stuck with her; she felt judged.[37]

Victim-survivors told us about negative experiences with police when reporting child sexual abuse by James Griffin (refer to Chapter 14 for a detailed discussion of Mr Griffin).[38] Keelie McMahon, a victim-survivor, told us that, while her initial contact with Tasmania Police was 'really good', after Mr Griffin's death 'everything just shut down' and she was told 'that's it, he's dead, there's nothing more we can do'.[39] Angelique Knight, another victim-survivor of Mr Griffin, was also told that there was nothing police could do.[40] She said:

> This made me really angry. I think this hurt the most because I had really built myself up to go in there. It was a big thing for me. I was really struggling to find what direction to go in and this made me feel like my experience wasn't important.[41]

Laurel House reported that victim-survivors it had contact with had mixed experiences with police, noting that some police demonstrated 'exemplary trauma-informed practice' while, in other cases, contact with police 'further traumatises victim-survivors or silences them'.[42]

In stakeholder consultations, we also heard a range of views on the efficacy of police responses to child sexual abuse, with some participants reporting police to be responsive and professional.[43] Some stakeholders noted that attitudes towards child sexual abuse are changing—it is now easier to report and police are more responsive.[44] Some participants reported complexity involved in deciding whether to pursue criminal charges, also noting that police decisions not to proceed with a matter are sometimes made to respect the wishes of victim-survivors and their families, and to avoid retraumatising a victim through the process.[45] Some stakeholders at our Burnie consultation spoke highly of police in North West Tasmania, with one participant describing police as trauma-informed and willing to 'go the extra mile to help victims'.[46]

In contrast, other consultation participants said police have a poor understanding of child sexual abuse and a tendency to believe adults over children.[47] Some participants raised concerns about the timeliness of investigations, particularly where there may be ongoing risks to children.[48]

As noted, Tasmania Police has introduced reforms to improve the experience of victim-survivors, including extensive changes to the *Tasmania Police Manual*. The following sections consider specific opportunities to improve the way police communicate with, and respond to, victim-survivors.

3.2.2 Establishing specialist police units

Investigating allegations of child sexual abuse is a highly complex task requiring specialised knowledge and skills. These investigations are sometimes limited by a scarcity of evidence, often due to the absence of independent witnesses and physical evidence. Therefore, police need a high level of skill in using all opportunities to gather evidence effectively, including the skills to elicit detailed, reliable and relevant accounts from complainants, particularly children.[49]

We heard evidence from Dr Patrick Tidmarsh, a consultant at Whole Story Consulting, who previously worked with Victoria Police as a forensic interview adviser and trainer in the Sexual Offence and Child Abuse Investigation Team.[50] According to Dr Tidmarsh, investigating child sexual abuse offences calls for a specific skill set that most police do not have, regardless of their level of experience.[51] We also heard from Victoria Police that some police officers have attributes that position them better for this work.[52] Dr Tidmarsh told us that specialisation in this area is important to maximise the number of complaints that progress to prosecution and conviction, and to minimise the compounding nature of the trauma adult and child victim-survivors experience as they move through the investigation.[53] Also, police specialisation has the potential to ensure those who investigate child sexual abuse cases take a trauma-informed approach to victim-survivors.

Tasmania Police does not have specialised child sexual abuse investigation teams. Responsibility for responding to a notification or an allegation of suspected child sexual abuse generally lies with the police geographical district where the offending is alleged to have occurred. Tasmania Police consists of nine commands: three geographical police districts (Southern, Northern and Western) and six specialist support commands.[54]

Tasmania Police has a High-Risk Child Exploitation Unit operating in its Crime and Intelligence Command. This unit assesses and acts upon referrals from the Joint Anti Child Exploitation Team or other information Tasmania Police receives, including from the Australian Centre to Counter Child Exploitation.[55]

Commissioner Hine informed us that initial responses to an allegation of child sexual abuse may involve general duties patrols, the Criminal Investigation Branch, Family Violence Units and Forensic Services.[56]

In its submission, Tasmania Police stated that relevant specialist teams are based under different commands, leading to inconsistent operating practices and reduced connectivity.[57] It advised us that, despite efforts to work together, differing priorities mean these organisational units can work in operational silos, which does not always support trauma-informed approaches to prevention, detection, investigation and collaboration, nor ensure police officers have the skills to appropriately support victim-survivors.[58] In June 2022, Commissioner Hine told us that, although all police officers conduct investigations, the Criminal Investigation Branch leads most investigations, including those into sexual abuse.[59]

Commissioner Hine said that Tasmania Police will refer victim-survivors of child sexual abuse to the relevant sexual assault support agency and (where the victim-survivor is a child) to the Child Safety Service.[60] Tasmania Police's *Initial Investigation and Notification of Child Sexual Abuse Guidelines* specify that a single investigator should conduct the whole investigation in child sexual abuse matters wherever possible.[61]

The generalist approach in Tasmania differs from practices in most other jurisdictions of Australia and New Zealand. Elsewhere, child sexual abuse investigations are undertaken by decentralised, specialist child abuse investigation units or by local policing child abuse investigation units with centralised specialist support.[62] In some jurisdictions, such as New South Wales (discussed below), Queensland and Western Australia, specialist units focus on child abuse. Other jurisdictions, such as Victoria (also discussed below), have units or groups within sex crime divisions that include adult sexual offences.[63]

We heard some concerns that the size and geography of Tasmania can be a practical barrier to having specialist units. Commissioner Hine told us that the challenge is to provide coverage across Tasmania, particularly in sparsely populated areas. He noted that some areas, such as Queenstown, Burnie and Devonport, are too small to have a dedicated resource.[64]

Police specialisation would need to consider these challenges. Tasmania Police emphasised that any reforms must ensure it can continue to provide a local response to meet community needs.[65] Tasmania Police further noted that this does not mean there has to be an identical presence in every population centre, but it does require consistency of response in regional areas with a surge capacity to respond effectively and equitably across Tasmania.[66]

We consider there is scope to draw on the key features and experience of specialist police models in other Australian jurisdictions and to adapt these to Tasmania, recognising unique considerations based on the size, scale and demographics of the State.

We heard evidence about the specialist police units in New South Wales and Victoria, where police officers receive extra training and become expert child sexual abuse investigators. Victoria Police's Sexual Offences and Child Abuse Investigation Teams

(referred to as 'SOCITs') provide specialist response and investigation for sexual assault and child abuse matters. In Victoria, 450 investigators are spread across 28 sites.[67] These investigators receive specialised training and are dedicated to investigating sexual assault and child abuse.

Some specialist police work in multidisciplinary centres across Victoria, which co-locate specialist police with child protection expertise, as well as counsellors and advocates from the Centres Against Sexual Assault.[68] In areas that do not have a multidisciplinary centre, other specialist police operate with the same interagency protocols to achieve the same collaborative approach, but each agency works from separate offices. In these areas, police must contact their local Centres Against Sexual Assault office within two hours of a report, to facilitate support.[69]

In Victoria, police receive reports of child sexual abuse through channels including referrals from Centres Against Sexual Assault and schools. The specialist police team receives most reports of child sexual abuse from the Department of Families, Fairness and Housing under its *Protecting Children* protocol.[70] Victoria Police also has a specialist task force (the SANO Taskforce) to investigate historical and new allegations of child sexual abuse in a religious or institutional setting. Police officers in this task force are specially trained to investigate sexual offences.

In New South Wales, a specialist referral team, the Joint Child Protection Response Program, handles most serious child abuse offences. The specialist team is a statewide centre-based response that includes specialist police ('Child Abuse Units') and child protection and health agencies. Cases for the specialist team come through a shared central reporting system. Cases are then assessed and triaged.[71] This differs from the approach in Victoria, where reports of child sexual abuse come through various channels rather than a central unit.

The Child Abuse Units, which work as part of the specialist referral team, are not attached to a region and operate under the Child Abuse and Sexual Crime Squad command. Peter Yeomans, Detective Chief Inspector, New South Wales Police Force, told us that a benefit of this approach is that Child Abuse Units are not 'swallowed up' if a particular region has a homicide or a large-scale investigation that uses up police resources.[72]

Detective Chief Inspector Yeomans told us there were 19 Child Abuse Units operating throughout New South Wales, most of which are located near the Department of Communities and Justice and New South Wales Health but are not co-located with them.[73] If necessary, police officers from the units travel to remote parts of the State.[74] With 19 units throughout the State, the maximum travel time is three hours.[75] Police mostly travel to the victim.[76]

A review conducted for the National Royal Commission on the efficacy of specialist police investigative units in responding to child sexual abuse identified some challenges, including access to resources, the availability of specialised training for investigators and effective interagency collaboration.[77] Having considered this review, as well as the experience in other Australian jurisdictions, we consider the key features that underpin successful specialist child sexual abuse investigative units are:

- specialised training, including training on interviewing child and vulnerable witnesses
- proactive strategies from police to encourage reporting and to build trust and credibility with the community
- partnerships with other agencies and support services commonly involved in the response (closely located but not necessarily co-located)
- a dedicated focus on child sexual abuse investigations (and possibly adult sexual offence investigations)
- that they support the emotional health and wellbeing of police officers
- that they are located in, or have access to, appropriately furnished and equipped facilities for interviewing victim-survivors, separate from accused persons
- that they have sites across the State to provide equitable access to victim-survivors regardless of where they live.

Specialised training, including training on interviewing child and vulnerable witnesses

We heard evidence that the most important aspect of skill specialisation for police in sexual offending cases is interviewing.[78] In child sexual abuse offence cases, the evidence of the victim-survivor is often the only evidence of offending. The police interview is therefore extremely important and will dictate if the investigation should proceed to the stage of interviewing the alleged offender.[79]

Dr Tidmarsh told us that most inconsistencies in interviews are created by interviewers and not the complainant. He stated that continuity of engagement and specialisation in interviewing are therefore key to the investigative process.[80]

The Victoria Police Specialist Development Unit developed the concept of the Whole Story framework for investigating sex offending and the sexual abuse of children. It is based on the concept that although the prosecution must prove that certain events happened in time and place, sex offending and the sexual abuse of children usually arises out of a pre-existing relationship. The relationship would have occurred before and during those events and often helps to contextualise the offending.[81] Dr Tidmarsh stated that when victim-survivors can use a narrative style, the breadth and depth of the information elicited increases dramatically.[82]

Daryl Coates SC, DPP, told us that there is great benefit in having specialist police conducting interviews for complainants and vulnerable witnesses, and in maintaining contact with these witnesses.[83] He noted that, in general, interviewing police officers have become more aware of the need to have complainants identify with as much detail as possible the instances of sexual abuse. There has also been an increase in the use of open-ended questioning and encouraging a 'narrative' from the witness.[84]

Witness intermediaries can assist police in improving the quality of their interviews by offering strategies to elicit the best evidence from the person (particularly children). Refer to Section 5.2.1 for more on Tasmania's Witness Intermediary Scheme pilot.

Partnerships with other agencies and support services, without the need for co-location

Strong partnerships with other agencies and support services are important for an effective specialist investigation unit. But co-location in a purpose-built facility is not necessary to create effective partnerships.[85]

Detective Chief Inspector Yeomans communicated the view of the New South Wales Police Force that it is now best to have the agencies near each other, rather than co-located. He noted that in New South Wales, effective and regular communication between agencies is critical to the success of the specialist referral team, whether a service is co-located or not.[86] He emphasised that working close to health centres and community services is most important.[87] He gave an example of how police work out of an old house in the township of Inverell, with a community service centre and a health centre across the road.[88]

Unfortunately, it is possible for services to be co-located and still operate in a highly siloed way. Conversely, others can be located separately and still work together effectively. What is important is a shared commitment to collaborate and for legislation and related processes to enable that collaboration (for example, through effective information sharing).

It is also important to have clear mechanisms within the response that build and sustain strong working relationships and collaborative practices to foster a multidisciplinary team approach, such as joint case strategy meetings and shared professional development.[89] Where multidisciplinary teams are responding to many cases in an area, there may be efficiency in co-location for undertaking the work and opportunities for incidental contact that strengthen relationships. Crisis and therapeutic supports for victim-survivors may also be more readily accessible. However, where teams are co-located, it is important that the facilities meet the different needs of each profession within the building; for example, police may need an evidence room and space for confidential case discussion.

Although we do not consider co-location is necessary, we do consider it is important to conduct interviews in a space where children feel comfortable. These spaces are better located outside police stations, such as in other services' facilities. Research indicates that conducting interviews in a space where a child is comfortable increases the likelihood of detailed disclosure, which is conducive to prosecution and conviction and reduces the likelihood that the child will be retraumatised.[90]

Tiffany Skeggs, a victim-survivor, told us that when police interviewed her, she was 'utterly terrified someone might see her walk into the police station'.[91] Ms Skeggs noted that being interviewed in a police station could deter some people from coming forward, a view other victim-survivors also expressed.[92]

We also note that for many people who may have a criminal background or who come from a community that does not trust police, attending a police station may feel unsafe or be a barrier to reporting.

The Victoria Police *Code of Practice for the Investigation of Sexual Crime* requires special investigators to respond to reports of recent sexual abuse in plain clothes and an unmarked vehicle.[93]

Detective Chief Inspector Yeomans also informed us that the specialist Child Abuse Units in New South Wales are not housed in police stations with uniformed police officers. He stated that children feel more comfortable engaging with police officers as a result, which appears to have contributed to more disclosures over time.[94]

Tasmania Police expressed support for new and improved 'soft' interview rooms (this is a term police use to describe rooms that are designed to feel safe and welcoming for adult and child complainants and witnesses). Glenn Hindle, Detective Senior Constable, Tasmania Police, told us that some soft interview rooms are in use but that the location of those interview rooms in police stations is contentious.[95] He told us of a soft interview room at Launceston police station where:

> … quite often we're having to separate the mother off from the child and that separation quite often occurs at the front counter of the police station and the child is then marched through the police station as an individual on their own as well, so the journey is not pleasant for everybody.[96]

We note that children may not disclose as much specific detail about their abuse when a parent is in the room because it might distress their parent. Ideally, there should be a private, family-friendly waiting room located adjacent to soft interview rooms, where families (including any siblings waiting to be interviewed) can wait with the support of a counsellor or advocate while a child is being interviewed.

Katrina Munting, a victim-survivor, described her experience of making a report to police: 'I found the police station quite frightening. I went to a small room that I think was usually used to interview suspects. It was small and bleak and not very comforting'.[97]

Detective Senior Constable Hindle said that a better environment to take a statement from a complainant might involve them entering a facility that is not so authoritative.[98] He noted that 'often it is a complainant's first dealing with police, and they walk into a building feeling like they've done something wrong'.[99]

At a consultation in Hobart, some police noted that new systems for recording evidence were being rolled out, and they spoke about intentions to improve soft interview rooms. Many expressed a preference for interviews to be conducted offsite to make victims more comfortable.[100]

Moreover, in a submission to us, Tasmania Police stated that soft interview rooms should be 'specifically designed, separate from police stations, fitted out and located across the State to ensure all victims have the most conducive environment to tell their story'.[101] We support such an approach.

A dedicated focus on child sexual abuse investigations

We consider there is a strong basis for having specialist investigation units focused on child sexual abuse cases, and possibly adult sexual offences, rather than being absorbed into another unit such as a family violence unit. Family and sexual violence often occur together (almost 40 per cent of sexual offences involve family violence).[102] But while there are some overlaps and similarities in family violence and sexual offending, there are also differences, particularly in the context of institutional child sexual abuse.

Where child sexual abuse investigations are absorbed into other units, especially those that are busy with a high number of reports like family violence, there is a risk that the child sexual abuse work (particularly where it may be historical) will be overwhelmed by the immediate pressures of managing high-risk family violence offenders. Victoria Police told us that, under its model, the two units work closely together and that it is important for police officers working in these areas to do so.[103] Specialist family violence teams also undergo specialised sexual offence and child abuse investigation training in Victoria.[104]

There may be scope for rotating police officers through specialised units to broaden skill sets and to help build specialisation over time. However, we consider that there should be a dedicated team of specialised police officers for child sexual abuse, which could include adult sexual assault.

Our consultations with police in Hobart and Launceston highlighted that, under current arrangements, resourcing challenges and competing pressures could slow the pace of work and reduce the ability of police to focus on sexual crimes, noting that these crimes are resource-intensive and complex.[105]

Detective Senior Constable Hindle told us that police investigating child sexual abuse face limitations, including conflicting priorities such as shift work and investigations unrelated to sexual offending.[106] He stated that in his position as an investigator focusing on interpersonal crimes, he is sometimes drawn away from that area to spend time dealing with a wounding or an armed robbery, for example.[107] Dr Tidmarsh also observed that, given its small size, Tasmania Police is set up for service delivery through single stations in different locations; it is normal for police officers to multi-task.[108] Resourcing and rostering demands can take specialist police officers away from their specialist work.

Dr Tidmarsh also gave evidence about the risks of absorbing sexual abuse investigations into another area such as family violence. According to Dr Tidmarsh, because family violence requires a crisis response in a way that sexual offending does not, and sexual offending is harder to prosecute and is fraught with more community myths and misconceptions than family violence, family violence can become the dominant area of work. Child sexual abuse investigations can therefore become engulfed in those processes and the sheer volume of family violence matters.[109] We are convinced by these concerns and have serious reservations about Tasmania's intention to incorporate family and sexual violence responses with child sexual abuse responses.[110]

We consider that establishing specialist child sexual abuse units in Tasmania will provide the best possible service for child and adult victim-survivors. As Detective Chief Inspector Yeomans told us:

> You've got to have a specialist squad that deals with this type of crime. You've got to have specially trained officers that deal with this type of crime, otherwise the risk is too high … to that child and to the community if we do our job poorly, because in the end … it's about the interview, it's about the investigation, because if we don't do that job, you're not talking about thieves here or robbers or whatever else, you're talking about the most vulnerable in our society, so you've got to have dedicated staff to do that …[111]

Establishing multidisciplinary centres provides one approach to foster greater specialisation and improved services to victim-survivors. We welcome Tasmania's commitment to setting up multidisciplinary centres but consider it should prioritise police specialisation to ensure virtual or physical multidisciplinary responses include specialists. We consider that the best approach for Tasmania is to set up specialist investigation units for child sexual abuse for child and adult victim-survivors (and possibly sexual offences against adults), but not include domestic and family violence. These specialist units should work closely with other agencies involved in the response. They may be, but do not have to be, co-located with them.

With cases of recent sexual abuse, best practice is to collect evidence and take statements as soon as possible. When specialist units are centrally located, this can require that children be transported for multiple hours to the specialist team—sometimes

without having bathed and still in the clothes in which they were sexually abused. Minimising the need for victim-survivors to travel long distances and enabling police to respond quickly are important features of a victim-centred response.

To provide a statewide response, specialist investigation units could be located in Hobart, Launceston and the North West. Staff who perform reception duties at these locations should be trained to treat victim-survivors in a trauma-informed way. Tasmania Police could draw on the experience in New South Wales to provide coverage and coordinated support to victim-survivors in remote areas. As previously noted, New South Wales police officers from the specialist units will, if needed, travel to the victim-survivor, who is usually located within a three-hour drive.[112]

The success of specialist units also depends on having enough staff. Tasmania is a small state with a limited number of senior detectives. Victoria Police told us that the specialist model requires shifting from more traditional generalist police structures that allow resources to be diverted when required.[113]

Commissioner Hine said there is no guarantee that specialist investigators in Tasmania's new multidisciplinary centres will not have to perform other duties.[114] This could include being routinely rostered to the Criminal Investigation Branch 'Crime Car'.[115] However, Commissioner Hine noted that Tasmania Police would always do its best to support police officers investigating child sexual abuse to perform their main role.[116]

There needs to be protection of this specialist resource so competing priorities do not overwhelm investigators. They should only be drawn into other policing areas when there are exceptional circumstances, such as natural disasters or public health emergencies.

Tasmania Police should attract people to work in this area by recognising the breadth of skills required, acknowledging the investigative complexity of these matters and properly rewarding this difficult work. Tasmania Police may learn from other jurisdictions, such as Victoria Police, to create incentives that attract well-suited police officers to join such units. In the case of Victoria Police, this includes supporting detective training and ensuring appropriate support for vicarious trauma.[117]

Support for emotional health and wellbeing of police

Police who specialise in child sexual abuse investigations can experience stress, trauma and burnout. The National Royal Commission review into the use and effectiveness of specialist police investigative units reported that staff in all types of specialist units raised concerns about their emotional health.[118] Staff in specialist police units commented on the high emotional toll of working solely on sexual abuse cases, noting that this might lead to burnout and secondary trauma.[119]

We heard evidence about the 'world-leading health and wellbeing strategy' for investigators developed by the Australian Centre to Counter Child Exploitation and Human Exploitation Operations.[120] Hilda Sirec, Commander, Australian Federal Police, who leads the Centre, told us that it is an 'opt in' environment, meaning that police officers must agree to transfer.[121] She also indicated that investigators have access to in-house psychological and wellbeing support, and that the physical work environment has been designed with health and wellbeing in mind.[122]

Detective Chief Inspector Yeomans highlighted the need to offer psychological support to police who specialise in this field.[123] In New South Wales, specialist police officers must take part in mandatory quarterly psychological tests. These are conducted by trained psychologists in the Psychology Unit of the New South Wales Police Force. The specialist investigators are also rotated into other areas of the New South Wales Police Force every three years. This rotation is usually for three months. Detective Chief Inspector Yeomans told us that the rotation policy is strictly adhered to for the development and welfare of police officers.[124] Victoria Police does not mandate rotations outside the specialist unit but is vigilant about vicarious trauma and other psychological impacts of the work, noting that some police officers will decide they need a change or move to a different area.[125]

Similarly, Dr Tidmarsh said that Victoria Police has a specialist Investigator Support Unit with therapeutic professionals who work onsite in the Sexual Offences and Child Abuse Investigation Teams. These professionals run group reflective practice sessions and work with individuals to look after the health and wellbeing of police officers in this field.[126]

Recommendation 16.1

1. The Tasmanian Government should fund and establish specialist units in Tasmania Police, based on the Victorian Sexual Offences and Child Abuse Investigation Teams model, to investigate child sexual abuse and to be based in three locations (Hobart, Launceston and the North West).
2. The specialist police units should:
    a. specialise in the investigation of child sexual abuse, including historical child sexual abuse (and potentially adult sexual assault) but not undertake domestic and family violence work unless it is directly connected to child sexual abuse (or adult sexual assault)
    b. be staffed by police officers who have undertaken specialised professional development (Recommendation 16.3) and members who have trauma-informed training (Recommendation 19.2)

c. partner with other agencies and support services involved in responding to child sexual abuse to create multidisciplinary teams. These teams do not have to be co-located, although this may be appropriate in some areas

d. have access to a 'soft' interview room, ideally offsite from police stations and potentially in multidisciplinary centres

e. be directed to perform other policing duties only in exceptional circumstances and not as part of a unit's usual roster

f. support the wellbeing of police officers and members working in the specialist unit

g. develop and implement strategies to engage and build trust with marginalised communities, particularly Aboriginal people and people with criminal histories (Recommendation 16.2).

3. Tasmania Police should measure and report on victim-survivor satisfaction with the operation of the specialist units within two years of establishment and regularly thereafter.

3.2.3 Making reporting easier

The processes for reporting child sexual abuse to police should be made easier, especially for vulnerable groups.

Online reporting

Not all victim-survivors of child sexual abuse will necessarily know how to make a report to police. In some cases, they may not even recognise what they have experienced as sexual abuse. Victim-survivors may also feel uncomfortable seeking information and support in person. We consider that victim-survivors should have easy access to information on ways to access support services, how to contact police, the process involved in making a complaint and what to expect at each stage of the criminal justice process.

The National Royal Commission recommended a national website and helpline as a 'gateway to accessible advice and information' and to connect people with support services.[127] It envisaged the website as 'a visible, central point of contact' for victim-survivors.[128] The Australian Government's National Redress Scheme website and its website on implementing the National Royal Commission's recommendations respond to this recommendation.[129]

The Victorian Law Reform Commission recommended that the Victorian Government set up a central website (or expand an existing website) with practical information on sexual violence and options for support, reporting and justice.[130] Like the Victorian Law Reform Commission, we consider that such a website could help young people and adult victim-survivors of child sexual abuse understand what is involved in making a report to police and help them access support. The Victorian Law Reform Commission considered that the website should provide information and access to support in a range of languages and formats and be tailored to diverse needs.[131]

The website recommended by the Victorian Law Reform Commission would apply to all forms of sexual violence and sexual abuse. Our Commission of Inquiry focuses on child sexual abuse, but such a website may be useful for victim-survivors of all sexual abuse.

Tasmania Police is examining opportunities to develop its digital capacity to allow online reporting of sexual abuse.[132] The purpose of this initiative is to encourage reporting of allegations of child sexual abuse, with an emphasis on vulnerable victims (including Aboriginal people and people in prison).[133]

Commissioner Hine told us that online reporting provides an opportunity for victims to tell their story (anonymously if they wish), have it recorded and receive information about support services. Commissioner Hine noted that, although computer literacy is not as high as it should be in Tasmania, online reporting would provide an alternative for young people to communicate with Tasmania Police.[134]

Commissioner Hine told us that Project Unify, an initiative to upgrade Tasmania Police's technology, has been allocated $46 million and aims to include online reporting. According to Commissioner Hine, this would offer an enhanced service for victim-survivors who want to remain anonymous. Funding for this project flows through to 2025–26.[135] We welcome this initiative and consider that Tasmania Police would benefit from reviewing online reporting platforms in other Australian jurisdictions.

Building trust with particular communities

Recommendation 16.1 above refers to the need to establish trust with marginalised communities. This section discusses barriers to reporting child sexual abuse that some community groups experience. It recommends that the specialist police units investigating child sexual abuse take steps to address these barriers.

People who have experienced discrimination from authorities or who have been in trouble with the law may be reluctant to report allegations of child sexual abuse to police.

Past inquiries have highlighted systemic racism as a barrier to disclosure for many Aboriginal people who have experienced child sexual abuse.[136] Aboriginal consultation participants told us of a reluctance among Aboriginal people to report allegations of child sexual abuse to police or other institutions because of a lack of trust in those institutions.[137]

The National Royal Commission made recommendations to encourage reporting of allegations of child sexual abuse from Aboriginal victim-survivors, as well as from people in prison and former prisoners.[138] In this section, we discuss these recommendations and consider whether more can be done to encourage reporting of child sexual abuse among particular communities.

To encourage reporting from Aboriginal victim-survivors, the National Royal Commission recommended that policing agencies take the lead in developing good relations with Aboriginal communities and provide channels for reporting outside of the community (such as phone and online reporting forms).[139] We understand that Tasmania Police views developing good relationships with communities as part of its 'business as usual' and is considering offering other reporting channels.[140]

Commissioner Hine gave evidence about the measures that Tasmania Police is taking to engage and build trust with Aboriginal communities, including the *Tasmania Police Aboriginal Strategic Plan 2014–2022*.[141] This plan includes strategies to develop and maintain appropriate and culturally respectful relationships and to deliver equitable and accessible policing services.[142] The plan covers, among other matters, liaison and engagement with Aboriginal communities, recruitment, training and education.[143]

Commissioner Hine also noted that the State Aboriginal Liaison Coordinator functions include contributing to local strategies to reduce the number of Aboriginal people entering the criminal justice system as victims or offenders.[144] We encourage Tasmania Police to continue efforts to build trust with Aboriginal people. More should be done to ensure Aboriginal people who have experienced sexual abuse, including child sexual abuse, can access information and support.

To encourage people in prison and people who have formerly been in prison to report child sexual abuse, including institutional child sexual abuse, the National Royal Commission recommended that policing agencies provide channels for reporting that can be used from prison and that allow reports to be made confidentially, and that former prisoners not be required to report at a police station.[145] The Tasmanian Government has not yet implemented this recommendation. In its *Fifth Annual Progress Report and Action Plan 2023* the Government said that:

> Consultation with the Department of Justice has commenced to identify a short-term solution to allow confidential reporting. A long-term solution to this recommendation will require procedural and technical development … The implementation date is predicted to be December 2024.[146]

In practice, victim reports from people in Risdon Prison are made to police officers from Bellerive Police Station (the nearest police station) or Bellerive Criminal Investigation Branch and facilitated by custodial officers at Risdon Prison (generally in a prepared Department of Justice report) and, as such, are not confidential.[147] Commissioner Hine

told us that reforms to this internal Department of Justice process could increase confidentiality, but he appeared to consider this the responsibility of the Department of Justice.[148] Police investigations and enquiries after Department of Justice reporting are confidential.[149]

Commissioner Hine explained that people formerly in prison can report matters to police via the Police Assistance Line.[150] This means they do not have to attend a police station to make an initial report. It would be the responsibility of police to visit the reporter at their home or another location to take a report. Direct phone contact with local police is also available to avoid the need to visit a station.[151]

We consider that the lack of confidentiality for a report to the Department of Justice is likely to deter reporting. We agree with Commissioner Hine that the process could be improved by increasing confidentiality at this point. We also consider that Tasmania Police should develop strategies to build trust with people in prison (and formerly in prison), which we accept is a significant but not insurmountable challenge. This is particularly important in Tasmania, given the high proportion of abuse claims that arise from (or are connected to) young people in detention at Ashley Youth Detention Centre, many of whom enter the adult prison system (refer to discussion in Chapter 10).

Many young people who were detained or had previously been detained in Ashley Youth Detention Centre told us about their experience of child sexual abuse at the Centre. Few of those we spoke to had reported their abuse. Many spoke of the shame and guilt they felt, the fear of not being believed and a lack of trust in police. One victim-survivor told us:

> What happened to me at Ashley has given me a massive distrust when it comes to the system. This includes the justice system and the police. The ones that are supposed to help are the ones you're trying to escape from.[152]

In its submission, the Tasmanian Aboriginal Legal Service expressed significant concerns for Aboriginal children and young people in contact with the justice system:

> Allegations of historic and current sexual abuse and a lack of trust in authority and institutions and cultural issues re 'dobbing in' remain issues for our Aboriginal clients. A clear and transparent complaints process, coupled with culturally sensitive, trauma-informed awareness and education campaign, would assist our clients to report sexual and other misconduct, particularly where there is a perceived and/or legitimate imbalance of power.[153]

More needs to be done to build trust in police for particularly vulnerable children and adults.

Police also need to address negative attitudes towards some groups of vulnerable young people. A submission from a youth worker cited prejudicial attitudes held by police in the 1990s against young people in out of home care. She said:

> I was told nothing they could do … no-one would believe the stories of 'those types of boys'. At this time police were not interested in actioning any disclosures from our clientele due to, in their words, 'these kids are troublemakers and crims and can't be trusted'. [154]

In Chapter 9, we discuss the need for increased police involvement in disrupting child sexual exploitation, particularly in relation to children in out of home care.

One serving Tasmania Police officer described the young people at Ashley Youth Detention Centre as 'the worst of the worst' and noted 'they are not very nice people, these kids'. Another police officer, also speaking about the young people at Ashley Youth Detention Centre, stated that it was 'too easy for kids to make allegations about these staff' and 'their reward for holding the line against these kids is to be the subject of allegations'.[155]

A former Acting Executive Director, People and Culture, at the former Department of Communities provided evidence of the attitude of one police officer towards young people at Ashley Youth Detention Centre. We were told about a police officer 'laughing' at a young person's claims against a member of staff at Ashley Youth Detention Centre. The police officer showed disbelief when told that the member of staff would be suspended because the young person was 'from a well-known criminal family, had a long criminal past' and 'should not be trusted, especially when there was money involved'.[156]

Jonathan Higgins APM, then Assistant Commissioner of Operations, Tasmania Police, conceded that Tasmania Police needs 'to work on [its] unconscious bias' against detainees or young people with a criminal history wanting to disclose child sexual abuse to police.[157]

It is clear that the following community groups are likely to experience barriers to reporting child sexual abuse to police:

- Aboriginal communities
- people who are or were in prison or youth detention
- people who are or were in out of home care (or youth support services).

We consider that the specialist police units (refer to Recommendation 16.1) should work with these groups to implement measures that build trust and encourage reporting.

Recommendation 16.2

1. Tasmania Police should establish ways for people to report child sexual abuse online.

2. The Department of Justice and the Department for Education, Children and Young People should review their internal processes to make it easier for people in prison and youth detention to report abuse to the police or other bodies, including online or by phone hotline, and ensure appropriate confidentiality of reports.
3. Specialist police units (Recommendation 16.1) should develop a strategy to engage with 'priority communities', by implementing measures to develop relationships, build trust and encourage reporting of child sexual abuse, and to assist prevention and 'disruptive' policing (Recommendations 9.29 and 9.30).
4. Priority communities include:
    a. Aboriginal communities
    b. people who are or were in prison or youth detention
    c. people who are or were in out of home care (or youth support services).

3.2.4 Improving professional development

Police officers who investigate child sexual abuse need specific professional development in the dynamics of child sexual abuse offending, as well as training in trauma-informed care and specialised techniques for interviewing children and vulnerable witnesses. They would also benefit from training to help create a safer environment and reporting experience for groups who are more likely to be sexually victimised.

Tasmania Police gave evidence to our Inquiry about the training it provides to police officers.[158] Different levels of training are provided to recruits, frontline police officers, investigators and detectives.[159]

Commissioner Hine stated that the training starts as part of the Recruit Training Program and is built on as a police officer moves into investigative phases.[160] He also noted opportunities to 'optimise investigative training', including developing a sexual assault investigating program specialising in trauma-informed practices and interviewing vulnerable witnesses.[161] Learning and Development Services is developing a curriculum for a specialised Sexual Assault Investigation Program that is due to start in 2023. The target audience is experienced detectives looking to further develop their investigative skills, specifically in sex crimes and family violence. It is intended that all detectives should refresh their training to ensure best practice when engaging with victims of sexual violence.[162]

Commissioner Hine also informed us that:

- Ninety-four per cent of all police officers have completed training in the *Initial Investigation and Notification of Child Sexual Abuse Guidelines*. This mandatory online training program is aimed at preventing and disrupting child sexual abuse and prioritising children's safety.[163]
- Tasmania Police is training police officers on the Whole Story framework, discussed in Section 3.2, as part of its Investigative Practice Program.[164]
- In 2017, Tasmania Police introduced a training package for interviewing vulnerable witnesses that includes a Whole Story component.[165] We understand this training is for detectives.

Commissioner Hine told us that Tasmania Police recognises its need for more education on grooming and boundary breaches.[166] We agree.

Dr Tidmarsh told us that the concept of grooming is one of the most important factors for investigators in this field to understand because it reveals the tactics of the abuser and their dynamics with the victim-survivor.[167] Dr Tidmarsh said that, in the training he conducted, inexperienced investigators in this field would (wrongly) start with the act that took place—the act that they were going to charge the abuser with—and they often thought that the relationship context from before that point was not relevant.[168]

We also consider that an understanding of grooming and the dynamics of child sexual abuse is crucial to police efforts to disrupt and prevent abuse. So, too, is challenging the myths of child sexual abuse. Dr Tidmarsh told us that when he started work with Victoria Police in 2007, there were still many myths and misconceptions about victim-survivor behaviours with respect to sexual crime. These included questioning the behaviour of the victim-survivor as contributing to the offending, querying the credibility of the victim-survivor and seeking an independent witness who saw the actual abuse take place.[169] He said that research he conducted shows that, following training, police investigators were better equipped to see through these myths and misconceptions about victim-survivor behaviours.[170] For example, investigators were less likely to blame victims.[171]

As well as specific professional development for police working in specialist police units, we have identified a need for continuous and contemporary training across Tasmania Police in ways to respond effectively to reports of child sexual abuse. Assistant Commissioner Higgins noted that general duties police officers are likely to be first responders in sexual abuse cases. A victim-survivor's initial contact with first responders and investigators affects their ongoing trust in the criminal justice system.[172]

It is also important that police officers receive ongoing professional development. Judith Cashmore AO, Professor of Socio-Legal Research and Policy, Sydney Law School, University of Sydney, told us: 'Interviewing child witnesses is a complex task and requires training, monitoring and feedback on an ongoing basis; it is not a single-shot "inoculation"'.[173]

Dr Tidmarsh also stated that not all gains from training are maintained once 12 months have elapsed—there is a need for a continuous approach to professional development.[174]

In Chapter 19, we recommend a whole of government approach to professional development on responding to trauma (Recommendation 19.2). Police members who have contact with victim-survivors will benefit from this professional development.

Finally, we note that, in addition to formal training, using witness intermediaries can improve police capacity to respond to the needs of child witnesses. We discuss Tasmania's Witness Intermediary Scheme in Section 5.2.1.

Recommendation 16.3

Tasmania Police should review its professional development on child sexual abuse to ensure:

a. all police are trained in
    i. the dynamics of sexual abuse and the concept of grooming, and perpetrators' use of these to facilitate a crime
    ii. myths and misconceptions about child sexual abuse and disclosure
    iii. responding to child and adult victim-survivors sensitively and with an understanding of trauma
b. child sexual abuse specialist detectives are trained in
    i. approaches to interviewing child and adult victim-survivors and vulnerable witnesses, including the Whole Story framework (or similar specialist interviewer training)
    ii. understanding the vulnerability of specific groups of children (such as those in out of home care and youth detention) and common myths about these children
c. all police receive scheduled and regular refresher training and ongoing professional development.

3.2.5 Conducting effective investigations

In this section, we explore factors that support effective police investigations (beyond the interviewing process discussed above).

We look at how processes are working and consider whether there is scope to improve the effectiveness of police investigations through:

- conducting routine audits to ensure minimum standards for investigations are met
- ensuring quality audiovisual equipment is available where witness statements are taken about child sexual abuse
- improving access to forensic examinations in regional and remote areas.

Routine audits to ensure minimum standards are met

Auditing police files would help identify areas for improvement, enhance the quality of investigations and build public confidence in investigative processes.

Auditing also has an important role to play in creating accountability in cases where police decide not to investigate a report of child sexual abuse. Police have considerable discretion in deciding whether to proceed with an investigation. Auditing could provide visibility of, and accountability for, these decisions.

Tasmania Police does not have any organisation-wide performance measures for investigating child sexual abuse.[175] Responses to child sexual abuse are conducted in line with the *Tasmania Police Manual* and the *Initial Investigation and Notification of Child Sexual Abuse Guidelines*. As noted, the guidelines came into force on 23 July 2021 and give police officers direction when they receive a report of child sexual abuse. They specify that a single investigator should lead child sexual abuse cases for the entire investigation wherever possible.[176]

We welcome these minimum standards for conducting police investigations into child sexual abuse. We consider the next step is to put processes in place to ensure these standards are met.

Victoria Police told us that every file run by its specialist unit is reviewed by a superior who checks for compliance against requirements before the file is closed or 'paused' (noting that some victim-survivors decide to return and pursue a process later).[177]

Tasmania Police supports measures to oversee police investigations into child sexual abuse. Commissioner Hine told us that Tasmania Police wants to do random audits on how it is dealing with child exploitation matters as well as family violence matters.[178] He said that these audits could be conducted by its Professional Standards or another management review team and could ensure police are getting feedback, doing the right

thing and identifying what they need to learn.[179] According to Commissioner Hine, the random audits would also enable Tasmania Police to differentiate between districts and identify factors such as response rates, matters that were not pursued and how long investigations took.[180]

In New Zealand, the Independent Police Conduct Authority conducted an inquiry after discovering more than 100 child abuse investigation files in one branch that had seen little or no progress on the original complaint. The Authority then urged New Zealand Police to conduct a nationwide audit of child abuse investigations. Among other things, the Authority recommended establishing a process to audit child abuse investigations that included random file sampling.[181]

New Zealand's *Quality Assurance and Improvement Framework* was introduced nationally in February 2016.[182] It aims to provide consistency in family violence, child protection and sexual assault investigation processes and practice.[183]

Recommendation 16.4

1. Tasmania Police should develop and implement quality audit and assurance processes for investigating child sexual abuse offences, including random file sampling.
2. File sampling should:
    a. capture data on how well police are complying with procedures for investigating child sexual abuse offences, including the requirements set out in the Initial Investigation and Notification of Child Sexual Abuse Guidelines
    b. assess whether
        i. contact was made with the person reporting child sexual abuse
        ii. every effort was made to establish the victim's identity and to assess and investigate the report, where appropriate
        iii. a thorough examination of intelligence on Tasmania Police databases was conducted
        iv. cross-agency and interstate requests for information checks were made to determine whether any intelligence held outside Tasmania might assist the investigation
        v. contact details of the investigating officer were provided to the victim, parent, guardian or other support person
        vi. a supervisor confirmed whether the above actions were taken

c. capture data on the timeliness of investigations

d. go beyond technical adherence to requirements and assess the overall quality of police investigative responses and outcomes for victim-survivors, including identifying any opportunities for improvement.

Quality of audiovisual recordings

Child sexual abuse is typically committed in secrecy and without direct witnesses.[184] Therefore, the complainant's account of what happened is the main evidence and, in many cases, the only evidence against the abuser. The quality of pre-recorded audiovisual interviews is extremely important because the pre-recorded interview is likely to be used as the complainant's evidence-in-chief (that is, it provides the foundation of the prosecution's case). A poor-quality recording, or an ineffective interview, may also mean that a complainant has to retell their experience, something that should be avoided if possible.

Where the complainant in a child sexual abuse matter is still a child, the prosecution is generally allowed to use their pre-recorded police interview in court, as some or all of the complainant's evidence-in-chief. This aims to reduce the stress placed on the complainant by giving evidence in court. It can also improve the quality of the evidence the complainant gives, because the interview can be conducted shortly after the abuse is reported to police, rather than months later when the trial begins. In instances where the complainant is a child, this also helps give the jury a more accurate visual representation of the age and vulnerability of a child closer to the time of the offence. These issues are discussed further in Section 5.

The DPP told us that, while the technical quality of audiovisual recordings has improved over recent years, there are still problems. For example, there have been instances where the camera equipment has failed and the recording has not been available, or the quality of the audio has been poor.[185] At times it is difficult to discern the subtleties of a witness' demeanour due to the positioning of the camera.[186] The DPP recommends reviewing the facilities in all interview rooms to ensure they are appropriate for children and vulnerable witnesses and to ensure visual images include a close-up of the complainant.[187] We support this suggestion.

Commissioner Hine indicated that Tasmania Police uses several methods to record interviews, and the quality of these recordings can fluctuate.[188] Most large police stations have vulnerable persons' interview rooms or 'soft' interview rooms (discussed in Section 3.2.2). These may use a standalone video recorder or another recording system.[189] Police officers have also conducted interviews using their police-issued tablets, and this can be effective.[190]

Commissioner Hine further noted that Tasmania Police is moving to provide new interview cameras to larger police stations, but they are not yet installed in soft interview rooms.[191] Commissioner Hine told us these cameras are of high quality and are designed to be discreet.[192] Commissioner Hine also informed us that better interview rooms are part of the planned design for the multidisciplinary centres.[193] These centres will roll out from 2023.[194]

Recommendation 16.5

Tasmania Police should:

a. review the adequacy and availability of equipment used to record evidence by video or audio, and ensure this equipment is available in all police facilities where victim statements relating to child sexual abuse are taken

b. ensure specialist child sexual abuse police officers receive training on the use of recording equipment and refresher training if they have not used the equipment for six months or more.

Improved access to forensic examinations in regional and remote areas

As part of a police investigation into child sexual abuse, a child may be asked to undergo a forensic medical examination. Forensic medical examinations are conducted by specially trained professionals.

A forensic examination is important in some cases, but often it is of little assistance. For example, it may be of limited use in non-penetrative offences. Even where there is penetration, forensic evidence may not be conclusive. In most cases of historical child sexual abuse, a forensic examination will not be of any use.

The process for conducting forensic examinations is outlined in the *Tasmania Police Manual*. The manual states that examinations of victim-survivors must be undertaken in a coordinated way between the medical examiner, police, crisis support services and/or the Child Safety Service if the victim is a child.[195]

Forensic Science Service Tasmania has developed a Sexual Investigation Kit for collecting evidence in sexual assault cases.[196] These kits are held at each major hospital and can only be used by a trained medical practitioner.[197] An Early Evidence Kit is used in cases where there is a delay in a full examination. These can be used at any location and are designed for the victim-survivor to take samples under the guidance of a second person.[198] Early Evidence Kits are held at rural police stations and at Hobart, Launceston, Burnie and Devonport police stations.[199]

Commissioner Hine explained to us how forensic examination processes work. He told us that whenever Tasmania Police receives a report of child sexual abuse, a notification is made to the relevant support service organisation for the area.[200] According to Commissioner Hine, all regions have strong protocols for the forensic procedures in sexual assault cases.[201] The *Tasmania Police Manual* stipulates that, before conducting a forensic examination of a child, consultation must occur with paediatric specialists:

- in the Southern police district, the on-call paediatrician at Royal Hobart Hospital
- in the Northern district, the on-call Sexual Assault Forensic Examiner Nurse
- in the Western district, the on-call paediatrician at North West Regional Hospital.[202]

Kathrine Morgan-Wicks PSM, Secretary, Department of Health, told us that although sexual assault forensic examinations are available across the State, there may be delays in accessing a forensic medical examiner due to limited availability, particularly out of hours if the on-call staff are busy attending to urgent medical cases.[203] Secretary Morgan-Wicks also informed us that if a victim-survivor is in a rural area, the distance required to attend an examination facility may cause delay. For example, she noted that the only examining facility in the North West is at North West Regional Hospital.[204] Commissioner Hine also said that time delays can occur for children living in remote areas.[205]

Secretary Morgan-Wicks further noted that while the North West does not have a formal acute paediatric sexual assault service, it has two senior paediatric specialists with training and experience in paediatric sexual assault. However, she noted there are times when children requiring assessment in the North West need to travel to Launceston.[206]

Secretary Morgan-Wicks stated that because these occurrences are relatively infrequent, there can be some confusion about the process, with presentations occurring to police, general practitioners, rural hospitals and emergency departments. She noted that the counsellors at the Sexual Assault Support Service and Laurel House can offer extra support and information to victim-survivors.[207]

At a stakeholder consultation in Burnie, participants spoke of a shortage of practitioners who can do forensic examinations in the area, with most children under 13 who require an examination having to travel to Launceston. This contributes to their distress. We were told of a child who presented at 8.00 pm but could not be examined until 1.00 pm the next day, and was unable to shower—noting that using the toilet or eating during that period also risked compromising forensic evidence.[208]

We observed that the Department of Health does not require a standard level of training for forensic examiners across the State. The level of training in different regions ranged from a 'tertiary level qualification in the Medical and Forensic Management of Adult Sexual Assault through the New South Wales Education Centre Against Violence' to an internal course run by the Tasmanian Health Service.[209]

Child sexual assault examinations require specialist skills and, again, we saw variation between the regions in the services available for children. In northern Tasmania, examinations are conducted by medical staff (paediatricians, gynaecologists or general practitioners) who have undergone 'formal training in child sexual assault'.[210] In southern Tasmania they are conducted or supervised by paediatricians with training from Monash University.[211] The North West does not have a 'formal acute paediatric sexual assault service', but Secretary Morgan-Wicks advised that the two senior paediatricians in the region have 'training and experience in paediatric sexual assault'.[212]

Children in all areas of Tasmania should be able to receive a child-friendly, trauma-informed forensic medical examination in a timely manner. While it would be preferable for a paediatrician who is trained in sexual assault to undertake forensic examinations with children, this may not always be possible.

Therefore, increasing the availability of forensic medical examinations for children will likely require increasing the skills of doctors and nurses around the State to undertake paediatric forensic medical examinations. This may involve training existing adult sexual assault forensic examination services to examine child victim-survivors. In other areas, where no sexual assault forensic examination services exist, the Department of Health should ensure suitably qualified local health practitioners are trained and supported in conducting forensic medical examinations for sexual assault.

Recommendation 16.6

1. The Department of Health should increase the availability of forensic medical examination services for child victim-survivors of sexual abuse to ensure all child victim-survivors can access an examination with minimal delay. To achieve this, the Department should:
    a. train existing adult sexual assault forensic medical examination services to examine child victim-survivors
    b. ensure, in areas of Tasmania where no sexual assault forensic medical examination services exist, suitably qualified local health professionals are trained and supported to conduct forensic medical examinations for child sexual abuse.

2. At a minimum, the training should include:
    a. an external, recognised qualification in forensic medical examinations
    b. external recognised training in sexual abuse care for children.

3.2.6 Implementing police complaints and oversight mechanisms

Our Commission of Inquiry mostly focused on government institutions whose primary functions relate to the care and supervision of children. However, during our Inquiry, we also received information about alleged child sexual abusers who were police officers, which caused us concern about how allegations of child sexual abuse against police officers are reported and dealt with.

Due to the relatively limited evidence we received on this topic, as well as time constraints, we have not explored this issue in detail. But based on what we heard, we consider that strong measures are needed to ensure independent oversight and accountability in cases where a police officer is alleged to have committed child sexual abuse. This will assist Tasmania Police to meet its obligations under the Child and Youth Safe Standards and the Reportable Conduct Scheme.

We start by sharing a question raised by Azra Beach, a victim-survivor, who alleged she was abused by several individuals, including a police officer. Ms Beach asked:

> … when someone wishes to proceed with historical sexual abuse charges that involve a member of Tas Police, what guarantee does the survivor have that it will be investigated fully and appropriately? … I feel like there needs to be someone independent investigating, not Tas Police …[213]

Commissioner Hine told us of 22 instances of complaints or information received concerning allegations related to child sexual abuse involving Tasmania Police officers since 2000.[214] We also note the recently reported case of Paul Reynolds, a police officer, who was investigated for child sexual abuse shortly before his death by suicide in September 2018.[215]

The following case example describes what we heard about the police handling of these allegations against Paul Reynolds. As we set out, in September 2018, Paul Reynolds was afforded a full police funeral, with a guard of honour. Yet his death followed significant police investigations and reports about his possible sexual abuse of multiple children, among other concerns.

Case Example: Tasmania Police complaints handling—Paul Reynolds

Paul Reynolds served as a Tasmania Police officer for almost 40 years. Shortly before his death by suicide in September 2018, he was investigated for child sexual abuse offences. The circumstances surrounding his death have been the subject of coronial proceedings and reported in the media, and we do not intend to repeat them here.

We heard that in 2008, police officers from an interstate police force were delivering training to Tasmania Police officers in Tasmania. After the first day of training concluded, at drinks at the Tasmania Police Academy bar, an interstate police officer alleged that a conversation occurred suggesting that then Inspector Reynolds was 'a paedophile'.[216] Two Tasmania Police officers, both with the rank of Inspector, reportedly gave examples of concerning behaviour.[217]

One Inspector reportedly said he had visited Inspector Reynolds' home and saw him with a 15-year-old boy between his legs, giving him a massage. Another Inspector reportedly said that his wife had been approached by people in the community concerned about Inspector Reynolds' behaviour around young boys.[218]

We were told that the interstate police officer who was present during this conversation became concerned 'about the nature of the discussion and potential truth around such serious allegations' and reported it to a Tasmania Police Divisional Inspector.[219] The Divisional Inspector then briefed the Commander of Internal Investigations.[220]

Shortly after, Darren Hine, then Deputy Commissioner, Tasmania Police, wrote to the Inspectors who had reportedly described the concerning behaviours, asking them to respond to the interstate police officer's report.[221] Both Inspectors replied to the Deputy Commissioner suggesting there had been a misinterpretation of comments made and that it had not been said Inspector Reynolds was a paedophile.[222] An Assistant Commissioner who was present when the conversation was alleged to have occurred was also approached to make a statement. Before providing his response, the Assistant Commissioner had been made aware of the responses of the Inspectors to the allegations against Inspector Reynolds. The Assistant Commissioner wrote a response indicating there was no mention of paedophilia in the bar that evening and that he did not believe there was any basis to pursue the matter further.[223] He suggested that the interstate police officer had 'seriously misunderstood' the conversation and said such an allegation had 'potentially very damaging consequences for a person wrongfully accused'.[224]

After receiving this advice, the Commander of Internal Investigations wrote to the Deputy Commissioner that 'the weight of evidence suggests [the interstate police officer] was either mistaken or misinterpreted' the comments.[225] In the absence of anything other than the interstate police officer's account, the Commander wrote that there was 'no other evidence' available.[226]

The two Inspectors were advised that the matter would be closed and filed for future reference.[227] The advice recommended that Inspector Reynolds not be told (given he was apparently unaware of the allegation) to avoid 'dissension between him' and the two Inspectors.[228]

In 2012, Inspector Reynolds reverted to the rank of Senior Sergeant following concerns about his work performance.[229]

In 2018, a senior police officer lodged a complaint using a tool (Blue Teams) for making complaints about colleagues.[230] It was alleged that Senior Sergeant Reynolds had sent and received child exploitation material and had groomed young men (including some involved with a local football club).[231] Shortly after these allegations, police searched his home and Senior Sergeant Reynolds died by suicide.

Senior Sergeant Reynolds received a police funeral following his death, at which now former Commissioner Hine spoke and outlined Senior Sergeant Reynolds' career.[232]

In 2022, Counsel Assisting the Coroner reportedly told an inquest into the deaths of four Tasmania Police officers (including Senior Sergeant Reynolds) that it was supposedly 'widely known in Deloraine that [Paul Reynolds] was a paedophile'.[233] We were told by Tasmania Police that it has 'no evidence that that asserted reputation of Senior Sergeant Reynolds was previously known to any member of Tasmania Police' before Senior Sergeant Reynolds' death.[234]

We acknowledge that, from 2018, Tasmania Police eventually investigated Senior Sergeant Reynolds for child sexual abuse and other offences. However, it is concerning that a decade before Senior Sergeant Reynolds' death there appeared to be credible reports that suggested an awareness (or at least a suspicion) of his engaging in inappropriate behaviour with children.

We consider that the approach to investigating the alleged conversation overheard by the interstate police officer was inadequate. The interstate police officer should have been invited to make a formal statement.

We are further concerned that Senior Sergeant Reynolds was given a police funeral. We received an anonymous submission from a community member who was 'furious' when they learned from a police contact that Senior Sergeant Reynolds had been investigated before his death for child sexual abuse offences.[235] The community member wrote:

> Why is it that Paul Reynolds was given a full police send off when he was under investigation before he killed himself? What impact has this public heroism had and will have on the alleged victims and their families?[236]

We share these questions. We can only imagine how distressing this would have been for those who heard rumours about Senior Sergeant Reynolds' behaviour and believed them to be true. We are concerned by the Commissioner's delivery of the eulogy, given the Commissioner was, at that stage, aware of the concerns about Senior Sergeant Reynolds.[237]

Commissioner Hine described the processes that apply when a police officer is alleged to have been involved in child sexual abuse. He told us that anything of that nature would go to the Professional Standards Command, which would investigate it under the direction of the Deputy Commissioner. The matter would then be reported to the Integrity Commission.[238] We note that this process specifies where known cases are investigated but does not address the concerns of victim-survivors about how they make a complaint or about complaints mechanisms other than attending or phoning a local police station.

Under the *Integrity Commission Act 2009*, the Integrity Commission has the power to audit the way Tasmania Police (a public authority) has dealt with complaints of police misconduct.[239] As well as audits of a class of police complaints, the Integrity Commission can undertake individual audits of police complaints.[240] The Integrity Commission reported in its 2020–21 annual report that it had undertaken an audit of 30 complaints files with varying levels of seriousness, as well as one audit of an individual police complaints file relating to the use of force.[241]

Commissioner Hine said that after a matter has been reported to the Integrity Commission it then goes to the DPP to be dealt with in court.[242]

Commissioner Hine said that specific steps ensure the Professional Standards investigation is done independently from the area where the police officer is based, and that there is oversight from the Integrity Commission.[243] He also pointed out that the issue is dealt with in the *Commissioner's Directions for Conduct and Complaint Management and Compliance Review* (2021), which is a publicly available document.[244] While this document sets out good processes for dealing with police misconduct, it is long (173 pages excluding appendices) and complex. And, while it refers to handling family violence complaints against police, it does not refer specifically to child sexual abuse. Noting that our Inquiry did not have the opportunity to explore this matter further in evidence, in our view this process is not transparent enough in terms of making victim-survivors aware of how to report child sexual abuse by a police officer. We also consider that the police investigation needs to be more independent than being overseen by the Deputy Commissioner.

Commissioner Hine said that, regarding family violence, there were issues relating to perpetrators or witnesses being police officers. Accordingly, Tasmania Police has changed its policy. There is now a review panel chaired by an independent person who looks at the investigation to ensure independence.[245] Commissioner Hine noted that it would be a natural progression for Tasmania Police to convene a similar review panel where a police officer is alleged to have been involved in child sexual abuse.[246]

In Victoria, complaints against police can be made directly to the Independent Broad-based Anti-corruption Commission, but most are referred to Victoria Police for investigation.[247] The Independent Broad-based Anti-corruption Commission oversees these investigations, which includes reviewing and auditing selected investigations.[248]

Victoria Police has established a specialist Sexual Offences and Family Violence Unit, formerly known as Taskforce Salus, in its Professional Standards Command to investigate allegations against Victoria Police employees involving sexual assault (including against children) or family violence.[249] Victoria Police has also published an 'options guide' for victim-survivors of sexual assault or family violence perpetrated by Victoria Police employees.[250] This guide is available online and sets out various options for reporting allegations.[251] It explains the criminal complaints and investigation process and the internal disciplinary process. It indicates that interim action can be taken to suspend or transfer a Victoria Police employee who is under investigation.[252]

We strongly support the need for independent oversight of internal police investigations. More broadly, we emphasise that workplace culture is a key pillar in detecting and preventing most forms of unethical police behaviour.[253] Supervisors and managers have significant influence over the culture of their workplaces and are positive role models of acceptable behaviours.[254] We consider that professional development and strong leadership are required to ensure police uphold the highest standards.

We urge Tasmania Police to continue its path to improving police responses to reports of child sexual abuse, noting that strong accountability measures are required when allegations are made against police members. The cost of failing to rigorously investigate allegations of child sexual abuse is too high.

Tasmania Police has told us that planning is well advanced to establish a Family and Sexual Violence Involving Police Review Committee. An independent person will chair the committee. We are glad to hear of the intention to establish such a body.

Recommendation 16.7

Tasmania Police should:

a. establish a clear, publicly accessible process for reporting and responding to allegations of child sexual abuse against a member of Tasmania Police, including the ability to report to an entity independent of police such as the Integrity Commission

b. expand the domestic violence review panel to cover child sexual abuse and ensure independence in investigations when a member is alleged to have been involved in child sexual abuse.

4 Prosecution responses

The DPP is responsible for prosecuting serious criminal matters, including institutional child sexual abuse cases.

In recent decades across Australia, significant changes have improved how prosecution agencies respond to victim-survivors of child sexual abuse.

In this section, we outline how the ODPP deals with child sexual abuse offence cases, focusing on:

- prosecution specialisation and training
- complaints and oversight mechanisms.

We then consider whether there are opportunities to strengthen and improve responses, and whether the ODPP is adequately funded to meet an increased demand for its services. In Section 9, we consider the ODPP's capacity to collect data and monitor outcomes in child sexual abuse cases.

4.1 Prosecution roles and responsibilities

The ODPP conducts criminal prosecutions in the Supreme Court and some summary criminal matters in the Magistrates Court. Prosecutors have a duty to present the case against an accused person fairly and honestly and to assist the court with submissions that allow the law to be properly applied to the facts.[255] The DPP acts on behalf of the State and is independent of the police and the courts.[256]

The prosecution has the responsibility to make decisions in line with the *Criminal Code Act 1924* ('Criminal Code Act') and the DPP *Prosecution Policy and Guidelines* ('DPP Guidelines') including:

- whether to start a prosecution
- whether to discontinue a prosecution
- the appropriate charge to be laid against an accused person
- whether to accept a plea of guilty to a lesser charge.[257]

These decisions can have a significant impact on victim-survivors.

The National Royal Commission made recommendations in its *Criminal Justice Report* that were directed at each Australian DPP.[258] The recommendations made to prosecuting authorities mostly relate to consultation, providing information to victim-survivors for court and having robust and transparent decision-making processes (particularly for decisions to discontinue or drop charges).[259] Tasmania's ODPP advised us that it has implemented all the National Royal Commission's recommendations for which it is responsible.[260]

The ODPP referred to improvements it had made in dealing with child sexual abuse. In particular, the ODPP referred to:[261]

- creation of the Witness Assistance Service, which began in July 2008[262]
- introduction of a pre-charging advice service for Tasmania Police[263]
- establishment of a victims' right of review to the DPP of decisions made by the ODPP[264]
- implementation of detailed policies about how decisions that affect victims are made.[265]

The DPP told us that the ODPP prioritises sexual offence prosecutions, giving precedence to matters where the victim is still a child, where there are child witnesses and where a pre-recording will be conducted in court under the *Evidence (Children and Special Witnesses) Act 2001* ('Evidence (Children and Special Witnesses) Act').[266] Also, where the victim is still a child, there is a direction from the Chief Justice that the ODPP informs the Supreme Court. Once this occurs, a judge case-manages the matter.[267]

The DPP also advised us that child sexual abuse prosecutions are treated differently from other prosecutions in the following ways:

- The ODPP has generally provided pre-charging advice to Tasmania Police before the accused person is committed for trial. We discuss the pre-charging advice service in Section 4.4.1.
- It is the ODPP's practice to have early and ongoing contact with victims of sexual offences.[268] This contact occurs mainly through the Witness Assistance Service, which we discuss in Section 4.4.2.

4.2 Communicating with and supporting victim-survivors

As with police, victim-survivors told us of mixed experiences with prosecuting authorities. Some victim-survivors were positive about their experiences with prosecutors. Katrina Munting, a victim-survivor, told us that the support staff at the Witness Assistance Service from the ODPP were excellent. She described the woman she worked with as 'the kind conduit between myself and the terrifying Supreme Court and lawyers'.[269] Although Ms Munting did not spend a great deal of time with the Crown Prosecutor, she told us 'was very kind, understanding and patient in all our interactions'.[270]

By contrast, Leah Sallese, a victim-survivor, said that she had a 'terrible time' during the prosecution stage in 2017 and noted that it was retraumatising to have to repeat the same information.[271] In response to Ms Sallese's evidence, the DPP provided our Inquiry with documents indicating how prosecutors handled Ms Sallese's case.[272] While our Inquiry does not suggest that these prosecutors were at fault, it is clear, and the DPP acknowledges, that the criminal justice system can be difficult for victims.[273]

There may be circumstances where complainants need to retell their stories to multiple people on multiple occasions. The issue is particularly acute where disclosures are made bit by bit. This emphasises the need, of which the DPP is conscious, for sensitive and trauma-informed processes in the ODPP. The recommendation made below for professional development for prosecutors and other ODDP staff and the availability of the Witness Assistance Service should help address this issue.

Robert Boost, a victim-survivor, told us that the decision of the ODPP not to proceed with his case after he reported to police in 2020 left him feeling as if the person he alleged abused him still had power over him. Mr Boost said he felt 'that the system is there to protect [the alleged abuser], not me'.[274]

Mr Boost said he felt a 'deep sense of injustice' when the ODPP declined to proceed to trial with his matter because of insufficient evidence:

> There is a real imbalance in these 'historical' cases. I was a little kid when I was abused, faced with a perpetrator in a position of power. That power imbalance must be factored in by the DPP when they consider whether or not to run a case … I was dismissed by the perpetrator as a child, and the system is still dismissing me as an adult now.[275]

Kerri Collins, a victim-survivor, told us that she learned two weeks before the trial was to begin that the ODPP had decided not to proceed with the prosecution. Ms Collins said she wrote to the ODPP expressing her 'utter horror' at what had been decided.[276] She spoke to us about feeling powerless, as a victim, against the system.[277]

Ms Collins' matter was dealt with in 2004. The DPP told us of changes in the law and greater emphasis on supporting victims since then, which means that Ms Collins' case would be dealt with differently today.[278]

The DPP also told us that there is now an expectation in the ODPP of communicating with complainants throughout the prosecution process. The DPP Guidelines (updated in 2022) state:

> Informing the complainant of the proposed discharge or reduction in charges is an important step in the process. It is important that the complainant understands the reasons why a decision is made. It is preferable that the complainant be informed of the reasons in person. However, if this is not possible, it should be done by telephone. When informing a complainant of the decision the prosecutor should advise how decisions are made, provide a brief history of the matter and brief reasons for the decision. The complainant should be given an opportunity to provide his or her views about the decision.[279]

The DPP stated that, in the past, communicating with victim-survivors was, to a large extent, left to the discretion of the counsel in charge of the matter.[280] We are pleased to hear about this change in approach.

The DPP also stated that complainants are now notified of key decisions and have a right to request a review of a decision.[281] Where the complainant is under 18 years of age or has disability, their parent, guardian or spokesperson will be notified.[282] We discuss this in Section 4.3.

4.2.1 Prosecution specialisation

Child sexual abuse prosecutions can be difficult and complex. As noted, in relation to child complainants, these cases typically involve the word of a child against an adult, with no eyewitnesses and often a lack of forensic evidence. Those who prosecute child sexual abuse offences should have specialised skills and training in the law as it pertains to child sexual abuse and the nature and impact of child sexual abuse.

Terese Henning, Adjunct Associate Professor, Faculty of Law, University of Tasmania, recommends specialisation among the police and prosecution in sexual assault matters:

> Expertise and special skills are needed to deal with these cases, in order to know what communication tools are available, and how to get the best evidence out of these kinds of witnesses. These cases need to be managed in particular ways, and you need to have particular expertise to manage them appropriately.[283]

The DPP told us that, since 2016–17, the ODPP has had a specialist Sexual Assault and Family Violence Team covering Hobart and Burnie.[284] The purpose of the team is to streamline sexual assault and family violence prosecutions and to facilitate oversight by a single Principal Crown Counsel to ensure consistency in approach and appropriate prioritisation.[285]

We support the specialist arrangements in the ODPP for child sexual abuse prosecutions. In Section 4.4, we consider the subject of funding to support specialisation.

4.2.2 Prosecutor training

The DPP told us that specific training for prosecuting child sexual abuse matters is mostly done 'on the job'. The DPP stated that the team structure in the ODPP enables mentoring of staff, supervision of work and a knowledge of each practitioner's workload and experience.[286] New prosecutors are given the opportunity to act as the junior in contested matters before conducting a hearing or trial on their own.

The DPP Guidelines set out the duties of prosecutors, including those that apply to children and special witnesses.[287] For this, the DPP Guidelines refer to the Australasian Institute of Judicial Administration's *Bench Book for Children Giving Evidence in Australian Courts*.[288] The Bench Book is primarily for judicial officers who deal with children giving evidence in criminal proceedings as complainants or witnesses, rather than for prosecutors. It covers the nature and impact of child sexual abuse, children's evidence and coping skills, and suggested procedures for children giving evidence. It includes a suggested script to use in special hearings with children or cognitively impaired witnesses.[289] The DPP Guidelines strongly encourage prosecutors with proceedings involving children or cognitively impaired witnesses to review the relevant portions of the Bench Book in preparing for trial.[290]

The DPP gave us examples of training provided to staff at Continuing Legal Education days, including:

- self-care and trauma, delivered by the Sexual Assault Support Service, June 2022
- interviewing complainants and leading evidence—in particular, children in the context of sexual assault—delivered by the Assistant Director (Summary Prosecutions), June 2022
- child sexual abuse and trauma-informed practice, delivered by the Sexual Assault Support Service, December 2021.[291]

The DPP also noted that Senior Crown Counsel are involved in and facilitate training courses. He said there are counsel in the ODPP who have considerable experience in prosecuting sexual abuse offences. The DPP stated that all practitioners are encouraged to, and regularly do, consult with experienced counsel.[292]

The DPP stated that it is always desirable for prosecutors to have ongoing training to help them prosecute child sexual abuse cases, including abuse in institutional contexts. The DPP noted that more training would be beneficial in the following areas:

- trauma-informed responses

- understanding the Evidence (Children and Special Witnesses) Act
- tendency and coincidence evidence
- issues that children may face in giving evidence in general and accommodations that can be made.[293]

We welcome the efforts the ODPP has made to train prosecutors on the nature and impact of child sexual abuse and the laws that apply to child sexual abuse offence prosecutions. We agree with the DPP that there is scope to build on and strengthen training, for example, to include training on the role of witness intermediaries.

It would also be helpful for defence lawyers to receive such training through The Law Society of Tasmania, or possibly Tasmania Legal Aid. Additionally, it might be possible to include prosecution lawyers sharing their experiences as part of the training.

Recommendation 16.8

1. The Office of the Director of Public Prosecutions should provide ongoing professional development to staff on child sexual abuse, including:
    a. specialist training on trauma-informed practice
    b. training on issues that children and adult victim-survivors may face in giving evidence and approaches that can be taken to make the process trauma-informed, including the role of witness intermediaries
    c. training on the laws of evidence and procedure that apply in child sexual abuse cases
    d. training on the nature, causes and methods of child sexual abuse and grooming, including addressing common myths about child sexual abuse.
2. The Office of the Director of Public Prosecutions should also explore opportunities with Tasmania Legal Aid and the Law Society of Tasmania for joint training on the dynamics of child sexual abuse and trauma-informed practice.

4.3 Complaints and oversight mechanisms

The ODPP has the power to decide whether to proceed with charges, what charges to proceed with and whether to discharge an accused person. These are significant decisions for complainants and accused people. Being involved in the criminal justice system is difficult for many complainants and their families, and it is inevitable that some of them will find the system unfair or insensitive. This makes it particularly important that there are internal review processes and clear and effective complaints mechanisms.

The National Royal Commission recommended that each Australian DPP:

- has comprehensive written policies for decision making and consultation with victim-survivors and police
- publishes all policies online
- provides a right for complainants to seek written reasons for key decisions
- offers opportunities to discuss the reasons for decisions in person before written reasons are provided.[294]

The DPP advised us that every decision to prosecute or to discharge a matter is internally reviewed.[295] The DPP explained the process as follows:

- When enough relevant information has been provided, the lead prosecutor must determine whether, in their view:
    - an indictment should be filed
    - the accused person should be discharged
    - alternative summary charges should be laid.[296]
- The prosecutor must prepare a memorandum setting out:
    - facts that are essential to the charges to be considered
    - strengths or difficulties with evidence, including with witnesses
    - possible legal arguments
    - the prosecutor's thoughts on the likely resolution.[297]
- The memorandum must be forwarded to the DPP, or to a committee whose members include the Deputy Director and Principal Crown Counsel.[298] In most cases, the memorandum is forwarded to the committee in the first instance. Generally, memorandums are only forwarded to the DPP in the first instance for charges that require the DPP's authorisation.[299]
- If an indictment on the same or similar charges for which the accused person has been charged and/or committed is sought, one other member must agree with the lead prosecutor. In the case of any committee member making the recommendation, the agreement of another member is required.[300]
- If discharging the accused person is recommended, the agreement of two committee members is required unless the recommendation is that of a committee member, in which case the agreement of another committee member is required.[301]

- If the recommendation is to prosecute the accused person on the same or similar charges but one member of the committee recommends a discharge or a substantial downgrading of charges, then two other committee members must also agree with such a discharge or downgrading of the charges.[302] Where the committee cannot agree in these terms, the matter is forwarded to the DPP for review and determination.[303]
- The DPP can overturn a committee decision.[304]

The DPP informed us that a decision to indict or discharge an accused person in a case involving child sexual abuse is considered in the same way as for any indictable crime. In most cases, it will involve a discussion with the complainant before a final decision is made.[305] If prosecuting an accused person discontinues after charges have been laid, detailed reasons for the discharge must be clearly documented.[306]

The DPP Guidelines state that 'ordinarily' a letter should be provided to the complainant confirming that the charges will not proceed and that the complainant has a right to request the DPP to review that decision.[307] The DPP Guidelines do not require the letter include an explanation for the decision, but complainants may request written reasons for decisions.[308] The ODPP told us that usually staff meet with complainants to explain why a decision not to proceed with a prosecution has been made.[309]

A complainant may apply to have the DPP review a decision to discharge an accused person or substantially downgrade a charge against an accused person (unless the decision was approved by the DPP).[310] Requests for review are generally to be made within seven days of notification of the decision.[311]

The DPP Guidelines state that a final decision to discharge an accused person will only be overturned if it is plainly wrong (that is, it was based on incorrect or irrelevant material or was plainly unreasonable, or unless new evidence becomes available).[312] The DPP told us that he will also overturn a non-final decision if a complainant requests him to review that decision and he disagrees with the decision.[313] The DPP Guidelines do not allow for reviews of DPP decisions, but a complainant may request to meet with the DPP or Deputy Director to have the reasons for the decision explained.[314]

Some people shared their dissatisfaction with us, not only with the decisions made on their matters but also with the way the ODPP handled their complaints or concerns.

One victim-survivor told us of their disappointment at being told in 2014 that there was not enough evidence to charge the person who abused them, only later discovering that there were more victim-survivors abused by the same person:

> I was also advised by the Public Prosecutions Office that any review of the decision not to prosecute [the abuser] would have to be made to Daryl Coates SC [the DPP] as "there was no formal procedure for review".[315]

We are pleased that there have been changes to the process since 2014.

The mother of another victim-survivor described her family's 'heartbreak' when advised in 2006 by a former DPP that her daughter's complaint would not proceed, despite initially being assured they had an extremely good case.[316] Later, they tried again with a subsequent DPP, only to be told that he could not overrule the previous decision. She said: 'DPPs are not God, and therefore decisions … should be able to be overturned by another DPP'.[317] (Refer also to the experience of Kerri Collins, described in Chapter 5).

The National Royal Commission considered whether there should be judicial review of DPP decisions.[318] Judicial review is when a court reviews a decision made by a public authority to ensure the decision is legal and that the decision maker considered everything that was legally relevant. In reviewing a decision, a court considers whether the decision was valid but does not review the merits of the decision itself (that is, a judicial review does not reconsider the facts of the matter or focus on whether the decision was correct). If a court is satisfied that the grounds for judicial review have been established, it can set aside the decision and refer it back to the decision maker for further consideration.

The DPP told us that he does not support judicial review of prosecutorial decisions.[319] In considering whether there should be judicial review of decisions by Directors of Public Prosecutions, the National Royal Commission cited longstanding judicial authority that has held that the integrity of the judicial process, including its independence, would be compromised if the courts were to decide or be in any way concerned with decisions about who is to be prosecuted and for what.[320] In light of strong opposition from Directors of Public Prosecutions and noting the position of the High Court, the National Royal Commission did not consider that judicial review would be likely to provide an effective means for victim-survivors to get a review of prosecutorial decisions.[321] We share the National Royal Commission's reservations about judicial review.

The National Royal Commission noted that in the absence of judicial review it is critical that Directors of Public Prosecutions and Offices of Directors of Public Prosecutions, and relevant governments, ensure complaints mechanisms for internal merit reviews are robust and effective.[322] The National Royal Commission recommended that Directors of Public Prosecutions establish robust and effective internal processes to audit their compliance with policies for decision making and consultation with victim-survivors and police.[323] Like the National Royal Commission, we emphasise the need for robust and effective mechanisms for internal merit reviews. We also note that care and diligence should be applied not only to the decision itself, but also to how it is delivered and explained to victim-survivors and their families.

The DPP informed us that, since 2017–18, the ODPP has conducted annual audits of discharge files for compliance with the DPP Guidelines. The DPP stated that 30 per cent of discharged cases are randomly selected and benchmarked against the DPP

Guidelines in respect of a discharge.[324] The ODPP noted that the audit results are published in its annual reports. The ODPP has also reviewed historical matters, noting that the standard of record keeping has significantly improved in the past 15 years.[325] The DPP stated that, following the annual audit, an email is sent to all staff to remind them of the discharge procedures and to identify any deficiencies in practice.[326] We welcome this change.

4.4 Properly funding and resourcing prosecution services

In this section we outline what we heard about funding and resource challenges for the ODPP and the impact this is having on its ability to meet demand.

We heard evidence that the increasing workload is placing pressure on the ODPP and resulting in:

- delays in providing pre-charging advice to police
- an inability of the ODPP's Witness Assistance Service to provide services to witnesses in cases other than sexual offence matters
- delays in prosecuting criminal cases.

These challenges are discussed in the sub-sections below.

We note that extra funding was provided to the ODPP in the 2022–23 Tasmanian Budget to help it reduce the backlog of cases in the Supreme Court.[327]

4.4.1 Delays in pre-charging advice

The National Royal Commission recognised the importance to victim-survivors of having the correct charges laid against an accused person as early as possible, so charges are not significantly downgraded or withdrawn at (or close to) trial. It made a recommendation to this effect.[328] The National Royal Commission noted that victims and their families are likely to experience significant distress if they believe there will be a criminal trial and are later told that the charges against the accused person will be dropped.[329]

Tasmania Police regularly requests and receives pre-charging advice from the ODPP on various matters, including child sexual abuse.[330] The ODPP provides the pre-charging advice service to police before charging a person with 'any sexual assault crime' in circumstances where there may be a question about the appropriateness of charges or the sufficiency of evidence.[331] Individual detective inspectors receive a file from investigators, via their supervisors, and assess the file. If specific advice is required before charging an accused person, the file is forwarded to the ODPP.[332]

Under section 125A of the Criminal Code Act, the approval of the DPP is required before a charge can be laid for the offence of persistent sexual abuse of a child or young person. Approval is also required under section 105A for the offence of failing to report the abuse of a child. Under protocols between the DPP and Tasmania Police, the DPP must be notified within four working days of charges for other sexual offences.[333]

According to Commissioner Hine, the arrangements 'work well' and Tasmania Police has discretion on whether to charge, based on the evidence at hand. Police can seek advice if in doubt.[334]

Commissioner Hine considers that the ODPP pre-charging advice service is effective at reducing the likelihood of charges being dropped, downgraded or dismissed due to better, more timely advice on the correct charge selection or on possible deficiencies in the evidence necessary to charge an accused person.[335]

Commissioner Hine considers that, while the police should be able to charge based on their discretion, for charges of persistent sexual abuse of a child or young person, DPP authorisation is appropriate because the process ensures the details that form the basis of an indictment are correct.[336]

The DPP stated that the benefits of pre-charging advice are well recognised, and it is an integral part of the work in the ODPP.[337] According to the DPP, the pre-charging advice service ensures:

- correct charges are laid at an early stage
- early advice is given about the prospect of gathering more evidence (where evidence is gathered before charging, there is less likelihood of the case being dropped after proceedings have started)
- matters with no reasonable prospect of conviction do not proceed, avoiding false expectations among complainants.[338]

Although Tasmania Police and the DPP value the pre-charging advice service, the DPP told us that resourcing constraints create delays in providing the advice. The ODPP aims to have advice completed within six weeks of referral.[339] In a consultation with us, and in its most recent annual report, the ODPP conceded that the six-week deadline for providing advice to Tasmania Police was not being met due to volume and resourcing pressures.[340] Between 1 January 2012 and 31 April 2022, the average time an advice file remained in the ODPP was 15.3 weeks.[341] This is a long wait for a complainant to find out whether a prosecution is likely to proceed.

A participant in our stakeholder consultation in Devonport noted the need for the ODPP to be adequately resourced to provide timely advice to police, with wait times of up to nine months in Devonport.[342]

The DPP stated that these files are complex and time-consuming.[343] The DPP also noted that these files are taking longer to review because many contain audiovisual statements, which can be more difficult to follow and longer to listen to and watch than written statements.[344] According to the DPP, they sometimes include irrelevant or inadmissible material and may not describe events in sequence.[345] We note that care needs to be taken with such statements—the Whole Story framework (discussed in Section 3.2) may produce material that appears irrelevant to a lawyer but is an important part of the complainant's story of the abuse.

The DPP stated that pre-charging advice to Tasmania Police is mainly provided by the Sexual Assault and Family Violence Team.[346] However, he noted that, more recently, charging advice has been provided by Crown Counsel outside of the team because the team has not been able to service an increase in workload.[347]

The DPP is of the view that the pre-charging advice targets could be better met if they had specialist prosecutors dedicated to providing this advice, without also having to conduct other criminal prosecutions. This is because urgent criminal work and court deadlines mean that pre-charging advice does not always get the priority it needs.[348]

4.4.2 Witness Assistance Service challenges

The National Royal Commission recommended that the prosecution Witness Assistance Service be funded and staffed to ensure it can perform its tasks of keeping victim-survivors and their families informed and putting them in contact with relevant support services.[349]

The ODPP established the service in 2008 to support witnesses and victims and their families while they go through the criminal justice processes.[350] The DPP informed us that the number of staff employed in the service has increased steadily since 2008.[351] Qualifications of staff include legal, psychology, criminology, social science and social work degrees.[352]

The Witness Assistance Service provides services to complainants and vulnerable witnesses, including:

- helping witnesses to understand court and legal processes
- providing information on court dates and outcomes
- offering support during charge selection, negotiation or discontinuance
- arranging, and supporting witnesses in, meetings with the prosecutor
- showing witnesses court facilities ahead of giving evidence
- supporting witnesses in court or on video link, or while waiting to give evidence

- helping to prepare victim impact statements
- providing a post-court briefing and helping to organise ongoing support.[353]

Sexual assault cases have been automatically allocated a Witness Assistance Service Officer since 2010.[354] The DPP outlined how the service operates:

- Once an accused person is charged with a sexual assault offence, Tasmania Police notifies the ODPP within four working days.
- Within two days of that notification, the Sexual Assault Liaison Clerk writes to the complainant to explain the usual course of proceedings.
- Following notification that charges have been laid, the Sexual Assault Liaison Clerk forwards a copy of the notification to the Witness Assistance Service Manager, who allocates the matter to a Witness Assistance Service Officer. This officer is responsible for contacting the complainant and providing any updates.[355]

The DPP informed us that a Witness Assistance Service Officer generally contacts a complainant in a child sexual abuse case before any application for bail and notifies the complainant of the outcome of any such application.[356]

The DPP noted that, as much as possible, allocated Witness Assistance Service staff continue working on a child sexual abuse matter until it is resolved.[357]

Ms Munting, also quoted above, described how someone from the Witness Assistance Service assisted her:

> The woman I worked with was so kind and understanding of my anxiety surrounding every step of the process … She also arranged for a private session in one of the courtrooms at the Supreme Court. This allowed me to know what to expect when I attended; the 'feel' of the room, who would be positioned where, what I needed to do at each point, to practice sitting in the witness box prior to the hearing, and to practice my victim impact statement in the same setting it would be required.[358]

Another victim-survivor acknowledged the significant support she received from a Witness Assistance Officer, adding:

> Given my experiences, I believe it should be standard practice for victims/survivors of crime involved in criminal cases to be given a package of information up-front explaining the roles and responsibilities of the Witness Assistance Service, the roles and responsibilities of the Witness Assistance Officer, the court process, the availability of support services and the dos and don'ts of being a witness.[359]

According to the DPP, the Witness Assistance Service is funded and staffed to ensure it can perform its tasks of keeping sexual abuse victims informed and connecting these victim-survivors with relevant support services.[360] The DPP advised us that contact with victim-survivors of sexual abuse offences is the service's priority. However, he noted

the growing demand for the service is affecting the assistance it can provide to other complainants and vulnerable witnesses.[361] The DPP told us that, because priority is given to sexual abuse matters and matters involving children, the Witness Assistance Service is funded well enough to meet these priorities.[362] However, the DPP noted that this limits the ability of the service to help other vulnerable complainants and witnesses.[363] The DPP also advised that contract positions make it difficult to keep qualified and suitable staff, stating that it would be much better if the positions were permanent.[364]

4.4.3 Delays in prosecuting criminal cases

The DPP told us that the ODPP struggles with criminal processes, workload increases and increased pressure because of a backlog of cases in the Supreme Court.[365] He stated that the effects of the increased workload and the resulting delays are significant for victim-survivors, accused people, witnesses, ODPP staff and the quality of justice.[366]

Delays can be highly distressing for victim-survivors and compromise their willingness and ability to take part in a criminal justice process.

Ms Munting told us:

> Each time there was another delay, another adjournment, or not meeting the next expected progress point, it tore me apart. I was so determined not to give up; however, the process drove me ever closer to suicide as I could not cope.[367]

The DPP told us of increasing pressures on the ODPP, noting:

- There is a relatively small pool of counsel, Crown and defence with experience in sexual offence cases. The DPP said this causes issues with continuity of counsel and adds to delays.[368]
- There has been an increase in pre-trial directions hearings and special hearings under the Evidence (Children and Special Witnesses) Act.[369] The DPP said that, while the provisions under this Act are well used and of great benefit, they inevitably lead to delays and affect the backlog.[370]
- The ODPP has a limited number of Senior Crown Counsel available to conduct complex prosecutions, including prosecutions for sexual abuse offences. The DPP said that junior practitioners have been employed but it will take time for these practitioners to gain the skills and experience necessary to prosecute sexual abuse offences.[371] The DPP noted this creates more pressure and requires more resources for training, continuity of counsel and delays.[372]

The DPP stated that, overall, the lack of resources is a problem. He noted that the workload of the specialist prosecution unit continues to increase and there are not enough resources to keep up with demand.[373] The DPP further stated that the criminal backlog cannot be properly addressed without a sizeable increase in ongoing funding to the ODPP and corresponding funding for criminal defence services.[374] Since the DPP's statement to us in June 2022, the Tasmanian Government has increased funding for staff in the ODPP to help reduce the backlog of criminal matters in the system.[375]

KPMG conducted an independent review into the ODPP in 2010.[376] The review concluded that, compared with similar jurisdictions, the Tasmanian ODPP was efficient and effective. KPMG suggested that there was little, if any, scope for further efficiency from the then resource base.[377]

The DPP stated that the review resulted in a substantial increase in funding for the ODPP in the 2012–13 Tasmanian Budget, but that the extra funding was taken from the ODPP in the 2013–14 and later budgets.[378] He stated that funding was subsequently given to the ODPP for other work, such as the Child Safety Group and the Unexplained Wealth Unit.[379]

The DPP told us there have been small increases for the criminal section before the past two budgets to account for rises in salaries and rent, and for the Sexual Assault and Family Violence Unit. He said that the 2021–22 Tasmanian Budget provided about $1.4 million to the ODPP for the new high-risk offenders legislation, which imposes significant obligations on the ODPP and the Sexual Assault and Family Violence Unit.[380] He further noted that this included extending funds that were previously given to the ODPP but were not ongoing.[381]

The Tasmanian Government could consider whether to further support the pre-charging advice service and to extend the Sexual Assault and Family Violence Unit to cover Launceston (in addition to Hobart and Burnie).

5 Offences, evidence and procedure

In this section, we consider criminal offences and the laws of evidence and procedure that apply in child sexual abuse cases.

Over the past decade, Tasmania has made many welcome amendments to the law in this area, including changes to the Evidence Act, introducing provisions to make it easier for children to give evidence in sexual offence trials and piloting the Witness Intermediary Scheme.

The Tasmanian Government also introduced the Justice Miscellaneous (Royal Commission Amendments) Bill 2022, which commenced as the *Justice Miscellaneous (Royal Commission Amendments) Act 2023* ('Justice Miscellaneous (Royal Commissions)

Act') on 20 April 2023. The Act made other changes including new child sexual abuse offences and introducing model provisions developed by the Uniform Evidence Law jurisdictions to address barriers to the admissibility of tendency and coincidence evidence.[382]

We also note that the Tasmanian Government is examining bail laws. We encourage the Department of Justice to consider the views and experiences of victim-survivors of institutional child sexual abuse as part of that review.[383] For example, Keelie McMahon, a victim-survivor of child sexual abuse perpetrated by James Griffin (refer to Chapter 14), told us how she felt when Mr Griffin was granted bail:

> Jim lived in the same suburb as me. Prior to him being charged we would go to the same shopping centre and I would frequently run into him there. After Jim was bailed I became really anxious and very rarely left my house because I was fearful of running into him. My mum told me he wasn't at his house anymore but I still had the anxiety of knowing he was out there somewhere.[384]

This section focuses on the areas in which we would like to see more improvements to criminal offences, rules of evidence and court procedures. We then consider whether improvements can be made to ensure:

- criminal offences cover the range of offending behaviour that can occur in child sexual abuse cases and also have a preventive role in condemning and deterring such behaviour
- adult victim-survivors of child sexual abuse offences are extended the same protective measures that exist for children to minimise the traumatic impacts of a trial
- audiovisual recordings of evidence given by witnesses in child sexual abuse offence cases are of high quality
- relevant evidence in child sexual abuse offence cases is admissible
- juries understand the dynamics of child sexual abuse so they can effectively assess evidence in trials
- information is available for judges and the legal profession on the nature of child sexual abuse and trauma-informed court practice
- judges can rule on the admissibility of evidence before a jury is sworn in and before the trial starts to allow trials to progress with minimal procedural disruption.

5.1 Offences

This section describes the offences that may apply to perpetrators who commit child sexual abuse in institutional settings. It also refers to offences applicable to those who do not act to prevent child sexual abuse from occurring and recommends some changes. In the period since our Commission of Inquiry has been operating, there have been several changes to these offences, which are noted below.

In Tasmania, a person who sexually abuses a child, permits the sexual abuse of a child or is in a position of authority and fails to protect a child from sexual abuse can be charged with various indictable offences. These offences are dealt with in the Supreme Court and include:[385]

- rape[386]
- indecent assault[387]
- penetrative sexual abuse of a child or young person[388]
- penetrative sexual abuse of a child or young person by a person in a position of authority[389]
- person permitting penetrative sexual abuse of a child or young person on a premises[390]
- persistent sexual abuse of a child or young person[391]
- doing an indecent act with or directed at a child or young person[392]
- procuring a child or young person to have unlawful sexual intercourse with another person or to commit an indecent act with another person[393]
- communicating with a child or young person to induce them to engage in an unlawful sexual act ('grooming')[394]
- communicating with any person with the intention of exposing a child or young person to indecent material without legitimate reason[395]
- failure by a person in authority to protect a child from a sexual offence.[396]

There are also various indictable offences relating to producing, using, possessing or accessing child exploitation material.[397]

There is no time limit (limitation period) for prosecuting indictable offences. An accused person can be prosecuted, at least in theory, for offences that are alleged to have occurred many years before. However, in practice, the ODPP could advise the police that an alleged perpetrator should not be charged because the available evidence means there is not a reasonable prospect of conviction.[398]

Until recently, there were time limits on prosecuting *summary* offences.[399] A time limit applied to assault with indecent intent, which may involve child sexual abuse, and a person could not be charged with the offence beyond 12 months after it was alleged to have occurred.[400]

The enactment of the Justice Miscellaneous (Royal Commission Amendments) Act removed this limitation period for assault with indecent intent.[401] The amendment is retrospective to enable historical offences to be pursued.[402] The Act also removed the two-year limitation period that applied to the offences of making, reproducing or procuring a child to be involved in making child exploitation material under the Classification (Publications, Films and Computer Games) Enforcement Act.[403] We support these recent reforms.

5.1.1 Persistent sexual abuse offence

An accused person is entitled to a fair trial, which includes knowing the details of the case against them. Normally, when a person is charged with an offence, the prosecution must specify when the offence is alleged to have occurred. This enables the accused person to properly defend themselves against accusations of child sexual offences.

However, it is often difficult for victim-survivors of child sexual abuse to give details of the offending against them because:

- young children may not have a good understanding of dates and times
- delays in reporting may cause memories to fade
- the abuse may have occurred repeatedly and in similar circumstances, so the victim-survivor cannot describe specific occasions.[404]

To overcome this difficulty, Tasmania introduced an offence in 1994 of 'maintaining a sexual relationship with a young person', which applies where the accused person is alleged to have committed at least three separate unlawful acts.[405] It is not necessary to prove the date on which any of the unlawful sexual acts were committed, nor the exact circumstances in which they were committed.[406]

The language of the offence, as originally drafted, misleadingly suggested that the child and abuser had a relationship, rather than indicating that the child had been subjected to continuing abuse. Although the National Royal Commission recognised this problem, it endorsed the language of 'sexual relationship' because it was used in similar Queensland legislation, which had previously operated successfully.[407]

Some states have since renamed the offence 'persistent sexual abuse'.[408] This occurred in Tasmania in 2020.[409] However, while the name of the offence has changed, the language of 'maintaining a sexual relationship' is still used within the section.[410] We consider that the provision should be redrafted to no longer use this terminology.

This change will not alter how the section operates, but it will have the important effect of acknowledging that sexual interaction between children and adults is inherently abusive and non-consensual and should never be condoned. We note the efforts of the Grace Tame Foundation, through its 'Harmony Campaign', to advocate for removing this language, which the Foundation describes as giving licence 'to characterise abuse as romance'.[411] This forms part of a broader campaign to strengthen and harmonise child sexual abuse offences across states and territories.[412] Victim-survivor Leah Sallese also agreed that the language of a 'relationship' is problematic:

> I think this language needs to change because it suggests that the victim-survivor shoulders the blame. We're already shaming and blaming ourselves, we don't need a description such as this adding to our trauma.[413]

The rewording of the provision to remove reference to 'maintaining a sexual relationship' will not change the substance of the law.

Tasmania Police will generally seek advice from the ODPP before charging an accused person with sexual offences in cases where there may be a question about the appropriateness of the charges or the strength of the evidence.[414] As discussed, this aims to ensure the charges laid are the most appropriate and to avoid charges being dropped or changed. Tasmania Police requires authorisation from the DPP to lay charges for the offence of persistent sexual abuse of a child or young person under section 125A of the Criminal Code Act.

5.1.2 Position of authority offence

As we discuss in Chapter 3, children in schools, out of home care, youth detention and hospitals are at risk of abuse from people who are employed by or otherwise associated with the institution. Staff, volunteers or carers in these organisations are often well placed to groom and abuse young people because of their power and close contact with them, as well as the trust others place in them.

The National Royal Commission recommended that all state and territory governments introduce offences that punish people in a 'position of authority' who sexually abuse children.[415] Most states and territories have introduced offences for misusing authority over children and young people to sexually abuse them.[416]

Child sexual abuse offences generally apply to sexual contact with children who are under the age at which they can consent to sexual contact with an adult. One of the purposes of a position of authority offence is to capture circumstances where the child is above the age of consent (17 in Tasmania) and the alleged offender is in a position of authority over them. Position of authority offences aim to cover a gap in existing laws, criminalising sexual conduct between a child over the age of consent and a person in a position of authority or care.[417]

Since our Inquiry began, Tasmania has enacted legislation prohibiting penetrative sexual abuse of a child or young person by a person in a position of authority over them through the enactment of the Justice Miscellaneous (Royal Commission Amendments) Act on 20 April 2023.[418] However, the offence only covers penetrative sexual acts.[419] It does not capture perpetrators in a position of authority who engage in acts of grooming or sexual touching before a child has turned 18. We heard of cases where the abuser deferred penetration until after the child turned 18. In our view, section 124A also needs to cover non-penetrative sexual acts committed by a person in a position of authority, as is the case in several other states.[420] We have recommended this change below.

An important feature of the offence is that it provides a non-exhaustive list of people in a position of authority. This list includes:

- a teacher if the child is a pupil of the teacher or is a pupil where the teacher works
- a parent (which is defined to include a stepparent or a foster parent)
- a person who provides religious, sporting, musical or other instruction to the child
- a religious or spiritual leader in a religious or spiritual group attended by the child
- a health professional or social worker providing professional services to the child
- a person who has the care of a child with a cognitive impairment
- a person employed or providing services in a prison or a youth detention centre
- a person who provides childcare or a childcare service
- an employer of the child or other person in a position of authority over a child in relation to the child's employment (or voluntary work).[421]

We are pleased that this offence has been introduced and welcome its broad application to a range of institutional settings including schools, out of home care, youth detention centres and hospitals.

One question that can arise in applying the position of authority offence is how it applies to a case where a child interacted with the alleged offender while there was a relationship of authority between them, but the sexual acts did not occur until after that relationship of authority ended. For example, a child could be groomed by a teacher in their high school who does not initiate sexual contact until the child transfers to college in Year 11. In some circumstances, this offence could apply where the position of authority has ceased by the time the sexual act occurs if a connection has been maintained between the child and the person in the position of care, supervision or authority. For example, in *Lydgate (a pseudonym) v The Queen* the Victorian Court of Appeal held that evidence of sexualised conversations and messages between the principal of a school and a student were admissible evidence to prove that the principal

was guilty of the similar Victorian offence, even though the sexual acts did not occur until after the school board had suspended the principal and he had resigned from his position.[422]

While we welcome the offence of penetrative sexual abuse of a child or young person by a person in a position of authority in Tasmania, we recommend broadening the offence to cover all forms of sexual contact (not just sexual penetration), as recommended by the National Royal Commission.[423]

5.1.3 'Failure to protect' offence

The National Royal Commission recommended introducing a new offence of failure to protect a child in a relevant institution from a substantial risk of sexual abuse by an adult associated with the institution.[424] As with failure to report offences, it is designed to protect children from abuse in institutional settings.

The National Royal Commission recommended that the offence apply where:

- an adult knows of a substantial risk that another adult associated with the institution will commit a sexual offence against
    - a child under 16
    - a child aged 16 or 17 years if the person associated with the institution is in a position of authority in relation to that child
- the person has the power or responsibility to reduce or remove the risk
- the person negligently fails to remove or reduce the risk.[425]

The National Royal Commission contemplated that relevant institutions would be defined to include institutions that run facilities for or provide services to children in circumstances where the children are in the care, supervision or control of the institution. Foster care and kinship services would be included, but individual foster carers and kinship carers would not.[426]

The Australian Capital Territory, South Australia and Victoria have enacted a failure to protect offence in broadly similar terms to the offence recommended by the National Royal Commission.[427] Unlike the National Royal Commission recommendation, the South Australian offence also applies to a provider of out of home care who knows of a substantial risk that another person providing out of home care will abuse the child.

In Tasmania, the Justice Miscellaneous (Royal Commission Amendments) Act introduced into the Criminal Code Act the offence of failure by a person in authority to protect a child from a sexual offence.[428] The offence is broadly consistent with the

recommendation of the National Royal Commission set out above. We consider that this offence could have an important symbolic and educative effect, as well as being a powerful tool for prosecutions. We welcome its introduction.

We note that the offence, as currently drafted, could potentially apply to a person who is under the age of 18. In contrast, the National Royal Commission considered that the offence should only be able to be committed by adults in the institution and not by children who are in leadership positions.[429] Like the National Royal Commission, we do not consider the offence of failure to protect should apply to children.

Recommendation 16.9

The Tasmanian Government should introduce legislation to amend the following provisions in the *Criminal Code Act 1924*:

a. section 125A to remove all language referring to 'maintaining a sexual relationship with a young person' and replace it with words referring to the 'persistent sexual abuse of a child or young person'

b. section 124A (the position of authority offence) to cover indecent acts with or directed at a child or young person under the age of 18 by a person in a position of authority in relation to that child or young person. The offence should

   i. not apply where the person accused of the offending is under the age of 18 at the time of the offence

   ii. qualify as an unlawful sexual act for the purposes of the offence of 'persistent sexual abuse of a child or young person' under section 125A of the *Criminal Code Act 1924*

c. section 125E (the offence of failure by a person in authority to protect a child from a sexual offence) to ensure the offence does not apply to a person who was under the age of 18 at the time of the offence.

5.2 Supporting victim-survivors of child sexual abuse to give evidence

In the past, complainants and other witnesses in sexual offence cases, including children, had to give oral evidence in a courtroom in the presence of the accused person and a judge and jury, or before a magistrate.

During hearings and sessions with a Commissioner, some people who had experienced institutional child sexual abuse told us how stressful it was to be required to give evidence describing traumatic details about what had happened to them, and to be cross-examined about the circumstances in which the alleged offence occurred. Fear of having to give evidence and being cross-examined may discourage victim-survivors from reporting offences and inhibit the capacity of the criminal justice system to hold abusers accountable for their actions.

One anonymous submitter described giving evidence when she was a child, as a witness to the sexual abuse of her friend:

> The cross-examination of me as a witness took half a day. The perpetrator's defence lawyer tried to confuse, intimidate, undermine, frustrate, trap, persuade, humiliate and degrade me. For example, he tried to make me make sexual noises in front of a room full of strangers to prove that I knew what sex sounded like.[430]

Ms Munting described her experience of being cross-examined as an adult:

> That was a harrowing and mortifying experience. I felt victim-blamed by the defence lawyer. [The accused] sat metres away from me, making dismissive noises and gestures while I was being questioned by the Crown and the defence.[431]

Judith Cashmore AO, Professor of Socio-Legal Research and Policy, Sydney Law School, University of Sydney, said that even 'gentle' questioning could be unsettling for a witness giving evidence.[432]

Most Australian jurisdictions have introduced laws to prevent harassing and offensive cross-examination. Under Tasmania's Evidence Act, the court must prevent a question being put in cross-examination in certain circumstances, including if the court believes the question is misleading or confusing, unduly annoying, harassing, intimidating, offensive or repetitive.[433]

Research on the effect of such provisions has shown that judges and magistrates take a variety of approaches in deciding whether counsel should be permitted to put a particular question in cross-examination.[434] Professor Cashmore told us:

> In my experience, effective cross-examination designed to discredit the child's evidence is rarely aggressive and may not be seen by those familiar and comfortable with the court process as oppressive.[435]

We are not aware of any research on the practices of Tasmanian judges and magistrates in deciding whether questions should be disallowed.

We make recommendations to assist courts to best exercise their powers in appropriate circumstances in Section 5.5.

Although controls on cross-examination can assist complainants and other witnesses to give evidence in child sexual abuse cases, adult victim-survivors of child sexual abuse spoke of finding court processes very difficult.[436] For children, court processes can be even more confusing, frightening and traumatic than for adults.

In this section, we discuss laws and processes aimed at making it easier for children (and in some cases adults) to give evidence. These include:

- the recent Witness Intermediary Scheme pilot
- special measures intended to make it easier for child witnesses (and, in some circumstances, adult victim-survivors of child sexual abuse) to give evidence
- improving the quality of audiovisual recordings used in trials.

5.2.1 Witness intermediaries

The Tasmanian Government piloted a statewide Witness Intermediary Scheme to help children give their best evidence as witnesses in the criminal justice system.[437] The scheme started on 1 March 2021, with 21 (now 28) witness intermediaries serving all Tasmanian regions.[438]

The scheme was introduced in response to recommendations of the National Royal Commission and the work of the Tasmanian Law Reform Institute in its 2018 report *Facilitating Equal Access to Justice: An Intermediary/Communication Scheme for Tasmania?* [439]

The Witness Intermediary Scheme makes witness intermediaries available to all children who are victims or witnesses in court proceedings relating to sexual offence and homicide matters, and to adults in such proceedings who have extra communication needs.[440] Although this is not covered by the legislation, Tasmania Police may also use witness intermediaries when investigating crimes.[441]

The role of intermediaries in court is to assist the judge and any lawyer to communicate with the witness and 'perform any other function that a judge in a specified proceeding considers is in the interests of justice'.[442]

A judge may order that an intermediary prepares an expert assessment report if a child is a witness or if the judge or a lawyer identifies an adult as having extra communication needs.[443] The assessment report provides recommendations to the judge and the lawyers appearing in court on adjustments that should be made to aid the witness' communication with the court.

If the judge orders that a witness intermediary can be used, a ground rules hearing will be held before the trial. At this hearing, the judge can make directions dealing with matters such as how the witness is to be questioned and for how long, when the questions are to be provided to the witness intermediary, and the use of any models, plans, body maps or other aids to help communicate a question or answer.[444]

In this way, the judiciary and legal profession can be educated and informed about the communication needs of an individual child witness and, as intermediaries come to be used more often, the general needs of child witnesses. Professor Cashmore described witness intermediary schemes as having particular 'educative value for lawyers, judges and others involved in the process'.[445]

We note that the Tasmanian Law Reform Institute's report recommended that the scheme be used for police interviews as well as for the pre-trial and trial stages of the criminal justice process.[446] The Department of Justice funds intermediaries to assist police in communicating with vulnerable witnesses. Ginna Webster, Secretary, Department of Justice, advised us that witness intermediaries may not be available to meet every request for assistance from Tasmania Police and that this will be adjudicated by the Department of Justice Intermediary Liaison Team.[447]

Although the Witness Intermediary Scheme pilot has only been running since 1 March 2021, the evidence we heard and the recent evaluation we refer to below suggest it is operating effectively.[448]

Commissioner Hine told us that, from the examples he has seen, the Witness Intermediary Scheme pilot is working well.[449] He noted that the way witness intermediaries assist in interviewing children provides a good opportunity to get the best evidence from a victim-survivor.[450]

The use of witness intermediaries can also help build the skills and understanding of police in interviewing children and vulnerable witnesses.

According to information provided to us by Secretary Webster as of 12 May 2022 and later updated:

- Twenty-seven (now 28) witness intermediaries had received specialist training and been appointed to the intermediaries panel.[451]
- Intermediaries had assisted 501 vulnerable witnesses by identifying their needs and providing advice on special measures to assist police, lawyers and the courts in Tasmania.[452]
- Police made the largest number of referrals to witness intermediaries (22 adults and 412 children). Of these, 343 referrals related to sexual abuse. A small number of intermediaries were used in family violence cases where the witness had a serious communication need.[453]

- In matters going to court, the Magistrates Court referred two adults and 24 children to intermediaries. The Supreme Court referred 12 adults and 26 children.[454]

Secretary Webster stated that the number of referrals had significantly exceeded the Department of Justice's expectations and that the Department had received 'resoundingly positive feedback' from judicial officers, lawyers and police officers.[455]

We did not hear directly from anyone who had been assisted by an intermediary in Tasmania, either when they were interviewed by police, communicated with a prosecutor or gave evidence at trial. However, we note that our own investigator was greatly assisted by witness intermediaries when interviewing some vulnerable victim-survivors.

On 30 May 2023, the Honourable Elise Archer MP, Attorney-General and Minister for Justice, provided an update in Parliament on the Witness Intermediary Scheme pilot. The Attorney-General said that, since the scheme began on 1 March 2021, witness intermediaries had assisted witnesses on more than 800 occasions by facilitating effective communication between children and vulnerable witnesses, police and the courts.[456]

The Attorney-General indicated that the Department of Justice had commissioned an independent process evaluation to 'analyse the data and conduct anonymous surveys and interviews with stakeholders'.[457] She said feedback from the evaluation had been 'overwhelmingly positive, with almost all stakeholders agreeing that the Witness Intermediary Scheme pilot is an important and necessary program promoting the interests of justice in criminal trials'.[458]

The key findings of the process evaluation were:

- There is a high level of support for the purpose of the [Witness Intermediary Scheme Pilot] among evaluation participants and its potential to contribute positively to criminal justice processes in Tasmania.
- Most [Witness Intermediary Scheme Pilot] activity involved child witnesses, with far fewer cases involving adults with communication needs.
- [Witness intermediaries] are generally considered essential for child witnesses. Stakeholders are divided on the need to involve witness intermediaries when interviewing/questioning teenagers with good communication capabilities, however the best way to determine this eligibility is unclear.
- In practice, the role and functions of [witness intermediaries] in the context of the role of other stakeholders (including police, Witness Assistance Officers, lawyers, prosecutors and judicial officers) requires further clarity and adherence.
- Stakeholders were largely satisfied with referral and matching processes.

- The expertise of [witness intermediaries] is valued, however there are some stakeholders who believe that the justice system already adequately caters to meeting the communication needs of vulnerable witnesses.
- Further stakeholder engagement and marketing of [Witness Intermediary Scheme Pilot] among stakeholders is required to clarify the unique role and functions of witness intermediaries and how all stakeholders can collaborate most effectively around vulnerable witnesses.
- The marrying of health and legal expertise in the criminal justice system has resulted in both positive and challenging experiences for stakeholders and requires further refinement in relation to communication assessments, recommendations, reports and court attendance.
- Training of [witness intermediaries] appears to be effective, however additional confidence building for working in court settings may be useful.
- Witness intermediaries are eager for structured peer support, mentoring and professional supervision.
- There are some concerns related to the administration of the [Witness Intermediary Pilot Scheme] covering areas of remuneration and working conditions, time management, opportunities for [witness intermediaries] and feedback mechanisms.
- There is widespread support for considering the use of witness intermediaries for other vulnerable groups.[459]

The use of witness intermediaries has also been evaluated positively in New South Wales.

The Attorney-General said that the findings and recommendations from the process evaluation are being considered and that the Department of Justice would implement them.[460]

The Justice Miscellaneous (Royal Commission Amendments) Act also made procedural amendments to the Witness Intermediary Scheme.[461]

Using intermediaries in child sexual abuse offence cases in Tasmania is an important measure. Although witness assistance officers can help children and vulnerable adult witnesses to some extent, communication difficulties may not be immediately recognisable or may be regarded as insurmountable barriers to prosecution. Prosecutors may decide not to proceed because a child witness has difficulty communicating what happened to them. The Witness Intermediary Scheme may allow some cases to proceed that previously would not have, as well as increasing the possibility of police and prosecutors getting the best evidence from witnesses with communication difficulties. We also consider that the Witness Intermediary Scheme pilot can help build the skills and understanding of police in interviewing children and vulnerable witnesses.

At present, the Witness Intermediary Scheme does not apply to a defendant in a prosecution for a sexual offence.[462] The Tasmania Law Reform Institute recommended that the scheme apply to all people with extra communication needs who are involved in the criminal justice system, whether as witnesses, victims of crime, suspects or accused persons.[463] Tasmania Legal Aid also supported extending the scheme to accused persons who are children or whose difficulties in communication mean they need help in engaging in proceedings.[464] We agree with that view and recommend accordingly. We believe there would also be advantages to amending the legislation to explicitly provide for use of witness intermediaries by police when interviewing children and young people. We also consider there may be benefits to using the scheme for vulnerable adult witnesses, including adult survivors of child sexual abuse, on a routine basis. This should be considered in the review being conducted by the Department of Justice following the evaluation of the pilot scheme.

Recommendation 16.10

1. The Tasmanian Government should extend the Witness Intermediary Scheme to include children who are under investigation for, or who have been charged with, sexual offences, and fund it to do so.
2. The Tasmanian Government should consider whether legislation should be enacted requiring police to use witness intermediaries in police interviews of children and young people and adults with communication needs (including defendants), relating to sexual offences.

5.2.2 Special measures

Children in child sexual abuse cases are a special category of witness. Most Australian jurisdictions have legislation to reduce the stress on child witnesses in child sexual abuse cases by providing special measures for how they give evidence. Some of these measures also apply to adult complainants in sexual offence cases.[465] These measures aim to minimise the potential for distress and retraumatisation in giving evidence.

In 2019, the Tasmanian Government changed the Evidence (Children and Special Witnesses) Act to provide a range of special measures for child witnesses. These provisions can apply to adult witnesses in the circumstances described below. The Act's special support provisions include:

- Use of special hearings to pre-record evidence. A court can make an order for a special hearing after hearing an application from the prosecution.[466] In a special hearing, the child gives evidence before the jury is empanelled and then does not need to attend the trial.

- Provision for giving of evidence by audiovisual link if facilities are available, unless otherwise ordered.[467] This means the child is not in the courtroom and is not exposed to the accused person.
- A prior statement, such as an audiovisual police interview, may be admitted into evidence, provided the judge makes an order.[468]
- A child is entitled to have a support person near them. The judge must approve the choice of support person.[469]
- A child witness' evidence at trial is automatically recorded. If there is a retrial it can be used again if the judge orders that this occurs.[470]

Under the Evidence (Children and Special Witnesses) Act, adult victim-survivors of child sexual abuse who are subject of a witness intermediary order, because they have been assessed as having a communication need, are also entitled to special support.[471] The same special measures that apply to child witnesses in sexual offence proceedings also apply to these adult witnesses. They can have an approved support person present, and a prior statement, such as an audiovisual interview, may be admitted into evidence. Evidence is given by audiovisual link unless otherwise ordered.[472]

There are also some other special measures for adult victim-survivors of child sexual abuse (an 'affected person') who are not the subject of a witness intermediary order.[473] A judge can make an order for a special hearing to pre-record the evidence if the judge considers this is in the interests of justice and the other party consents.[474] A judge can also make such orders after hearing an application for a special hearing, including orders for a support person and giving evidence by audiovisual link at the special hearing (which means the victim-survivor does not need to be in court).[475] Even if there is no special hearing, the evidence of an adult victim-survivor of child sexual abuse will be automatically audiovisually recorded at trial, and this recording may be used as evidence in a future trial.[476]

If any further orders are required to assist a witness, a judge can make an order declaring that person to be a 'special witness' if satisfied that:

a. by reason of intellectual, mental or physical disability, the person is, or is likely to be, unable to give evidence satisfactorily in the ordinary manner; or

b. by reason of age, cultural background, relationship to any party to the proceeding, the nature of the subject matter of the evidence or any other factor the court considers relevant, the person is likely –

   i. to suffer severe emotional trauma; or

   ii. to be so intimidated or distressed as to be unable to give evidence or to give evidence satisfactorily.[477]

The DPP told us that pre-recording the entire evidence of children and other special witnesses (in a special hearing) has resulted in positive outcomes, such as:

- lessening stress on the witness, in that the witness can come at an appointed time and have their evidence heard
- creating a more streamlined process than a trial and providing the ability to edit the evidence played to the jury. This allows children and special witnesses to be 'eased into' the proceedings in a less formal way and may enable them to take more frequent breaks
- increasing the likelihood that judges will intervene and control questioning.[478]

The DPP stated that these special measures are routinely used in child sexual abuse trials.[479]

The DPP also informed us that, on some occasions, this process has resulted in an earlier plea of guilty because several people have entered pleas shortly after the pre-recording.[480]

Professor Cashmore agrees that measures of this kind ease the prosecution process for children. She said these measures:

> … are valuable measures that ease child witnesses' experience of giving evidence in ways that do not impugn the defendant's right to a fair trial. It is also my observation that these measures, and particularly witness intermediaries, may have some educative value for lawyers, judges and others involved in the process. This understanding promotes and improves the adoption of a child-sensitive approach by all stakeholders in the prosecutorial process.[481]

For a witness under 18 years of age or a victim-survivor of an alleged sexual assault, the DPP Guidelines state that the prosecutor must consider whether the special measures in the Evidence (Children and Special Witnesses) Act apply. [482] If they do, the prosecutor should advise the witness of their options and consider, especially with a child witness, having their evidence pre-recorded.[483]

We heard how daunting the court process can be for adult victim-survivors because it may mean reliving traumatic experiences that occurred when they were children. As Ms Sallese told us:

> The lead-up to the court hearing was quite harrowing for me. I had buried it all for 24 years, and then I was suddenly experiencing all of the things that I should probably have experienced at the time, again in my forties.[484]

Professor Cashmore said there should be an opportunity for adult victim-survivors to have allowances when giving evidence:

> … I think there needs to be the opportunity, a window there for those people to be protected in the same way with special measures so that they can give their evidence in a fair way. If you're under immense stress you don't give your best evidence.[485]

We consider that adult victim-survivors of child sexual abuse should have the same protections that are available to child complainants. Often, adult victim-survivors will have suffered significant trauma over many years. Tiffany Skeggs, a victim-survivor of child sexual abuse, told us that the need to recount events each time she spoke with someone different, including the police and lawyers, was exhausting and traumatic.[486]

Making it easier for adult victim-survivors of child sexual abuse to give evidence by using special measures recognises that trauma. The protections available to child witnesses should automatically apply to all complainants in cases involving child sexual abuse, regardless of their age at the time of giving evidence. The DPP told us he thought it would be beneficial to have a presumption in favour of admitting prior audiovisual statements (from police interviews) and having evidence at a special hearing given by audiovisual link for adult victim-survivors of child sexual abuse (not just for child witnesses).[487]

The DPP considered that introducing a non-exhaustive list of special measures that can be made during a trial, such as the use of a screen between the victim-survivor and the accused person when the victim-survivor gives evidence in court, should be included in the Evidence (Children and Special Witnesses) Act.[488] We agree it would be useful for the court to direct the use of a screen in cases where the witness wants to give evidence in court.

The Justice Miscellaneous (Royal Commission Amendments) Act made changes to the special measures provisions in the Evidence (Children and Special Witnesses) Act by extending:

- the ability to admit audiovisual recordings of police interviews as all, or part of, the evidence-in-chief of adult victims or special witnesses in sexual offence or family violence proceedings[489]
- the use of pre-recording of audiovisual evidence to any other witness where it is in the interests of justice to conduct the pre-recording, and the parties agree.[490]

We support these changes.

Finally, in our view, the special measures in the Evidence (Children and Special Witnesses) Act are unnecessarily complex, poorly drafted and extremely difficult to understand. The DPP shares this view, telling us that the Act is:

> … somewhat clunky and difficult to follow. It is particularly confusing that there are definitions for affected child, affected person, prescribed proceedings, prescribed witnesses, special witnesses, specified offence and specified proceeding.[491]

These provisions should be redrafted so the measures that apply to children, adult victim-survivors of child sexual abuse and people who are using a witness intermediary are much clearer. The special measures provisions could be simplified and rationalised as much as possible at the same time as drafting the amendments we recommend to the special measures.

Recommendation 16.11

1. The Tasmanian Government should introduce legislation to amend the *Evidence (Children and Special Witnesses) Act 2001* to simplify the legislation to clarify when special measures are available to adults who are complainants in trials relating to child sexual abuse and allow them to:
   a. have a support person present when they give evidence in court
   b. give their evidence at a special hearing before the trial unless the judge considers that this would be contrary to the interests of justice, regardless of whether the accused consents
   c. be shielded from the view of the accused person by a screen or partition if they choose to give evidence in court.
2. The Tasmanian Government should ensure courts, public defence counsel (such as Tasmania Legal Aid) and the Office of the Director of Public Prosecutions are appropriately funded to carry out this recommendation.

5.2.3 Quality of audiovisual recordings

We have discussed the need for audiovisual recording facilities in all locations where specialist police take statements from victim-survivors of child sexual abuse. We also heard about the need for modern and consistent statewide audiovisual recording facilities in the Supreme and Magistrates courts.[492] These facilities support police interview recordings being used as victim-survivors, evidence at trial. They also support victim-survivor recordings being used as evidence in a special hearing at which the victim-survivor will be cross-examined. These special hearing recordings are played to the jury in the trial, avoiding the need for the victim-survivor to attend the trial to give evidence in person. If there is a retrial, the same recording can be played to the new jury.

The DPP stated that the audiovisual recording facilities in the Supreme and Magistrates courts are poor, and that the quality of recordings is far from desirable.[493] The DPP further stated that:

> The recordings often do not adequately capture the subtle emotions of a witness. We have instances where the recording has not worked and the witness has

> been required to participate in the pre-recording again. In one other matter a pre-recording included a portion where the witness listened to some telephone intercept material. In court it was evident that the material was highly distressing to the witness; however, on the recording the image of the 'recording playing' [audio only] was the predominant image with the image of the witness being in a small box.[494]

The DPP advised us that it is not uncommon for Supreme Court staff to have limited understanding of how the audiovisual facilities work.[495] He noted that, apart from the standard of the system generally, this can further diminish the presentation of the recordings and the way these recordings are played in court.[496]

In our consultations, the ODPP also cited problems with the court's technology and capability, which can result in complainants having to give evidence again. Image quality can be grainy, and it can be difficult for the jury to assess the witness and their credibility.[497] Defence counsel told us that recordings of police interviews are generally of good quality but described video links into court as 'notoriously bad'.[498]

The DPP suggested that issues with audiovisual recordings in court could be overcome by funding and installing new audiovisual recording facilities and training staff to operate these new facilities.[499] We support that approach.

The Solicitor for the State informed us that the 2020–21 Tasmanian Budget allocated $1.8 million to upgrade audiovisual technologies across Tasmanian courts and the Tasmanian Prison Service, and that the project will be finished by the end of 2023.[500] We welcome that assurance and emphasise the urgency of improving the equipment as soon as possible. We also consider that improving the equipment will be of limited use without the equipment operators receiving proper training.

Recommendation 16.12

The Tasmanian Government should:

a. update the audiovisual equipment available to the Supreme and Magistrates Courts

b. discuss with the Supreme and Magistrates Courts ongoing training for relevant staff on using audiovisual equipment.

5.3 Ensuring relevant evidence is admissible

5.3.1 Broadening the test for tendency and coincidence evidence

The unfortunate reality in our criminal justice system is that, in cases of child sexual abuse where the only evidence of the abuse is the victim-survivor's evidence, it can be difficult for the prosecution to prove beyond reasonable doubt that the alleged offence occurred. Tendency and coincidence evidence (in the past often referred to as propensity or similar fact evidence) is evidence that attempts to show that:

- an accused person has a tendency to commit certain acts based on them having done it before, or
- it is likely that an accused person committed multiple offences based on the similarity of multiple allegations against them.

In the context of institutional child sexual abuse, an abuser may have committed offences against more than one child. In such cases, the laws of tendency and coincidence evidence apply to determine whether:

- evidence from other victim-survivors should be admitted in the trial, or
- whether a joint trial could be held to determine charges against an accused person made by multiple complainants.

In the past, the law was restrictive in its approach to allowing tendency or coincidence evidence. This has been distressing for victim-survivors who have felt that a jury was not getting the full picture of an accused person and the potential nature and breadth of their offending.

Professor Cashmore described the way such evidentiary rules can make it difficult for victim-survivors giving evidence:

> But then we have a legal system that tends to split and dice those stories so you don't get a whole narrative, a coherent narrative, about what happens; where you have separated trials and there are issues around tendency and coincidence evidence. All of it makes it very much harder for a complainant to tell a story in terms that is really the whole of the story. You're asked to tell the truth, the whole truth and nothing but the truth, but telling the whole story can be really difficult, particularly if you're not being questioned in a way that actually allows that whole story to emerge.[501]

Restrictions on tendency and coincidence evidence reflected a concern that a jury would give too much weight to the evidence, which may be unfairly prejudicial to the accused person.[502] However, Jury Reasoning Research conducted for the National Royal Commission found no evidence of unfair prejudice to the accused person.[503] The National Royal Commission recommended that the laws for tendency and

coincidence evidence in prosecutions for child sexual abuse offences be reformed to allow for greater admissibility and cross-admissibility of tendency and coincidence evidence and to make it easier to try charges involving multiple complainants in a single trial.[504]

Legislative changes in recent years have broadened the admission of tendency and coincidence evidence.[505] In 2017, Tasmania introduced a presumption for joint trials to take place where there are two or more charges for sexual offences joined in the same indictment.[506]

These legislative changes, together with recent decisions of the High Court of Australia, have considerably relaxed the earlier principles that restricted the admission of such evidence.[507]

The Justice Miscellaneous (Royal Commission Amendments) Act introduced further amendments to the Evidence Act, to broaden the test for the admission of tendency and coincidence evidence in criminal prosecutions involving child sexual offences.[508] The Act introduced the model provisions developed by the Uniform Evidence Law jurisdictions, which have already been introduced in New South Wales.[509] The provisions aim to address barriers to the admissibility of relevant evidence of an accused person's tendency to perpetrate sexual violence against children.[510]

The test for the admission of tendency and coincidence evidence is whether the court thinks it has 'significant probative value'.[511] If the prosecutor seeks the admission of the evidence, its probative value must outweigh 'the danger of unfair prejudice' to the accused person.[512] Section 97A(2) of the Evidence Act now provides that, where the accused is charged with a child sexual offence, it is presumed that certain categories of tendency evidence have a significant probative value. These include:

a. tendency evidence about the sexual interest that the defendant has or had in children (even if the defendant has not acted on the interest)

b. tendency evidence about the defendant acting on a sexual interest that the defendant has or had in children.

This applies whether the sexual interest or act relied upon relates to the complainant in the proceeding, or any other child or children generally.[513]

Under section 97A(4), the court has a discretion to decide that evidence falling within the provisions described above does not have significant probative value if it is satisfied that there are sufficient grounds to do so.

Section 97A(5) allows courts to consider certain matters, that they could not previously take into account, when deciding whether evidence can be admitted to show that the defendant had a tendency to offend sexually against children. For example, the court can now consider that evidence of the defendant having a sexual interest in children

is 'of significant probative value' even if the child to whom the evidence relates is of a different age, gender or sex than the victim.[514] The recent legislative changes have made it easier for the court to allow the jury to hear tendency and coincidence evidence.[515]

We are mindful that the changes made to the tendency and coincidence evidence provisions in the Evidence Act because of enacting the Justice Miscellaneous (Royal Commission Amendment) Act reflect an agreement between the Council of Attorneys-General (now the Standing Council of Attorneys-General).[516] We consider there are advantages in clearly setting out this complex area of law in legislation and do not propose any changes to these provisions.

5.3.2 Admitting evidence from the Magistrates Court

During our Commission of Inquiry, we heard about restrictions in the way evidence from a case in the Magistrates Court can be used in any later case involving the same victim-survivor.

Ms Collins told us about her experience with the criminal justice system.[517] The trial in her case did not proceed, and it appears that the charges were dismissed in the Magistrates Court in 2004, even though no evidence was presented to the Court and the Court did not decide whether sexual abuse had occurred.[518]

The DPP told us that it was not possible to reopen the case, even though there had been changes to the law since 2004 that would make it easier to prosecute the accused person today.[519]

There is no power for a matter to be reopened after charges have been dismissed in the Magistrates Court. The DPP informed us that a similar restriction applies in family violence offences but that this has been overcome by amending the *Family Violence Act 2004* ('Family Violence Act').[520]

The DPP recommends inserting a new provision into the Criminal Code Act like the approach taken in family violence cases.[521] Section 13B of the Family Violence Act provides that if:

> a. a person is charged with a family violence offence (the first charge) in [the Magistrates Court] but is acquitted because the prosecution has informed the court that it will not be offering any evidence in support of the charge; and
>
> b. the person is charged with another family violence offence (the second charge) [in any court]
>
> [the earlier acquittal in the Magistrates Court does not prevent the court from hearing evidence of the first charge as evidence that the accused person had a tendency to commit certain acts based on the assertion that they have done it before].

We consider this a sensible approach that should be adopted for all sexual assault matters, including child sexual abuse matters.

Recommendation 16.13

The Tasmanian Government should introduce legislation to extend the principles of section 13B of the *Family Violence Act 2004* to sexual assault matters, including child sexual abuse. This will ensure that where a person is acquitted in the Magistrates Court because the prosecution has informed the Court it will not be offering any evidence in support of the charge, the acquittal does not prevent admitting evidence of relationship, tendency or coincidence evidence in a later related matter.

5.4 Improving case management

In this section, we recommend a change to a procedure that would allow judges to make rulings on the admissibility of evidence before a jury is sworn in. This will reduce delays and improve case management.

5.4.1 Pre-trial rulings

Before a criminal trial occurs, a judge may make rulings ('pre-trial rulings') on procedural questions and legal arguments put by the prosecution or defence counsel, including arguments about the admissibility of certain evidence. This makes the trial process more efficient by sometimes making it unnecessary to suspend witness testimony during the trial while these legal arguments are considered.

Section 361A(1) of the Criminal Code Act provides that after a person has entered their plea, but before a jury is sworn in, among other things, the court may:

- determine any question of law or procedure that has arisen or is expected to arise in the trial3
- determine any question of fact that may lawfully be determined by a judge alone without a jury
- determine any other question that it considers necessary or convenient to determine to ensure the trial will be conducted fairly and expeditiously
- give such directions as it sees fit to resolve any issue or matter that it considers necessary or convenient to resolve before a jury is sworn.

Any admission, determination or direction made or given under section 361A(1) of the Criminal Code Act has the same status for the purposes of a new trial as if it had been made or given during the new trial.[522]

The DPP told us of limits in how this provision works in practice. Under the provision a judge can only make a ruling if the accused person has entered a plea. When an accused person enters a plea, the trial starts. The DPP stated that sometimes judges refuse to make rulings under the provision if they may not be the ultimate trial judge and that this can cause scheduling difficulties and delays.[523] He pointed out that all judges sit in Hobart, Burnie and, on occasion, Launceston, noting:

> If a pre-trial ruling is required for a matter listed in Burnie, and there is insufficient time for the trial proper to immediately follow the ruling, it may be a matter of months (perhaps over a year) before the judge who made the ruling is sitting in Burnie again. It would be beneficial to amend section 361A to avoid this situation.[524]

We understand there are now two Supreme Court judges who permanently sit in Launceston and Burnie (respectively), and that other judges travel on circuit to these courts. We also note it is up to the DPP to list trials in the Supreme Court. The DPP's concern about section 361A(1) may now be less acute.

However, we consider it would be beneficial to expand the circumstances in which such rulings can be made. In Victoria, section 199 of the *Criminal Procedure Act 2009* (Vic) allows pre-trial rulings to be made before an accused person has entered a plea.

Under section 204 of that Act:

> An order or other decision made at a directions hearing or other pre-trial hearing by a judge who is not the trial judge is binding on the trial judge unless the trial judge considers that it would not be in the interests of justice for the order or other decision to be binding.

Under section 205(1) of the Act:

> If a new trial is held, the court may treat any order or other decision made at a directions hearing or other pre-trial hearing held in connection with the earlier trial as if it had been made at a directions hearing or other pre-trial hearing held in connection with the new trial.[525]

We recommend that Tasmania's Criminal Code Act be amended to provide that a judge can make a ruling before the accused person has entered a plea.

Recommendation 16.14

The Tasmanian Government should, in similar terms to sections 199, 204 and 205 of the *Criminal Procedure Act 2009* (Vic), amend the *Criminal Code Act 1924* (including section 361A) to:

a. allow pre-trial rulings or orders to be made before the accused person has entered a plea

b. provide that such pre-trial rulings or orders are binding on a trial judge, even where a different judge made the order, unless the trial judge considers that would not be in the interests of justice

c. provide that such pre-trial rulings or orders apply at a new trial unless this would be inconsistent with any order or decision made on an appeal or would not be in the interests of justice.

5.5 Assisting juries to assess the evidence of children

In a criminal trial, the jury must listen to all the evidence and decide which parts of the evidence should be accepted. The judge is responsible for directing the jury about the law and for ensuring the proceedings are conducted according to the law.

After witnesses have given their evidence and prosecution and defence counsel have made their closing submissions, the judge directs the jury about the elements of the offence and summarises the evidence. The judge also directs or warns the jury about how to consider certain matters. Various legal principles govern the jury directions that a judge must give.

The National Royal Commission recommended that each state and territory develops jury directions about children and the impact of child sexual abuse.[526] Victoria has introduced legislation about jury directions that is designed to assist juries to assess a child's evidence and to consider other questions relevant to the trial.[527] We discuss the Victorian provisions in more detail below.

In this section, we discuss jury directions in the context of child sexual abuse offence cases and make recommendations for helping juries to assess the evidence of children.

5.5.1 Reliability of children's evidence

Both the prosecution and defence can ask a judge to warn the jury that a witness' evidence may be unreliable. Unless the judge considers there are good reasons for not doing so, the judge must:

- warn the jury that the evidence may be unreliable
- inform the jury of matters that may cause it to be unreliable
- warn the jury of the need for caution in determining whether or not to accept the evidence and the weight to be given to it.[528]

Evidence that could be considered unreliable includes that which may be affected by 'age, ill health, whether physical or mental, injury or the like'.[529]

A warning cannot be based on the child's age alone.[530] But there may be aspects of the evidence of a child that could be thought to cast doubt on what they have said. In these circumstances the judge can, on their own initiative or on an application of the prosecution or defence, give a warning in the terms listed above.[531]

Failure to give such a warning may be a basis for an appeal against conviction. For that reason, judges may warn about the reliability of a child's evidence out of an abundance of caution. Excessive use of warnings, combined with a commonly held (and incorrect) belief that children often lie about sexual matters, could influence some juries to disbelieve a child because of the way they have given their evidence. Adjunct Associate Professor Terese Henning told us:

> Prosecution counsel and complainants are faced with generations of deeply embedded and persistent perceptions about sexual offences and prejudices around children's credibility … so those complainants start off at a considerable disadvantage in addition to the difficulties of withstanding the rigours of the trial process itself.[532]

In Victoria, the *Jury Directions Act 2015* (Vic) ('Jury Directions Act (Vic)') codifies the directions that judges must give in criminal trials. Like Tasmanian legislation, it provides for judicial warnings about matters that may affect the reliability of a child's or other person's evidence and specifies the way in which juries should be warned about factors affecting reliability. Unlike in Tasmania, Victoria also provides for juries to be given directions about the difficulties child witnesses often face in giving evidence in the same way that adults can, which may affect the way juries assess the reliability of a child's evidence. Professor Cashmore described these difficulties in the following way:

> A large body of evidence has established that children's memory is reliable. Often, however, those questioning children do not ask questions in ways that optimise the reliability or accuracy of the child's answer. Further, once a matter is in court, the child witness is potentially exposed to a range of stressors that make it more difficult to process information, answer questions and provide reliable evidence. These include the formality of the court, potentially facing the alleged abuser and cross-examination that is often confusing and developmentally inappropriate, designed to discredit the evidence of the witness.[533]

In Victoria, if a trial judge considers, before any evidence is given and after hearing submissions from the prosecution and defence, that the reliability or credibility of a child witness is likely to be an issue, section 44N of the Jury Directions Act (Vic) requires the judge to tell the jury that:

a. children can accurately remember and report past events; and

b. children are developing language and cognitive skills, and this may affect—

    i. whether children give a detailed, chronological or complete account; and

    ii. how children understand and respond to the questions they are asked; and

c. experience shows that, depending on a child's level of development, they—

i. may have difficulty understanding certain language, whether because that language is complicated for children or complicated generally; and…

ii. may have difficulty understanding certain concepts, whether because those concepts are complicated for children or complicated generally; and…

iii. may not request the clarification of a question they do not understand; and

iv. may not clarify an answer they have given that has been misunderstood.[534]

Judges must give this direction to juries before any evidence is given and after hearing submissions from the prosecution and defence.

The Jury Directions Act (Vic) provides some examples of situations in which children may have problems in answering questions, including the use of 'hypothetical, ambiguous, repetitive, multi-part or yes/no questions', or questions involving the use of 'passive voice, negatives and double negatives'.[535]

While we consider witness intermediaries are likely to play an important role in supporting child witnesses to give their best evidence, a provision like section 44N of the Jury Directions Act (Vic) could help juries to understand the difficulties that children face in giving evidence and the distinctive ways in which they may do so.

5.5.2 Children's reactions to sexual abuse

Research into the reactions of children who have been sexually abused shows that victim-survivors respond in a variety of ways. Not all children who have been abused avoid the perpetrator; indeed, many of the witnesses we heard from continued to have some contact with their abuser after the abuse had stopped.

In our hearings, some victim-survivors told us that they continued to see the person who abused them for a long time after they were first abused because they did not understand they had been abused or had been groomed to believe that the abuser loved them or that they were in a 'relationship'.[536] Some victim-survivors had no choice but to continue seeing the abuser because of a family relationship or because the abuser held a role that they could not avoid (for example, as their teacher).[537]

Research also shows that sexual abuse disclosure typically occurs in stages.[538] If the child's first attempt to tell someone about their experience is not understood or acknowledged they may never go on to describe the extent of the abuse or they may do so many years later, often into adulthood. Michael Salter, Scientia Associate Professor of Criminology, School of Social Sciences, University of New South Wales, told us:

> Disclosure of child sexual abuse should be understood as an ongoing process rather than a discrete event, characterised by diverse behavioural and psychological indicators of trauma, as well as delayed, conflicted and even unconvincing disclosures followed by retraction or recantation. During this process, children are hyper-sensitive to displays of scepticism or disbelief in the conduct and tone of the adults they are trying to connect with. They anticipate not being believed or being blamed for their abuse and are likely to withhold further information or recant their disclosure entirely if they detect blame or scepticism.[539]

The DPP told us he supports jury directions to the effect that it is not uncommon for a complainant to maintain ties with the accused person many years after the sexual abuse occurred.[540]

Because juries may not understand these features of institutional child sexual abuse, we consider it would be useful for them to receive a direction from the judge informing them of these matters.

5.5.3 Corroboration warnings

Previous inquiries have discussed the history of warnings issued by judges in relation to child witnesses and sexual abuse.[541] In summary, historically, children who alleged they had been sexually abused were regarded as suspect witnesses, so the law required that their evidence be corroborated. Similar suspicions applied to adult victim-survivors of child sexual abuse. However, we know that abusers generally conceal their offending and that prosecutions for child sexual abuse offences often rest on word-against-word evidence.

Even after legislation abolished this formal corroboration requirement, judges presiding over sexual offence trials used to be required to warn juries that it could be 'dangerous to convict' based on the complainant's evidence alone and/or that the evidence of complainants in sexual offence cases should be scrutinised with great care. The use of the words 'dangerous to convict' may well have been interpreted by some juries as a direction to find the accused person not guilty.

Judges also had to give jury directions based on myths and assumptions about the typical behaviour of people alleging they had been raped or sexually abused—for example, the false belief that sexual offence victim-survivors usually tell someone about the offence soon after it occurs, although research shows that this is rarely the case. The National Royal Commission recommended changes to jury directions or warnings.[542] These changes were intended to encourage reporting of offences against children and address incorrect assumptions that members of the community (including the judiciary and legal profession) may hold about the behaviour of child victims of sexual abuse.[543]

In 2010, Tasmania enacted provisions that prohibited a trial judge from warning the jury:

- that children are unreliable witnesses
- that the evidence of children is inherently less credible or reliable, or requires more careful scrutiny, than the evidence of adults
- about the unreliability of a particular child's evidence solely because of their age
- in a criminal proceeding, of the danger of convicting on the uncorroborated evidence of a witness who is a child.[544]

The requirement that the evidence of all complainants in sexual offence trials be corroborated has also been removed. Adjunct Associate Professor Henning described these as 'the most significant reforms' in relation to children and sexual offences.[545]

Section 136 of the Criminal Code Act provides that:

- At the trial of a person accused of certain sexual offences, no rule of law or practice requires a judge to give a warning to the jury to the effect that it is unsafe to convict the person on the uncorroborated evidence of a person against whom the crime is alleged to have been committed.
- A judge shall not give a warning of this kind unless satisfied that the warning is justified in the circumstances.[546]

This provision means that the judge is not required to give such a warning, but it does not prohibit such a direction being given.

The DPP told us that some Tasmanian judges in sexual offence trials will give what is often referred to as a 'Murray direction' (derived from the case of *R v Murray*), which directs the jury that where there is only one witness asserting that a crime has been committed, the evidence of the complainant should be scrutinised with great care before a verdict of guilty is delivered.[547] The DPP said that, on occasion, that direction is given even when there are other witnesses who give supporting evidence.[548] He told us that this is done on the basis that if the jury rejected the evidence of other witnesses, the complainant's evidence should be treated as if it were the evidence of only one witness.[549]

The DPP said that giving the Murray direction in these circumstances undermines the effect of section 136 of the Criminal Code Act, which, as explained above, removes the requirement to warn the jury about the dangers of conviction on the uncorroborated evidence of the complainant in sexual offence cases. This practice may make juries reluctant to convict in cases where the prosecution case depends solely on the complainant's evidence.

The practice of issuing a Murray direction may undermine uncorroborated evidence from a victim-survivor. Robert Boost, a victim-survivor, described his experience reporting to Tasmania Police in 2020 as 'fantastic' until the DPP decided not to proceed based on the absence of corroborating evidence:

> My bad experience with the criminal justice system really occurred when Tasmania Police approached the DPP to discuss laying charges on the perpetrator. Unfortunately, I heard from Tasmania Police that the DPP had formed the view that, while I was likely to be a reliable witness, there was insufficient corroborating evidence from other witnesses, and the matter did not meet the DPP's threshold for proceeding to trial.[550]

In *Ewen v R,* the New South Wales Court of Appeal was critical of the practice of giving a Murray direction solely because the evidence of the complainant was uncorroborated. Justice Simpson commented that:

> A 'Murray direction', based only on the absence of corroboration, is, in my opinion, tantamount to a direction that it would be dangerous to convict on the uncorroborated evidence of the complainant.[551]

The DPP supports adopting a provision along the lines of section 294AA of the *Criminal Procedure Act 1986* (NSW), which limits the warnings that can be given in word-against-word cases to a further extent than the Tasmanian provisions.[552] This provision prohibits the Murray direction from being given solely because the complainant's evidence is uncorroborated.[553] Instead, the DPP proposes that, when a Murray direction is given, the judge should have to warn the jury that it is the circumstances of the case generally, and not the complainant, that require the direction; and that it is not unusual in cases of sexual assault that the conduct is not witnessed.[554]

We agree that it is appropriate to limit the use of Murray directions where the complainant is still a child or is an adult who is giving evidence about childhood abuse. Legislation that does so should not prevent counsel from requesting that the judge draws the jury's attention to features of the complainant's evidence, other than the lack of corroboration, that may be relevant in determining whether the accused person can be found guilty beyond reasonable doubt.

5.5.4 The effect of delay

In the past, judges were also required to warn juries about the danger of convicting a person accused of a sexual offence when there was a delay in reporting the offence. We heard from victim-survivors of child sexual abuse who had not told anyone about the offending for many years after it had ceased. Their reasons for not doing so included:

- not recognising the experience(s) as abuse
- shame and embarrassment about having been abused

- not wanting their families to know they had been abused
- fear about what the abuser would do if they reported.

Mr Boost told us how he grappled with shame for many years after he was abused in the early 1990s:

> I kept the perpetrator's abuse to myself until 2014. I felt ashamed of what had happened. I blamed myself for what I saw at the time as a relationship with the perpetrator, not grooming or abuse.[555]

Victim-survivor Rachel (a pseudonym) also told us:

> After bottling the child sexual abuse for almost two years, I broke down and finally came out with details about the sexual abuse I had suffered … It was really difficult for me to talk about what I had been holding back for years.[556]

Victim-survivor Azra Beach, who told us she was abused while in the out of home care system, explained that she had no understanding that what was happening was abuse:

> [A fellow victim-survivor] and I didn't tell anyone about what was going on. We had no-one to tell. For me, I also didn't realise anything abnormal was happening. It was just the way that it was. This is what people do.[557]

Some victim-survivors were also afraid they would not be believed. Ms Skeggs told us: 'When I made my report I was terrified of not being believed by the authorities. [James] Griffin was a well-respected and seemingly powerful member of the community'.[558]

In years gone by, warnings about delay may have made juries reluctant to convict people for offences that occurred many years previously.

The National Royal Commission recommended states and territories legislate that jury directions about delay and credibility were not required. It recommended such legislation provide that no direction or warning that delay affects the complainant's credibility should be given, unless it was requested by the accused person and is warranted on the evidence; and that if a direction or warning is given, the judge should not use expressions such as 'dangerous or unsafe to convict' or 'scrutinise with great care'.[559]

In her witness statement, Professor Cashmore referred to a research report that she and co-authors had prepared for the National Royal Commission titled *The Impact of Delayed Reporting on the Prosecution and Outcomes of Child Sexual Abuse Cases*.[560] She summarised data on delayed reporting in New South Wales and South Australia. In these states, most reports were made within three months of the incident, but nearly one in four sexual assaults were reported more than five years after the offence, with some reports being made after 20 years.[561] Men were more likely to delay their reporting, and they delayed reporting for longer than women. The longest delays occurred when the accused perpetrator was a person in a position of authority. In these cases, most reports were made at least 10 years after the incident.[562]

Professor Cashmore commented that this data showed that:

> … there are relatively high instances of delayed reporting of child sexual abuse where that abuse occurs in institutional settings. These reports relate to historical child sexual abuse in some older-style residential institutions, as well as some more recent church-based and sporting organisations. Whether the very delayed reporting evident in these earlier cases will continue for more recent and current sexual abuse is uncertain, given the increased awareness and exposure of both sexual abuse and the associated cover-up to protect the institutions.[563]

Adjunct Associate Professor Henning described the way many of these repealed laws or practices, including warnings about delays, 'played to stereotypes that juries have in relation to who is a "genuine victim"'.[564] However, she noted that reform can only go some way to ameliorate this, with an example:

> … in cases of historical sexual assault, there is obviously an absence of recent complaint. Defence counsel play on that and it doesn't matter that the judge is mandated to instruct the jury that absence of recent complaint does not necessarily indicate the mendacity of the complainant, or fabrication of the offences. It's just one of those misconceptions that are difficult to dislodge.[565]

The Criminal Code Act reflects the National Royal Commission's recommendation to some extent. It provides that where the alleged victim does not make a complaint, or where the complaint comes a long time after the alleged offence, the judge shall:

- warn the jury that absence of complaint or delay in complaining does not necessarily indicate that the allegation that the crime was committed is false
- inform the jury that there may be good reasons why such a person may hesitate in making, or may refrain from making, a complaint.[566]

Victoria's Jury Directions Act goes further than the Tasmanian provision. It provides that if, after hearing the submissions from the prosecution and defence, the trial judge considers that there is likely to be evidence of a delayed complaint, the judge must give the jury certain information before evidence of delay can be given. In these circumstances, the trial judge must inform the jury that:

- people may react differently to sexual offences and there is no typical, proper or normal response to a sexual offence
- some people may complain immediately to the first person they see, while others may not complain for some time, and others may never make a complaint
- delay in making a complaint about a sexual offence is common
- there may be good reasons why a person may not complain, or may delay complaining, about a sexual offence.[567]

The provision applies to trials regardless of whether the victim-survivor is an adult or a child.

We prefer the positive framing of this direction, which focuses on common practices, compared with the Tasmanian direction, which is framed in the negative. The DPP supports introducing a direction about the effects of sexual abuse on a child, including that it is known that children often do not complain for many years.[568] We recommend that a provision similar to that in Victoria be adopted in Tasmania.

5.5.5 Timing of jury directions

Jury directions are usually given near the end of a trial as part of what is known as the judge's charge to the jury.

The National Royal Commission noted considerable merit in allowing the trial judge to give a direction at any time before the close of evidence at the discretion of the judge and requiring some directions to be given at particular times in the trial, generally earlier than might otherwise occur.[569]

In its report *Improving the Justice System Response to Sexual Offences*, the Victorian Law Reform Commission noted that research suggests if jurors hear a jury direction early in the trial, they will have an informed position in their minds before they hear the complainant's evidence and before they form any opinions based on misconceptions.[570]

The Victorian Law Reform Commission recommended jury directions be given before or during the evidence and that judges repeat them at any time in the trial, if either party requests, or if the judge considers there is evidence in the trial that requires the direction to be given.[571] We consider this is sensible and recommend a similar approach be taken in Tasmania.

5.5.6 Non–case specific jury education

Myths and misconceptions about sexual offences, including child sexual abuse, have long affected the criminal justice system's responses to child sexual abuse.[572] As the National Royal Commission noted, these myths and misconceptions have influenced the law and the attitudes that jurors bring to their decision making.[573]

The National Royal Commission identified the following myths and misconceptions as being particularly prominent in child sexual abuse cases:

- women and children make up stories of sexual abuse
- a victim of sexual abuse will cry for help and attempt to escape the abuser
- a victim of sexual abuse will avoid the abuser
- sexual assault, including child sexual abuse, can be detected by a medical examination.[574]

Adjunct Associate Professor Henning told us that prosecutions of sexual offences are uniquely difficult. She indicated this is largely because of deeply held and persistent societal views about 'genuine victims', who they are and their behaviour, and the nature of consent.[575]

We heard evidence from Dr Tidmarsh from Whole Story Consulting that non-specific training for jurors, conducted before a trial starts, could minimise the impact of myths and misconceptions that defence counsel may want to use during trial.[576]

Dr Tidmarsh stated that:

> … given what we know about how strongly juries struggle to move beyond their own psychological schema, their own understanding of sexual relationships, of sexual offending relationships, their own judgment, to leave jury members unprepared to meet the complexity and the nuance of these kinds of stories, I think it does them and the justice system a significant disservice, and that anything we can do, without prejudicing the fairness, the rights of the accused, to inform them of the background of these stories; what grooming is, for example, would be very beneficial and would certainly level the playing field.[577]

Dr Tidmarsh informed us that some models have used non-case specific educational sessions for jurors and potential jurors before trial. These sessions encourage defence counsel to use fewer myths and misconceptions than they otherwise would have.[578]

When we put this idea to Professor Cashmore at hearings, she agreed we should not assume jurors understand the dynamics of child sexual abuse. She added:

> But for jurors coming in, it is a strange environment and these are difficult cases to determine, and the evidence … it's not an equal playing field … So, I think having jurors who have a better understanding of what the dynamics and the context and the consequences, you know, why children behave in certain ways: they may never have had any experience, and hopefully they haven't had any experience, of knowing a child who's been sexually abused and understanding that. So, it makes sense to me to even the playing field a little.[579]

One witness in a child sexual abuse matter (who was herself a child at the time of trial) described her frustration at the fact that most female jurors were excluded through defence challenges, leaving mainly men around the same age or older than the abuser.[580] She added:

> The entire defence hinged on the prevailing attitude of 'children lie about sexual abuse'. But how true is this underlying assumption? The literature shows that children rarely lie about child sexual abuse.
>
> I wonder what these kinds of trials would look like if the jury (and the public) were made aware of this fact. What if decision-making in the justice system was informed by facts and statistics, just like medicine and science are, rather than being informed only by the attitudes of the average juror? Sounds radical, but it shouldn't be.[581]

In New Zealand, the *Sexual Violence Legislation Act 2021* (NZ) introduced a requirement for judges to direct juries as 'necessary or desirable to address any relevant misconception relating to sexual cases' with a non-exhaustive list of possible misconceptions relating to false allegations, victim blaming and rape myths.[582] A New Zealand study on juror use of cultural misconceptions in sexual violence trials noted that such directions rely on sound judicial education and implementation by individual judges.[583] The study noted that, if done poorly, directions may focus jurors on the misconceptions they set out to rectify and could make the situation worse.[584]

The New Zealand study also observed a growing interest in other forms of jury education; for example, information about cultural misconceptions could be sent out with jury summons, provided in writing or by video at the time of jury selection, or left in the jury room.[585] However, as with other forms of juror education about misconceptions, the New Zealand study indicates there is relatively little knowledge about what works and to what extent awareness raising affects reasoning in real cases.[586] We consider that any information given to jurors should be factual and focus on common practices in relation to child sexual abuse, rather than being negatively framed to overcome common myths.

The National Royal Commission reported mixed views about the benefits or otherwise of providing video or other material to juries, particularly about child sexual abuse. It considered that authorising trial judges to give directions about child witnesses and child sexual abuse is better than developing extra educational material to assist juries.[587]

Section 108C of the Tasmanian Evidence Act provides for juries to be educated about child development and child behaviour—for example, why their failure to complain or their failure to respond to sexual abuse in a particular way is normal. The ODPP told us that this provision is not often used but that it is a valuable provision.[588] In our view, the ODPP should consider whether to use this section in child sexual abuse cases. We are aware that section 108C of the *Evidence Act 1995* (NSW) has been used in New South Wales to admit opinion evidence to help understand the behaviours of child sexual abuse victim-survivors and common misconceptions about their behaviours and responses.[589]

Although we consider that providing non-case specific information to juries about common practices relating to child sexual abuse is not enough in itself to dispel myths and change attitudes, we consider such information could play an important role.

Recommendation 16.15

The Tasmanian Government should introduce legislation to:

a. require trial judges to explain to juries the difficulties child witnesses often face in giving evidence in court, and the distinctive ways in which they give evidence, in cases where the reliability or credibility of a child witness is likely to be in issue, in similar terms to section 44N of the *Jury Directions Act 2015* (Vic)

b. provide that in jury trials of a person accused of a child sexual abuse offence, if a party so requests, the judge must, unless the judge considers there are good reasons for not doing so, direct the jury that

    i. children who have been subjected to child sexual abuse respond in a variety of ways and some children who have been abused do not avoid the alleged perpetrator

    ii. disclosure of abuse may occur over time and not all on one occasion

c. prohibit, in similar terms to section 294AA of the *Criminal Procedure Act 1986* (NSW), a judge in a trial of a person indicted for sexual offences against a child from

    i. warning a jury against convicting the accused person solely because the only evidence is the evidence of the complainant

    ii. directing the jury about the danger of conviction in the absence of corroboration

d. amend the *Evidence Act 2001*, in similar terms to section 52 of the *Jury Directions Act 2015* (Vic), to require a trial judge who considers that delay in complaining is likely to be raised in a trial for a child sexual abuse offence to inform the jury that

    i. people react differently to sexual abuse and there is no typical, proper or normal response to a sexual offence

    ii. some people may complain immediately to the first person they see, while others may not complain for some time, and others may never make a complaint

    iii. it is common for a person to delay making a complaint of sexual abuse, particularly if it occurred when they were a child

    iv. there may be good reasons why a person may not complain, or may delay complaining about sexual abuse

e. amend the *Evidence Act 2001* to provide that the warnings and directions can be

   i. given by a judge to the jury at the earliest opportunity, such as before the evidence is called or as soon as practicable after it is presented in the trial

   ii. repeated by the judge at any time during the trial

   iii. given by the judge's own motion, or if requested by either party before the trial or at any time during the trial.

5.6 Improving professional education for judicial officers

As the Victorian Law Reform Commission acknowledged in its work on sexual offences reform in 2003, discussion and education that foster cultural change in the criminal justice system are essential elements for change.[590]

The Victorian Law Reform Commission stated that those who work in the system, including police, lawyers, magistrates and judges, are likely to be more responsive to the needs of victim-survivors, and to perform their role more effectively, if they understand the context in which sexual offences commonly occur and the social and psychological aspects of sexual offences that affect complainants.[591] These reflections on the importance of education remain just as relevant today.

In most states, it has become increasingly common for judicial officers to attend education programs. The Judicial College of Victoria has been offering such programs, including programs on sexual assault, for many years. We consider such programs should be offered in Tasmania and/or that Tasmanian judicial officers could be encouraged to attend interstate programs.

Changes in relation to understanding the myths and misconceptions about child sexual abuse over the past few years, together with legislative changes, make it important for the courts to be supported with information and training.

Adjunct Associate Professor Henning said that in her experience:

> ... there's not a resistance on the part of the [Tasmanian] judiciary to obtaining information to inform themselves in areas of expertise and specialisation where they feel they need to have a great deal more information.[592]

Professional development of judicial officers can be achieved in various ways. Professor Cashmore spoke to us about educating judges, lawyers and jurors via witness intermediaries, which we discuss in Section 5.2.1.[593] She observed that, in New South Wales, the need for witness intermediaries to intervene has diminished as judges have become more alert to the needs of child witnesses.[594]

Tasmania could draw on training and materials developed in other Australian jurisdictions. For example, the Judicial Commission of New South Wales has recently published a new chapter in the *Equality Before the Law Bench Book* to raise judicial awareness about the nature and impact of trauma and its prevalence, and how to apply trauma-informed principles to the task of judicial decision making. The chapter also covers trauma and its impact on victim-survivors of child sexual abuse.[595] In addition, the Australasian Institute of Judicial Administration has published the *Bench Book for Children Giving Evidence in Australian Courts*, which was updated in March 2020.[596] The Supreme Court could consider developing professional development material based on this bench book.

In Victoria, the Chief Justice of the Supreme Court directs the professional development and continuing education and training of judicial officers.[597] In discharging this responsibility, the Chief Justice may direct a judicial officer to take part in specified professional development or continuing education and training activity.[598] We consider that Tasmania should adopt a similar provision.

We encourage the Supreme Court to support members of the Bench to actively seek out and participate in professional development and continuous education programs and activities as a matter of course. Judicial officers could attend programs already developed in other jurisdictions, such as the programs offered by the Judicial College of Victoria.

Recommendation 16.16

The Tasmanian Government should:

a. fund the Supreme Court to support the professional development of judicial officers on the dynamics of child sexual abuse and trauma-informed practice

b. consider introducing legislation dealing with the responsibility of the Chief Justice to direct the professional development and continuing education and training of judicial officers, in similar terms to section 28A of the *Supreme Court Act 1986* (Vic).

6 After a conviction

In this section, we focus on what happens after an accused person pleads guilty or is found guilty of child sexual abuse. We discuss:

- sentencing in child sexual abuse cases and recent sentencing trends
- the availability of perpetrator programs for child sex offenders in the community
- restorative justice as an alternative to traditional criminal justice responses.

We discuss victim support services in Chapter 17.

6.1 Sentencing

After an accused person pleads guilty or is found guilty, a sentencing hearing decides their sentence. At a sentencing hearing, the court may hear submissions from the prosecution and defence about:

- the facts of the case, including any mitigating factors (facts or circumstances that could lessen the severity of a sentence) or aggravating factors (facts or circumstances that could increase the sentence received)[599]
- the offender's circumstances (for example, the prosecution might refer to the offender's criminal history, while the defence might state that the offender has shown remorse)
- relevant sentencing principles (for example, the principle of proportionality, which means that the severity of the sentence must fit the seriousness of the crime)
- the type of sentence that might be appropriate (for example, imprisonment or a community-based order).[600]

A victim impact statement may be read out at a sentencing hearing, either by the victim or by the prosecution on the victim's behalf.[601]

After hearing submissions from the prosecution and defence, a court must consider factors in deciding the appropriate sentence to impose on an offender including:

- sentencing practices for the offence type
- the nature and seriousness of the offence
- the impact of the offence on any victim, including any injury, loss or damage caused by the offence
- the personal circumstances of any victim

- whether the offender pleaded guilty and at what stage of the proceedings this occurred
- any mitigating or aggravating factors.[602]

We heard from victim-survivors about their experience with the sentencing process. Victim-survivor Katrina Munting explained to us that she 'found the experience of the criminal justice system devastating' and that she was not sure she could put herself through it again.[603] However, she said:

> … I felt believed by the court and this helped me. I found his Honour's disputed facts findings and sentencing remarks really helpful because they came from an impartial and authoritative perspective, and they recognised the pain and suffering I had been through.[604]

As noted above, when a court is sentencing an offender for child sexual abuse offences, the victim-survivor may make a written statement to the court that describes how they were affected by the offence and can refer to any injury they have suffered. The victim-survivor can request that they or another person acting on their behalf read the statement to the court before the offender is sentenced.[605] The Witness Assistance Service at the ODPP can help a victim-survivor prepare their statement.[606]

The Victims of Crime Service in the Department of Justice also provides support in preparing victim impact statements.[607] Catherine Edwards, Manager, Victims Support Services, Department of Justice, said that all counsellors at the Victims of Crime Service provide support with writing and submitting victim impact statements based on the victim's capacity and their request.[608] This includes proofreading a victim's draft statement, interviewing the victim and working with them.[609]

Victim-survivors told us of their experiences in making their victim impact statements. Sam Leishman, a victim-survivor, remembers standing up in court and starting to read his statement. He told us:

> … I suddenly felt like the biggest person in the room because I was there standing up in front of everyone, including him, speaking up for the child that I once was when I felt that that had never been done before, and that was 36 years after when it first started, and that's a long time.[610]

By contrast, victim-survivor Leah Sallese described her experience as 'really traumatic'. She said:

> I had help … to prepare my victim impact statement. They also wrote and rewrote what I had to say. Because everything had to be so carefully put, basically, you know, and that was really traumatic because I was actually trying to say—I wanted to say certain things, and I was told I couldn't do that, and this is what you have to do, so I felt like a little bit of my power had been taken away … I didn't really get to say everything I wanted to say, basically.[611]

6.1.1 Sentencing trends

In Tasmania, the maximum penalty that a court can impose on a person for all sexual offences in the Criminal Code Act is 21 years' imprisonment.[612] Courts exercise discretion in sentencing and have established a range of sentences for different offences.[613]

The approach to sentencing child sex offenders, and the length of prison sentences imposed, have changed significantly in recent years.[614]

In Tasmania, the number of offenders who receive custodial sentences and the lengths of sentences for child sexual abuse have both increased. The Sentencing Advisory Council's research paper *Sentencing for Serious Sex Offences Against Children* confirmed a marked upward trend in sentencing in Tasmania for serious child sexual abuse offences when comparing the period 1 January 2015 to 30 September 2018 with the period 1 January 2008 to 31 December 2014.[615]

Also, the DPP can appeal against a sentence if they consider a different sentence should have been given.[616]

The DPP will take the complainant's view into consideration when determining whether to appeal.[617] The ODPP told us that the DPP had undertaken appeals against sentences in child sexual abuse matters, including in the case of *Director of Public Prosecutions v Harington*, which they considered provided strong guidance to courts in sentencing for these matters.[618] In that case, Justice Wood remarked that sentences for maintaining a sexual relationship (now persistent sexual abuse) were increasing, observing that:

> To some extent this is an inevitable consequence and a reflection of the greater community understanding of the long-term effects of child sexual abuse. The hearings of the Royal Commission into Institutional Responses to Child Sexual Abuse have provided the community and the courts with valuable insight with regard to the serious impact of abuse on child victims.[619]

The Sentencing Advisory Council reported that the median sentence for this offence doubled from three to six years in the period from 1 January 2008 to 31 December 2014 to the period from 1 January 2015 to 30 September 2018.[620] The DPP told us that the sentencing range for rape is generally higher than the sentencing range for penetrative sexual abuse of a child.[621] However, he noted that 'the sentencing range for penetrative sexual abuse of a child is becoming higher than it used to be. It used to be quite low compared to rape; it is less so now'.[622]

Prosecutors felt the courts were increasingly recognising the long-term impacts of child sexual abuse and were taking this into account for sentencing, with an upward trend in sentencing for these matters.[623]

Nevertheless, victim-survivors reported feeling that sentences applied to their abusers were inadequate.[624] We discuss data collection for sentencing in child sexual abuse cases in Section 9.

6.2 Perpetrator programs

Perpetrator programs aim to stop offenders committing further offences, working to change their behaviours and attitudes. This aim recognises that almost all child sex offenders (even those who have been imprisoned) will remain in or re-enter the community. For this reason, interventions directed at abusers are a crucial way to prevent them from harming children.

The Tasmanian Prison Service delivers an adult sex offender program (the New Directions Program) to all people in custody for sex-based offending who are assessed as suitable for the program, except those who refuse to engage in treatment.[625]

A sex offender may also have to take part in sex offender treatment as a requirement of a community-based sentencing order. A court can direct an offender to have treatment in the community as a condition of a community-based order.[626] The Parole Board also has the power to order an offender take part in rehabilitation and treatment as a condition for parole.[627] We did not hear any evidence about treatment programs for sex offenders in the community.

In addition, the Tasmanian Government has recently introduced the *Dangerous Criminals and High Risk Offenders Act 2021*. The Act introduces a scheme for detaining dangerous offenders indefinitely and for making high-risk offender orders, the latter providing for extended supervision of high-risk offenders when released from prison.[628] The Act commenced on 13 December 2021.[629]

To reduce the risk of reoffending, the National Royal Commission emphasised the need to offer support services to child sex offenders moving back into the community.[630] However, it did not consider this issue in detail and noted that it did not have the evidence or submissions necessary to make recommendations in relation to it. The National Royal Commission considered that state and territory governments should continually review the adequacy of support services they provide for child sex offenders in the community.[631]

In 2017, the Sentencing Advisory Council released a research paper on mandatory treatment for sex offenders in custody and in the community.[632] The research paper considered the scope and availability of support services for child sex offenders in the community.

The research paper states that there were only limited treatments available for sex offenders in the community at the time of the report.[633] It further indicates that treatment relies on independent counselling services accessed through private providers and that it may be difficult to get treatment in the north and North West because of a lack of providers.[634] The research paper notes there are no government funded community-based treatment programs for sex offenders in Tasmania.[635] It also considers

that it would not be feasible to run group programs in the community in Tasmania because of the small number of offenders involved and the geographic dispersion of these offenders.[636]

The research paper does, however, note that sex offenders in the community are subject to mandatory intervention by Community Corrections under the Community Based Sex Offender Case Management and Interventions program.[637] It notes that all sex offenders under the supervision of Community Corrections are actively managed and that individual treatment is available if this is a requirement of a parole or court order.[638] According to the research paper, this reflects the need for community-based treatment for sex offenders who have been released from prison to be individualised and targeted rather than treatment that is simply a repeat of the group rehabilitation programs in prison.[639] The research paper states that Community Corrections staff working with sex offenders have received extensive training about sexual offending, managing sex offenders and case management.[640]

The Tasmanian Government should ensure community-based preventive programs for child sex offenders who are released from prison are properly funded. Such programs should also comply with best practice for treating abusers. In this regard, James Ogloff AM, Distinguished Professor of Forensic Behavioural Science, Swinburne University of Technology, drew our attention to Association for the Treatment of Sexual Abusers practice guidelines that specify standards for treating adults and young people.[641] Professor Ogloff explained that these practice guidelines focus on three elements—cognitions (including cognitive distortion, where perpetrators convince themselves that what they are doing is not wrong), behaviours (including strategies for controlling specific behaviours) and emotions (including developing insight into emotional states and the triggers that may cause inappropriate behaviours).[642]

The National Royal Commission also recommended a national strategy to prevent child sexual abuse (refer to Chapter 18).[643] It recommended that the national strategy encompass information and help-seeking services to support people who are concerned they may be at risk of sexually abusing children, highlighting the Stop It Now! program as a potential model to adopt.[644]

The Stop It Now! program operates in North America, the Netherlands, the United Kingdom and Ireland. It has also operated on a small scale in Queensland.[645] The program has been positively evaluated in the Netherlands and the United Kingdom.[646]

In Victoria, Jesuit Social Services is piloting Stop It Now! for those who self-identify a sexual interest in children and want to address this.[647] The pilot started in late August 2022 and was to run for a year.[648] The program aims to reduce and eliminate the sexual abuse and exploitation of children, and seeks to achieve this by engaging with adults who may go on to harm children.[649]

The program's key feature is an anonymous helpline for people who are worried about their own sexual thoughts and behaviour in relation to children, as well as professionals and family members who are concerned about the behaviour of others.[650] The service includes a website with advice, self-help materials and guidance to raise awareness of child abuse.[651] While the service can be accessed anonymously and confidentially, it complies with all mandatory reporting guidelines.[652]

The University of Melbourne will evaluate the effectiveness of the program and its potential for national scale-up.[653] We welcome programs such as Stop It Now! that seek to reduce and eliminate child sexual abuse.

Recommendation 16.17

The Tasmanian Government should ensure preventive programs for adults who are at risk of abusing, or have abused, children are available beyond the custodial setting. These programs should be:

a. properly funded

b. align with the practice guidelines issued by the Association for the Treatment and Prevention of Sexual Abusers

c. include a monitoring and evaluation process.

6.3 Restorative justice

Restorative justice involves people affected by a crime, including the victim-survivor and the offender, communicating about the damage caused by the offence and how it can be repaired. It can include methods such as an exchange of letters, engagement with an institution where the harm occurred and supported conferencing processes with professionals.[654]

We heard evidence about restorative justice as an alternative to traditional criminal justice responses to child sexual abuse, given their inherent limitations.

Elena Campbell, Associate Director, Research, Advocacy and Policy at the Centre for Innovative Justice, told us that:

> Restorative justice approaches recognise that, while the adversarial system meets the imperative of the State in prosecuting wrongdoing, it does very little to meet the needs of the people who have experienced this wrongdoing. By contrast, restorative justice approaches give victim-survivors a voice and validation, essentially allowing them to be heard, to ask questions and to feel that somebody who has caused harm to them has taken steps to repair it.[655]

Professor Cashmore gave evidence about the potential for restorative justice to play a role in the criminal justice system's response to child sexual abuse. She told us that there needs to be some serious consideration of other avenues of justice, including certain restorative justice approaches.[656] She also drew our attention to a pre-trial diversion program in New South Wales in which familial child sex offenders had to take responsibility by pleading guilty and complying with strict requirements, including disclosing their conduct to family members and their work managers and colleagues, with breaches resulting in the offender returning to court for sentencing.[657]

The National Royal Commission considered the potential of restorative justice approaches for institutional child sexual abuse. It noted some stakeholder support for restorative justice approaches. However, the National Royal Commission indicated that, based on evidence at the time, it was ultimately not 'satisfied that formal restorative justice approaches should be included as part of the criminal justice response to institutional child sexual abuse, at least in relation to adult offenders'.[658] The National Royal Commission highlighted issues that often make restorative justice approaches unsuitable, including where there is a significant power imbalance, where the victim-survivor does not want to take part or where the passage of time may mean relevant parties are unable or unwilling to participate.[659]

The National Royal Commission did not express a firm view on whether there is a role for restorative justice in the criminal justice system, either as a sentencing option for offenders or as an alternative for victim-survivors to access justice. However, the National Royal Commission considered that such principles could, and should where appropriate, be embedded in institutional responses to child sexual abuse, including in the National Redress Scheme.[660]

In its report *Improving the Justice System Response to Sexual Offences,* the Victorian Law Reform Commission noted strong support for restorative justice for adult sexual offending. It indicated that restorative justice can be an avenue to meet the needs and wishes of a victim-survivor that a criminal justice system cannot provide.[661] The Victorian Law Reform Commission noted the risks associated with using restorative justice processes involving children who have been sexually abused and, while it acknowledged that such processes are unlikely to be suitable in many instances involving young victim-survivors, it recommended that suitability be determined on a case-by-case basis rather than by a blanket exclusion.[662] We note, however, that Victoria has well-established restorative justice processes in place. We are not aware of Tasmania having a similar system.

We have not made any recommendations on applying restorative justice for institutional child sexual abuse as an alternative to criminal justice. We consider that there may be limited circumstances in which restorative justice could be appropriately applied. This may include some cases where the harmful sexual behaviour is by a child, and

for non-sexual offences such as failing to report the abuse of a child.[663] Also, as recommended by the National Royal Commission, we consider that restorative justice may have a role to play in institutional responses to child sexual abuse and note that these principles are embedded in the National Redress Scheme. We discuss the National Redress Scheme in Chapter 17.

7 Changing the language of consent in child sexual abuse cases

In this section, we highlight the need for the judiciary and legal professionals to avoid reinforcing outdated understandings of child sexual abuse in sentencing remarks and in making submissions.

The language the judiciary and legal professionals use during a trial and when sentencing a child sex offender can have a powerful and sometimes devastating effect on victim-survivors. It can also have a broader symbolic effect on the understanding of child sexual abuse. In this section, we also discuss how the language of consent can send inaccurate and damaging messages to victim-survivors of child sexual abuse and the broader community, and consider whether there are ways to address this.

Benjamin Mathews, Research Professor, School of Law, Queensland University of Technology, told us that child sexual abuse:

> … is inflicted in secret, and usually by an adult who is known to the child or a family member. It can be inflicted in circumstances where force or coercion is clearly apparent, but it can also be inflicted where such coercion is not as stark but where the victim is not developmentally capable of understanding the acts and/or where the child is in a position of physical, cognitive, emotional or psychological vulnerability such that consent is not freely given.[664]

The issue of consent is generally not relevant to child sexual abuse offences because, except in the case of similarity of age which we explain below, children under the age of 17 are legally incapable of consenting to sexual contact. Consent is considered relevant in the following two instances:

- when an accused person and victim-survivor are close in age
- when an accused person is charged with rape, rather than with offences specifically related to the abuse of a child.

The closeness (or similarity) in age defence recognises that there might be good reason not to criminalise a young person who is involved in sexual behaviour with another young person of a similar age—for example, where the complainant is 14 and the accused person is 15, and there was genuine consent in the circumstances.[665] In relation to these types of offences, we recognise that discussing consent is entirely appropriate.

If a person is charged with the rape of a child or young person, and does not plead guilty to that offence, the prosecution must prove that the complainant did not consent and that the accused person was aware of the lack of consent. This may result in the child or young person being cross-examined on the issue of consent.[666]

An accused person may argue that they believed the complainant was consenting at the time the sexual penetration occurred.[667] That belief on the part of the accused person must be 'honest and reasonable'. The Criminal Code Act provides that:

> … a mistaken belief by the accused as to the existence of consent is not honest or reasonable if the accused –
>
> a. was in a state of self-induced intoxication and the mistake was not one which the accused would have made if not intoxicated; or
>
> b. was reckless as to whether or not the complainant consented; or
>
> c. did not take reasonable steps, in the circumstances known to him or her at the time of the offence, to ascertain that the complainant was consenting to the act.[668]

However, consent is defined in the Criminal Code Act as meaning 'free agreement'.[669] Section 2A(2) sets out situations in which a person does not 'freely agree'. Two of these situations may be particularly relevant to whether a child or young person has consented. They include where a person 'agrees or submits because he or she is overborne by the nature or position of another person' or where the person is 'unable to understand the nature of the act'.

Under section 335 of the Criminal Code Act, a person can be charged with rape but convicted of penetrative sexual abuse of a child or young person, or penetrative sexual abuse of a child or young person by a person in a position of authority, if the jury is not satisfied beyond reasonable doubt about lack of consent.[670]

As discussed in Section 6.1, the sentencing range for rape is higher than the sentencing range for penetrative sexual abuse of a child.[671] The DPP told us that, depending on the circumstances, the DPP may charge an accused person with the offence of rape and the jury will be directed that if it is not satisfied beyond reasonable doubt that the complainant did not consent, then it can consider the alternative offence of penetrative sexual abuse of a child.[672] Where it is relevant, the jury may also be directed that it can consider the alternative and recently introduced offence of penetrative sexual abuse of a child or young person by a person in a position of authority.

If an accused person is convicted of or pleads guilty to rape, the issue of consent is irrelevant, though physical violence or other factors present at the time of the offence may be relevant to sentencing. Because consent is technically irrelevant, defence counsel should not be able to raise consent in sentencing hearings where a person

pleads guilty or is convicted of rape. If this is done, the prosecutor should object to the issue being raised and the judge should make it clear that consent is irrelevant to sentencing in these circumstances.

When the accused person is convicted of, or charged with, a child sexual abuse offence, or is convicted of that offence as the alternative to rape, consent is also irrelevant unless the defence of similarity of age applies. Evidence we heard suggests the notion of 'consent' in child sexual abuse matters perpetuates outdated ideas about where responsibility sits and reveals a limited understanding of the way in which abusers groom children to submit to sexual abuse. Applying the notion of consent has the potential to reinforce victim-survivors' fears that they are to blame for the abuse, which they are not.

Victim-survivor Leah Sallese told us she believed for decades that, as a child, she had had an 'affair' with her teacher. It was not until she was in her forties, when a psychotherapist told her that what she had experienced was child sexual abuse, that she could question the 'narrative' in her mind and understand that she was a victim of abuse.[673] Ms Sallese referred to the 'offensive' language used by the judge in her case, who described the abuse as 'consensual', and in the offence itself as it was then known: 'maintaining a sexual relationship with a young person'.[674] She emphasised the importance of changing the language, which has now occurred in relation to the title of the offence.[675] We support that change, although we recommend a further change to the language of the provision (refer to Recommendation 16.9). The language prosecutors, defence counsel and judges use can also have a profound effect on the wider community's understanding of child sexual abuse.

Given the effects of applying the notion of consent on victim-survivors and the wider community, we consider that its use is inappropriate in child sexual abuse matters. The DPP concedes that prosecutors could use the unlawful act being alleged rather than the word 'consent' in child sexual abuse matters.[676] He stated that:

> … you'll see many judges comment when passing sentence [for persistent sexual abuse] where they say 'It's not suggested it's consensual'. Now, having thought about it, we don't have to say that, what might be better to say is that what the Crown is alleging is penetrative sexual abuse of a child …[677]

After our hearings, the DPP wrote to us to suggest one way of changing the language used in the criminal justice system would be to amend the *Sentencing Act 1997* ('Sentencing Act'). He suggested, for example, that a statement could be included in section 11A to the effect that, for child sexual abuse offences, consent is not a mitigating factor and that the court is to presume that the sexual abuse will result in long-term and serious physical and psychological harm to the victim-survivor.[678] He considers that such a change would avoid criminal trials and disputed facts hearings requiring the complainant to give evidence on the issue of consent.[679]

We agree that it could be beneficial to amend section 11A of the Sentencing Act to include a provision to the effect that, for child sexual abuse offences, consent is not a mitigating factor. This would also reflect the existing case law as set out in *Director of Public Prosecutions v Harington* and *Clarkson v The Queen; EJA v The Queen*.[680] This would mean that the submission, acquiescence or apparent consent of a child is not relevant in sentencing.

We also consider training for the judiciary and legal profession is needed to help ensure the language used in court does not suggest or imply that a child consented to abuse. We discuss prosecutor training in Section 4.2.2 and improving professional education for judges in Section 5.6. The DPP Guidelines should be amended to make it clear that the language of consent should be avoided when prosecuting child sexual abuse offences.

Recommendation 16.18

1. The Tasmanian Government should introduce legislation to amend section 11A of the *Sentencing Act 1997* to provide that, in determining the appropriate sentence for an offender convicted of a child sexual abuse offence, the acquiescence or apparent consent of the victim is not a mitigating circumstance.
2. The Director of Public Prosecutions should amend its *Prosecution Policy and Guidelines* to make it clear that in child sexual abuse matters where consent is not an element of the offence, then the language of consent should not be used by prosecutors.
3. Professional education for judicial officers (Recommendation 16.16) and prosecutors (Recommendation 16.8) should include challenging the myths and misconceptions about consent in relation to child sexual abuse.

8 Responses to children and young people displaying harmful sexual behaviours

Harmful sexual behaviours cover a broad range of behaviours, from those that are developmentally inappropriate and involve only the child displaying the behaviours, to those that involve one child sexually harming another child. In our hearings and in sessions with a Commissioner, we heard from victim-survivors who had been sexually harmed by other children in institutions. Harmful sexual behaviours can have a detrimental and lasting impact on victim-survivors and need to be managed with great care and sensitivity.

While the impact of harmful sexual behaviours is significant, it is generally recognised that punitive responses are often not appropriate because children can display such behaviours for a range of complex reasons, including because of their own sexual victimisation.

In addition, research about children who have displayed harmful sexual behaviours indicates a low rate of recurrence for these behaviours.[681] This means that adopting stigmatising criminal justice interventions is unlikely to be effective. Professor Ogloff informed us that harmful sexual behaviours displayed by young people are usually highly treatable, with treatment based on gaining cognitive and emotional control, and often there is a strong element of remorse and a desire to change.[682]

The National Royal Commission considered that interventions are needed to respond to children who display harmful sexual behaviours, ranging from prevention and early identification to assessment and therapeutic intervention.[683] It found that a public health model should be applied to address and prevent problematic and harmful sexual behaviours displayed by children. The Victorian Law Reform Commission also recommended in 2021 that the Victorian Government strengthens the support available to children and young people who have engaged in harmful sexual behaviours.[684]

The National Royal Commission noted that, for a small group of children, a child protection or criminal justice response may be necessary.[685] It recommended state and territory governments ensure there are clear referral pathways for children who have displayed harmful sexual behaviours to access expert assessment and therapeutic intervention, regardless of whether the child is engaging voluntarily, on the advice of an institution or through their involvement with the child protection or criminal justice system.[686]

We discuss responses to children who have engaged in harmful sexual behaviours in Chapter 21. In that chapter, we recommend funding be increased for specialised therapeutic services for young people in the context of a statewide, whole of government framework for responding to harmful sexual behaviours, so all children and young people can access the appropriate responses for their situation. Here we consider whether there are opportunities in the youth justice framework for courts to direct the small number of young people who have displayed harmful sexual behaviours and are charged with an offence to therapeutic services.

We note that the Tasmanian Government has developed the *Draft Youth Justice Blueprint 2022–2032: Keeping Children and Young People out of the Youth Justice System,* which outlines the strategic direction for Tasmania's youth justice system for the next 10 years.[687] The draft blueprint's aim is to improve the wellbeing of children, young people and their families while addressing the underlying drivers of offending behaviours, reducing offending and improving community safety. We welcome this initiative and consider there is an urgent need for youth justice system reform. We discuss the draft blueprint further in Chapter 12.

There is potential in the existing legislative frameworks for courts to divert young people who have displayed harmful sexual behaviours to specialised therapeutic services. The *Youth Justice Act 1997* ('Youth Justice Act') provides the legislative framework for administering youth justice in Tasmania. The Youth Justice Division of the Magistrates Court deals with most young people charged with criminal offences. But the Supreme Court deals with more serious offences such as aggravated sexual assault, rape and persistent sexual abuse of a child.

Instead of proceeding to sentence a young person, the Magistrates Court can do one of the following:

- Order the young person to attend a community conference.[688] If the Court makes such an order, it can require the young person to enter into an undertaking to do anything else that may be appropriate in the circumstances.[689] The Court can then dismiss a charge after the young person takes part in the community conference.[690]
- Defer sentencing of a young person to allow them to take part in an intervention plan.[691] An intervention plan is a plan that specifies the activities or programs that a young person is expected to undertake while on bail.[692]

In addition, when sentencing a young person under the Youth Justice Act, the Magistrates Court can order that the young person undergoes psychiatric or psychological treatment as a special condition of a probation order or a community service order.[693]

We note that, where a young person is charged with a family violence offence, the court also has the power to order a rehabilitation program assessment and direct the young person submit to that assessment.[694] This power is limited to offences committed by a person against their spouse or partner.[695]

When a young person is sentenced in the Supreme Court, the court has discretion to sentence the person under the Sentencing Act or the Youth Justice Act. In sentencing a young person under the Sentencing Act, the court can:

- order release of the offender if the offender undertakes to comply with specified conditions
- make a community correction order with special conditions if the young person has reached 18 years, which could include a treatment program order.[696]

We consider the courts should have broader powers to refer young people to rehabilitation assessments and supports. In Chapter 21, we recommend that the Magistrates Court be given the power to divert a young person who has engaged in harmful sexual behaviours from the criminal justice system by adjourning the criminal proceedings to enable the young person to take part in therapeutic treatment (Recommendation 21.9). They could then discharge the young person after completing the treatment.

In addition, we consider that courts should use their powers to direct young people who have been charged with criminal offences and who have displayed harmful sexual behaviours to specialist therapeutic services, whenever this is appropriate.

Recommendation 16.19

We encourage the courts to consider using their powers to direct young people engaging in harmful sexual behaviours who are charged with a criminal offence to specialist therapeutic services.

9 Monitoring and evaluation

There is a lack of comprehensive data on child sexual abuse offences in the Tasmanian criminal justice system. In its report *Improving the Justice System Response to Sexual Offences,* the Victorian Law Reform Commission highlighted the challenges of building an evidence base for reform without the benefit of regularly published data.[697]

Of the child sexual abuse matters that are reported to police (and we know that many are not), we heard that only a small proportion result in prosecution and conviction—in New South Wales, about 12 per cent of reported cases (and we heard this is broadly consistent with other studies).[698] Other data from New South Wales shows that, of the cases in which a person pleads guilty or goes to trial, almost half are convicted of at least one child sexual abuse offence.[699] Conviction rates for cases that are prosecuted in Tasmania are higher than in New South Wales.

The DPP's *Annual Report 2021–22* states that:

> … between 2017 and 2021 the Office finalised 231 sexual assault cases involving child complainants, with a conviction rate of 67.33% and a discharge rate of 23.9%. A previous study between 2010 and 2014 showed a similar result. The conviction rate was higher than that for all crimes whereas the discharge rate was significantly lower than that for all crimes.[700]

The report attributed the high conviction rate to the DPP Guidelines ensuring early contact with complainants, the conduct of matters by experienced prosecutors and the pre-charging advice service the ODPP provides to Tasmania Police, which was said to mean that the 'correct charges are laid and additional evidence is obtained at an early stage'.[701]

Figures provided to our Commission of Inquiry on conviction rates for sexual assault crimes (which would have included some adults who reported child sexual abuse) were similarly high.[702] These figures showed a conviction rate of 67.53 per cent and a discharge rate of 23.3 per cent.[703]

Although the ODPP's figures are encouraging, we do not know what proportion of these cases involved institutional child sexual abuse. Moreover, the ODPP figures do not show the attrition rate between cases reported to Tasmania Police and cases that get a conviction. Research has consistently shown that the majority of sexual offences are not reported, preliminary enquiries made to police do not always result in a formal report, and only some cases reported to police proceed to prosecution. If police do not encourage victim-survivors to formally report an offence, or if a charge is never laid because of the ODPP's pre-charging advice, only a low proportion of reports of child sexual abuse proceed through the criminal justice process. For example, a study on the attrition of sexual offence incidents in the Victorian criminal justice system covering the period 2015–16 to 2016–17 shows that only one in seven sexual offence incidents reported to police was ultimately proven in court and that attrition was 'highest during the police investigation stages of the justice system process'.[704] Police formally identified an offender for about half (48 per cent) of the incidents reported and laid charges against about half (52 per cent) of those offenders they identified.[705] We note these figures relate to sexual offence incidents generally and are not confined to sexual offences against children or offences occurring in an institutional context.

For this reason, we consider the Tasmanian Government should ensure data is collected on the proportion of child sexual abuse cases reported to police that result in prosecution and conviction. This information should be compared with statistics from other Australian jurisdictions where such data is collected. The analysis of this data should consider jurisdictional differences in systems (for example, in Tasmania a magistrate cannot refuse to commit a matter).[706] Such a comparison would provide a more objective means of assessing the performance of the Tasmanian criminal justice system in investigating, charging and convicting child sexual abuse offenders than currently exists.

Attrition data—indicating when and why cases stop progressing through the criminal justice system—is also required to help identify factors and barriers that have contributed to decisions by victim-survivors to withdraw from criminal justice processes. This could also inform future policy and reform.

It should be possible to track how many incidents of child sexual abuse offending progress through the criminal justice system to be proven in court and at what points incidents 'exit' the system. We note that the ODPP already collects some of this data, including the reasons for matters being discharged, and reports on it in its annual report.

In respect of the ODPP's pre-charging advice service, the ODPP keeps a record of the number of advice files provided to Tasmania Police in which the ODPP recommended, in respect of child sexual abuse offences, that:

- charges be laid
- charges not be laid
- further police enquiries be made.

The ODPP has provided our Commission of Inquiry with figures for 2016–17 to 2022–23 (up until 5 May 2023). These are shown in Table 16.1.[707] This table indicates that, in some years many matters reported to police did not result in charges being laid, although in recent years the proportion of cases where charges are laid appears to be increasing.

Table 16.1: Office of the Director of Public Prosecutions, Pre-charge advice files relating to child sexual offences provided to police, 2015–2023[708]

Year	Charges laid	Charges not laid	Further police enquiries be made	Total (charges laid or not laid)	Percentage of cases with charges laid, of those with a charge laid or not laid
2015–16	19	54	15	73	26%
2016–17	17	58	19	75	23%
2017–18	59	66	50	125	47%
2018–19	63	89	33	152	34%
2019–20	72	98	26	170	42%
2020–21	44	46	14	90	49%
2021–22	63	59	26	122	51.6%
2022–23	46	59	14	105	43.8%

Source: Office of the Director of Public Prosecutions, *Advice Provided Statistics 2015–2023*, 5 July 2023.

The National Royal Commission recommended that the DPP monitors the number, type and success rate of appeals in child sexual abuse matters to identify any areas of potential reform and to ensure any National Royal Commission recommendations are working as intended.[709] We acknowledge that, in recent years, police and the ODPP have made improvements including:

- developing a specialised unit within the ODPP
- developing and expanding the Witness Assistance Service
- implementing early engagement with victim-survivors
- establishing the ODPP's pre-charging advice service.

Nevertheless, throughout this chapter we have identified areas where it is still difficult to assess the performance of the police and the ODPP without other transparency measures.

Commissioner Hine told us Tasmania Police 'holds a wealth of data across many different systems'.[710] He said that 'currently more than 10 years of offence reporting data is at hand from which we can examine trends across offence types, locations, clearance and other factors over time'.[711] He also said integration and reporting on this data will improve with the upcoming migration of more applications into Atlas, the Tasmania Police data system.[712]

The DPP told us that the ODPP's in-house file management and record keeping methods need to be modernised to better record data and automatically generate reports. He said that the Department of Justice is undertaking a project (called 'Justice Connect') to improve information sharing between stakeholders. The DPP said that it is not clear how this system will benefit the ODPP.[713] We recommend that the Tasmanian Government supports the ODPP to improve its data collection.

We also consider that more work needs to be done to collect data about child sexual abuse across the criminal justice system. We therefore recommend the Tasmanian Government prioritises collecting comprehensive data on the criminal justice system's response to child sexual abuse.

Although data is important, it only tells part of the story. Victoria Police noted its view that not every victim-survivor wants to go through the court process, and prosecution is not always the goal and only measure of 'success'.[714] We agree.

In Section 3.2.2, we recommend that specialist police units measure and periodically report on victim-survivor satisfaction with the specialist police units (refer to Recommendation 16.1).

We also recommend below that periodic qualitative surveys be conducted with victim-survivors of child sexual abuse. These should focus on their experiences and satisfaction with the criminal justice system. Such surveys could measure whether the victim-survivor felt listened to and believed, whether they understood the process and whether they were kept informed of the progress of their case.

Recommendation 16.20

1. The Department of Justice should:
    a. prioritise collecting and publishing key data about institutional child sexual abuse, including
        i. the number of reports of child sexual abuse made to police
        ii. police, prosecution and court outcomes of reports, and reasons for outcomes, including the reasons why cases did not proceed
        iii. the time between reporting, charging or a decision not to progress, and prosecution
        iv. whether the abuse took place in an institutional setting
        v. basic demographics of victim-survivors and alleged perpetrators (for example, age, gender and Aboriginal status)
        vi. trends in relation to particular groups, including Aboriginal people
    b. support the Office of the Director of Public Prosecutions to improve its data collection for child sexual abuse cases so it can effectively monitor
        i. the cases on which police seek advice, that proceed to court and that are discontinued, including the reasons for discontinuance
        ii. the number, type and success rate of appeals in child sexual abuse matters
    c. cause periodic surveys to be conducted and published with victim-survivors of child sexual abuse on their experience and satisfaction with the criminal justice system, including on whether the victim-survivor
        i. felt listened to
        ii. felt believed
        iii. understood the process
        iv. was kept informed of the progress of the case.

2. The Sentencing Advisory Council should periodically review trends in sentencing for child sexual abuse offences in Tasmania and compare them with sentencing outcomes for equivalent offences in other Australian jurisdictions.

10 Conclusion

As recognised by the National Royal Commission, the criminal justice system is unlikely ever to provide an easy or straightforward experience for a victim-survivor of institutional child sexual abuse. The very nature of the crime and the criminal justice system mean that the experience is likely to be distressing and stressful.[715] However, we understand that the criminal justice system represents an important mechanism to condemn child sexual abuse, hold abusers to account and intervene to stop abusers offending.

The criminal justice system should do everything possible to avoid retraumatising victim-survivors, who must be listened to, respected and treated with dignity in all their interactions with the criminal justice system. A victim-survivor's experience of the system can be shaped by how they are spoken to and the support they receive. We heard that, for some people, aspects of the criminal justice process were ultimately affirming and rewarding, particularly when victim-survivors felt heard and believed and the offending was condemned.

While every victim-survivor of child sexual abuse has individual experiences and needs, some common themes emerged from the victim-survivors who shared their experiences with us. They spoke of how difficult it was to recount their experience multiple times and how important it is to be offered support throughout the criminal justice process.

We heard about the importance of victim-survivors having a voice, being believed and not having damaging myths or language wielded against them throughout the criminal justice process. We also heard about how important it is for police and prosecutors to speak to victim-survivors with kindness, care and patience, and to keep them informed about the progress of their case.

We accept that the criminal justice system, as an adversarial system, is not well equipped to respond to the complex and sensitive issues that arise from child sexual abuse. We consider recent reforms, such as introducing a witness intermediary scheme and using special measures to support complainants in giving evidence, can help alleviate some of the system's limitations, but we accept victim-survivors will always find reporting offences and giving evidence a very difficult process.

We welcome recent reforms to the criminal justice system but consider more can be done.

Like the National Royal Commission, our recommendations aim to reduce the extent to which a victim-survivor might feel marginalised, vulnerable, attacked or retraumatised.[716]

Our key recommendations in this chapter include:

- establishing specialist police units for child sexual abuse investigations
- ensuring police and prosecutors are trained on the nature and dynamics of child sexual abuse and trauma-informed care
- implementing independent oversight of investigations of allegations of child sexual abuse involving police officers
- assisting juries to assess the evidence of child witnesses through jury directions
- improving professional development for judicial officers and legal professionals
- changing the language of consent in child sexual abuse offence cases
- improving data collection across the criminal justice system.

Underlying all our recommendations is the need to improve education and training for police, prosecutors and the courts, as well as the wider community, on the nature and dynamics of child sexual assault and trauma-informed practice.

Notes

1 Royal Commission into Institutional Responses to Child Sexual Abuse, *Criminal Justice Report – Executive Summary and Parts I and II* (Report, August 2017) 9.

2 Royal Commission into Institutional Responses to Child Sexual Abuse, *Criminal Justice Report – Executive Summary and Parts I and II* (Report, August 2017) 75.

3 Task Force on Sexual Assault and Rape in Tasmania, *Report of the Task Force on Sexual Assault and Rape in Tasmania* (Report, 1998) 28.

4 Section 310(4) of the *Criminal Code Act 1924* provides that a person cannot be indicted unless there is sufficient evidence to put the accused person on trial or to raise a strong or probable presumption of guilt.

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275 Statement of Robert Boost, 2 September 2022, 4 [23].

276 Statement of Kerri Collins, 11 April 2022, 3 [14].

277 Statement of Kerri Collins, 11 April 2022, 6 [28].

278 Transcript of Daryl Coates, 7 July 2022, 2623 [27–42].

279 Director of Public Prosecutions, *Prosecution Policy and Guidelines* (18 October 2022) 17.

280 Statement of Daryl Coates, 6 June 2022, 16 [79].

281 Statement of Daryl Coates, 6 June 2022, 16 [77].

282 Director of Public Prosecutions, *Prosecution Policy and Guidelines* (18 October 2022) 17.

283 Statement of Terese Henning, 1 July 2022, 8 [39–40].

284 Statement of Daryl Coates, 6 June 2022, 12 [51].

285 Statement of Daryl Coates, 6 June 2022, 38 [139].

286 Statement of Daryl Coates, 6 June 2022, 38 [139].

287 Director of Public Prosecutions, *Prosecution and Policy Guidelines* (18 October 2022) 52–53.

288 Director of Public Prosecutions, *Prosecution and Policy Guidelines* (18 October 2022) 53.

289 The Australasian Institute of Judicial Administration, *Bench Book for Children Giving Evidence in Australian Courts* (February 2015).

290 Director of Public Prosecutions, *Prosecution and Policy Guidelines* (18 October 2022) 53.

291 Statement of Daryl Coates, 6 June 2022, 38–39 [140].

292 Statement of Daryl Coates, 6 June 2022, 41 [144].

293 Statement of Daryl Coates, 6 June 2022, 43 [153], [155].

294 Royal Commission into Institutional Responses to Child Sexual Abuse, *Criminal Justice Report – Executive Summary and Parts I and II* (Report, August 2017) 60, Recommendation 40.

295 Statement of Daryl Coates, 6 June 2022, 105 [340].

296 Statement of Daryl Coates, 6 June 2022, 9 [37].

297 Statement of Daryl Coates, 6 June 2022, 9 [38].

298 Director of Public Prosecutions, *Prosecution Policy and Guidelines* (18 October 2022) 16.

299 Statement of Daryl Coates, 6 June 2022, 10 [39]. Several offences under the *Criminal Code Act 1924* require the DPP's authorisation before a prosecution against an accused person can be commenced. These offences include persistent sexual abuse of a child or young person (s 125A) and failing to report abuse of a child (s 105A).

300 Statement of Daryl Coates, 6 June 2022, 10 [40].

301 Director of Public Prosecutions, *Prosecution Policy and Guidelines* (18 October 2022) 16.

302 Director of Public Prosecutions, *Prosecution Policy and Guidelines* (18 October 2022) 16–17.

303 Statement of Daryl Coates, 6 June 2022, 11 [44].

304 Office of the Director of Public Prosecutions, *Procedural Fairness Response*, 20 March 2023, 3.

305 Statement of Daryl Coates, 6 June 2022, 10 [41].

306 Statement of Daryl Coates, 6 June 2022, 10 [43].

307 Director of Public Prosecutions, *Prosecution Policy and Guidelines* (18 October 2022) 18.

308 Director of Public Prosecutions, *Prosecution Policy and Guidelines* (18 October 2022) 18.

309 Targeted consultation, Office of the Director of Public Prosecutions, Hobart, 20 August 2021.

310 Director of Public Prosecutions, *Prosecution Policy and Guidelines* (18 October 2022) 17.

311 Director of Public Prosecutions, *Prosecution Policy and Guidelines* (18 October 2022) 17–18.

312 Director of Public Prosecutions, *Prosecution Policy and Guidelines* (18 October 2022) 18.

313 Office of the Director of Public Prosecutions, *Procedural Fairness Response*, 20 March 2023, 3.

314 Director of Public Prosecutions, *Prosecution Policy and Guidelines* (18 October 2022) 18.

315 Submission 057 Anonymous, 3.

316 Submission 005 Anonymous, 4.

317 Submission 005 Anonymous, 4.

318 Royal Commission into Institutional Responses to Child Sexual Abuse, 'Criminal Justice Report' (Consultation Paper, September 2016) 35.

319 Statement of Daryl Coates, 6 June 2022, 110 [364].

320 *Maxwell v The Queen* [1996] HCA 46; 184 CLR 501; *Magaming v The Queen* [2013] HCA 40; (2013) 87 ALJR 1060.

321 Royal Commission into Institutional Responses to Child Sexual Abuse, *Criminal Justice Report – Executive Summary and Parts I and II* (Report, August 2017*)* 64.

322 Royal Commission into Institutional Responses to Child Sexual Abuse, *Criminal Justice Report – Parts III – VI* (Report, August 2017) 406.

323 Royal Commission into Institutional Responses to Child Sexual Abuse, *Criminal Justice Report – Executive Summary and Parts I and II* (Report, August 2017) Recommendation 42.

324 Statement of Daryl Coates, 6 June 2022, 26 [110].

325 Targeted consultation, Office of the Director of Public Prosecutions, Hobart, 20 August 2021.

326 Statement of Daryl Coates, 6 June 2022, 87 [286].

327 Director of Public Prosecutions, *Annual Report 2020–21* (Report, September 2021) 5, 24.

328 Royal Commission into Institutional Responses to Child Sexual Abuse, *Criminal Justice Report – Executive Summary and Parts I and II* (Report, December 2017) Recommendation 10.

329 Royal Commission into Institutional Responses to Child Sexual Abuse, *Criminal Justice Report – Parts III to VI* (Report, August 2017) 338.

330 Statement of Darren Hine, 14 June 2022, 87 [387].

331 Tasmanian Director of Public Prosecutions, *Prosecution Policy and Guidelines* (18 October 2022) 28.

332 Statement of Darren Hine, 14 June 2022, 87 [388].

333 Statement of Darren Hine, 14 June 2022, 75 [308].

334 Statement of Darren Hine, 14 June 2022, 75 [310].

335 Statement of Darren Hine, 14 June 2022, 87 [390].

336 Statement of Darren Hine, 14 June 2022, 87 [391].

337 Statement of Daryl Coates, 6 June 2022, 16 [76].

338 Statement of Daryl Coates, 6 June 2022, 46 [166].

339 Director of Public Prosecutions, *Prosecution Policy and Guidelines* (18 October 2022) 28.

340 Targeted consultation, Office of the Director of Public Prosecutions, Hobart, 20 August 2021; Director of Public Prosecutions, *Annual Report 2021–22* (Report, September 2022) 7.

341 Statement of Daryl Coates, 6 June 2022, 51 [184].

342 Stakeholder consultation, Devonport, 27 August 2021.

343 Statement of Daryl Coates, 6 June 2022, 47 [169].

344 Statement of Daryl Coates, 6 June 2022, 47 [171].

345 Statement of Daryl Coates, 6 June 2022, 48 [177].

346 Statement of Daryl Coates, 6 June 2022, 13 [57].

347 Statement of Daryl Coates, 6 June 2022, 47 [171].

348 Statement of Daryl Coates, 6 June 2022, 51 [188].

349 Royal Commission into Institutional Responses to Child Sexual Abuse, *Criminal Justice Report – Executive Summary and Parts I and II* (Report, August 2017) Recommendation 37(d).

350 Statement of Daryl Coates, 6 June 2022, 95 [305].

351 Statement of Daryl Coates, 6 June 2022, 15 [71].

352 Statement of Daryl Coates, 6 June 2022, 96 [311].

353 Statement of Daryl Coates, 6 June 2022, 96 [309].

354 Statement of Daryl Coates, 6 June 2022, 53 [71].

355 Statement of Daryl Coates, 6 June 2022, 15 [72].

356 Statement of Daryl Coates, 6 June 2022, 64 [231].

357 Statement of Daryl Coates, 6 June 2022, 98 [316].

358 Statement of Katrina Munting, 5 April 2022, 7 [34].

359 Submission 014 Anonymous, 29.

360 Statement of Daryl Coates, 6 June 2022, 19 [91].

361 Statement of Daryl Coates, 6 June 2022, 19 [91].

362 Statement of Daryl Coates, 6 June 2022, 97 [315].

363 Statement of Daryl Coates, 6 June 2022, 97 [315].

364 Statement of Daryl Coates, 6 June 2022, 97 [314].

365 Statement of Daryl Coates, 6 June 2022, 32 [124].

366 Statement of Daryl Coates, 6 June 2022, 72 [254].

367 Statement of Katrina Munting, 5 April 2022, 6 [32].

368 Statement of Daryl Coates, 6 June 2022, 33 [127].

369 Statement of Daryl Coates, 6 June 2022, 33 [128].

370 Statement of Daryl Coates, 6 June 2022, 33 [128].

371 Statement of Daryl Coates, 6 June 2022, 31 [119].

372 Statement of Daryl Coates, 6 June 2022, 31 [119].

373 Statement of Daryl Coates, 6 June 2022, 45 [163].

374 Statement of Daryl Coates, 6 June 2022, 32 [124].

375 Department of Treasury and Finance, *Government Services* (Budget Paper No 2, Vol 2, 2022–23) 58.

376 Statement of Daryl Coates, 6 June 2022, 31 [121].

377 Statement of Daryl Coates, 6 June 2022, 31 [121].

378 Statement of Daryl Coates, 6 June 2022, 31 [122].

379 Statement of Daryl Coates, 6 June 2022, 31 [122].

380 Statement of Daryl Coates, 6 June 2022, 31 [122].

381 Statement of Daryl Coates, 6 June 2022, 31 [122].

382 *Justice Miscellaneous (Royal Commission Amendments) Act 2023*.

383 Elise Archer, 'Delivering on Bail Reform to Keep Tasmanians Safe' (Media Release, 3 February 2021) <https://www.premier.tas.gov.au/site_resources_2015/additional_releases/delivering_on_bail_law_reform_to_keep_tasmanians_safe>.

384 Statement of Keelie McMahon, 9 May 2022, 5 [28].

385 While the offences referenced in this chapter are part of the Schedule to the *Criminal Code Act 1924*, we have followed Tasmanian custom by citing them as if they are sections in the Act.

386 *Criminal Code Act 1924* s 185.

387 *Criminal Code Act 1924* s 127.

388 *Criminal Code Act 1924* s 124.

389 *Criminal Code Act 1924* s 124A.

390 *Criminal Code Act 1924* s 125.

391 *Criminal Code Act 1924* s 125A.

392 *Criminal Code Act 1924* s 125B.

393 *Criminal Code Act 1924* s 125C.

394 *Criminal Code Act 1924* s 125D(1).

395 *Criminal Code Act 1924* s 125D(3).

396 *Criminal Code Act 1924* s 125E.

397 *Criminal Code Act 1924* ss 130–130F.

398 The relevant test to be applied by the ODPP is whether there is 'evidence against the defendant sufficient to put him on his trial or to raise a strong or probable presumption of his guilt'. Refer to *Criminal Code Act 1924* s 310(4).

399 *Justices Act 1959* s 26.

400 *Police Offences Act 1935* s 35(5).

401 *Police Offences Act 1935* s 35(5A) as amended by *Justice Miscellaneous (Royal Commission Amendments) Act 2023* s 39.

402 *Police Offences Act 1935* s 35(5B) as amended by *Justice Miscellaneous (Royal Commission Amendments) Act 2023* s 39.

403 *Classification (Publications, Film and Computer Games) Enforcement Act* 1995 s 79 as amended by *Justice Miscellaneous (Royal Commission Amendments) Act* 2023 s 6.

404 Royal Commission into Institutional Responses to Child Sexual Abuse, *Criminal Justice Report – Executive Summary and Parts I and II* (Report, August 2017) 37.

405 *Criminal Code Act 1924* s 125A, later amended to 'persistent sexual abuse of a child or young person' by the *Criminal Code Amendment (Sexual Abuse Terminology) Act 2020* s 3 on 6 April 2020.

406 *Criminal Code Act 1924* s 125A(4)(b).

407 Royal Commission into Institutional Responses to Child Sexual Abuse, *Criminal Justice Report – Executive Summary and Parts I and II* (Report, August 2017) Recommendations 21–24 and Appendix H: Draft provisions in relation to the persistent child sexual abuse offence.

408 *Crimes Act 1958* (Vic) s 49J; *Criminal Code Compilation Act 1913* (WA) s 321A.

409 *Criminal Code Amendment (Sexual Abuse Terminology) Act 2020* s 3.

410 *Criminal Code Act 1924* s 125A.

411 The Grace Tame Foundation, *The Harmony Campaign* (Web Page) <https://www.thegracetamefoundation.org.au/the-harmony-campaign>.

412 The Grace Tame Foundation, The Harmony Campaign (Web Page) <https://www.thegracetamefoundation.org.au/the-harmony-campaign>.

413 Statement of Leah Sallese, 4 July 2022, 4 [35].

414 Director of Public Prosecutions, *Prosecution Policy and Guidelines* (18 October 2022) 28.

415 Royal Commission into Institutional Responses to Child Sexual Abuse, *Criminal Justice Report – Executive Summary and Parts I and II* (Report, August 2017) Recommendations 27–29.

416 *Crimes Act 1900* (ACT) s 55A; *Crimes Act 1900* (NSW) ss 61A, 77 and 73A; *Criminal Code Act 1983* (NT) ss 128, 130 and 139A; *Criminal Law Consolidation Act* (SA) ss 49(5) and 57; *Crimes Act 1958* (Vic) ss 49C, 49E, 49G and 49I; *Criminal Code Act Compilation Act 1913* (WA) s 322.

417 Refer to Royal Commission into Institutional Responses to Child Sexual Abuse, *Criminal Justice Report – Parts III–VI* (Report, August 2017) 98–99.

418 *Justice Miscellaneous (Royal Commission Amendments) Act 2023* s 13 inserting *Criminal Code Act 1924* s 124A.

419 *Criminal Code Act 1974* s 124A(2).

420 Refer, for example, to *Crimes Act 1900* (NSW) s 73A(1); *Crimes Act 1958* (Vic) s 49E(1); *Criminal Code Act Compilation Act 1913* (WA) s 322(4); *Crimes Act 1900* (ACT) s 56(1); *Criminal Code Act 1983* (NT) s 128(1).

421 *Justice Miscellaneous (Royal Commission Amendments) Act 2023* s 13.

422 *Lydgate (a pseudonym) v The Queen* (2014) 46 VR 78.

423 Royal Commission into Institutional Responses to Child Sexual Abuse, *Criminal Justice Report – Executive Summary and Parts I and II* (Report, August 2017) Recommendation 28.

424 Royal Commission into Institutional Responses to Child Sexual Abuse, *Criminal Justice Report – Executive Summary and Parts I and II* (Report, August 2017) Recommendation 36.

425 Royal Commission into Institutional Responses to Child Sexual Abuse, *Criminal Justice Report – Executive Summary and Parts I and II* (Report, August 2017) Recommendation 36.

426 Royal Commission into Institutional Responses to Child Sexual Abuse, *Criminal Justice Report – Executive Summary and Parts I and II* (Report, August 2017) Recommendation 36.

427 *Crimes Act 1900* (ACT) s 66A; *Crimes Act 1958* (Vic) s 49O; *Criminal Law Consolidation Act 1935* (SA) s 65.

428 *Justice Miscellaneous (Royal Commission Amendments) Act 2023* s 13 inserting *Criminal Code Act 1974* s 125E.

429 Royal Commission into Institutional Responses to Child Sexual Abuse, *Criminal Justice Report – Executive Summary and Parts I and II* (Report, August 2017) 56.

430 Submission 148 Anonymous, 5.

431 Statement of Katrina Munting, 5 April 2022, 7 [36].

432 Statement of Judith Cashmore, 3 May 2022, 18–19 [69].

433 *Evidence Act 2001* s 41.

434 For an overview of the research on the effect of cross-examination of children in sex offence trials, which also includes reference to alternative means of giving evidence, refer to Annie Cossins, 'Cross-Examination in Child Sexual Assault Trials: Evidentiary Safeguard or an Opportunity to Confuse?' (2009) 33(1) *Melbourne University Law Review* 68.

435 Statement of Judith Cashmore, 3 May 2022, 18 [69].

436 Statement of Katrina Munting, 5 April 2022, 7 [36]; Statement of Leah Sallese, 4 July 2022, 4 [26]; Anonymous session, 14 October 2022.

437 *Evidence (Children and Special Witnesses) Act 2001* pt 2A.

438 Tasmania Government, *Fourth Annual Report and Action Plan 2022* (December 2021) 7; Tasmania, *Parliamentary Debates,* House of Assembly, 30 May 2023, 25 (Elise Archer, Attorney-General).

439 Tasmanian Law Reform Institute, *Facilitating Equal Access to Justice: An Intermediary/Communication Scheme for Tasmania*? (Report No 23, January 2018).

440 *Evidence (Children and Special Witnesses) Act 2001* s 7, definitions of 'affected child, 'affected person', 'specified person' and 'specified proceeding'. Refer also to *Evidence (Children and Special Witnesses) Act 2001* s 7I.

441 Tasmania Police, *Tasmania Police Manual* (4 August 2021) 234 [4.4.10.9], 249 [4.6.3].

442 *Evidence (Children and Special Witnesses) Act 2001* s 7H.

443 *Evidence (Children and Special Witnesses) Act 2001* s 7I.

444 *Evidence (Children and Special Witnesses) Act 2001* s 7K. Note that under *Evidence (Children and Special Witnesses) Act 2001* s 7G(2)(b), where a person has unique knowledge of an individual with communication needs, the Court can refer the matter to the Secretary of the Department of Justice for consideration for temporary inclusion on the panel of intermediaries, so that person can be used as an intermediary for the particular individual.

445 Statement of Judith Cashmore, 3 May 2022, 19 [71].

446 Tasmanian Law Reform Institute, *Facilitating Equal Access to Justice: An Intermediary/Communication Scheme for Tasmania*? (Report No 23, January 2018) Recommendation 2.

447 Statement of Darren Hine, 14 June 2022, 89 [398].

448 Statement of Glenn Hindle, 21 June 2022, 8 [30].

449 Transcript of Darren Hine, 6 July 2022, 2483 [45–47].

450 Transcript of Darren Hine, 6 July 2022, 2484 [21–27].

451 Statement of Ginna Webster, 10 June 2022, 56 [352].

452 Statement of Ginna Webster, 10 June 2022, 56 [353].

453 Statement of Ginna Webster, 10 June 2022, 56–57 [354]; State of Tasmania, *Procedural Fairness Response*, 16 March 2023, 8–9.

454 Statement of Ginna Webster, 10 June 2022, 56–57 [354].

455 Statement of Ginna Webster, 10 June 2022, 56–57 [354].

456 Tasmania, *Parliamentary Debates,* House of Assembly, 30 May 2023, 25 (Elise Archer, Attorney-General).

457 Tasmania, *Parliamentary Debates,* House of Assembly, 30 May 2023, 25 (Elise Archer, Attorney-General).

458 Tasmania, *Parliamentary Debates,* House of Assembly, 30 May 2023, 25 (Elise Archer, Attorney-General).

459 Miriam Vandenberg, *Process Evaluation of the Witness Intermediary Scheme Pilot in Tasmania* (Report, December 2022) 35–36.

460 Tasmania, *Parliamentary Debates,* House of Assembly, 30 May 2023, 25 (Elise Archer, Attorney-General).

461 *Justice Miscellaneous (Royal Commission Amendments) Act 2023* ss 15, 30, 32.

462 *Evidence (Children and Special Witnesses) Act 2001* s 7I, 7J.

463 Tasmanian Law Reform Institute, *Facilitating Equal Access to Justice: An Intermediary/Communication Scheme for Tasmania?* (Report No 23, January 2018) Recommendation 3.

464 Targeted consultation, Tasmania Legal Aid, 2 September 2021.

465 Refer to, for example, *Criminal Procedure Act 2009* (Vic) pt 8.2 divs 1, 4–8.

466 *Evidence (Children and Special Witnesses) Act 2001* ss 6, 6A.

467 *Evidence (Children and Special Witnesses) Act 2001* s 7.

468 *Evidence (Children and Special Witnesses) Act 2001* s 5.

469 *Evidence (Children and Special Witnesses) Act 2001* s 4.

470 *Evidence (Children and Special Witnesses) Act 2001* s 7A.

471 *Evidence (Children and Special Witnesses) Act 2001* ss 3, 7J.

472 *Evidence (Children and Special Witnesses) Act 2001* ss 4, 5 6B.

473 *Evidence (Children and Special Witnesses) Act 2001* s 3, definition of 'affected person'.

474 *Evidence (Children and Special Witnesses) Act 2001* ss 6A, 6.

475 *Evidence (Children and Special Witnesses) Act 2001* s 7J.

476 *Evidence (Children and Special Witnesses) Act 2001* ss 7A, 7B.

477 *Evidence (Children and Special Witnesses) Act 2001* s 8(1).

478 Statement of Daryl Coates, 6 June 2022, 58–9 [210].

479 Statement of Daryl Coates, 6 June 2022, 57 [206].

480 Statement of Daryl Coates, 6 June 2022, 59 [210].

481 Statement of Judith Cashmore, 3 May 2022, 19 [71].

482 Director of Public Prosecutions, *Prosecution Policy and Guidelines* (18 October 2022) 52.

483 Director of Public Prosecutions, *Prosecution Policy and Guidelines* (18 October 2022) 52.

484 Statement of Leah Sallese, 4 July 2022, 3 [23].

485 Transcript of Judith Cashmore, 6 May 2022, 512 [9–14].

486 Statement of Tiffany Skeggs, 23 June 2022, 45 [192].

487 Statement of Daryl Coates, 6 June 2022, 82 [271].

488 Statement of Daryl Coates, 6 June 2022, 82 [274].

489 *Justice Miscellaneous (Royal Commission Amendments) Act 2023* s 28.

490 *Justice Miscellaneous (Royal Commission Amendments) Act 2023* s 29.

491 Daryl Coates, Director of Public Prosecutions, 'Response to NTP-DPP-001', 20 September 2021, 26 produced in response to a Commission notice to produce, 26.

492 Statement of Daryl Coates, 6 June 2022, 80 [266].

493 Daryl Coates, Director of Public Prosecutions, 'Response to NTP-DPP-001', 20 September 2021, 24, produced in response to a Commission notice to produce.

494 Daryl Coates, Director of Public Prosecutions, 'Response to NTP-DPP-001', 20 September 2021, 24, produced in response to a Commission notice to produce, 1 September 2021.

495 Daryl Coates, Director of Public Prosecutions, 'Response to NTP-DPP-001', 20 September 2021, 25, produced in response to a Commission notice to produce, 1 September 2021.

496 Daryl Coates, Director of Public Prosecutions, 'Response to NTP-DPP-001', 20 September 2021, 25, produced in response to a Commission notice to produce, 1 September 2021.

497 Targeted consultation, Office of the Director of Public Prosecutions, 20 August 2021.

498 Targeted consultation, defence lawyers, 9 September 2021.

499 Daryl Coates, Director of Public Prosecutions, Statement produced in response to a Commission notice to produce, 1 September 2021, 25.

500 State of Tasmania, *Procedural Fairness Response*, 16 March 2023, 10.

501 Transcript of Judith Cashmore, 6 May 2022, 505 [25–35].

502 For a general discussion on tendency and coincidence evidence in Australian jurisdictions refer to Royal Commission into Institutional Responses to Child Sexual Abuse, *Criminal Justice Report – Parts III–VI* (Report, August 2017) 417–454.

503 Royal Commission into Institutional Responses to Child Sexual Abuse, *Criminal Justice Report – Parts III–VI* (Report, August 2017) 262.

504 Royal Commission into Institutional Responses to Child Sexual Abuse, *Criminal Justice – Executive Summary and Parts I and II* (Report, August 2017) Recommendations 44–51.

505 *Evidence Act 2001* s 101(5); *Criminal Code Act 1924* s 326A.

506 *Criminal Code Act 1924* s 326A.

507 *R v Bauer* [2018] HCA 40; *IMM v R* [2016] HCA 14; *Hughes v R* [2017] HCA 20.

508 *Justice Miscellaneous (Royal Commission Amendments) Act 2023* ss 22, 23.

509 *Evidence Act 1995* (NSW) s 97A.

510 Tasmania, *Parliamentary Debates*, House of Assembly, 24 November 2022, 55 (Elise Archer, Attorney-General).

511 *Evidence Act 2001* s 97 (tendency evidence) and s 98 (coincidence evidence).

512 *Evidence Act 2001* s 101(2).

513 *Evidence Act 2001* s 97A(3).

514 *Evidence Act 2001* s 97A(5)(c). To some extent these provisions reflect recent court decisions that have broadened the principles of admissibility of tendency evidence.

515 There are also changes designed to make it easier to admit coincidence evidence, refer to *Evidence Act 2001* s 98(1A).

516 Council of Attorneys-General, *Council of Attorneys-General (CAG) Communiqué* (Web Page, 29 November 2019) <https://parlinfo.aph.gov.au/parlInfo/download/media/pressrel/7363430/upload_binary/7363430.pdf;fileType=application%2Fpdf#search=%22media/pressrel/7363430%22>; Council of Attorneys-General, *Model Uniform Evidence Bill* (Web Page, 29 November 2019) <https://pcc.gov.au/uniform/2019/Evidence_Model_Bill_Nov-2019.pdf>.

517 Statement of Kerri Collins, 11 April 2022, 3 [13–14].

518 Transcript of Daryl Coates, 7 July 2022, 2624 [37–45].

519 Transcript of Daryl Coates, 7 July 2022, 2624 [5–21]; Statement of Daryl Coates, 6 June 2022, 122 [402]–124 [405].

520 Statement of Daryl Coates, 6 June 2022, 78 [265(d)].

521 Statement of Daryl Coates, 6 June 2022, 78 [265(d)].

522 *Criminal Code Act 1924* s 361A(2).

523 Statement of Daryl Coates, 6 June 2022, 78 [265(d)].

524 Statement of Daryl Coates, 6 June 2022, 77–8 [265].

525 Section 205 does not apply to a new trial if the order would be inconsistent with any order, decision made or direction given on an appeal or would otherwise not be in the interests of justice: *Criminal Procedure Act 2009* (Vic) s 205(2).

526 Royal Commission into Institutional Responses to Child Sexual Abuse, *Criminal Justice Report – Parts VII to X and Appendices* (Report, August 2017) Recommendation 70.

527 *Jury Directions Act 2015* (Vic).

528 *Evidence Act 2001* s 165(2).

529 *Evidence Act 2001* s 165(1)(c).

530 *Evidence Act 2001* s 165(6).

531 *Evidence Act 2001* s 165A(2).

532 Statement of Terese Henning, 1 July 2022, 7–8 [37].

533 Statement of Judith Cashmore, 3 May 2022, 13–14 [47].

534 If the trial judge considers that the reliability or credibility of a child witness is likely to be in issue during the trial, the trial judge must direct the jury as set out above as soon as is practicable, unless there are good reasons for not doing so: *Jury Directions Act 2015* (Vic) s 44N.

535 *Jury Directions Act 2015* (Vic) s 44N(4).

536 Transcript of Tiffany Skeggs, 30 June 2022, 2027 [44]–2028 [3].

537 Statement of Katrina Munting, 5 April 2022, 4 [17].

538 Catherine Esposito, *Child Sexual Abuse and Disclosure: What Does the Research Tell Us?* (Research Paper prepared for the Department of Family and Community Services, New South Wales Government, 2014) 12.

539 Statement of Michael Salter, 7 April 2022, 18 [67].

540 Statement of Daryl Coates, 6 June 2022, 80 [265].

541 Refer to, for example, Victorian Law Reform Commission, *Sexual Offences: Interim Report* (2003) [5.98]–[5.124]; Victorian Law Reform Commission, *Sexual Offences: Final Report* (2004) 84–85. Refer also to *Ewen v R* [2015] NSWCCA, 117 [10].

542 Royal Commission into Institutional Responses to Child Sexual Abuse, *Criminal Justice Report – Executive Summary and Parts I and II* (Report, August 2017) Recommendations 64–65.

543 Royal Commission into Institutional Responses to Child Sexual Abuse, *Criminal Justice Report – Executive Summary and Parts I and II* (Report, August 2017) Recommendations 64–65.

544 *Evidence Act 2001* s 165A(1) inserted by the *Evidence Amendment Act 2010* s 46.

545 Statement of Terese Henning, 1 July 2022, 9 [42].

546 This provision was inserted by the *Criminal Code Amendment (Sexual Offences) Act 1987* s 17.

547 *R v Murray* (1987) 11 NSWLR 12.

548 Statement of Daryl Coates, 6 June 2022, 79 [265].

549 Statement of Daryl Coates, 6 June 2022, 79 [265].

550 Statement of Robert Boost, 2 September 2022, 4 [22].

551 [2015] NSWCCA 117 [140].

552 Statement of Daryl Coates, 6 June 2022, 79 [265(f)].

553 *Ewen v R* [2015] NSWCCA 117.

554 Statement of Daryl Coates, 6 June 2022, 79 [265(f)].

555 Statement of Robert Boost, 2 September 2022, 3 [16].

556 The name 'Rachel' is a pseudonym; Order of the Commission of Inquiry, restricted publication order, 11 May 2022; Statement of 'Rachel', 14 April 2022, 3–4 [16].

557 Statement of Azra Beach, undated, 3 [19].

558 Statement of Tiffany Skeggs, 23 June 2022, 22 [84].

559 Royal Commission into Institutional Responses to Child Sexual Abuse, *Criminal Justice Report – Executive Summary and Parts I and II* (Report, August 2017) Recommendation 65(a).

560 Judy Cashmore et al, *The Impact of Delayed Reporting on the Prosecution and Outcomes of Child Sexual Abuse Cases* (Report prepared for the Royal Commission into Institutional Responses to Child Sexual Abuse, August 2016).

561 Statement of Judith Cashmore, 3 May 2022, 9–10 [32(b)].

562 Statement of Judith Cashmore, 3 May 2022, 10 [32(b)].

563 Statement of Judith Cashmore, 3 May 2022, 10 [33].

564 Statement of Terese Henning, 1 July 2022, 7 [36].

565 Statement of Terese Henning, 1 July 2022, 7 [36].

566 *Criminal Code Act 1924* s 371A.

567 *Jury Directions Act 2015* (Vic) s 52(4).

568 Statement of Daryl Coates, 6 June 2022, 80 [265].

569 Royal Commission into Institutional Responses to Child Sexual Abuse, *Criminal Justice Report – Executive Summary and Parts I and II* (Report, August 2017) 93.

570 Victorian Law Reform Commission, *Improving the Justice System Response to Sexual Offences* (Report, September 2021) 442 [20.54].

571 Victorian Law Reform Commission, *Improving the Justice System Response to Sexual Offences* (Report, September 2021) Recommendation 79.

572 Royal Commission into Institutional Responses to Child Sexual Abuse, *Criminal Justice Report – Executive Summary and Parts I and II* (Report, August 2017) 11.

573 Royal Commission into Institutional Responses to Child Sexual Abuse, *Criminal Justice Report – Executive Summary and Parts I and II* (Report, August 2017) 11.

574 Royal Commission into Institutional Responses to Child Sexual Abuse, *Criminal Justice Report – Executive Summary and Parts I and II* (Report, August 2017) 11.

575 Statement of Teresa Henning, 1 July 2022, 6 [34].

576 Statement of Patrick Tidmarsh, 16 June 2022, 15 [83].

577 Transcript of Patrick Tidmarsh, 6 July 2022, 2495 [20–30].

578 Statement of Patrick Tidmarsh, 16 June 2022, 15–16 [86].

579 Transcript of Judith Cashmore, 6 May 2022, 510 [7–29].

580 Submission 148 Anonymous, 5.

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17 Redress, civil litigation and support

A note on language

In other chapters of our report, we generally use the terms victim-survivor and perpetrator or abuser. However, in this chapter, we also use the terms claimant and offender because they have particular meanings in redress and civil systems. A reference to victim-survivors is a reference to child and adult victim-survivors, unless otherwise specified.

1 Introduction

Victim-survivors of child sexual abuse often suffer serious harms, including difficulty in forming and maintaining relationships, a continuing sense of shame and loss of trust in others.[1] Victim-survivors often experience depression, anxiety, flashbacks and other physical and mental health impacts of trauma, which can make it difficult to complete education, work and maintain a career.[2] The impacts of child sexual abuse can lead to substance misuse, poverty, homelessness and difficulty in parenting. Victim-survivors of child sexual abuse in institutional settings also experience the additional impacts of betrayal and loss of trust in public institutions. Some victim-survivors who might objectively be 'okay' still live with the memory of the abuse and mourn the life and opportunities they could have had if they had not been sexually abused.[3]

Many victim-survivors who shared their experiences with our Commission of Inquiry wanted an apology or recognition of the harm they suffered.[4] They also wanted the Government to acknowledge its responsibility for their harm, and to take steps to ensure children were better protected in the future.[5]

Victim-survivors of child sexual abuse often need psychological support and an individual response to their experience. Some wish to seek financial compensation. The terms of reference for our Commission of Inquiry required us to consider:

> what the Tasmanian Government should do to address, or alleviate the impact of, past and future child sexual abuse in institutional contexts, including, in particular, ensuring justice for victims through … support services.[6]

The National Royal Commission published several interim reports during its five-year inquiry, including a 2015 report on redress and civil litigation, which dealt with these issues.[7] In its final report, the National Royal Commission recommended introducing a redress scheme for victim-survivors of child sexual abuse that would include:

- monetary payments
- counselling and psychological support
- a direct personal response
- changes to the approaches of state and territory governments to civil litigation claims by victim-survivors.[8]

Many of the National Royal Commission's recommendations have been adopted in Tasmania, which has also joined the National Redress Scheme.[9] The Government provides some psychological support and limited compensation to victims of crime through a Victims of Crime Assistance Scheme.

What we heard suggests there is a need for significant additional reform to improve the operation of existing mechanisms that support and compensate victim-survivors. The mechanisms discussed in this chapter include the National Redress Scheme, civil litigation, apologies, support (including financial assistance) for victims of crime, and access to information and records.

The important reforms we recommend in this chapter include measures to:

- ensure victim-survivors of child sexual abuse in Tasmanian Government institutions continue to have access to a redress scheme, including in relation to child sexual abuse experienced on or after 1 July 2018 (which falls outside the scope of the present National Redress Scheme)

- review the Government's litigation practices and how civil claims arising from allegations of child sexual abuse are managed, and clarify the roles of the Solicitor-General, departmental secretaries and other Heads of Agencies in the conduct and settlement of civil litigation arising from allegations of child sexual abuse in institutional settings
- ensure government institutions adopt a consistent and appropriate approach to apologies to individual victim-survivors of child sexual abuse
- ensure the Victims of Crime Assistance Scheme is administered in a way that minimises delays and handles applications in a sensitive and trauma-informed manner
- enable victim-survivors of child sexual abuse who have applied for an award under the *Victims of Crime Assistance Act 1976* ('Victims of Crime Assistance Act') to seek merits review of decisions of Criminal Injuries Compensation Commissioners by the Tasmanian Civil and Administrative Tribunal
- review the operation of the *Right to Information Act 2009* ('Right to Information Act') and the *Personal Information Protection Act 2004* ('Personal Information Protection Act') to ensure victim-survivors of child sexual abuse in institutional contexts can get access to information relating to that abuse.

In Chapter 3, we recognise that non-sexual forms of abuse can contribute to an institutionalised culture that treats violence, bullying and harassment as normal, and that sexual abuse can co-occur with other types of abuse and neglect. This was the case in Ashley Youth Detention Centre. Responses for victim-survivors of child sexual abuse should take into account their whole experience of abuse.

2 The National Redress Scheme

The National Royal Commission recommended establishing a single national redress scheme for victim-survivors of institutional child sexual abuse. The scheme would apply in all states and territories. The National Royal Commission saw a national scheme as the most effective structure.[10] It recommended the elements of redress schemes should include:

- the offer of an apology and a direct personal response from institutions to victim-survivors
- counselling and psychological care
- monetary compensation as tangible recognition of the seriousness of the hurt and injury suffered.[11]

The Australian Parliament enacted the *National Redress Scheme for Institutional Child Sexual Abuse Act 2018* (Cth) ('National Redress Scheme Act') to establish the National Redress Scheme. The National Redress Scheme began operating on 1 July 2018.[12]

To create the National Redress Scheme, state and territory governments needed to refer legislative power to enact it to the Australian Parliament. All states and territories have now joined the National Redress Scheme. Tasmania adopted the National Redress Scheme from 1 November 2018.[13]

In this chapter, we consider the National Redress Scheme at a high level, including eligibility requirements, the life of the Scheme, direct personal responses and advice and support. In Volume 5, we discuss the amount of claims the State has been receiving about current staff and the challenges of initiating disciplinary action based on claims under the Scheme. We recommend, in Chapter 12, that the Government improve its information sharing processes in relation to the National Redress Scheme to protect the safety of children and to advocate at a national level for a review of the information sharing framework under the Scheme.

2.1 Entitlement requirements

The entitlement requirements for the National Redress Scheme are set out in the National Redress Scheme Act.[14] Broadly, the National Redress Scheme applies to any Australian citizen or permanent resident born before 30 June 2010, who was subjected to child sexual abuse in a government institution or participating institution before 1 July 2018. To apply for redress, the applicant must be 18 years of age or turn 18 before 30 June 2028. This date is known as the 'sunset date'—the date when the National Redress Scheme ends.[15] The closing date for applications is 30 June 2027 (12 months before the sunset date).[16]

We heard from some victim-survivors who do not qualify for redress under the National Redress Scheme, in some cases because the abuse occurred more recently. There are likely to be others who did not contact us.

The sunset date for the end of the National Redress Scheme was also identified as a barrier to people accessing redress. In his evidence, Warren Strange, Chief Executive Officer, knowmore Legal Service ('knowmore'), emphasised the difficulties the application deadline for redress will create for many people. He said:

> So, we know it takes a long time, and at least 22 years on average for survivors to make a disclosure about their experience of child sexual abuse, often longer. There will be people who are eligible to apply for the National Redress Scheme, and it won't be the right time for them or they won't have the supports or the safety to apply during its life. … I feel very much that these people need to have justice options available into the future that are appropriate for them and suit their timing rather than the timing of what we or what governments might impose.[17]

Some people are not eligible for redress under the National Redress Scheme, even if they were abused in an institution during the period required and make a claim prior to the sunset date. A person who is in gaol at the time the application is made is not eligible for redress unless the National Redress Scheme Operator ('Operator') determines the circumstances are exceptional.[18]

A person who has been sentenced to imprisonment for five years or longer for a state, territory, federal or foreign country offence cannot receive redress unless the Operator determines the person is eligible.[19] The Operator may determine a person is entitled to redress as long as this would not:

- 'bring the scheme into disrepute'
- 'adversely affect public confidence in, or support for, the scheme'.[20]

In determining eligibility, the Operator must consider any advice from a 'specified advisor'. Where the abuse occurred in a Tasmanian Government institution or the offence was against a Tasmanian law, the Tasmanian Attorney-General is the specified advisor.[21]

The Operator must also consider:

- the nature of the offence
- the length of sentence of imprisonment
- the length of time since the person committed the offence
- any rehabilitation of the person
- any other relevant matters.[22]

The National Redress Scheme requires the Operator give greater weight to advice received from the Tasmanian Attorney-General than to any other matter.[23]

In June 2021, a review of the National Redress Scheme expressed 'significant and immediate concern' about the eligibility of prisoners under the Scheme 'given the representation of child abuse survivors in the prison population'.[24] The review noted the restrictions on the eligibility of prisoners:

- 'potentially deny individuals the subject of institutional child sexual abuse the opportunity to apply for redress'
- 'appear to be deterring eligible applicants from applying'
- have an 'adverse impact on Aboriginal and Torres Strait Islander survivors'.[25]

The review recommended the eligibility criteria be changed to enable a single application process for prisoners and those with serious criminal convictions, as well as non-citizens and non-permanent residents who experienced child sexual abuse in Australia.[26]

The Australian and state and territory governments released their final response to the review in May 2023. In this response, they committed to changing the National Redress Scheme, including its eligibility criteria.[27] All governments agreed to:

- remove the restriction on people in prison applying to the Scheme
- refine the special assessment process for determining eligibility for applicants with serious criminal convictions
- enable child migrants who are not Australian citizens or permanent residents to be eligible for redress.[28]

However, the Australian Government also considered the current special assessment process for people with serious criminal convictions 'should be adjusted rather than removed entirely, to ensure that public confidence in the Scheme is maintained'.[29] The Australian Government stated that once these changes are implemented, 'only people with certain types of particularly serious offences (such as homicide and sexual offences) or where there may be a risk to the integrity of the Scheme in allowing access to redress will go through the special assessment process'.[30] These adjustments have not yet been made. We discuss this review below in more detail.

2.2 What does the Scheme provide?

The National Redress Scheme has three components.

The first component is a maximum payment of $150,000.[31] To receive financial redress, the victim-survivor must relinquish any claim for damages against the institution. In the case of government institutions, this would be the relevant state government.[32]

The second is a counselling and psychological component. This component comprises access to counselling and psychological services provided under the Scheme or a payment (of up to $5,000) to enable the person to access counselling and psychological services provided outside the Scheme.[33]

The third is a 'direct personal response' from the relevant institution. This can include one or more components of an:

- apology or a statement of acknowledgement or regret
- acknowledgement of the impact of the abuse on the person
- assurance about the steps the institution has taken, or will take, to prevent abuse from occurring again.

The legislation also allows the response to include an opportunity for the person to meet with a senior official of the institution.[34]

Victim-survivors who spoke to the National Royal Commission emphasised the importance of receiving an explanation of why the abuse occurred and why they did not receive an appropriate response.[35] Many of them wanted reassurance that other children would not suffer in the same way in the future.[36] Our Commission of Inquiry received similar evidence from victim-survivors.[37] The National Redress Scheme, through a direct personal response (if a victim-survivor chooses to receive one), may enable victim-survivors to access such information.

2.3 The operation of the National Redress Scheme in Tasmania

The Operator of the National Redress Scheme, and not the Tasmanian Government, determines entitlement for redress. The Operator is the Australian Government Secretary of the Department of Social Services.[38]

The Child Abuse Royal Commission Response Unit ('Royal Commission Response Unit') in the Department of Justice coordinates the Tasmanian Government's response to redress claims.[39] Ginna Webster, Secretary, Department of Justice, described the Tasmanian Government's role in the administration of the National Redress Scheme as summarised below.[40]

When the Operator identifies the Tasmanian Government as potentially responsible for a case of abuse, the Operator notifies the Tasmanian Government of the application and gives limited time to provide necessary information.[41] The Royal Commission Response Unit summarises the application and sends it to the relevant body (in the case of Tasmanian Government institutions, this will be a department or agency). The relevant body must then retrieve relevant records.[42] The department or agency is given six weeks to provide records for a non-priority application and three weeks for a priority application (where the applicant is elderly or ill).[43]

Information the Royal Commission Response Unit obtains through this process is then forwarded to the Operator, who determines eligibility to apply under the National Redress Scheme.[44] If the Tasmanian Government department or agency needs extra details to satisfy the request for information, the Royal Commission Response Unit approaches the Operator who may contact the applicant.[45]

The Royal Commission Response Unit makes the request for relevant government records so the applicant does not need to apply for information under the Right to Information Act. As discussed below, the need to apply for information under the Right to Information Act often creates difficulties for victim-survivors who want to seek damages from the Tasmanian Government, rather than make a claim under the National Redress Scheme.

Secretary Webster told us the Tasmanian Government offers counselling and psychological care to any applicant who accepts the monetary payment and contracts with organisations to provide this care.[46] The Tasmanian Government manages and facilitates requests for counselling and psychological care and a direct personal response through the Royal Commission Response Unit.[47]

Based on the information Secretary Webster provided on 8 April 2022, as modified by subsequent information provided by the Solicitor-General of Tasmania:[48]

- 689 claims have been made in relation to Tasmanian Government institutions since the National Redress Scheme started[49]
- the Operator had finalised 494 applications by offering a monetary payment, counselling and a direct personal response[50]
- the Tasmanian Government's total monetary compensation amounted to $31,204,169.66[51]
- 48 claims were not approved by the Operator or were withdrawn by the applicant, while 147 claims had not been determined when our Commission of Inquiry received this information[52]
- 275 applicants were eligible for counselling and psychological care, but when Secretary Webster gave her evidence, only 53 applicants had requested those services[53]
- 10 applicants had requested face-to-face direct personal responses, with four of those applicants also choosing to receive a written direct personal response, and an additional nine applicants choosing to receive only a written response.[54]

The Royal Commission Response Unit normally responds to requests for information within the specified time. Fourteen two-week extensions had been granted for providing information.[55] Secretary Webster confirmed these were all completed within the permitted two-week extension time.[56]

2.3.1 A direct personal response

A key part of the Tasmanian Government's responsibilities under the National Redress Scheme is managing individual requests for a direct personal response from government institutions or the Tasmanian Government.

The Tasmanian Government cannot contact applicants to the National Redress Scheme and is not given the contact details of individuals. The Royal Commission Response Unit must wait for an individual to make contact.[57]

2.3.2 Redress advice and support services

In Tasmania, several organisations advise and support victim-survivors regarding applications under the National Redress Scheme. They include knowmore, the Sexual Assault Support Service, Relationships Australia Tasmania and the South East Tasmanian Aboriginal Corporation.[58]

In particular, victim-survivors need to be carefully advised about how and whether to make a National Redress Scheme claim, because accepting redress will prevent them from seeking damages from the relevant institution or government.[59]

Mr Strange explained to us the advice and support knowmore provides.[60] Established in 2013, this organisation is a national community legal service that helps victim-survivors of institutional child sexual abuse. The Australian Government funds knowmore to provide various services to victim-survivors of institutional child sexual abuse.[61] It does not have an office in Tasmania, but visits Tasmania regularly and provides advice remotely. When comparing the state's population with the rest of Australia, Tasmania is disproportionately represented among knowmore's clients, amounting to 4 to 5 per cent of its clients.[62]

Mr Strange told us that where a National Redress Scheme claim:

> … appears to be straightforward and the client does not have complex support needs and/or has existing relationships with support workers, such as social workers and psychologists, knowmore may refer the client to a local Redress Support Service to progress their … application. [63]

Mr Strange said knowmore advises and supports victim-survivors to help them decide whether to make a claim under the National Redress Scheme or to pursue a civil claim for damages. It also gives clients initial advice on the pros and cons of this choice.[64] Mr Strange emphasised the difficulty of gaining a client's trust because of the complex trauma they have suffered and the fact they had often told their stories to police or other officials with no outcome.[65] He commented on the importance of building trust with local communities and respecting 'the scepticism, and often difficulty of engaging, that many victims and survivors of child sexual abuse understandably have'.[66]

If a person is considering suing for damages, knowmore does not advise them about their prospects of success, but will refer the client to a member of a panel of private law firms that have entered into a memorandum of understanding with knowmore. This memorandum is intended to ensure the firm responds sensitively and appropriately to victim-survivors.[67] If the person decides to apply under the National Redress Scheme, they will be referred back to knowmore who will help them apply, free of charge, or will refer them to a local redress support service.[68]

Mr Strange said knowmore handles complex redress claims such as those:

- that need to be resolved quickly because the client has a terminal illness

- where cultural support is needed from knowmore's Aboriginal and Torres Strait Islander Engagement Team
- where the client has received a sentence of five or more years of imprisonment and must demonstrate exceptional circumstances to qualify for redress.[69]

Mr Strange said knowmore had seen examples where the Tasmanian Attorney-General had opposed claims on the basis of a client's imprisonment, in situations where at least some other state Attorneys-General would not have done so on the same facts. While we acknowledge Mr Strange's view, we note that some applicants under the National Redress Scheme have been convicted of serious crimes, including child sexual abuse. The Tasmanian Government told us that of the 21 requests for advice received through the National Redress Scheme, the Tasmanian Attorney-General has provided advice supportive of redress in 13 of those cases.[70] While the Operator must consider advice from the Tasmanian Attorney-General on such matters, the final decision rests with the Operator. Mr Strange also stated there had been 'lengthy delays' in such cases.[71]

As well as giving initial advice to victim-survivors, knowmore provides training and information to local support services and helps them by reviewing draft National Redress Scheme applications, where necessary.[72] It also provides information to clients about speaking to police about their abuse and has helped clients to engage directly with specialist units or taskforces.[73]

2.4 Criticism of the National Redress Scheme

We heard evidence that the handling of enquiries by the National Redress Scheme had not taken sufficient account of the trauma that victim-survivors had experienced. For example, Kylee Pearn, who was abused by James Griffin, telephoned the National Redress Scheme in 2020 to ask some general questions about eligibility for redress. Ms Pearn was referred to a lawyer.[74] Ms Pearn told us that the following occurred at a subsequent phone appointment with this lawyer:

> Before determining eligibility, they went through a series of questions about what abuse had actually occurred to me, and I certainly wasn't anticipating that, I felt they didn't ask those questions in a very trauma-informed way. One particular question I remember is, they asked if his 'penis, tongue or finger had penetrated any of my orifices'. [75]

Ms Pearn, a social worker, said, in that role, she would never have asked the question in that way.[76] Presumably, the question was asked because the amount of compensation paid under the National Redress Scheme depends on the nature of the abuse, including whether the offence was penetrative or non-penetrative.[77] Still, we agree with Ms Pearn's concern that questions about the details of her abuse were raised during a phone appointment with a lawyer in the context of a general enquiry about eligibility.

The lawyer responding to her enquiry could have explained how the National Redress Scheme operated in a general way, without asking her for details about her abuse.

We accept the Tasmanian Government may often be unaware of victim-survivors' concerns or complaints about their interactions with the National Redress Scheme, given the Australian Government administers the Scheme and there is often no direct contact between the Tasmanian Government and victim-survivors seeking redress. However, where the Tasmanian Government is aware of insensitive interactions with victim-survivors in responding to enquiries or managing applications under the National Redress Scheme, it should bring these issues to the attention of the Australian Government.

The Australian Government should ensure that staff, including contractors who assess entitlement for redress, are appropriately trained to do this in a sensitive and trauma-informed manner.

There was also criticism of delays in the assessment process. Secretary Webster told us that the time limits are usually met for the Tasmanian Government to provide relevant information.[78] This suggests that overcoming perceived delays in assessment will require changes in the Australian Government's administration of the National Redress Scheme. The Australian Government (and all other participating jurisdictions) should examine what measures are needed to reduce application processing delays under the Scheme.

2.5 The Second Year Review of the National Redress Scheme

Between July 2020 and March 2021, Robyn Kruk AO undertook an independent review of the National Redress Scheme.[79] As noted above, the final report on the *Second Year Review of the National Redress Scheme* ('Second Year Review') was delivered at the end of March 2021.[80]

The Second Year Review concluded 'there remains a strong commitment to the original objectives that led to the set-up of the Scheme'.[81] However, it also noted consensus among victim-survivors and stakeholders in several areas relating to:

> ... the need to improve survivor experience; hold institutions accountable; strengthen the levers being utilised to facilitate non-government institutions signing on; support Scheme integrity; increase transparency; drive ongoing improvement of Scheme operation and performance; and address unintended or negative survivor consequences identified in the Scheme's early conduct linked to legislation, policy and practice.[82]

As the National Redress Scheme was approaching its third year of operation and the timeframe for improving the National Redress Scheme was 'extremely limited', the Second Year Review focused on issues that had the greatest potential to

improve participation and experience for victim-survivors and sustain the viability of the Scheme.[83] Among other things, it examined the following topics:

- improving survivor experience
- access and applying for redress
- assessing abuse
- eligibility
- redress payments
- counselling and apologies (direct personal responses)
- staffing capability and support
- Scheme information management systems
- funding arrangements.[84]

The Second Year Review made 38 recommendations relating to improving survivor experience, delivering better outcomes, enhancing fairness integrity, staff capability and support and improving communications. Some of these recommendations included:

- amending the National Redress Scheme Inter-governmental Agreement, so survivors and non-government institutions have formal input into the Scheme's operation (Recommendation 1.1)
- developing a co-designed Survivors' Service Improvement Charter by the end of 2021 (Recommendation 2.1)
- amending the eligibility criteria to include a single application process for all applicants, including non-citizens, non-permanent residents, prisoners, people with serious criminal convictions and care leavers (Recommendation 3.2)
- exploring alternative mechanisms to enable access to the Scheme for vulnerable individuals, Aboriginal and Torres Strait Islander, culturally and linguistically diverse and applicants with disability (Recommendation 3.8)
- making assessment and policy guidelines publicly available by removing legislative protections to achieve greater transparency in decision making and consistency with contemporary practices of other government schemes (Recommendation 3.13)
- co-developing and implementing a clinically designed recruitment and selection process for all new staff to ensure they are trauma aware and possess the capability and capacity to provide a trauma-informed redress service to survivors (Recommendation 6.4)

- mandating the auditing and reporting on staff participation in clinically designed and delivered training programs that include modules on:
    - trauma-informed and culturally safe practices
    - work health
    - safety and wellbeing
    - privacy
    - protected information
- monitoring the efficacy of the training programs through survivor feedback mechanisms (Recommendation 6.5)
- assessing whether the redress Information and Communications Technology system is fit for purpose (Recommendation 6.8)
- committing to continue improvements in complaint management and reflecting these in the Survivor's Service Improvement Charter (Recommendation 6.11).

The Second Year Review noted that because of the 'extremely limited' time available to implement changes, 'unprecedented cooperation by all governments that enabled the Scheme's establishment' would be required.[85]

In May 2023, the Australian Government released its full response to the Second Year Review, in which it outlined the Government's actions and ongoing commitment to improving the National Redress Scheme for victim-survivors. It noted that state and territory governments had collaborated closely on the agreed responses to the Second Year Review's recommendations.[86] In summary, the Australian Government:

- supported 30 of the 38 recommendations in full
- supported four recommendations in part or with amendment (including recommendation 3.2 referred to above)
- did not support four recommendations (including Recommendation 3.13 referred to above).

In response to Recommendation 3.2 (also referred to above), the Australian Government advised that a Service Charter had been co-developed with victim-survivors, redress support services and advocacy groups. The Charter began in September 2022 and is publicly available on the National Redress Scheme's website.[87] It sets out 'standards to be maintained in ensuring the Scheme operates in a safe, transparent and responsive way for survivors, and also outlines what survivors who apply to the Scheme can expect from the redress process'.[88]

We are pleased the Australian, state and territory governments support many of the Review's recommendations. Implementing these recommendations may help improve the operation of the Scheme and overcome concerns we heard about how enquiries and applications for redress are managed. We encourage the Australian Government to further extend the Scheme to people who have committed serious crimes.

2.6 Our observations

As we have explained, victim-survivors of child sexual abuse in Tasmanian Government institutions are entitled to redress under the National Redress Scheme only where the abuse occurred before 1 July 2018. Victim-survivors must apply for redress on or before 30 June 2027, 12 months before the end of the Scheme.[89] At the time of the application, victim-survivors must be 18 years of age or be turning 18 before 30 June 2028.[90]

The limited life of the National Redress Scheme diverges from the recommendations of the National Royal Commission, which recommended that redress schemes, when established, should have no fixed closing date. The National Royal Commission contemplated that when applications had declined to such a level it would be reasonable to consider closing the Scheme, a closing date might be specified at least 12 months into the future.[91]

Counsel Assisting our Commission of Inquiry asked Secretary Webster about planning for alternative or replacement schemes to meet the compensation and counselling needs of victim-survivors when the National Redress Scheme does not apply. She accepted that any replacement scheme should consider what had been learned from experience of the limitations of the National Redress Scheme, including the need to minimise delays in responding and provide trauma-informed case management of applicants.[92]

We are heartened by Secretary Webster's recognition that a redress scheme is needed to assist victim-survivors who were abused after 1 July 2018 and who have never been covered by the National Redress Scheme. We understand the Tasmanian Attorney-General has indicated the Tasmanian Government is open to taking action to ensure compensation and counselling is available for these victim-survivors.[93]

Our Inquiry has shown the Tasmanian Government has failed to protect some children in Tasmanian Government institutions from child sexual abuse and related conduct, in historical and contemporary contexts. In our view, the Tasmanian Government should have a responsibility to continue to provide an avenue for victim-survivors to obtain appropriate redress for past abuse, other than by pursuing a civil claim against the Tasmanian Government.

We are not convinced that applications to the National Redress Scheme have declined to such a degree that the National Redress Scheme should close, as provided for under the National Redress Scheme Act. The findings of our Commission of Inquiry make it clear that child sexual abuse remains a contemporary issue, in and beyond Tasmanian Government institutions.

Some barriers to taking civil action for damages relating to child sexual abuse have been removed, notably where institutions responsible for children have failed to exercise a duty of care to take reasonable precautions to prevent child sexual abuse. However, victim-survivors seeking damages will still meet obstacles of cost, delay and cross-examination if the matter goes to trial. This is in addition to the traumatic effect of having to constantly recount their experience of child sexual abuse. In contrast, well-designed redress schemes allow victim-survivors to obtain a measure of justice without facing these problems.

The Australian Government should consider extending the scope of the National Redress Scheme to allow all people who have experienced child sexual abuse to access the Scheme, irrespective of when they were born or when the abuse occurred. This would cover child sexual abuse that occurred on or after 1 July 2018, in addition to abuse that occurred before 1 July 2018. The time for making applications for redress under the existing Scheme would also have to be extended beyond 30 June 2027. We also note the National Redress Scheme currently requires that the victim-survivor turns 18 before the Scheme's sunset date, which would also need to be removed. If the Australian Government does extend the Scheme, it should consider the Second Year Review in full, noting that the review focused on changes achievable within the life of the Scheme at the time.

If the Australian Government does not extend the National Redress Scheme to cover child sexual abuse that occurred on or after 1 July 2018, we recommend the Tasmanian Government step in to establish a redress scheme covering child sexual abuse in Tasmanian Government institutions that falls outside the scope of the current National Redress Scheme.

Any Tasmanian redress scheme should also consider the recommendations of the Second Year Review (discussed in Section 2.5) and ensure redress is available to victim-survivors of institutional child sexual abuse, regardless of when that abuse occurred. The scheme should also minimise the kinds of problems that have arisen with the National Redress Scheme. In particular, the scheme should reduce delays, and manage applications for redress in a sensitive and trauma-informed manner.

We consider that any redress scheme—a national or a Tasmanian one—should be available to people with serious criminal convictions in the same way it is to other victim-survivors. We are conscious that many children and young people who were abused at Ashley Youth Detention Centre are now in the adult justice system, some for serious offences. This approach is in line with the recommendation of the Second Year Review.

The scheme should also be structured to allow information to be shared to reduce current risk to children, wherever possible, and to facilitate disciplinary action and reporting to Tasmania Police, Child Safety Services, the Registrar of the Registration to Work with Vulnerable People Scheme and the Independent Regulator under the *Child and Youth Safe Organisations Act 2023* (refer to Recommendation 12.5).

Our findings in relation to Ashley Youth Detention Centre demonstrate that physical, sexual and psychological abuse of children can co-occur in institutions. While we have not inquired into this matter in detail, the Government might explore the benefits of extending any redress scheme to any serious abuse of a child in an institutional context, particularly as it would provide an alternative to civil litigation.

Recommendation 17.1

1. The Tasmanian Government should ensure victim-survivors of child sexual abuse in Tasmanian Government institutions have access to a redress scheme irrespective of when the abuse occurred, when they were born or whether they have committed a serious offence.
2. To achieve this outcome, the Tasmanian Government should advocate at a national level for:
    a. the National Redress Scheme to apply to child sexual abuse in institutions experienced on or after 1 July 2018, with no specified closing date for applications
    b. changes to the National Redress Scheme that will allow access to redress for people sentenced to imprisonment for five years or longer for a state, territory, federal or foreign country offence.
3. If the National Redress Scheme is not extended, the Tasmanian Government should itself establish a redress scheme for victim-survivors of child sexual abuse in Tasmanian Government institutions, with no specified closing date for applications to be made.
4. The design and operation of any Tasmanian redress scheme should:
    a. ensure delays are minimised and that applications for redress are handled in a sensitive and trauma-informed manner
    b. incorporate relevant recommendations made in the *Second Year Review of the National Redress Scheme*

c. make it available to people sentenced to imprisonment for five years or longer for a state, territory, federal or foreign country offence

d. allow information to be shared to reduce current risk to children wherever possible, and to facilitate disciplinary action and reporting to Tasmania Police, Child Safety Services, the Registrar of the Registration to Work with Vulnerable People Scheme and the Independent Regulator under the *Child and Youth Safe Organisations Act 2023* (Recommendation 12.5).

3 Civil litigation

A person injured by the wrongful act or negligence of another person may seek damages from the person who injured them and, in some situations, from the institution or organisation where that person worked. In some situations, they may be able to sue the employer for damages for the acts of an employee.

In theory, a person injured by the perpetrator of child sexual abuse may be able to recover damages from that perpetrator.[94] However, this is of little practical use if the perpetrator has no financial resources and is not covered by insurance.

In these situations, the victim-survivor may wish to seek damages against the body that failed to protect them from abuse. In the context of our Commission of Inquiry, this would require a civil claim against the State of Tasmania. If a claim is initiated, the Tasmanian Government may admit liability and enter negotiations with the claimant to settle the claim and pay damages, or contest the claim in court proceedings. The following discussion relates to civil damages claims against the Tasmanian Government in relation to child sexual abuse in government institutions. We do not discuss civil claims against perpetrators.

The National Royal Commission acknowledged there are many difficulties victim-survivors may face in pursuing civil litigation other than those addressed in its final report. These include legal costs, difficulties in bringing class or group actions, and the burden of giving evidence and being subject to cross-examination.[95] These difficulties may be shared by many other people who pursue civil litigation relating to personal injury or other claims.

Academic commentators have expressed concerns about access to compensation through the torts system (the civil law system) for at least the past 20 years.[96] Apart from the problems of cost and delay faced by all those who seek to recover damages for harm they have suffered, the system is particularly difficult for victim-survivors of child sexual abuse in institutional settings. They may have to repeat their account of abuse several times. They will be subjected to cross-examination that seeks to cast doubt on the accuracy of their recollections.

There have also been many inquiries into access to justice in the civil system. In 2014, the Productivity Commission concluded that, while court processes in all jurisdictions have undergone reforms to reduce the cost and length of litigation, 'progress has been uneven and more needs to be done to avoid unnecessary expense'.[97]

More resources may be needed to better meet the legal needs of disadvantaged Australians. The Law Council of Australia's Justice Project states Australians who experience disadvantage can find it more difficult to get access to justice for a multitude of reasons, including:

- education and literacy levels
- language barriers
- financial constraints
- lack of accessibility
- access to information and digital technology
- past traumas and hesitation to engage in legal processes
- lack of knowledge around rights and where to go for advice or help.[98]

3.1 Reforms based on National Royal Commission recommendations

The National Royal Commission identified other barriers that prevented victim-survivors of child sexual abuse from obtaining damages from institutions. They recommended various law reforms to address these barriers.[99] The Tasmanian Government enacted legislative reforms to implement these recommendations, though some of these changes do not apply to past (or 'historical') abuse. The most important of these legislative changes, for our purposes, were removing time limits and expanding the liability of institutions.

On 1 July 2018, time limits were removed from civil actions started by victim-survivors of child sexual or serious physical abuse. The change was retrospective, so it applies to historical abuse claims.[100]

Legal principles were reformed that made it difficult to hold institutions, including government agencies, liable for child sexual abuse.[101] Under amendments made to the *Civil Liability Act 2002* ('Civil Liability Act'), which came into operation on 1 May 2020, institutions responsible for children now have a duty of care to take reasonable precautions to prevent relevant individuals associated with the organisation from abusing those children.[102] The onus is on the institution to prove it took reasonable precautions to prevent the abuse.[103] Institutions are also vicariously liable for the actions of employees (or people similar to employees) who abuse a child.[104] These provisions only apply to child abuse perpetrated after 1 May 2020.[105]

This means most of the settlement negotiations in which the Tasmanian Government is currently engaged will be conducted under the previous law.

The National Royal Commission also noted that some states had adopted model litigant policies and principles to guide their approach to civil litigation arising out of child sexual abuse.

In this context, the Solicitor-General released *Model Litigant Guidelines* in 2019.[106] These guidelines require the Tasmanian Government and its agencies to:

- settle legitimate claims promptly and without resort to litigation
- not contest liability where the only issue is the amount of damages, or the application of a remedy
- not require a party to prove a matter that the Tasmanian Government knows to be true
- not rely on technical issues where the Tasmanian Government will not suffer prejudice, unless it is necessary to do so in the public interest, or to protect the Tasmanian Government's interests.

In 2019, the Solicitor-General also released *Guidelines for the Conduct of Civil Claims*, which contain guidance relevant specifically to litigation involving victim-survivors of child sexual abuse.[107] These guidelines state the Tasmanian Government and its agencies must:

- acknowledge the potential for litigation to retraumatise claimants, and act to minimise this potential
- avoid unnecessarily adversarial conduct and communications
- facilitate access to records relating to the claimant and the alleged abuse, subject to other privacy and legal restrictions
- offer alternative forms of acknowledgement or redress, in addition to monetary claims.

As discussed in more detail below, we consider that further practice changes should be made to ensure the spirit of these guidelines is reflected in practice.

3.2 Criticism of State conduct of civil litigation

Paul Turner SC, the then Assistant Solicitor-General, who oversaw the conduct of litigation on behalf of the Tasmanian Government, said in evidence that the *Model Litigant Guidelines* were taken seriously. He said:

> From time to time the contention will be made that the state is not acting as a model litigant or hasn't complied with the guidelines which the Cabinet have directed apply to abuse in care claims. We, by and large, don't think that those have substance, those complaints—they're rare, I hasten to say, but we're just acutely conscious of these and how they are to apply and how the state is to conduct litigation.[108]

However, our Commission of Inquiry heard evidence about the considerable difficulties faced by people who seek damages from the Tasmanian Government. A submission from Laurel House, a sexual assault support service, observed that:

> … there remains significant challenges for victim-survivors of child sexual abuse to bring about civil claims against any organisation, especially the Tasmanian Government. In particular, the process for bringing civil claims against the Tasmanian Government is not sufficiently transparent, and many victim-survivors can find it difficult to pursue legal action due to significant functional challenges related to trauma. Further, for many victim-survivors concerns about the potential cost of legal action and fear about how they will be treated through … civil proceeding acts as a barrier.[109]

We heard from lawyers who have acted for claimants that, at least until recently, the Tasmanian Government response did not consider claimants' trauma and the delays and other obstacles they may encounter in resolving their claim. These factors may worsen the harm caused by child sexual abuse and may cause some people to give up a damages claim that might otherwise have succeeded.

Angela Sdrinis, Director, Angela Sdrinis Legal, a plaintiff law firm that specialises in sexual and institutional abuse and has acted for more than 1,700 victim-survivors across Australia, gave evidence about the responses faced by claimants. She said:

> Whilst the Solicitor-General's Office lawyers are good lawyers, their approach to responding to child sexual abuse matters has been noticeably different to that of government lawyers we deal with in other Australian jurisdictions. It is evident that there has either been a lack of understanding amongst the Tasmanian Solicitor-General's Office lawyers that such matters must be conducted in a more trauma-informed way or their approach has been based on instructions from the Government.[110]

Ms Sdrinis said there had been some improvements in approach over the more than six years she had been involved in the process, but at least until recently, there was

- a reluctance to discuss settling a claim before filing proceedings
- a technical and legalistic approach to claims
- an insensitive approach to claimants.[111]

Ms Sdrinis also stated that following the record award of $5.3 million to a sexual abuse survivor, the settlement offers being made in Tasmania were now more consistent with settlements and awards made in the mainland states.[112]

Similarly, Mr Strange referred to feedback from their panel of independent lawyers that the Tasmanian Government was less willing than some religious institutions to take part in genuine settlement conferences and, sometimes, adopted an overly adversarial approach.[113]

We note that knowmore supported providing appropriate training to all government lawyers and departmental staff involved in responding to child sexual abuse claims, so they could better understand child sexual abuse and its impacts. In knowmore's view, lawyers involved in child sexual abuse matters would benefit from understanding the impacts of abuse and how delays and failures to negotiate can compound a person's trauma.[114]

In the following sections, we briefly describe specific problems raised by these witnesses and others who spoke to us about the difficulties of pursuing civil litigation in relation to child sexual abuse. Specific issues raised with us included:

- the reliance by the Solicitor-General's Office on the 'consent' of the victim-survivor of child sexual abuse to deny civil liability
- the approach of Tasmanian Government institutions and the Solicitor-General's Office in settlement negotiations, including in relation to access to medical reports and making apologies
- delays by Tasmanian Government institutions in providing information and settling claims.

We also acknowledge the changes that have been made during our Commission of Inquiry in response to some of these concerns, including the Tasmanian Attorney-General's statement in March 2023 about managing civil claims in a sensitive and not unnecessarily adversarial manner through the establishment of a new State Litigation Office.[115]

3.2.1 Reliance on consent

Ms Sdrinis told us that:

> … in some matters the Tasmanian Government has argued that limitation periods still apply where the claimant allegedly 'consented' to a sexual relationship even though the claimant was a minor and the sexual conduct might be a criminal offence under s124 of the *Criminal Code*.[116]

Ms Sdrinis said she was unaware of any other jurisdiction that had relied on 'consent' in this way where the victim was a minor and the perpetrator was an older person. She also stated that, to her knowledge, the 'consent' argument had only been made in relation to female young people and not male young people.[117]

As far as we understand it, such an argument would rely on an interpretation of the meaning of the term 'sexual abuse' in the *Limitation Act 1974* which, in our view, is legally dubious. It also appears to be inconsistent with a legislative and policy intention to remove the limitation period for child abuse.

The Tasmanian Government has told us the issue has only arisen in two cases (both of which involved a female young person).[118] We have undertaken no consideration or analysis of those cases, including whether or not there was discrimination or bias.

Following media publicity about one of these cases, the Attorney-General directed that no reliance should be placed on consent, to avoid the reform of limitation periods.[119] We are glad that is now the case, but consider it would be useful for the Solicitor-General to provide guidance to lawyers working in that Office to ensure they do not take this position in the future.

We also encourage the Tasmanian Government to actively monitor whether the notion of 'consent' is being used in responding to civil claims relating to child sexual abuse and whether the legislative and policy intention to remove the limitation period for child abuse is being honoured.

3.2.2 Approach in settlement negotiations

Ms Sdrinis also told us that despite the adoption of the Solicitor-General's *Model Litigant Guidelines* (referred to in Section 3.1), the Tasmanian Government originally showed little interest in non-litigious settlements of child sexual abuse claims.[120] One client had settled against Ms Sdrinis's legal advice because of the Tasmanian Government's resistance to the claim.[121]

Ms Sdrinis said that, initially, the Solicitor-General's Office had shown no interest in agreeing to an informal protocol to govern the settling of claims, as is the process in Victoria. She had first written to the Tasmanian Government in 2015 proposing such a protocol.[122] She was told, in late 2017, the Tasmanian Government would no longer require the filing of proceedings before settling child sexual abuse claims, but it took another couple of years for further progress.[123] The Tasmanian Government now no longer requires statements of claim to be drafted before settlement negotiations can occur, which reduces the cost of making a claim.[124]

Ms Sdrinis also criticised the requirement that claimants attend the opening session of an informal settlement conference between their solicitor and lawyers representing the Tasmanian Government.[125] She said this requirement did not apply elsewhere and considered its purpose had been to demonstrate the Tasmanian Government's 'hard-line approach' to settling claims.[126] Clients who had been abused in out of home care were particularly vulnerable. She said:

> People who are abused as children often develop self-destructive behaviours post the abuse. In ward of state claims we have situations where children probably experienced trauma or at least neglect, because that's why they've gone into care, so to sit there and hear government lawyers analyse those life experiences in a way which is designed to support an argument that compensation should be reduced or minimised because of non-related trauma, can obviously be very hurtful to a claimant.[127]

It appears the Solicitor-General's Office no longer insists claimants attend opening sessions, and even if there is a legitimate reason for raising these issues, the Tasmanian Government 'seems to be more aware of the trauma that can be caused to claimants if participation in a mediation or informal settlement conference is not well managed'.[128]

We also received a submission from Shine Lawyers, the third-largest specialist plaintiff litigation law firm in Australia. Shine Lawyers has represented numerous victim-survivors of institutional sexual abuse in civil litigation and other legal proceedings.[129]

Shine Lawyers criticised the Tasmanian Government's response to damages claims, pointing out that statutory reforms 'did not mean survivors had an unobstructed path towards justice'.[130] Criticisms of inadequate responses to civil claims causing further roadblocks for victim-survivors included:

- an unnecessarily adversarial approach to civil claims
- an implication that victim-survivors ought to pursue redress under the National Redress Scheme rather than through a civil claim
- the lack of a collaborative framework to respond to civil claims against the Tasmanian Government.[131]

In their submission, Shine Lawyers gave many examples of the Tasmanian Government's obstructive and uncompassionate behaviour, including a case where the Tasmanian Government suggested that the victim-survivor should make a claim against the individual perpetrator, rather than the institution.[132] In another case, a victim-survivor, who had entered into a deed settling her claim for an inadequate amount, was pressured by the Tasmanian Government not to seek further compensation.[133] Months later, the Tasmanian Government agreed to set aside the deed rather than pursue a contested application in court.[134] Regarding those two matters, the Tasmanian Government told us its view was that one or both matters did not involve the State of Tasmania.[135]

3.2.3 Medical reports

Ms Sdrinis also acknowledged some positive changes, including how the Tasmanian Government is now more prepared to consider joint medical examinations, the cost of which the Tasmanian Government will cover.

The Solicitor-General's *Guidelines for the Conduct of Civil Claims* provide that the Tasmanian Government must, in appropriate matters, suggest a range of potential experts to claimants that:

- are acceptable to the Tasmanian Government
- provide genuine choice to claimants
- where appropriate, help both parties agree to use a single expert.[136]

Using a single expert ensures both parties have access to medical reports or other expert evidence.

However, as we discuss below, the Tasmanian Government has previously also claimed privilege over independent medical examination reports.[137]

Victim-survivors will usually produce a medical report or a report from a psychologist to support their claim for damages. The Tasmanian Government, sometimes, will require them to attend another health practitioner (or practitioners), so an independent medico-legal report can be prepared about the nature and cause of the harm on which the claimant relies.

Ms Sdrinis was critical that the Tasmanian Government is able to claim, and has claimed, legal professional privilege over such reports because such an approach is not trauma-informed.[138] Further, Ms Sdrinis said the Tasmanian Government sometimes relies, in negotiations, on aspects of the medical report that have not been made available to the claimant or their lawyer.[139] Ms Sdrinis said, in Victoria, if the Victorian Government were to arrange a medical assessment, the contents of the report would be made available to the claimant.[140]

In his evidence, Mr Turner attributed to the previous Solicitor-General the practice of claiming privilege over medical reports. He said the position is 'generally that, in circumstances where a report has been obtained [that] attracts that privilege it won't be waived unless an advertent decision is made that it is favourable to the interests of the state, in which case it will be'.[141] As we understand it, that meant medical evidence that supported the claim for damages was not necessarily revealed to the victim-survivor. The Tasmanian Government has now informed us this position changed in July 2022 after instructions were sought and received from the Attorney-General to waive privilege in relation to medical reports as a matter of general policy.[142] We are pleased this change has been made.

3.2.4 Reinforcing the Litigation Guidelines

The *Model Litigant Guidelines* and the *Guidelines for the Conduct of Civil Claims* were released in 2019, and while there have been some improvements in negotiating settlements, these guidelines appear to have had limited impact. In its *Fifth Annual Progress Report and Action Plan 2023*, the Tasmanian Government refers to a statement by the Honourable Elise Archer MP, Attorney-General and Minister for Justice, to the effect that:

> … the management of civil claims is to be conducted with the utmost sensitivity to victim-survivors and in a manner that is not unnecessarily adversarial. This included that all state lawyers apply a trauma-informed lens to all decisions relating to the management of child sexual abuse civil litigation matters against the State.[143]

We welcome this statement and other changes in practice that may have occurred recently. However, to ensure civil claims are handled appropriately, Tasmanian Government lawyers need to understand the effect of child sexual abuse on victim-survivors and the problems they may face during the litigation process. Secretary Webster told us it was the responsibility of the Solicitor-General to ensure that lawyers in her office were aware of these issues.[144] She said, in 2021, members of the Litigation Division of the Office of the Solicitor-General had taken part in training on trauma awareness and providing a trauma-informed direct personal response.[145]

3.2.5 Delays in providing information and settling claims

Mr Strange, Ms Sdrinis and Shine Lawyers told us victim-survivors often experienced long and stressful delays in obtaining information they had requested to support their claims.[146] Both Ms Sdrinis and Mr Strange said the situation in Tasmania was worse than in other states, which was retraumatising for clients.[147] Shine Lawyers said that even when the Tasmanian Government was notified of a likely claim, it might take months to be given details of the person handling the matter.[148] Further, when the Tasmanian Government was initially notified of some claims, 'the notice bounced around between different officers and departments who responded variously with comments such as "we don't know who looks after these claims"'.[149]

Lengthy delays in responding to lawyers' requests for information may also be caused by inadequate record keeping or insufficient numbers of state servants who can recover and provide the information. In her evidence, Secretary Webster said:

> Yes, so in terms of what we have found since certainly the matters that came to the attention of the Commission … but also through the civil and criminal litigation areas, that we do need some additional resourcing in the civil litigation, the Abuse in State Care area. It's clear that that includes legal practitioners, administrative support, and I think, depending on the final model, the management of those matters could probably also benefit from some clinical advice on how they're managed as well; and by that I mean trauma-informed practice.[150]

Shine Lawyers told us delays make it harder for a claimant to recover from the harm they have suffered and adds to their stress.[151] While the Tasmanian Government has made some changes, improvements have been patchy. As we explain below, some but not all delays appear to relate to the operation of the Right to Information Act. We discuss this issue in Section 6.2.

3.3 The Solicitor-General's role

The Solicitor-General acts as a lawyer for the Tasmanian Government, including in relation to legal issues relevant to institutional child sexual abuse. In this section, we discuss the role of the Solicitor-General and their Office in advising whether claims for damages against the Tasmanian Government by victim-survivors should be settled,

and in conducting litigation where the Tasmanian Government denies liability. We also, briefly, discuss the role of the Solicitor-General more broadly.

The *Solicitor-General Act 1983* ('Solicitor-General Act') establishes the Solicitor-General as an independent statutory office that is accountable to the Tasmanian Parliament. Under section 7 of the Solicitor-General Act, the Solicitor-General's functions are to:

- act as counsel for the Crown in right of Tasmania or for any other person for whom the Attorney-General directs or requests them to act
- perform such other duties ordinarily performed by legal practitioners as the Attorney-General directs or requests them to perform
- perform such duties (if any) as are imposed on them by or under any other Act.

A direction from the Attorney-General, dated 13 January 2022, made under section 7(b) of the Solicitor-General Act, requires the Solicitor-General to act for the Tasmanian Government in civil proceedings.[152]

Under section 8 of the Solicitor-General Act, the Attorney-General can delegate responsibility for powers and functions that can be performed by the Attorney-General, to the Solicitor-General. At present, there has been no delegation under section 8 to the Solicitor-General.[153]

Section 51(1) of the *Financial Management Act 2016* ('Financial Management Act') allows the Treasurer of the Tasmanian Government to issue instructions relating to the principles, practices and procedures all agencies must observe in their financial management. 'Agencies' covers specified Tasmanian Government departments, authorities, bodies, organisations and offices.[154] Accountable authorities and officers within these agencies have a duty to comply with the Treasurer's instructions.[155] Section 55 of the Financial Management Act allows the Treasurer to authorise payment to a person if the Treasurer is satisfied it is appropriate to do so because of special circumstances, even though the payment would not otherwise be authorised by law or be required to meet a legal liability (also known as an 'ex gratia payment').

Under a Treasurer's instruction made under section 51 of the Financial Management Act, all agencies and instrumentalities of the Crown must get legal advice only from Law Officers of the Crown. They must follow that legal advice in relation to 'the legal functions, powers or responsibilities of the Crown; or the lawfulness of any action, or proposed course of action, by the Crown'.[156] The effect of that Treasurer's Instruction is that all departments must seek advice only from the Solicitor-General's Office unless Crown Law—the administrative entity responsible for providing legal services to the Tasmanian Government—agrees in writing that the agency can get external advice.[157]

The accountable authority (in most cases, the Head of the relevant Agency) 'must not directly engage external counsel or commercial legal services without the written agreement of Crown Law'.[158]

During our hearings, we sought to clarify the roles of the Solicitor-General, departmental secretaries and other Heads of Agencies in settling civil claims arising from child sexual abuse in government institutions.

We heard evidence on this issue from Sarah Kay SC, Solicitor-General, and Mr Turner. At the time of our hearings, Mr Turner was the head of the section of the Solicitor-General's Office that deals with civil litigation.

The Solicitor-General referred to the Treasurer's Instruction under the Financial Management Act, which requires the Solicitor-General to act as Counsel for the Crown, and the Attorney-General's direction that the Solicitor-General conducts all civil litigation on behalf of the Tasmanian Government.[159]

The Solicitor-General said these instructions were based on 'a constitutional convention'.[160] The Treasurer's Instruction, which prevents agencies from getting external legal advice, states the Instruction reflects the following constitutional principles:

- the Crown must ascertain and obey the law
- unless otherwise lawfully permitted, the Crown must get its legal advice from Law Officers of the Crown.[161]

The Treasurer's Instruction, including the Instruction that prevents getting external legal advice without an exemption, applies to the Ombudsman and the Chief Executive Officer of the Integrity Commission.[162] Arguably, the application of the Instruction to these specified Agencies and Accountable Authorities is inconsistent with the intention these bodies be independent from the Executive.

In response to questions from Counsel Assisting, the Solicitor-General differentiated between advising on the legal rules which regulate how agencies can act, and instructing agencies about the decision they should make, stating 'we might assist [agencies] to form their decision within correct legal parameters in order to protect that ultimate decision from challenge, but we do not dictate what sort of decision that might be made'.[163] The Solicitor-General did not elaborate on how that distinction operated in the case of advice about settlement of civil claims.

In addition, the Treasurer's Instruction does not clearly cover Solicitor-General advice about the precise amount of a settlement, which requires using discretion rather than a determination on whether a settlement is lawful.

According to their evidence, the Heads of Agencies generally consider the Solicitor-General makes the final decision on whether a claim should be settled. However, there was a lack of clarity about the role of a Head of Agency regarding payment amounts when a secretary considers the proposed settlement amount is too low.[164]

A Head of Agency or department may take the view the settlement amount the Office of the Solicitor-General proposes is too low because the:

- abuse was longstanding
- department responded inadequately to reports of risk of harm
- claimant suffered extreme harm
- department's reputation would be negatively affected by offering meagre damages in the situation that led to the claim.

Although a secretary can raise these concerns with the Solicitor-General's Office, the general view seems to be the Treasurer's Instruction relates to decisions about liability and amount of damages.[165]

Mr Turner said if there was a disagreement between the Solicitor-General's Office and a Head of Agency or department on this issue, they would discuss it, but if they could not resolve the matter, the Solicitor-General's Office would be the decision maker 'because we are part of the Crown'.[166] He based this interpretation of the Treasurer's Instruction on the approach taken by the Solicitor-General's predecessor and on the Solicitor-General Act.[167]

The usual duty of a lawyer is to advise their client, who can then accept or reject that advice. By contrast, it appears the Solicitor-General's role goes beyond advising a client to making decisions on behalf of Tasmanian Government agencies. We do not doubt the dedication of the lawyers who work in the Solicitor-General's Office. We also realise that Tasmanian public funding is stretched and the rationale for the Solicitor-General's virtual monopoly on providing legal advice may be to limit public spending.

We are concerned that restricting the ability of departmental secretaries and other Heads of Agencies to seek alternative advice in relation to settlements and litigation in all child sexual abuse cases could lead to complacency and reinforce practices that cannot be justified.

Restricting access to external sources of legal advice may also have negative consequences in other contexts relating to child sexual abuse in Tasmanian Government institutions. These contexts include when agencies seek advice about access to information applications, laws around information sharing, or in employment law disputes. Across our report, we have identified times when legal advice has affected whether agencies have taken action to protect the safety of children. We understand most other states do not prevent Heads of Agencies from obtaining external legal advice in situations where they consider it appropriate.

3.4 Our observations

Some barriers to recovering damages from the Tasmanian Government for child sexual abuse occurring in Tasmanian government institutions have been removed by legislative reforms following the final report of the National Royal Commission. However, in our view, other improvements can be made to help victim-survivors seek compensation through the civil litigation system without trauma.

Lawyers representing the Tasmanian Government have a duty to serve their client to the best of their ability. That duty may require a lawyer involved in settlement discussions to raise legal issues that may be obstacles to a successful claim by a victim-survivor. However, as the *Model Litigant Guidelines* recognise, and the Attorney-General has acknowledged, this duty should not prevent lawyers managing claims sensitively, for example, by considering a claimant's difficulties in having to talk about their abuse, sometimes on multiple occasions, and to submit to medical examinations.[168]

Secretary Webster's evidence suggests the Tasmanian Government is reconsidering its civil litigation practices. She noted:

> Work has been undertaken to review the structure and processes with respect to civil litigation and the management of child sexual abuse claims and information has been provided to the Attorney-General regarding potential changes that comply with her announced expectations with respect to the management of civil litigation.[169]

Nevertheless, we consider that staff who deal with civil claims relating to child sexual abuse need more detailed guidance. We recommend regular staff training on the nature and effects of child sexual abuse on victim-survivors and how to consider these effects when victim-survivors are involved in civil litigation processes.

We recommend the Tasmanian Government review its litigation practices and how it manages claims arising from allegations of child sexual abuse.

In this context, we note the Attorney-General's recent instruction that claims should not be made by the Tasmanian Government's representatives for legal professional privilege in relation to medical reports or other expert evidence relevant to child sexual abuse.

As noted above, in March 2023, the Attorney-General announced the Tasmanian Government would 'establish a new separate State Litigation Office to take over the management of the Tasmanian Government's civil litigation'. The Attorney-General stated: 'this is an opportunity to contemporise the management of civil litigation and ensure an understanding of the impact of trauma and harm is embedded in all areas of the State's legal system'.[170]

The new State Litigation Office would provide the Attorney-General with 'advice regarding specific guidelines and directions on the handling of civil claims, including any changes to ensure that processes are more victim-centric and trauma-informed'.[171]

In performing its functions, the new Office should consider our conclusions and recommendations concerning Tasmanian Government litigation practices and the management of claims arising from allegations of child sexual abuse in Tasmanian Government institutions.

In addition, we consider that the respective roles of departmental secretaries and the Solicitor-General need to be clarified, particularly in relation to determining the amount of damages that should be offered in civil litigation matters. We also consider that departmental secretaries and other Heads of Agencies should be authorised to seek external legal advice when they consider it appropriate. The Tasmanian Government should consider whether external advice should be available more broadly in other contexts where agencies wish to seek legal advice relating to child sexual abuse in government institutions.

Recommendation 17.2

1. The Tasmanian Government should ensure all lawyers who act for the Tasmanian Government in civil claims relating to child sexual abuse receive regular professional development on:
    a. the nature and effects of child sexual abuse, including institutional child sexual abuse, perpetrator tactics and impacts on victim-survivors
    b. how to consider these effects when victim-survivors are involved in civil litigation processes.
2. The Solicitor-General or the new State Litigation Office should issue and ensure compliance with guidelines relating to:
    a. trauma-informed management of settlement processes and conferences in child sexual abuse cases
    b. whether and when legal professional privilege should be claimed by the Tasmanian Government in relation to medical reports or expert evidence, adopting the principle that generally legal professional privilege should be waived
    c. making apologies before reaching a final settlement.

Recommendation 17.3

1. The Attorney-General should issue guidelines to clarify the respective roles of the Solicitor-General and the new State Litigation Office, departmental secretaries and other agency heads where Tasmanian government agencies are engaged in the conduct and settlement of civil litigation arising from allegations of child sexual abuse.
2. The Treasurer's Instruction relating to obtaining external legal advice should be amended to:
    a. make it consistent with the Attorney-General's guidelines on civil litigation arising from allegations of child sexual abuse
    b. specify the circumstances in which departmental secretaries and other agency heads should be able to seek external legal advice on matters related to child sexual abuse.

4 Apologies

4.1 The importance of apologies to victim-survivors

Victim-survivors, who gave evidence at our hearings, made submissions or took part in a session with a Commissioner, spoke about the importance of receiving a direct personal response to their experiences. Alex (a pseudonym), for example, stated:

> I would have loved to have got an apology. I went [to the health service] wholly and solely to find out the outcome of that incident and if that perpetrator is still working amongst children … if I'd received the help when I asked for it [at the time] and when I asked for it [4 years later], I don't think I would be this broken person.[172]

Katrina Munting, who in 2018 disclosed alleged abuse by a teacher, also spoke about the Department of Education's failure to acknowledge what had happened to her, even after the teacher had been charged with offences. She wrote to the Minister for Education 16 times in 2020 requesting to meet, and received 'two, maybe three, replies' signed by the Minister declining her request.[173] After many attempts to arrange meetings, she was referred to meet with the Deputy Secretary of the Department of Education.[174] Ms Munting said that although the Deputy Secretary listened well to her story and apologised to her, she would have 'preferred a proper, personalised apology from the Department of Education itself and a proper discussion with them so that they could hear me personally'.[175] At our hearings, Ms Munting indicated she needed more than just a 'generic' or 'sweeping' apology.[176] In her own words:

> … they need to be sorry that I was abused in their institution and they chose to ignore it, and they chose not to follow it up, and they chose to ignore me, and, you know, they need to name up exactly what it is that they're sorry for, because I don't want a hollow 'I'm sorry'. What are you sorry for? Because, not only have I been devastated by the abuse, the fallout that I've had to deal with since has made it so much worse.[177]

Azra Beach also gave evidence about the absence of any apology from the Tasmanian Government about the abuse she experienced in out of home care. She said a politician with whom she had raised this issue had assured her she would receive an apology, but this had not happened.[178] She told us:

> … no-one should have to chase up their own apology at all, and I think what makes this even worse is that the people that I have spoken with already knew that this was happening long before this Commission even came about; I raised it so many times, but I suppose because of who I am and, you know, sometimes how I talk and how I communicate it was complete—I felt, again, completely dismissed.[179]

In her evidence, Ms Sdrinis spoke about how an apology can help victim-survivors recover from the abuse. She said:

> In my experience, it's not always about the money for survivors. The money's important because that's the tangible acknowledgment of wrongdoing, but when survivors go on a journey where they're listened to, where they're believed, where the right amount of compensation is offered—and that's not always more money—it's about an amount of money that the survivor feels is adequate recognition—where there's an apology, a proper apology at the end of that process, and I'll say it again, most importantly, where the survivor feels listened to and believed, then that is trauma-informed practice and I've seen it change survivors' lives; like, completely change their lives.[180]

4.2 Apologies by the Tasmanian Government

The Tasmanian Government has made apologies relating to child sexual abuse in Tasmanian Government institutions.

On 26 February 2021, the Honourable Peter Gutwein MP, the then Premier of Tasmania, and the Tasmanian Police Commissioner issued an apology about police failings in the investigation of allegations against James Griffin.[181] The then Premier also referred to this apology in the Tasmanian Parliament on 2 March 2021.[182]

On 11 November 2021, Premier Gutwein also apologised on behalf of the Tasmanian Government and previous governments to victim-survivors of historical abuse in schools and other education facilities.[183]

During our Commission of Inquiry, the secretaries of the then Department of Education, the Department of Justice, the Department of Health and the then Department of Communities also acknowledged the failure to prevent, investigate and respond adequately to institutional child sexual abuse and its devastating effect on victim-survivors.[184]

On 8 November 2022, the Tasmanian Parliament delivered an apology to all victim-survivors of child sexual abuse in Tasmanian Government institutions.[185] As part of this apology, the current Premier, the Honourable Jeremy Rockliff MP, expressed deep regret for the institutional failures that led to a profound violation of trust, and for the harm caused to victim-survivors, some of whom had died and would not hear the apology. The Premier also acknowledged the bravery of people who had shared their experience with our Inquiry. He thanked those who had spoken up to protect children whose voices had previously been ignored. The Premier made an undertaking to all Tasmanians 'to never allow a repeat of this abuse, of the secrecy and the suppression' and 'to never allow a repeat of the failures that allowed such abuse to occur'.[186] He undertook to implement the recommendations of our Commission of Inquiry: 'Our Government is acutely aware of the enormous responsibility to act swiftly and to act decisively to implement the Commission's recommendations'.[187]

4.3 Apologies and civil litigation

Despite, or in addition to, these general apologies, some victim-survivors are likely to want a direct personal response from a senior state servant in the department that oversaw the institution where the abuse occurred. Ms Sdrinis told us the Tasmanian Government has not formally agreed to apologise to victim-survivors who are involved in civil litigation until their claim has been resolved. This contrasts with the approach of some organisations that apologise as soon as a claim has been served on them.[188]

Ms Sdrinis said apologies that recognise the suffering of the victim-survivor could also be offered before settlement in some civil damages claims.[189]

Where a victim-survivor is seeking damages from the Tasmanian Government, the Tasmanian Government may be reluctant to apologise because an apology could be treated as an admission of liability.

Under section 7 of the Civil Liability Act, an apology made by or on behalf of a person is not:

- an admission of fault or liability
- relevant to the determination of fault or liability
- admissible for that purpose in any civil proceedings.[190]

However, this provision does not apply to cases involving intentional acts of child sexual abuse.[191] This provision may also inhibit government agencies' ability to offer an apology when they first receive an allegation or complaint about child sexual abuse.

Some victim-survivors will not consider apologies as any consolation, unless the Tasmanian Government is prepared to settle the claim for damages.[192] However, an appropriately delivered apology that acknowledges an individual's suffering would provide solace to some. In her statement, Secretary Webster recognised this approach could be useful and said:

> The Office of the Solicitor-General has recently sought to improve their provision of trauma-informed redress to civil litigants. The Child Abuse Royal Commission Response Unit will engage with civil litigants to access redress by preparing personal apologies using … trauma-informed principles and support other forms of redress as requested.[193]

4.4 Our observations

We welcome the apologies the secretaries of Tasmanian Government departments gave during our Commission of Inquiry. We hope they will be of some comfort to victim-survivors. We recognise the symbolic significance of the public apology to victim-survivors by the Premier and the Tasmanian Parliament on 8 November 2022. We also welcome the Premier's commitment to implementing our recommendations.

In relation to a direct personal response, we recognise the risk of future harm to victim-survivors where apologies are given in relation to allegations of child sexual abuse and institutional failings that the Tasmanian Government later contests. Vacuous or meaningless apologies are of little help to victim-survivors. Institutions should adopt an approach that allows agency staff to give a human and compassionate response when interacting with victim-survivors.

We consider an apology should acknowledge what happened to the victim-survivors, answer any questions they might have about their time in the institution and the institution's response, and be prepared to answer questions about what steps have been taken to prevent child sexual abuse happening again.

Some of the difficulties victim-survivors have experienced in obtaining adequate responses, including apologies, may have been based on legal advice or concerns that an apology would be used by people to support a damages claim against the Tasmanian Government. In our view, the Tasmanian Government should be allowed to apologise for institutional child sexual abuse, without this affecting the liability of the Tasmanian Government.

In relation to civil litigation matters, we consider that, at least in some cases, it would be appropriate for the Tasmanian Government to apologise before the resolution of a claim. Similarly, when institutions receive allegations or complaints about child sexual abuse, they should feel able to make an immediate and genuine apology.

We recommend the Civil Liability Act be amended to ensure the Tasmanian Government and government institutions can apologise in relation to child sexual abuse without compromising any defence the Tasmanian Government may have, for example, based on all reasonable steps having been taken to protect a child from abuse.[194] There should be no legal disincentive to apologising.

Recommendation 17.4

The Tasmanian Government should ensure individual victim-survivors of child sexual abuse who request an apology receive one. Proactive steps should also be taken to offer an apology to victim-survivors who make contact in relation to their abuse. The apology should include:

a. the opportunity to meet with a senior institutional representative (preferably the Secretary) and receive an acknowledgment of the abuse and its impact

b. information about the victim-survivor's time in the institution

c. information about what steps the institution has taken or will take to protect against further sexual abuse of children, if asked.

Recommendation 17.5

The Tasmanian Government should introduce legislation to amend the *Civil Liability Act 2002* to ensure that an apology in relation to child sexual abuse can be made without amounting to an admission of liability.

5 Support for victims of crime

Victims Support Services in the Department of Justice provides various services to victims of crime, including child sexual abuse victim-survivors. These services are described below.[195] In addition, under the *Victims of Crime Assistance Act 1976* ('Victims of Crime Assistance Act'), eligible child sexual abuse victim-survivors can be financially compensated up to a prescribed maximum.[196] At present, this maximum is $30,918 in the case of the primary victim who suffers a single offence, and up to $51,531 for a victim of more than one offence. Compensation for the cost of medical, dental, psychological or counselling services, which a Criminal Injuries Compensation Commissioner is satisfied the primary victim will require in the future, can be awarded in addition to the prescribed maximum.[197]

5.1 Victims Support Services

Police or the Office of the Director of Public Prosecutions often refer victims of crime to Victims Support Services. Psychologists, counsellors or health practitioners sometimes make referrals. There is also a Victims Support Services website, which was reviewed and redesigned in 2021.[198]

Victim-survivors can also contact the service directly and often do. Victims Support Services includes a Victims of Crime Service, which provides access to counselling and other forms of support.[199] We discuss the Victims of Crime Service in more detail in Chapter 21 and make a recommendation to increase these services across the State (refer to Recommendation 21.5). In summary, the Victims of Crime Service can:

- refer a victim-survivor to other service providers
- provide information about the criminal justice system
- help victim-survivors prepare a victim impact statement.[200]

An estimated 85 per cent of all Victims Support Services clients accessing the Victims of Crime Service are supported to complete a victim impact statement.[201] These can be used for sentencing in criminal courts or for the Parole Board.[202] Statements also frequently form the basis of Victims of Crime Assistance applications.

Victims Support Services also keeps an Eligible Persons Register.[203] The Register allows victims to be given information about offenders.[204] This information is available to anyone who is registered as the victim of a violent crime, committed in Tasmania, where the offender has received a custodial sentence.[205] A victim-survivor of violent crime who is on the Register is entitled to receive certain information about the offender, including 'their location, security classification, parole hearing dates and possible release dates'.[206]

The Victims Support Services could not provide any figures on the number of victim-survivors who had sought counselling for child sexual abuse. Data on the Eligible Persons Register has similar limitations. Catherine Edwards, Manager, Victims Support Services, Department of Justice, told us a new case management system will enable this data to be obtained. The system is expected to be rolled out by December 2023.[207] In our view, it would be helpful if that database could differentiate between child sexual abuse in government institutions and in other contexts.

5.2 Victims of Crime Assistance Scheme

Victims of crime may be able to access financial assistance under the Victims of Crime Assistance Scheme. The Victims Assistance Unit in Victims Support Services provides administrative support for the Criminal Injuries Compensation Commissioners, who decide whether a victim of crime is eligible to receive financial support (or compensation) and the amount that should be awarded.[208] Ms Edwards said the Unit actively manages applications, liaises with victims of crime and their solicitors, and advises victims on its processes.[209]

Applications for compensation are initially reviewed by an assessment officer and then by a Commissioner, whose decision can be based on the papers alone, a telephone hearing or an in-person hearing.[210] Victims are supposed to be able to choose whether to attend a hearing, although one victim-survivor told us she was not given this choice.[211]

The victim may be asked to provide certain information, for example, medical records. Ms Edwards said if the person makes a direct claim, rather than being represented by a solicitor, Victims Support Services collects police and court records, rather than requiring the victim to do so.[212]

There are seven Criminal Injuries Compensation Commissioners. Ms Edwards told us a full-time fixed-term Commissioner was appointed in September 2018, and has been acting in this role since this time. There are six sessional Commissioners—two in Burnie, one in Launceston and three in Hobart.[213] Ms Edwards also told us the number of Criminal Injuries Compensation Commissioners was not fully funded and, as a result, the budget for Victims Support Services was in structural deficit, making it difficult to plan and recruit suitable Commissioners.[214] The Department of Justice told us, in March 2023, that it has now met this deficit to enable the full-time Commissioner position to be funded on an ongoing basis.[215]

Compensation can be awarded where the victim (or, in some situations, a family member) suffers injury or death as the result of an act that was a criminal offence or would have been an offence if the person committing the act were not too young to be criminally liable or was insane.[216] This would include victim-survivors of child sexual abuse. To award compensation, the Commissioner who hears the application must be satisfied, on the balance of probabilities, that the death or injury resulted from criminal conduct.[217]

The payments made under the scheme are modest. The amount of the award may cover:

- expenses reasonably incurred because of the injury
- the cost of future medical, dental, psychological or counselling services
- loss of wages or salary caused by the victim's total or partial incapacity for work
- compensation for the pain and suffering arising from the injury
- expenses reasonably incurred by the primary victim in claiming compensation.[218]

The following sections discuss factors potentially relevant to the success or otherwise of applications for compensation made by victim-survivors for institutional child sexual abuse.

5.2.1 Time limits

An application for an award under the Victims of Crime Assistance Act must generally be made within three years of the date of the relevant offence, unless the applicant was a child at the time of the offence, in which case they will have three years from the date they turn 18 years of age to apply.[219]

There is provision for a victim-survivor to apply for an extension of time if the Criminal Injuries Compensation Commissioner is satisfied there are special circumstances that justify the extension.[220] Victim-survivors and others expressed concern about the time limit for making applications for compensation. As one victim-survivor told us:

> Even with the best policies, processes and practices in the world, most victim/survivors of child sexual abuse, because of the very nature of the abuse, are going to take years to disclose. Is it fair for the time limit to apply to victims/survivors of child sexual abuse relative to other victims of crime?[221]

Ms Edwards told us that, since 2017, there had been two applications relating to child sexual abuse where an extension of time had been refused.[222]

We are pleased to note the recent commencement of the *Justice Miscellaneous (Royal Commission Amendments) Act 2023* on 20 April 2023 removed the time limits for applicants seeking compensation for child sexual abuse under the Victims of Crime Assistance Act.[223]

5.2.2 Behaviour of the victim

When deciding whether to make an award or the amount of the award, the Victims of Crime Assistance Act requires a Criminal Injuries Compensation Commissioner to: 'have regard to any behaviour, condition, attitude, or disposition of the victim that appears to him to have directly or indirectly contributed to the injury or death in relation to which the award is sought'.[224]

We would be concerned if a Criminal Injuries Compensation Commissioner used this provision to disqualify or reduce the compensation payable to children or young people who were groomed to believe their sexual abuse occurred in the context of a relationship with a perpetrator. We have already referred to civil litigation where a victim-survivor was told limitation periods still apply (and, therefore, damages were not payable) because they had 'consented' to the abuse. However, the Attorney-General intervened to change that practice (refer to Section 3.2). Similarly, issues about a child or young person's consent should never be raised in response to an application for compensation under the Victims of Crime Assistance Act.

5.2.3 Compensation and assisting prosecution

Although compensation can be awarded to a victim-survivor of child sexual abuse even if the perpetrator was not convicted of the offence or offences, under the Victims of Crime Assistance Act:

> The Commissioner shall not make an award to a person if that person has failed to do any act or thing which, in the opinion of the Commissioner, that person should reasonably have done to assist in the identification, apprehension, or prosecution of any person alleged to have committed the criminal conduct or alleged criminal conduct for which compensation is claimed. [225]

This could result in a denial of compensation if it would have been reasonable for a report to have been made. Ms Edwards told us if the victim had told a person in authority about the abuse or had suffered a psychological injury that made it difficult for them to tell anyone about it, these factors could be considered in deciding whether it was reasonable for the applicant not to report the offence.[226]

5.2.4 Compensation and civil proceedings

A Criminal Injuries Compensation Commissioner can refuse to make an award of compensation if satisfied the person has or had an adequate remedy in civil proceedings. They can consider any amount that was or was likely to be recovered in civil proceedings.[227] Potentially, this could place inappropriate pressure on a victim-survivor to become involved in civil litigation, even if they do not want to do so.

5.2.5 Review of decisions under the Victims of Crime Assistance Act

A decision by a Criminal Injuries Compensation Commissioner that compensation should not be awarded is not subject to merits review by the Tasmanian Civil and Administrative Tribunal. The decision cannot generally be appealed in the courts.[228]

In Victoria, a person affected by a decision of the Victims of Crime Assistance Tribunal, including refusing to make an award or determining the amount of assistance, may apply to the Victorian Civil and Administrative Tribunal for review of the decision.[229] This position is to be maintained under Victoria's new Financial Assistance Scheme, which is expected to open in 2024, and will replace the Victims of Crime Assistance Tribunal in Victoria.[230]

In New South Wales, some decisions of the Commissioner of Victims Rights are reviewable by the New South Wales Civil and Administrative Tribunal. This includes decisions about 'recognition payments' that are made in recognition of the trauma suffered by a victim of an act of violence.[231]

5.3 Criticisms of the operation of the Victims of Crime Assistance Scheme

5.3.1 Management of claims

Some victim-survivors criticised the management of applications for compensation under the Victims of Crime Assistance Scheme. We received an anonymous submission from a victim-survivor who told us she was abused by a teacher, employed by the Department of Education, for four years between the ages of 14 and 18.

This victim-survivor queried whether applications were actively managed and called for a mechanism for complaints about how Criminal Injuries Compensation Commissioners deal with applications.[232] She also commented on Commissioners' lack of training and accountability.[233]

More generally, she said that questions put to her by a Criminal Injuries Compensation Commissioner were 'unnecessary, intrusive, inappropriate, re-traumatising, contrary to Item 1 of the Victims Support Services Charter of Rights for Victims of Crime'.[234] She told us the questions were 'not in line with the findings and recommendations of [the National Royal Commission] or the Tasmanian Government's response to those recommendations'.[235] Among other things, the Criminal Injuries Compensation Commissioner asked her 'how I as an intelligent, well-educated and accomplished person was in a relationship with [the perpetrator] for so long (if not those exact words, words to that effect)'.[236]

5.3.2 Training

Ms Edwards said budget constraints limited her ability to implement comprehensive annual training for Victims Support Services staff.[237] In April 2016, counselling staff attended Blue Knot Foundation's two-day professional development training 'Working Therapeutically with People who have Complex Trauma Histories'.[238] She had also allowed staff to attend some professional development training, although the topics covered did not appear to relate specifically to trauma-informed practice or sexual abuse of children.[239] She said there was no budget for training Criminal Injuries Compensation Commissioners and she was 'limited' in her ability to direct Commissioners to take part in training, 'even in response to complaints'.[240]

Secretary Webster acknowledged the need to fund training for staff and Commissioners to ensure services and decisions were appropriately trauma-informed. She said:

> … I think the work [we're] doing around the Child Safe organisations and rolling training out around trauma-informed practice and a range of other things through that will be training that will be provided to the Victim Support Service of course, but I would expect that those statutory officers, I would also make that training available to those statutory officers.[241]

5.3.3 Delays

Significant delays may occur in operating the Victims of Crime Assistance Scheme because departments and other agencies fail to provide timely access to relevant records. This problem is discussed in more detail below, in relation to access to information and records.

5.4 Our observations

It is essential that staff of the Victims Support Services receive regular professional development on how to respond, in a trauma-informed and sensitive manner, to those who seek support or compensation for child sexual abuse. In Chapter 19, we recommend the Tasmanian Government develop a whole of government approach to professional development in responding to trauma within government and government funded services that provide services to children and young people or adult victim-survivors of

child sexual abuse (refer to Recommendation 19.2). The Victims Support Services staff should also receive targeted professional development on child sexual abuse.

People being considered for appointment as full-time or sessional Criminal Injuries Compensation Commissioners should have professional development about the issues faced by victim-survivors of institutional child sexual abuse, before their appointment and regularly afterwards. The Tasmanian Government should fund this training. It may be useful for Victims Support Services staff and Commissioners to attend such training alongside others who regularly deal with sexual abuse matters.

We also consider there should be a right to appeal on the merits of a decision of a Criminal Injuries Compensation Commissioner to the Tasmanian Civil and Administrative Tribunal.

In Tasmania, while the maximum amount of compensation that can be awarded to victim-survivors of child sexual abuse may seem modest, awards of compensation also constitute important recognition of victim-survivors and their suffering. The interests of victim-survivors of child sexual abuse which are affected by an administrative decision about criminal injuries compensation seem sufficiently important to justify access to merits review by the Tasmanian Civil and Administrative Tribunal.[242]

While merits review should extend to decisions on the amount of compensation, to avoid disputes over small amounts, the legislation could specify the amount of an award in relation to which merits review is available. Alternatively, merits review could require the Tribunal's leave (permission) to apply for review.

Recommendation 17.6

The Department of Justice should ensure that:

a. in relation to claims for financial assistance under the Victims of Crime Assistance Scheme, delays are minimised and applications for compensation are handled in a sensitive and trauma-informed manner

b. staff in Victims Support Services receive regular professional development on the effects of child sexual abuse and how to respond to victim-survivors in a trauma-informed manner

c. people being considered for appointment as Criminal Injuries Compensation Commissioners are required to take part in professional development on the effects of child sexual abuse and how to respond to victim-survivors in a trauma-informed manner before their appointment and regularly thereafter.

Recommendation 17.7

The Tasmanian Government should introduce legislation to amend the *Victims of Crime Assistance Act 1976* to create a right of review on the merits by the Tasmanian Civil and Administrative Tribunal in relation to a decision of the Criminal Injuries Compensation Commissioners:

a. to refuse financial assistance to a victim-survivor of child sexual abuse

b. about the amount of financial assistance to which a victim-survivor of child sexual abuse is entitled.

6 Record keeping and access to information

To support a claim of civil liability or application for redress, victim-survivors of institutional child sexual abuse often need access to information held by government. This information can also be critical helping victim-survivors understand the context in which the abuse occurred and the response at the time (if any). It may also provide a sense of recognition and acknowledgment of the abuse and harm it caused. For some victim-survivors, access to this information can help to fill gaps in their personal story. This role is particularly important for victim-survivors who have been in state care. These victim-survivors often have limited personal records of their childhood and may lack a network of family and friends from that time, who can help them tell or make sense of their experiences.[243]

Individuals have a legislative right to access government information, unless an exemption applies.[244] Despite this right, in hearings, consultations and statements to our Commission of Inquiry, victim-survivors and their representatives described systemic barriers to exercising this right, including costs, poor record keeping, lengthy delays, refusals and extensive redactions, with many resorting to slow and non-binding review processes.

This evidence highlighted an administrative culture that was not pro-disclosure and which, combined with a complex legislative scheme and insufficient resourcing, limits the release of information in practice.

In this section, we consider access to government information in Tasmania and its implementation in relation to victim-survivors of child sexual abuse in institutional contexts. First, we review record creation and record-keeping practices in Tasmania. We then focus on the operation of the legislative scheme established by the Right to Information Act and the Personal Information Protection Act.[245]

While on the surface, the legislative scheme may appear to be an administrative or bureaucratic process, in practice, victim-survivors' experiences of delays, redirections, refusals, redactions and additional costs can subject them to more trauma. One victim-survivor said:

> I felt completely stymied by the process. I felt like I was up against a wall, and I just didn't understand the implications of it. … [I]t just didn't sit well at all. I thought, I just—this is a rabbit hole I'm not gonna go down, I can't do it.[246]

Ultimately, the experience can leave victim-survivors with a sense that the interests of others are being protected at their expense. Urgent reform of the access to information scheme and its operation is needed to ensure it is as accessible, efficient, transparent and trauma-informed as possible.

6.1 Records and record keeping

For an access to information scheme to support the principles of open and transparent government, good records of government activities need to be created in the first place, and subsequently managed, retained and disposed of in a systematic way.247

6.1.1 National Royal Commission

The final report of the National Royal Commission highlighted the importance of good records and record-keeping practices, stating:

> The creation of accurate records and the exercise of good recordkeeping practices play a critical role in identifying, preventing and responding to child sexual abuse. Records are also important in alleviating the impact of child sexual abuse for survivors. Inadequate records and recordkeeping have contributed to delays in or failures to identify and respond to risks and incidents of child sexual abuse and have exacerbated distress and trauma for many survivors.[248]

The National Royal Commission recommended all institutions that engage in child-related work implement five principles for records and record keeping to a level that responds to the risk of child sexual abuse occurring within the institution.[249] The Principles state:

1. Creating and keeping full and accurate records relevant to child safety and wellbeing, including child sexual abuse, is in the best interests of children and should be an integral part of institutional leadership, governance and culture.
2. Full and accurate records should be created about all incidents, responses and decisions affecting child safety and wellbeing, including child sexual abuse.
3. Records relevant to child safety and wellbeing, including child sexual abuse, should be maintained appropriately.
4. Records relevant to child safety and wellbeing, including child sexual abuse, should only be disposed of in accordance with law or policy.
5. Individuals' existing rights to access, amend or annotate records about themselves should be recognised to the fullest extent.[250]

The National Royal Commission stated that: 'State and territory governments should require all institutions that care for or provide services to children to comply with the five principles for records and recordkeeping'.[251]

Besides the five principles, the National Royal Commission recommended minimum retention periods for records relevant to child sexual abuse.[252] Specifically, it recommended: 'institutions that engage in child-related work should retain, for at least 45 years, records relating to child sexual abuse that has occurred or is alleged to have occurred'.[253] It made further recommendations that the National Archives of Australia and state and territory public records authorities develop records disposal schedules accordingly, and provide guidance to help institutions to identify relevant records.[254]

6.1.2 Tasmanian records and record keeping

In August 2018, the Tasmanian Government started implementing the National Royal Commission's five record and record-keeping principles and has adopted measures related to retention and document maintenance.

In December 2019, the Office of the State Archivist issued a new *Disposal Schedule for Records Relating to Child Abuse*.[255] The new Disposal Schedule applies to all organisations (including Tasmanian Government agencies) as defined in the *Archives Act 1983* ('Archives Act').[256] The Office of the State Archivist also imposed a document disposal freeze that applies until 2029 to retain 'all records that contain the best information about children, services provided to them, and employees that provide the service'.[257] It aims to prevent the destruction of documents held by institutions that provide services to children that may be relevant to claims for compensation concerning child sexual abuse and applications for redress under the National Redress Scheme.

In October 2020, the Office of the State Archivist released a new Information and Records Management Standard, which 'aligns to the Royal Commission's records and recordkeeping principles'.[258] All government organisations subject to the Archives Act must comply with these principles.[259] The Tasmanian Government further noted the Office of the State Archivist offers:

> … an Information Management Foundations training course specifically for government employees modelled on the standard, which includes relevant content about the Royal Commission, child abuse records and good recordkeeping practices. Non-government employees can attend.[260]

In its latest report on implementing the National Royal Commission recommendations, the Government indicated that work is ongoing.[261]

Evidence before our Inquiry raised two key areas of concern regarding record keeping. First, we heard evidence of poor document maintenance, which affected searchability and accessibility. Second, we heard evidence of inadequate document retention and disposal practices, leading to a loss or destruction of relevant records. Sometimes it can be difficult to know whether a record has been lost, not well maintained, or never created.

Document maintenance: searchability and accessibility

During our Commission of Inquiry, we heard evidence of records kept across multiple systems in various locations in a mix of digital and hard copy formats, which impedes identifying and accessing relevant documents. For example, in response to Commission notice to produce concerning incident reports from Ashley Youth Detention Centre, we were informed that a manual document review would be required to identify relevant documents, suggesting the incident reporting system was not easily searchable.[262] During our Inquiry, the problems of record keeping at Ashley Youth Detention Centre became more apparent (refer to Chapter 12). Mr Strange described knowmore's experience of communicating with the former Department of Communities in relation to right to information requests. He said knowmore was aware of records and information (both physical and electronic) existing across multiple bodies and areas, sometimes at up to five or six different locations.[263]

The Department of Communities confirmed difficulties in retrieving records about out of home care and youth justice. Michael Pervan, former Secretary, Department of Communities, reported that in response to the initiation of our Commission of Inquiry: 'The biggest initial issue was the retrieval of documentation in the Department's possession or control, given the physical nature and location [of] files throughout the State and the breadth of the Out of Home Care model over time'.[264] Secretary Pervan gave examples of 'records [which] have not been consistently catalogued and boxes [that] are often labelled incorrectly', noting 'many high-priority hard and soft copy files within the Children, Youth and Families Division require remediation, such as through comprehensive cataloguing of handwritten content'.[265]

Other departments described similar challenges. For example, Kathrine Morgan-Wicks, Secretary, Department of Health, described at least 10 different record-keeping systems that contained documents of potential relevance to child sexual abuse.[266] Secretary Morgan-Wicks acknowledged that: 'the standard of record keeping across the Department of Health requires significant improvement to achieve statewide consistency'.[267] Similarly, Timothy Bullard, Secretary, Department for Education, Children and Young People described the mixed approach to record keeping in schools, stating:

> There was no central system to collect student information until 2014, when [the Student Support System] was introduced. Before 2014, schools used a mixture of practices, with some using a paper-based method of recording files and notes, and some using a system built by a teacher within the respective school.[268]

Recognising the need to improve searchability and accessibility of records, several departments reported establishing remediation projects. For example, the former Department of Communities had started a project to digitise approximately 110,000 hard copy files concerning out of home care and youth justice (refer to Chapter 11, Case study 7, and Chapter 12).[269] The Department of Health stated that improvement of the standard of record keeping 'is a key priority within Health's Digital Strategy and Record Audit', noting the commencement of 'an Information Remediation Project for the roll out of the Content Management system across the Department'.[270]

The Department for Education, Children and Young People has been taking part in discussions with the Department of Health about the Department of Health's complaints management system project.[271] If the Department of Health system meets its needs, the Department for Education, Children and Young People may move across to that system in the future.[272] The Department for Education, Children and Young People's Strategic Systems Development team has been asked to reserve time in 2023 to deliver an alternative solution should the Department of Health's complaints management system be deemed not fit for purpose.[273]

According to the Tasmanian Government, the Case Management Platform 'will deliver a streamlined approach to the way information is recorded, accessed, managed and interpreted'.[274]

Document retention and disposal

In evidence, we heard examples of victim-survivors frustrated by the apparent loss or destruction of documents they believed did or should exist. Victim-survivor, Rachel (a pseudonym), spoke of her mother receiving a letter in response to a request for information that essentially stated: 'the [Teachers Registration Board] have no record of any investigation in 2007'.[275] In evidence, Rachel expressed her distress at this response, stating:

> That was hard to read because I was like, "What the heck? What do you mean there was no investigation? I have a statement that I signed in 2008 from the [Teachers Registration Board]". I just don't get it. I just don't understand.[276]

When the Tasmanian Government responded to this evidence, it suggested the letter may not have come from the Teachers Registration Board, which does hold documents relating to Rachel's complaint, but from the Department of Education. It is possible that Rachel was mistaken regarding the source of the letter to her mother, but it is troubling that she received no help to get this information.[277]

Rachel's experience was shared by representatives of other victim-survivors. For example, Ms Sdrinis noted instances of clients insisting they had made a complaint to the police of which the police had no record.[278] She further stated: 'it is not uncommon in Department of Education matters for clients to instruct me that they made a complaint to a teacher or even the Principal and no record has been kept'.[279]

We are informed that the Department for Education, Children and Young People is reviewing and improving its complaints management system, and has a new policy for handling complaints that should help to address these problems.[280]

6.1.3 Our observations

It is critical that remediation of historical records is prioritised and adequately resourced across Tasmanian Government institutions, extending to non-government institutions that are funded to provide government services. It is also critical that searchable and accessible document management systems are introduced and maintained in line with the National Royal Commission's records and record-keeping principles.

We discuss the preservation of Ashley Youth Detention Centre and out of home care records in more detail in Chapter 12. We recommend in that chapter that the Department for Education, Children and Young People work with the Office of the State Archivist to establish an approach to preserve historical records relevant to children and young people and staff at Ashley Youth Detention Centre and in state care. We consider preserving these records a matter of priority.

We welcome the Tasmanian Government's response to the National Royal Commission's recommendations concerning document maintenance and retention. To ensure successful implementation of the recommendations, it is critical that staff within relevant government and government funded institutions engage in ongoing training about their record and record-keeping obligations, and that regular compliance audits are conducted. We consider the Office of the State Archivist may be best placed to provide the necessary ongoing training and to regularly measure and assess the quality of record-keeping capability and practice across institutions. We welcome their Information Management Foundations training course.

6.2 Access to information

Multiple people may be seeking information in relation to an institution's response to child sexual abuse, including, for example, victim-survivors seeking 'personal information' or journalists seeking information about an institution's response to child sexual abuse.

Tasmania, like most Australian jurisdictions, has separate pieces of legislation regulating access to information and protecting personal information.[281] An individual's right to access, amend or annotate personal information is generally contained as a principle in privacy or personal information protection legislation. This is compared to the broader right of access to government information in right to information legislation (sometimes referred to as 'freedom of information' legislation). Access to information the Tasmanian Government holds is regulated by a legislative scheme established by the Right to Information Act and the Personal Information Protection Act.

Government information is provided to the public through a range of channels such as:

- annual reporting obligations
- selective publication of policies, procedures and other reports
- in response to requests such as letters from the public.[282]

If information is not disclosed through these channels, as a 'last resort', individuals can apply under the Right to Information Act for an 'assessed disclosure', otherwise called a right to information application.[283] Individuals have a right to the information requested, unless an exemption applies.[284] There are 18 types of exempt information, including information disclosing personal information of a person other than the person making the application, information affecting national or state security, defence or international relations, information relating to enforcement of the law, legally privileged information and other information that is contrary to the public interest to disclose.[285] A person can apply to the Ombudsman for a review of an agency's decision about a right to information request.[286]

The Personal Information Protection Act regulates the 'collection, maintenance, use, correction and disclosure of personal information relating to individuals'.[287] It contains 10 Personal Information Protection Principles, including Principle 6, which regulates access to and correction of personal information.[288] It states that if a 'personal information custodian' holds personal information about an individual, the custodian 'may' provide that individual with access to their personal information upon receipt of a written request.[289]

On its face, the legislative scheme appears to set clear parameters for releasing or protecting Tasmanian Government information through established processes in line with fixed timeframes. However, in practice, victim-survivors and their representatives described a frustratingly slow, complex, and obstructive system. Their experiences align with evidence the National Royal Commission reported about the operation of freedom of information and privacy legislation across Australia: 'we have been told by many survivors and their advocates and by records holders that many people still find navigating the current systems complex, costly, adversarial and traumatising'.[290]

As outlined above, the National Royal Commission sought to address these difficulties by implementing records and record-keeping principles. Specifically, Principle 5 requires: 'Individuals' existing rights to access, amend or annotate records about themselves should be recognised to the fullest extent'.[291] Detailing what is required in practice under Principle 5, the National Royal Commission stated:

> Individuals whose childhoods are documented in institutional records should have a right to access records made about them. Full access should be given unless contrary to law. Specific, not generic, explanations should be provided in any case where a record, or part of a record, is withheld or redacted.

> Individuals should be made aware of, and assisted to assert, their existing rights to request that records containing their personal information be amended or annotated, and to seek review or appeal of decisions refusing access, amendment or annotation.[292]

According to the Tasmanian Government, the new *Information and Records Management Standard* introduced in 2020 aligns with the National Royal Commission's records and record-keeping principles.[293] However, evidence before us suggests, in practice, individuals' rights to access information are still not being 'recognised to the fullest extent'.[294]

The concerns expressed to us about the operation of the access to information scheme in Tasmania fall within the following themes:

- an administrative culture that limits the release of government information
- legislative and procedural complexity, particularly where the Right to Information Act and the Personal Information Protection Act overlap, hampering access to personal information
- lengthy delays in responding to applications
- inadequate and unenforceable review processes when the release of information is delayed, refused or extensively redacted
- under-resourced and decentralised assessment processes contributing to delays and inconsistent outcomes
- inconsistent approaches to fees and waivers for right to information requests.

Ultimately, these issues cause significant distress and frustration for victim-survivors of institutional child sexual abuse, who can be retraumatised by the process. Consequently, urgent reform of the legislative scheme, together with additional resources and improved implementation in practice, is required.

6.2.1 Administrative culture

Evidence to our Commission of Inquiry indicates that when responding to requests for information related to child sexual abuse, public authorities frequently adopt an approach that is not 'pro-disclosure'. The following example outlines the Department of Health's reluctance to provide access to information it held about James Griffin.

Review of a journalist's request for information about James Griffin

Journalist Camille Bianchi requested information from the Department of Health in relation to paediatric nurse James Griffin on 1 April 2020.[295] The Department of Health had not released its decision to Ms Bianchi by 29 June 2020. At this point, the Ombudsman accepted her request for external review because the Department's failure to respond to the request in this time constituted a refusal to provide the requested information.[296] The Department indicated to the Ombudsman that the delay was because of the diversion of resources to the COVID-19 pandemic response.[297]

On 22 July 2020, the Department released its decision to Ms Bianchi, identifying 104 pages of relevant information.[298] However, it refused to release any of these pages, claiming exemptions under four separate sections of the Right to Information Act.[299]

Following a comprehensive review, released on 4 November 2021, the Ombudsman concluded that all claimed exemptions were not made out or should be varied.[300] Ultimately, the Ombudsman directed the release of 74 pages, subject to the redaction of some personal information.[301] Of the remaining 30 pages, 10 were already publicly available and 20 pages were out of scope of the original request.[302]

In his decision, the Ombudsman stated that: 'Public servants have a public role and duties, which brings with it the potential to be publicly identified. Service to the public is not intended to be shrouded in secrecy…'.[303] He noted: 'There is a fine line between protecting public servants from distressingly intense scrutiny and limiting their accountability to the people of Tasmania which comes from transparency of administrative action'.[304]

The Ombudsman expressed concern about the weight the Department of Health placed on the interests of its staff, without sufficient consideration of the interests of the victims of Mr Griffin's alleged offending, or the public interest in holding the Government and its administration to account. He stated:

> While the Department's consideration of the interests of its staff and Mr Griffin's associates is understandable, I am concerned that it does not appear to have considered the interests of the victims of Mr Griffin's alleged offending while he was in its employ and the concerns of [Launceston General Hospital] patients and the general public about the adequacy of management of concerns by the Department as highly. … I consider that the public interest in protecting the interests of alleged sexual abusers of children is lower than that of the victims of such abuse. In contrast, the Department does not once mention or appear to consider the victims of Mr Griffin's alleged offending or the valid community concern and desire for accountability from the Department, given that abuse is alleged to have occurred against vulnerable child patients receiving care in a public hospital over an extended period. [305]

The Ombudsman also identified several relevant documents that had been omitted from the Department of Health's response. In his decision, he commented:

> The failure to produce this information or properly respond to my office's requests for an explanation as to why the information is not in the possession of the Department is inexplicable and disappointing. I am concerned with the sufficiency of the search conducted by the Department for all information responsive to Ms Bianchi's request due to failure to properly respond to requests regarding these documents.[306]

Despite the Ombudsman's direction to the Department to release 74 pages of documents (as detailed above), the Department did not immediately do so.[307] Following media reports in December 2021 about the Ombudsman's decision, the Department finally released the documents to Ms Bianchi, approximately 22 months after her original request was submitted.[308]

This administrative culture towards non-disclosure is reflected in concerns expressed in the Ombudsman Tasmania's *Annual Report 2021–22*. Richard Connock, Ombudsman Tasmania, found that 95 per cent of the external reviews of right to information requests conducted in 2021–22 'identified issues with the manner in which the public authority had responded to a request for assessed disclosure…'.[309] While some progress has been made compared to previous years, the Ombudsman stated:

> The express object of the [Right to Information] Act is clear in relation to its pro-disclosure focus, seeking to increase government accountability and acknowledging that the public has a right to the information held by public authorities who are acting on behalf of the people of Tasmania. Too often, sadly, adherence to this object is not evident in practice and a closed, and at times obstructive, approach is taken when responding to requests for assessed disclosure which come before my office.[310]

For completeness, we note the Right to Information Act and the Ombudsman's comments apply to 'public authorities', which includes bodies such as councils and statutory authorities, not only government departments and agencies.

In 2020, the Ombudsman reported that, for the year 2018–19, the rate at which Tasmanian public authorities refused access to *any* information in response to Right to Information requests was 7.5 times the rate of Australia's most open jurisdictions (Victoria and the Northern Territory).[311]

Legal representatives of victim-survivors expressed concerns about the reluctance of Tasmanian public authorities to release information. For example, Ms Sdrinis stated:

> It has been my experience that the Department of Education has a general reluctance to provide information responsive to [right to information] requests in a timely way. The Department appears to me to take a broad view of the various exemptions that it can apply. … I have found the provision of documents in Tasmania to be generally less forthcoming than in other jurisdictions.[312]

Ms Sdrinis stated she was not satisfied the records the Department of Education provide in response to requests 'contain everything they could or should give us, and they appear to be heavily redacted'.[313] Similarly, Mr Strange of knowmore described the Tasmanian Government's response to requests for records as 'often less than desirable'.[314] He highlighted frequent delays and extensive redactions in released material as being 'particularly pronounced in Tasmania'.[315]

A comparative analysis of the public use of information access rights across Australia for the period 2020–21 indicated Tasmania had:

- the second-lowest number of formal applications per capita at 2.6 applications per 1,000 population (the lowest was the Commonwealth at 1.4 applications per 1,000 population), compared to Western Australia with the highest number of applications per capita of 7.6 per 1,000 population. This may reflect a view that it is not worth making an application which has a limited chance of succeeding
- the lowest percentage of all decisions made on formal applications nationally where access was granted in full or in part (75 per cent), compared to the next lowest percentages from Queensland (82 per cent) and the Commonwealth (82 per cent)
- the highest percentage of decisions where access was refused in full (25 per cent), compared to the next highest percentages from Queensland (18 per cent) and the Commonwealth (18 per cent)
- the second-lowest percentage of decisions made within the statutory timeframe (73 per cent) above South Australia (67 per cent), based on the data available (noting that no data is available from Queensland in relation to this metric) and compared to the next lowest percentage from the Commonwealth (77 per cent)
- the highest percentage of applications reviewed by the Information Commissioner or Ombudsman (6.1 per cent) compared to the next lowest percentages from the Northern Territory (3.9 per cent) and Queensland (3.7 per cent).[316]

Broadly, similar percentage differences between state approaches to the release of information appear in 2017–18 and 2018–19.

This analysis reflects the published statistics regarding access to information nationally. However, the Ombudsman informed us of a recently identified difference in how Tasmania records this data compared to other states and territories. Tasmania's figures include applications that are withdrawn or transferred and where the release of information is deferred in full. We understand such applications are not included in the published statistics of other jurisdictions. The Ombudsman told us this difference is 'somewhat distorting the accuracy' of these statistics. The Ombudsman said 'efforts are being made to correct this misalignment as soon as possible', and once it is corrected, 'it is expected that Tasmania will no longer be an outlier in these statistics'.[317]

Some of these differences may be attributed to differing legislative schemes. For example, the Right to Information Act does not include an explicit principle in favour of the release of information. Instead, it includes a statement that: 'It is the intention of Parliament … that discretions conferred by this Act be exercised so as to facilitate and promote, promptly and at the lowest reasonable cost, the provision of the maximum amount of official information'.[318] In comparison, the freedom of information schemes in New South Wales, Queensland and the Australian Capital Territory all include an explicit 'pro-disclosure bias' or overarching principle in favour of disclosure to guide assessment decisions.[319] The lack of an explicit statement to this effect may contribute to a tendency to restrict access rather than release information, although building a pro-release culture is also important.

Another difference in access to information schemes across Australia is the approach to exemptions subject to an assessment of whether release of that information would be contrary to the 'public interest'. For example, in Victoria, the 'public interest test' is embedded in the exemptions themselves, which specify the public interest considerations relevant to each exemption.[320] In contrast, public interest considerations in the Tasmanian Right to Information Act are contained separately in a lengthy Schedule to the Act.[321] Differences in legislative approaches between states and territories make it difficult to determine how this affects the decision not to release documents.[322] However, some exemptions may contribute to a decision refusing the release of information, particularly in the absence of a pro-release culture.

Ultimately, the impact of these legislative differences on decision making in practice is unclear. However, considering the comparative metrics summarised above, combined with the Ombudsman's comments and evidence before us about individuals' experiences seeking access to information, we are concerned the administrative culture may, at times, frustrate the intended pro-disclosure intent of the Right to Information scheme in Tasmania and limit the release of government information.[323]

6.2.2 Protection of personal information

The process to request access to personal information relies on a connection between the right to information and personal information protection schemes, as is the case in most Australian jurisdictions. The Personal Information Protection Act establishes a process for an individual to make a written request to the organisation holding their personal information.[324] If the request is refused or there is no response within 20 working days, the individual may submit a second written request. This second request is to be assessed as if it were a right to information application under the Right to Information Act.[325]

On its face, the initial written request process under the Personal Information Protection Act provides a more informal, cost-free channel to access personal information. However, in practice, victim-survivors of child sexual abuse have experienced additional

delays because this process defaulted to a two-step process when their initial request was refused or they received no response. Consequently, their second request was treated as a formal right to information application. In consultation, the Ombudsman stated he had encouraged people to use the Right to Information Act process rather than the Personal Information Protection Act process.[326]

The reasons for the refusal or lack of response to the first written request under the Personal Information Protection Act may be because of the nature of the discretion granted to the 'personal information custodian'. The Personal Information Protection Act provides that the personal information custodian 'may' provide access to the personal information.[327] In contrast, other jurisdictions state the holder of the information 'must' provide access, subject to exemptions.[328]

Another reason for refusal or delay under both the Personal Information Protection Act and Right to Information Act is the approach to protection of personal information concerning another person. Under the Right to Information Act, information is exempt if it would involve disclosing personal information of a person other than the applicant.[329] Other jurisdictions include similar exemptions.[330] Some jurisdictions include a 'reasonableness' test in the assessment. For example, in Victoria, information is exempt if 'providing access would have an unreasonable impact on the privacy of other individuals'.[331]

Under the Right to Information Act, if disclosing the information about another person is likely to be of concern to that person, the public authority must seek that person's views on whether the information should be released.[332] If, following this process, the public authority decides to release the information, they must notify the other person and they can apply for a review of that decision.[333] Set timeframes regulate providing notices and applications for review, which must elapse before the information can be released.[334]

In child sexual abuse matters, information requested by a victim-survivor or their representative frequently includes other people's personal information. For example, records of investigations are likely to include statements by other witnesses or the alleged perpetrator. In such cases, the public authority must seek the other person's views before making a final determination on whether to release the information.

In evidence, legal representatives of victim-survivors highlighted their experiences of extensive delays and redactions associated with requests to access information that captures information about other people. For example, Mr Strange noted documents the Tasmanian Government provided were often heavily redacted, particularly when the information related to third parties.[335] He commented the Tasmanian Government used the third party provisions 'in a very black and white way to make those redactions'.[336]

At our hearings, Sam Leishman described his attempts to access information from the Department of Education and the way it made him feel.[337]

Case example: Barriers to accessing personal information

Sam Leishman is a victim-survivor of child sexual abuse perpetrated by teacher Darrel Harington, which occurred when Mr Leishman was a school student. We discuss Mr Leishman's experience in detail in Chapter 5. Here, we focus on his experience of seeking information from the then Department of Education.

In 2015, Mr Harington was convicted of offences against Mr Leishman and sentenced to gaol. Following the conviction, Mr Leishman requested information related to the offending from the Department of Education. The Department told Mr Leishman to make a formal right to information application. In response to the application, Mr Leishman recalls being told that because most of the information concerned Mr Harington, Mr Harington's permission would be needed to release it.[338] At that point, Mr Leishman described feeling 'completely stymied by the process' and unwilling to go down a 'rabbit hole' of asking permission from the man who had committed offences against him.[339]

At our hearings, Mr Leishman described the Department's lack of support or action throughout the process, which ultimately spanned a period of two years. He said:

> … I was given no answers to anything. I felt that … I was just going to be made to jump through hoops and things were just going to be made more and more difficult for me. … I thought, what is it, what is it? There must be something that they do have to tell me and they don't want to tell me: I don't know.[340]

The process set out in the Right to Information Act requires the public authority to seek the views of the other party before releasing information concerning them, which occurred in this case. Secretary Bullard recognised that: 'Mr Leishman felt uncomfortable with that, and who wouldn't?'[341] He stated the perpetrator refused release of the information, 'but in the public interest the decision maker agreed that some of the information should proceed'.[342] He concluded that: 'to me, [for] a third party like Mr Leishman sitting there thinking he has a right to know [it] looks like a lack of accountability and transparency, albeit it is operating within a legislative framework, whether or not that be right or fit for purpose for these kinds of situations'.[343] While some information was ultimately released, Mr Leishman concluded: 'I still don't feel that everything's been laid on the table'.[344]

It is clearly necessary to balance the competing right of access to information with other parties' right to privacy, while ensuring a procedurally fair process. However, in practice, this process can be traumatic for victim-survivors. Victim-survivors may feel a perpetrator has control over what information they can access, or government employees are protecting their own or their colleagues' personal interests over the interests of victim-survivors. The additional steps required can also lead to significant delays.

6.2.3 Lengthy delays

The Right to Information Act and Personal Information Protection Act set timeframes for responses to requests for information. Under the Right to Information Act, the applicant must be notified of a decision on a right to information application as soon as practicable, and no later than 20 working days after the application has been accepted.[345] This timeframe can be extended for a further 20 working days if the information request includes personal information about another person or relates to the business affairs of another party who should be consulted before releasing information.[346] The timeframe can also be extended by agreement with the applicant or by the Ombudsman.[347] Under the Personal Information Protection Act, if a request to access personal information is refused or no response is received within 20 days, the applicant can make a further written request, which is treated as a right to information application, as outlined previously.[348]

Despite these statutory timeframes, we heard evidence of responses to requests for information being delayed and subject to multiple extensions. For example, Ms Sdrinis noted that the right to information process had deteriorated since 2018. She commented:

> Initially, unlike the Department of Human Services and Corrections, the Department of Education dealt with [Right to Information] requests relatively promptly. More recently time lines have blown out … to about 12 months and I anticipate that the time lines will blow out further as we are regularly receiving requests for extensions of time…[349]

Similarly, Mr Strange commented while delays were an issue nationwide, they are 'particularly pronounced in Tasmania. Record requests in Tasmania have taken as long as two years, and generally can take up to 18 months'.[350] Ms Sdrinis agreed the situation was worse in Tasmania compared to other states.[351]

We also heard examples of extreme delays for some individuals seeking access to records. For example, the submission from Care Leavers Australasia Network ('CLAN') noted one CLAN member waited four years to receive his state ward records from the Tasmanian Government, with many of the records redacted and labelled out of scope.[352]

Rachel provided information relating to repeated delays and requests for extensions from the Teachers Registration Board in response to her right to information application.[353] Rachel submitted a right to information application to the Teachers Registration Board in October 2021. Over the next 12 months, Rachel repeatedly contacted the Board seeking a response.

When questioned about Rachel's experience, Ann Moxham, Registrar, Teachers Registration Board, pointed to a lack of staffing (exacerbated by the absence of a key staff member on extended leave) impeding the Board's capacity to process requests in a timely way.[354]

Ms Bianchi's right to information request in relation to Mr Griffin, outlined previously, was also subject to significant delays. Emily Baker, a journalist, also indicated Ms Bianchi's experience was consistent with her experience of submitting right to information applications, stating: 'Oh, it's completely consistent. It seems, frankly, a waste of time, and it doesn't mean we don't still file them, we do, but it is absolutely an issue of last resort—you're gearing up for a fight'.[355] She described being 'fobbed around, rebuffed, it goes away'.[356] However, Ms Baker noted she thought this approach was changing.[357]

The systemic nature of individuals' experiences of delays is confirmed by the comparative analysis of access to information schemes across Australia for the period 2020–21, noted above. It found more than a quarter of decisions on requests for information in Tasmania did not meet the statutory timeframe.[358] Of the jurisdictions surveyed, only South Australia had a lower rate of response to requests completed on time.[359]

Ombudsman Tasmania's *Annual Report 2021–22* also expresses concern regarding delays in Tasmanian Government responses to access to information applications, particularly by the Department of Health and the former Department of Communities. Between them, right to information applications to these departments accounted for 26 per cent of all external review requests in 2021–22.[360] The Ombudsman stated:

> While I acknowledge that both departments have advised of a significant increase in the volume of assessed disclosure applications, there are improvements that could be achieved by both departments in relation to issuing of decisions within the statutory timeframe, improving communication with applicants regarding delays and ensuring decisions are of high quality. Such improvements might reduce the volume of external review requests relating to these departments.[361]

6.2.4 Under-resourced and mixed assessment processes

Currently, requests for information (either for personal information under the Personal Information Protection Act or right to information applications under the Right to Information Act) are sent to and processed by the public authority holding the relevant information. Representatives of Tasmanian Government departments and agencies described different processes and levels of resourcing dedicated to managing these requests.[362]

Generally, the relevant business unit within the department manages requests for personal information under the Personal Information Protection Act. There is no centralised register recording requests and responses. In contrast, right to information applications are managed by designated staff within each department, such as the legal services area or Office of the Secretary, and centralised departmental records are maintained. For example, in the Department of Education, seven legally trained staff were responsible for assessing right to information requests (in addition to other responsibilities).[363] Several senior executives in the Department (separate to the legal services area), have delegated responsibility to conduct internal reviews. In the words of Secretary Bullard, he remains at 'arms-length' from the process.[364] In contrast,

the Office of the Secretary in the Department of Justice manages responses to right to information applications.[365] Similarly, the Legal Services Unit in the Office of the Secretary of the Department of Health manages right to information applications.[366]

Departmental secretaries and other Tasmanian Government Heads of Agencies reported increases in the number of right to information requests over recent years.[367] For most, the increase had an adverse impact on their capacity to respond within the statutory timeframes. For example, the average number of days taken by the Department of Health to respond to a right to information application had increased significantly: from 23 days in 2019–20 to 59 days in 2021–22.[368] Similarly, the Department of Education confirmed the increase in right to information applications relating to historical sexual abuse has 'impacted the substantive response timeframes and the Department's ability to consistently meet the statutory timeframe of 20 business days'.[369] Commenting on the Teachers Registration Board's delayed response to Rachel's right to information application outlined above, Ms Moxham stated:

> … we find it extremely difficult to meet the timelines that are in the Act because we have such a small workforce … with the huge volume of historical matters that have now descended upon us that makes it even more problematic to sort out those sorts of issues for our office.[370]

In contrast, Secretary Webster gave evidence that while the number of right to information applications from 'plaintiff law firms' had increased in recent years, the average number of days to respond to an application from either a 'plaintiff law firm' or relating to a person's correctional records potentially relating to child sexual abuse had decreased from 21 days in 2018–19 to 13 days in 2020–21.[371]

In addition to delays, victim-survivors and their representatives expressed concerns about inconsistent approaches and inadequate search practices, potentially resulting in information not being identified or incorrectly assessed. As noted above, Ms Sdrinis was not satisfied that responses to right to information applications provided all relevant documents. She said it was sometimes possible to compare documents provided through the right to information process with records provided at a later date through discovery processes.[372]

Similarly, in the Ombudsman's review of Ms Bianchi's right to information application, he identified several relevant documents that had been omitted from the Department of Health's response.

The evidence before us suggests that, for most government departments and agencies our Commission of Inquiry examined, current resourcing levels and procedures to process right to information applications are not adequate to meet statutory timeframes, particularly in the face of increasing demand. Nor do they ensure full disclosure of all relevant documents as required by the legislative scheme.

6.2.5 Fees and waivers

In Tasmania, the fee for a right to information application under the Right to Information Act is currently $44.50.[373] There is no fee for requests for personal information under the Personal Information Protection Act. For information concerning child sexual abuse, some Tasmanian Government authorities exercise their discretion to waive the fee under the Right to Information Act. To do so requires the applicant to seek a waiver on one of the grounds set out in the Act, which include if the applicant is 'impecunious' (that is, does not have any or much money) or if it is sought for 'a purpose of general public interest or benefit'.[374] Requests concerning child sexual abuse may fall into one of these categories. The approach to fees is similar to that in other jurisdictions.[375]

Neither the Right to Information Act nor the Ombudsman's guidelines on fee waivers specifically refer to matters concerning child sexual abuse. Further, the decision to waive fees is discretionary.[376] Consequently, the approach of government authorities and agencies to fee waivers for victim-survivors of child sexual abuse varies. For example, the Department of Education's practice was to waive the fee for applicants who identify they are seeking records relating to child sexual abuse. The fee is waived based on public interest.[377] In contrast, representatives of victim-survivors spoke of the cost burden of these fees. They noted civil litigation may result in multiple requests from government authorities for revised right to information applications, which incur a fee each time.[378] Imposing a fee, even if it can be waived, can be an added barrier to victim-survivors seeking compensation and redress, which can reinforce their sense of being obstructed and not supported. If fee waivers are not granted in these situations, they should be.

6.2.6 Limited review and enforcement mechanisms

We heard about two issues of concern regarding the external review process for right to information requests. First, the process is lengthy because of the:

- level of scrutiny required
- resources involved in processing external review applications
- high number of applications for external review.

Delays in reviews add to the delay in an applicant receiving the information they request, or having a final decision about their right to the information. The Ombudsman's *Annual Report 2021–22* highlighted the backlog of external review applications they have been trying to clear since 2019.[379] The report noted:

> Unfortunately, though modest inroads have been achieved, due to a range of issues (most particularly high staff turnover, unexpected leave and major difficulty in recruiting, but also a high number of new external review requests requiring formal decisions), this has not occurred and the backlog remains.[380]

To address the backlog, Ombudsman Tasmania has dedicated additional resources and sought to recruit new staff to manage the external review process.[381] The Ombudsman has also updated its priority policy and approved a greater number of external review applications for expedited processing.[382] Prioritised requests include government responses to child sexual abuse in institutional settings.[383] As a consequence of focusing on the backlog, the Ombudsman could not offer formal training to public authorities in 2021–22.[384] Suspending training concerns us because regular training is likely to increase and maintain the skills and capabilities of staff managing right to information applications. In turn, this will reduce the need for victim-survivors to make applications for external review.

Despite these efforts, it appears the backlog is worsening. In February 2023, it was reported in the media that the backlog of active external right to information review requests had increased from 101 at 30 June 2022 to 129 at 7 February 2023.[385] It was also reported that some applicants for external review had been waiting for more than three years for the external review process to begin.[386] The Ombudsman has cited staffing and recruitment issues and a high number of external review requests as the reason for the continuing backlog.[387]

The second issue of concern regarding the external right to information review process is that the Ombudsman's decision is not enforceable.[388] While the Ombudsman is empowered to give directions (for example, to release documents), the public authority is not obliged to comply with these directions. The examples concerning Rachel and Ms Bianchi's right to information applications show a level of noncompliance, or at least delayed compliance, by the relevant public authorities in response to the Ombudsman's directions.

In a consultation, the Ombudsman proposed the Tasmanian Civil and Administrative Tribunal be given a right of review.[389] An order of the Tribunal would be enforceable. Other jurisdictions such as Victoria and New South Wales provide for review by a tribunal.[390]

The extensive delays associated with external reviews and the lack of enforceability of the Ombudsman's directions may contribute to public authorities' poor compliance with their obligations under the Personal Information Protection Act and Right to Information Act. Poor accountability and enforcement mechanisms may limit the incentive for public authorities to comply with their obligations.

6.2.7 Impact of the access to information scheme on victim-survivors

A persistent theme in statements, submissions and hearings was the significant adverse impact of the access to information scheme and its implementation on victim-survivors of institutional child sexual abuse. As highlighted in the examples discussed previously, victim-survivors described feeling obstructed, not prioritised and, ultimately,

retraumatised by a process that often required them to repeatedly tell their story and justify why they should be given access to records concerning their experiences of abuse.

Representatives of victim-survivors confirmed the traumatic impact of the process. Mr Strange commented that extensive redactions 'can be re-traumatising for a victim-survivor. … they can leave the victim in the dark about parts of their own history and abuse'.[391] He stated: 'the applicant's trauma is exacerbated by such decisions (about redaction) being made by the same institution perceived as responsible for the victim-survivor's child abuse'.[392] Referring to victim-survivors taken into state care as children, Mr Strange stated that:

> … to have significant redactions that take out, for instance, the name of those family members, it is viewed as perpetuating the abuse that happened to them as children and the negative experiences of being placed in an institution; they see that as re-traumatising, that it took them so long to try and reconnect with their family and here is the government or the state trying to keep information from them about their family again….[393]

Mr Strange also confirmed that delays can be retraumatising for victim-survivors who 'have difficulty in progressing their options for justice due to inability to access records made about them in a timely way'.[394] Ultimately, according to Ms Sdrinis, these delays can cause her clients to lose motivation to pursue their claims.[395] Representatives of victim-survivors called for the Government to adopt trauma-informed practices in responding to right to information applications, supported by training for all decision makers.[396]

In evidence, several departmental secretaries acknowledged they needed to adopt a trauma-informed response when dealing with matters involving child sexual abuse. Responding to questions about the Department of Health's investigation of allegations of child sexual abuse at Launceston General Hospital, Secretary Morgan-Wicks stated: 'It is apparent that trauma-informed practice is not embedded practice and may be a new way of working for many Departmental Officials. This must be a priority moving forward so that any communication and interactions with victim-survivors is applied to "do no harm"'.[397] Several departments have started providing training in trauma-informed practice to their staff, particularly in their legal services teams.[398]

6.2.8 Our observations

The concerns outlined above, and the traumatic impact on victim-survivors, confirm the current framework for providing victim-survivors with access to information does not meet the principle the National Royal Commission recommended that: 'Individuals' existing rights to access, amend or annotate records about themselves should be recognised to the fullest extent'.[399] Cultural, legislative, procedural and resourcing barriers have combined to impede individuals' ability to exercise their rights to access information in a meaningful and supportive way.

On 24 May 2022, Premier Rockliff committed to a number of actions to keep children safer, including:

> Improve the Right to Information process, including providing training across the State Service to ensure more consistent responses.[400]

The Premier's commitment is an important acknowledgement of the need for reform. However, the extent of progress towards that reform is unclear, with progress indicated to be 'underway', a discussion paper circulated, and an expected delivery date of July 2024.[401]

It is imperative the Government progress reforms urgently to overcome the current delays and lack of clarity that impedes victim-survivors' access to information in the current system. We recommend the Tasmanian Government review and reform the access to information scheme in Tasmania, with a particular focus on child sexual abuse in institutional contexts. Reforms should focus on the legislative scheme established by the Right to Information Act and Personal Information Protection Act. Reforms should also focus on their implementation in practice, to ensure it is as accessible, efficient, transparent and trauma informed as possible. In particular, the review should consider:

- including an explicit presumption in favour of disclosure in the Right to Information Act and Personal Information Protection Act
- embedding the public interest test in specific exemptions in the Right to Information Act, tailored to those exemptions
- streamlining the interface between the Right to Information Act and Personal Information Protection Act to overcome what has become a two-step process by default to request personal information
- requiring that a personal information custodian under the Personal Information Protection Act 'must provide' rather than 'may provide' personal information upon request from the individual who is the subject of that information (subject to exemptions)
- including a 'reasonableness' test in the Right to Information Act as part of the assessment of whether to withhold personal information relating to a person or third party other than the person making the request for information, which would allow for competing factors to be weighed when assessing whether to disclose information, including on review
- strengthening and streamlining internal and external review processes in the Right to Information Act and Personal Information Protection Act, with a focus on options to enforce decisions of the Ombudsman and review by the Tasmanian Civil and Administrative Tribunal

- providing an automatic fee waiver for Right to Information Act right to information applications which relate to child sexual abuse.

We recognise legislative reform can take time. To address the impact of the current access to information scheme on victim-survivors in the short term, the Tasmanian Government should allocate additional resources to:

- Tasmanian Government departments and agencies to enable them to process requests for information under the Right to Information Act and Personal Information Protection Act within statutory timeframes
- Ombudsman Tasmania to speed up external reviews of right to information decisions.

We also understand the Tasmanian Government has investigated the roll out of trauma-informed training across the State Service. It has partnered with Lifeline Tasmania through the Tasmanian Training Consortium to pilot trauma-informed training sessions for leaders. Feedback from these pilot sessions has informed the development of courses on trauma, trauma-informed practice and trauma-informed organisations for:

- State Service employees
- those involved in State Service Code of Conduct investigations
- State Service leaders.[402]

We recommend, in Chapter 19, the Government develops a whole of government approach to professional development in responding to trauma within government and government funded services that provide services to children and young people, and statutory bodies who have contact which child sexual abuse survivors.

We also recommend the Government considers centralising how they access information requests within a specialist unit or department. The evidence above shows varying levels of expertise, resourcing, responsiveness and resourcing across government departments and agencies. In our view, centralising the management of access to information processes would:

- promote a culture committed to transparency with a presumption in favour of disclosure
- prioritise requests for information as its core business, rather than as part of a larger role competing with other demands and resourcing
- minimise potential conflicts of interest which may arise within units which operate in the same department or agency which is subject to the access to information application
- ensure deeper understanding and consistent application of legislative obligations, particularly in the application of exemptions

- develop deeper expertise in Tasmanian Government record-keeping systems and obligations helping to identify relevant records
- promote trauma-informed practice through dedicated staff training specific to access to information applications
- enable more transparent monitoring of and reporting on the access to information scheme, with a centralised source of data.

To implement centralised management of access to information processes, departments and other government agencies should establish access to information liaison officers with adequate resourcing to ensure timely and comprehensive responses to requests for information.

Recommendation 17.8

1. The Tasmanian Government should review and reform the operation of the *Right to Information Act 2009* and the *Personal Information Protection Act 2004* to ensure victim-survivors of child sexual abuse in institutional contexts can obtain information relating to that abuse. This review should focus on what needs to change to ensure:
    a. people's rights to obtain information are observed in practice
    b. this access is as simple, efficient, transparent and trauma-informed as possible.
2. The review should consider reforms to the *Right to Information Act 2009* and the *Personal Information Protection Act 2004* to:
    a. include an explicit presumption in favour of disclosure in the *Right to Information Act 2009* and *Personal Information Protection Act 2004*
    b. embed the public interest test in specific exemptions in the *Right to Information Act 2009*, tailored to those exemptions
    c. streamline the interface between the *Right to Information Act 2009* and *Personal Information Protection Act 2004* to overcome what has, by default, become a two-step process to obtain personal information
    d. require that a personal information custodian under the *Personal Information Protection Act 2004* 'must provide' rather than 'may provide' personal information upon request from an individual who is the subject of that information, subject to any appropriate exemptions to that requirement
    e. include a 'reasonableness' test in the *Right to Information Act 2009* as part of the assessment of whether to withhold personal information relating to a person or third party other than the person making the request for information

f. strengthen and streamline internal and external review processes in the *Right to Information Act 2009* and *Personal Information Protection Act 2004*, with a focus on options to enforce decisions of the Ombudsman and to apply for review by the Tasmanian Civil and Administrative Tribunal

g. provide an automatic fee waiver for right to information applications relating to child sexual abuse made under the *Right to Information Act 2009* by victim-survivors or a person acting on their behalf.

3. The Tasmanian Government should consider centralising management of access to information processes in a specialist unit or department, supported by access to information liaison officers located in government departments and agencies.

4. The Tasmanian Government should provide funding to government departments, agencies and the Ombudsman, as the case may be, to:

   a. ensure access to information requests are processed within statutory timeframes

   b. speed up external review of right to information decisions

   c. provide trauma-informed training to the Tasmanian State Service in relation to victim-survivor access to information (Recommendation 19.2).

7 Conclusion

This chapter has examined the National Redress Scheme, civil litigation, the provision of apologies to victim-survivors and supports (including financial assistance) available to victim-survivors of institutional child sexual abuse who are also victims of crime. It has also explored access to information and records. While many of the National Royal Commission's recommendations relating to these areas have been adopted in Tasmania, there is still a need for further reform to improve the operation of mechanisms that seek to support and compensate victim-survivors of institutional child sexual abuse. It is essential that victim-survivors can:

- access redress or make civil claims
- access ongoing support
- where appropriate, have avenues available to receive a direct personal apology
- be given information and records that may provide much-needed clarification about the circumstances of their abuse and, potentially, support a National Redress Scheme or civil litigation claim.

These are the goals of the recommendations throughout this chapter.

Notes

1 Refer to, for example, Chapter 3; Statement of Azra Beach, 14 June 2022, 10 [60]–11 [64]; Transcript of 'Alex', [date redacted], 1676 [27–30]; Statement of 'Alex', 23 March 2022, 11 [47–49]. The name 'Alex' is a pseudonym; Order of the Commission of Inquiry, restricted publication order, 30 August 2022.

2 *Royal Commission into Institutional Responses to Child Sexual Abuse* (Final Report, December 2017), vol 3.

3 Transcript of Katrina Munting, 10 May 2022, 717 [9–47].

4 Transcript of 'Alex', [date redacted], 1681 [5–7]; Transcript of Stephen Smallbone, 9 May 2022, 647 [7–30]; Transcript of Katrina Munting, 10 May 2022, 716 [5–40]; Transcript of Angela Sdrinis, 12 May 2022, 1031 [2–14]; Transcript of Azra Beach, 16 June 2022, 1447 [40–45]; Statement of Katrina Munting, 5 April 2022, 11 [55]; Statement of Angela Sdrinis, 5 May 2022, 12 [52]; Statement of Azra Beach, 14 June 2022, 6 [36].

5 Transcript of Katrina Munting, 10 May 2022, 716 [31–40]; Statement of Azra Beach, 14 June 2022, 6 [36].

6 Commission of Inquiry into the Tasmanian Government's responses to Child Sexual Abuse in Institutional Settings, *Terms of Reference* (2021) <https://www.commissionofinquiry.tas.gov.au/__data/assets/pdf_file/0008/610388/Terms-of-reference.pdf>.

7 Royal Commission into Institutional Responses to Child Sexual Abuse, *Redress and Civil Litigation Report* (Report, August 2015).

8 *Royal Commission into Institutional Responses to Child Sexual Abuse* (Final Report, December 2017) Recommendations, 73 [1], 79 [26–32], 88 [85–89], 89 [89].

9 Department of Justice, *Tasmanian Response: Royal Commission into Institutional Responses to Child Sexual Abuse* (Report, June 2018) <https://nla.gov.au/nla.obj-1382488533/view>.

10 *Royal Commission into Institutional Responses to Child Sexual Abuse* (Final Report, December 2017) Recommendations, 79 [26–32].

11 *Royal Commission into Institutional Responses to Child Sexual Abuse* (Final Report, December 2017) Recommendations, 73 [2], 74 [5]–77 [15].

12 *National Redress Scheme for Institutional Child Sexual Abuse Act 2018* (Cth).

13 *National Redress Scheme for Institutional Child Sexual Abuse Act 2018* (Cth) s 43; *National Redress Scheme for Institutional Child Sexual Abuse (Commonwealth Powers) Act 2018* s 2; Elise Archer, 'Ministerial Statement – National Redress Scheme' (Media Release, 22 May 2018) <https://www.premier.tas.gov.au/releases/tasmania_opts_in_to_the_national_redress_scheme>.

14 *National Redress Scheme for Institutional Child Sexual Abuse Act 2018* (Cth) ss 12–17.

15 National Redress Scheme, *Applying* (Web Page) <https://www.nationalredress.gov.au/applying>.

16 National Redress Scheme, *Applying* (Web Page) <https://www.nationalredress.gov.au/applying>.

17 Transcript of Warren Strange, 12 May 2022, 1029 [23–35].

18 *National Redress Scheme for Institutional Child Sexual Abuse Act 2018* (Cth) s 20(1)(d) and (2). For these purposes, the *Social Security Act 1991* (Cth) s 23(5) defines a person as being in gaol if: (a) the person is being lawfully detained (in prison or elsewhere) while under sentence for conviction of an offence and not on release on parole or licence; or (b) the person is undergoing a period of custody pending trial or sentencing for an offence. Similarly, a person cannot make an application for redress if a security notice is in force in relation to them: s 20(1)(b).

19 *National Redress Scheme for Institutional Child Sexual Abuse Act 2018* (Cth) ss 62, 63(1), (2).

20 *National Redress Scheme for Institutional Child Sexual Abuse Act 2018* (Cth) s 63(5).

21 *National Redress Scheme for Institutional Child Sexual Abuse Act 2018* (Cth) s 63(3)(b)(i), (iii), (4), (6)(a).

22 *National Redress Scheme for Institutional Child Sexual Abuse Act 2018* (Cth) s 63(6)(b)–(f).

23 *National Redress Scheme for Institutional Child Sexual Abuse Act 2018* (Cth) s 63(7).

24 Robyn Kruk, *Second Year Review of the National Redress Scheme* (Report, 23 June 2021) 11.

25 Robyn Kruk, *Second Year Review of the National Redress Scheme* (Report, 23 June 2021) 11.

26 Robyn Kruk, *Second Year Review of the National Redress Scheme* (Report, 23 June 2021) 11, Recommendation 3.2.

27 Australian Government, *The Australian Government Response to the Final Report of the Second Year Review of the National Redress Scheme* (4 May 2023).

28 Australian Government, *The Australian Government Response to the Final Report of the Second Year Review of the National Redress Scheme* (4 May 2023) 5–6.

29 Australian Government, *The Australian Government Response to the Final Report of the Second Year Review of the National Redress Scheme* (4 May 2023) 6.

30 Australian Government, *The Australian Government Response to the Final Report of the Second Year Review of the National Redress Scheme* (4 May 2023) 6.

31 *National Redress Scheme for Institutional Child Sexual Abuse Act 2018* (Cth) s 16(1)(a).

32 *National Redress Scheme for Institutional Child Sexual Abuse Act 2018* (Cth) s 43.

33 *National Redress Scheme for Institutional Child Sexual Abuse Act 2018* (Cth) s 16(1)(b).

34 *National Redress Scheme for Institutional Child Sexual Abuse Act 2018* (Cth) ss 16(1)(c) 54(2).

35 Royal Commission into Institutional Responses to Child Sexual Abuse, *Redress and Civil Litigation Report* (Report, August 2015) 145, 146, 282.

36 Royal Commission into Institutional Responses to Child Sexual Abuse, *Redress and Civil Litigation Report* (Report, August 2015) 151.

37 Transcript of Katrina Munting, 10 May 2022, 716 [31–40]; Statement of Azra Beach, 14 June 2022, 6 [36].

38 *National Redress Scheme for Institutional Child Sexual Abuse Act 2018* (Cth) s 9; Australian Government, 'Operator', National Redress Guide (Web Page) <https://guides.dss.gov.au/national-redress-guide/1/1/o/30>.

39 Statement of Ginna Webster, 29 April 2022, 50 [323].

40 Statement of Ginna Webster, 29 April 2022, 50 [321]–52 [334].

41 Statement of Ginna Webster, 29 April 2022, 50 [324], 51 [328].

42 Statement of Ginna Webster, 10 June 2022, 51 [325].

43 Statement of Ginna Webster, 10 June 2022, 51 [330] as modified by the Solicitor-General of Tasmania, *Procedural Fairness Response*, 16 March 2023, 2. Secretary Webster gave evidence to our Commission of Inquiry that the internal timeframe for agencies or departments to respond to priority applications was two weeks. However, the State of Tasmania has subsequently clarified that the relevant priority application timeframe is three weeks.

44 Statement of Ginna Webster, 10 June 2022, 51 [330–331].

45 Statement of Ginna Webster, 10 June 2022, 51 [327].

46 Statement of Ginna Webster, 10 June 2022, 53 [335(k)].

47 Statement of Ginna Webster, 10 June 2022, 53 [335(k)].

48 Department for Education, Children and Young People, *Procedural Fairness Response*, 16 March 2023.

49 Statement of Ginna Webster, 10 June 2022, 52 [335(a)].

50 Statement of Ginna Webster, 10 June 2022, 52 [335(c)].

51 Statement of Ginna Webster, 10 June 2022, 53 [335(e)].

52 Statement of Ginna Webster, 10 June 2022, 52 [335(d)].

53 Statement of Ginna Webster, 10 June 2022, 53 [335(f)]; Department for Education, Children and Young People, *Procedural Fairness Response*, 16 March 2023, 2–3.

54 Statement of Ginna Webster, 10 June 2022, 53 [335(g)]; Department for Education, Children and Young People, *Procedural Fairness Response*, 16 March 2023, 3.

55 Statement of Ginna Webster, 10 June 2022, 51 [329].

56 Statement of Ginna Webster, 10 June 2022, 51 [329].

57 National Redress Scheme, *Operational Manual for Participating Institutions* (August 2018) 56.

58 Refer to National Redress Scheme, *Tasmania Redress Support Services* (Web Page) <https://www.nationalredress.gov.au/support/explore/tas-redress-support-services?gclid=CjwKCAiAzp6eBhByEiwA_gGq5KjhUwg8-gQfCUjngjbft_8sPKVvjc5ShuIGZutsghZjha7mvFsSkBoCV3cQAvD_BwE&gclsrc=aw.ds>. Other organisations that may provide advice in relation to redress applications include Youth Law Australia, Laurel House, and Shine Lawyers. Organisations that may provide counselling or other forms of support include Blue Knot, Sexual Assault Counselling Australia, Bravehearts, People With Disability, Australia Care Leavers Australasia Network, the Child Migrants Trust and the In Good Faith Foundation.

59 *National Redress Scheme for Institutional Child Sexual Abuse Act 2018* (Cth) s 43.

60 Statement of Warren Strange, 28 April 2022; Transcript of Warren Strange, 12 May 2022, 1026 [1]–1044 [20].

61 Statement of Warren Strange, 28 April 2022, 2 [9]–3 [10].

62 Statement of Warren Strange, 28 April 2022, 13–14 [45].

63 Statement of Warren Strange, 28 April 2022, 12 [39].

64 Statement of Warren Strange, 28 April 2022, 5–6 [21].

65 Statement of Warren Strange, 28 April 2022, 3 [13]–4 [18].

66 Statement of Warren Strange, 28 April 2022, 4 [18].

67 Statement of Warren Strange, 28 April 2022, 5 [21], 8 [28]–9 [29].

68 Statement of Warren Strange, 28 April 2022, 9 [29(h)].

69 Statement of Warren Strange, 28 April 2022, 10 [32]–11 [34].

70 Department for Education, Children and Young People, *Procedural Fairness Response*, 16 March 2023, 4–5.

71 Statement of Warren Strange, 28 April 2022, 11 [37].

72 Statement of Warren Strange, 28 April 2022, 12 [41].

73 Statement of Warren Strange, 28 April 2022, 12 [43–44].

74 Transcript of Kylee Pearn, 28 June 2022, 1792 [18–26].

75 Transcript of Kylee Pearn, 28 June 2022, 1792 [39–45].

76 Transcript of Kylee Pearn, 28 June 2022, 1793 [4–12].

77 Australian Government, 'Redress Payment (Monetary Payment)', *National Redress Guide* (Web Page, 8 November 2021) <https://guides.dss.gov.au/national-redress-guide/5/1>.

78 Statement of Ginna Webster, 10 June 2022, 51 [329].

79 *National Redress Scheme for Institutional Child Sexual Abuse Act 2018* (Cth) s 192.

80 National Redress Scheme, *Second Anniversary Review* (Web Page) <https://www.nationalredress.gov.au/about/second-anniversary-review?gclid=EAIaIQobChMI7-rIuaOy_wIVVpFmAh2V8wO0EAAYASAAEgJty_D_BwE&gclsrc=aw.ds>.

81 Robyn Kruk, *Second Year Review of the National Redress Scheme* (Report, 26 March 2021) 8.

82 Robyn Kruk, *Second Year Review of the National Redress Scheme* (Report, 26 March 2021) 8–9.

83 Robyn Kruk, *Second Year Review of the National Redress Scheme* (Report, 26 March 2021) 9.

84 Robyn Kruk, *Second Year Review of the National Redress Scheme* (Report, 26 March 2021) 9–13.

85 Robyn Kruk, *Second Year Review of the National Redress Scheme* (Report, 26 March 2021) 13.

86 Australian Government, *The Australian Government Response to the Final Report of the Second Year Review of the National Redress Scheme* (4 May 2023) 2.

87 Australian Government, *The Australian Government Response to the Final Report of the Second Year Review of the National Redress Scheme* (4 May 2023) 3; National Redress Scheme, *Service Charter for Your National Redress Scheme* (Web Page) <https://www.nationalredress.gov.au/applying/charter?gclid=EAIaIQobChMI1tf8yLuy_wIVmLuWCh0vrA88EAAYASAAEgIRsvD_BwE&gclsrc=aw.ds>.

88 Australian Government, *The Australian Government Response to the Final Report of the Second Year Review of the National Redress Scheme* (4 May 2023) 3.

89 Refer to *National Redress Scheme for Institutional Child Sexual Abuse Act 2018* (Cth) s 14(1)(c).

90 Refer to *National Redress Scheme for Institutional Child Sexual Abuse Act 2018* (Cth) ss 13(1)(b), 14(1)(c), 20(1)(c), 193(1).

91 Royal Commission into Institutional Responses to Child Sexual Abuse, *Redress and Civil Litigation Report* (Report, August 2015) Recommendation 48.

92 Transcript of Ginna Webster, 8 July 2022, 2718 [42–47].

93 Transcript of Ginna Webster, 8 July 2022, 2718 [17–32].

94 For an example of a successful legal action by a victim-survivor against a perpetrator of child sexual abuse in a non-institutional context, refer to *Horne, Cherie Jayne v Wilson, Graeme James Gregory (No 2)* [1998] TASSC 44.

95 Royal Commission into Institutional Responses to Child Sexual Abuse, *Redress and Civil Litigation Report* (Report, August 2015) 432.

96 Professor Harold Luntz has played a leading role in this area. Refer to Rebecca Graycar, 'Teaching Torts as if the World Really Existed: Reflections on Harold Luntz's Contribution to Australian Law School Classrooms' (2003) 27(3) *Melbourne University Law Review* 677, particularly Part III, which contains a critique of the torts system.

97 Productivity Commission, *Access to Justice Arrangements* (Report No. 72, September 2014) 42.

98 Refer to Law Council of Australia, *Access to Justice: The Justice Project* (Web Page) <https://www.lawcouncil.asn.au/justice-project/access-to-justice>.

99 Royal Commission into Institutional Responses to Child Sexual Abuse, *Redress and Civil Litigation Report* (Report, August 2015) 76–78.

100 *Limitation Act 1974* s 5B, which provides that no limitation period applies to an action for damages for personal injury or death of a person arising from or related to the sexual abuse, or serious physical abuse, of the person when the person was a minor. Under section 5C of the *Limitation Act 1974*, the Court can set aside a previous settlement of such an action. This is likely to be relevant to claims settled by institutions.

101 Royal Commission into Institutional Responses to Child Sexual Abuse, *Redress and Civil Litigation Report* (Final Report, August 2015) 53–57; *Justice Legislation Amendment (Organisational Liability for Child Abuse) Act 2019*.

102 *Civil Liability Act 2002* pt 10C, ss 49C (defines the 'organisations' which are covered by pt 10C and includes a 'public sector body' as defined, which covers a State agency), 49G (defines an 'associated person' which includes, but is not limited to, an individual who is an 'office holder, officer, employee, owner, volunteer, or contractor', of the organisation*)* and 49H(5) (the definition of child abuse includes sexual, psychological or physical abuse).

103 *Civil Liability Act 2002* s 49H(4). This 'reverse onus' provision was recommended by the National Royal Commission (Recommendation 98).

104 *Civil Liability Act 2002* s 49I.

105 *Civil Liability Act 2002* ss 4(7)–(8).

106 Office of the Solicitor-General, *Model Litigant Guidelines* (2019).

107 Office of the Solicitor-General, *Guidelines for the Conduct of Civil Claims* (2019).

108 Transcript of Paul Turner, 8 July 2022, 2670 [34–41].

109 Submission 069 Laurel House, 6.

110 Statement of Angela Sdrinis, 5 May 2022, 11 [48].

111 Statement of Angela Sdrinis, 5 May 2022, 4 [18]–5[21].

112 *ZAB v ZWM* [2021] TASSC 64. This case did not concern institutional sexual abuse but the abuse of a boy by his father when he was aged between 10 and 15. Nevertheless, the principles involved in the calculation of the award could also be relevant in assessing damages for institutional sexual abuse and in negotiating settlements for such abuse. The son was professionally qualified and a significant proportion of his loss related to how his earning capacity had been reduced by the effect of the abuse.

113 Statement of Warren Strange, 28 April 2022, 32 [109(a)].

114 Statement of Warren Strange, 28 April 2022, 33 [110].

115 Elise Archer, 'New State Litigation Office to Support Victim-Survivors' (Media Release, 1 March 2023) <https://elisearcher.com.au/new-state-litigation-office-to-support-victim-survivors/>.

116 Statement of Angela Sdrinis, 5 May 2022, 11 [48].

117 Statement of Angela Sdrinis, 5 May 2022, 5 [23]; Transcript of Angela Sdrinis, 12 May 2022, 1038 [40–49].

118 Department for Education, Children and Young People, *Procedural Fairness Response*, 16 March 2023, 8.

119 Transcript of Angela Sdrinis, 12 May 2022, 2039 [1–16].
120 Statement of Angela Sdrinis, 5 May 2022, 3–4 [17].
121 Transcript of Angela Sdrinis, 12 May 2022, 2039 [21–23].
122 Statement of Angela Sdrinis, 5 May 2022, 3–4 [17].
123 Statement of Angela Sdrinis, 5 May 2022, 3–4 [17].
124 Statement of Angela Sdrinis, 5 May 2022, 11 [49].
125 Statement of Angela Sdrinis, 5 May 2022, 4 [18].
126 Statement of Angela Sdrinis, 5 May 2022, 4 [18].
127 Transcript of Angela Sdrinis, 12 May 2022, 1036 [21–29].
128 Statement of Angela Sdrinis, 5 May 2022, 10 [46].
129 Submission 048 Shine Lawyers, 2.
130 Submission 048 Shine Lawyers, 3.
131 Submission 048 Shine Lawyers, 3.
132 Submission 048 Shine Lawyers, 6.
133 Submission 048 Shine Lawyers, 7.
134 Submission 048 Shine Lawyers, 7.
135 State of Tasmania, *Procedural Fairness Response*, 16 March 2023, 9.
136 Office of the Solicitor-General, *Guidelines for the Conduct of Civil Claims* (2019) cl 15.
137 Statement of Angela Sdrinis, 5 May 2022, 8 [37]–9 [41].
138 Statement of Angela Sdrinis, 5 May 2022, 8 [37]–9 [41].
139 Statement of Angela Sdrinis, 5 May 2022, 9 [40].
140 Statement of Angela Sdrinis, 5 May 2022, 8 [37].
141 Transcript of Paul Turner, 8 July 2022, 2691 [31–35].
142 Office of the Solicitor-General, *Procedural Fairness Response*, 16 March 2023, 10 [20].
143 Department of Justice, *Fifth Annual Progress Report and Action Plan 2023* (Report, December 2022) 21.
144 Statement of Ginna Webster, 29 April 2022, 8 [66–68].
145 Statement of Ginna Webster, 29 April 2022, 8 [66–68].
146 Submission 048 Shine Lawyers, 4–5; Transcript of Warren Strange, 12 May 2022, 1032 [44]–1033 [4]; Transcript of Angela Sdrinis, 12 May 2022, 1034 [3].
147 Transcript of Warren Strange, 12 May 2022, 1033 [40–45]; Transcript of Angela Sdrinis, 12 May 2022, 1034 [3–5].
148 Submission 048 Shine Lawyers, 5.
149 Submission 048 Shine Lawyers, 5.
150 Transcript of Ginna Webster, 12 September 2022, 3957 [10–19].
151 Submission 048 Shine Lawyers, 6.
152 With an exception for proceedings under the *Crime (Confiscation of Profits) Act 1993*.
153 Solicitor-General, *Report for 2021–22* (Report, 29 September 2022) 4.
154 Under section 3 of the *Financial Management Act 2016,* ''Agency' means a Government department, State authority, body, organisation, or office that is specified in Column 1 of Part 1 or 2 of Schedule 1'.
155 *Financial Management Act 2016* s 51(4). Under section 3 of the *Financial Management Act 2016* an 'Accountable authority' means a person, from time to time, holding or acting in a position specified in Column 2 of Part 1 or 2 of Schedule 1, opposite an Agency specified in Column 1 of that Part of the Schedule, or the position of a person specified in an order under section 6(3) to be the accountable authority in relation to an entity. 'Officer' means a person who is a State Services officer or State Service employee, or employed by or in an Agency or by the Governor-in Council pursuant to the royal prerogative or pursuant to any written law, or for the purposes of an Agency pursuant to any written law, whether that person is employed under a contract of service or a contract for service and whether or not that person received any remuneration for the employment.

156 Department of Treasury and Finance, *Treasurer's Instruction, Financial Management Act 2016, FC-17 Engagement of Legal Practitioners* (1 July 2019) 1 [17.2–17.3]. The direction also applies to independent bodies such as the Ombudsman, the Commissioner for Children and Young People and the Integrity Commission, as well as government agencies.

157 *Financial Management Act 2016* s 51; Department of Treasury and Finance, *Treasurer's Instruction, Financial Management Act 2016, FC-17 Engagement of Legal Practitioners* (1 July 2019), 1 [17.2–17.3], [17.6–17.8]. The direction also applies to independent bodies such as the Ombudsman, the Commissioner for Children and Young People and the Integrity Commission, as well as Government agencies.

158 Department of Treasury and Finance, *Treasurer's Instruction, Financial Management Act 2016, FC-17 Engagement of Legal Practitioners* (1 July 2019) 2 [17.6–17.8].

159 *Solicitor-General Act 1983* s 7; Statement of Ginna Webster, 10 June 2022, 44 [277–278].

160 Transcript of Sarah Kay, 8 July 2022, 2652 [11–21].

161 Department of Treasury and Finance, *Treasurer's Instruction, Financial Management Act 2016, FC-17 Engagement of Legal Practitioners* (1 July 2019) 1 [17.2].

162 *Financial Management Act 2016* sch 1, Pt 1.

163 Transcript of Sarah Kay, 8 July 2022, 2652 [23]–2653 [28].

164 Refer to, for example, Statement of Michael Pervan, 14 June 2022, 93 [512]; Transcript of Kathrine Morgan-Wicks, 9 September 2022, 3850 [3–15].

165 Statement of Ginna Webster, 14 June 2022, 43 [272]; Transcript of Ginna Webster, 6 May 2022, 579 [31–40]; Transcript of Ginna Webster, 8 July 2022, 2716 [20–32]; Transcript of Timothy Bullard, 12 May 2022, 973 [38]–974 [5]; Transcript of Timothy Bullard, 13 May 2022, 1086 [3]–1089 [35]; Statement of Tim Bullard, 10 May 2022, 71 [426]–73 [443]; Statement of Michael Pervan, 14 June 2022, 93 [512]–94 [514]. Secretary Morgan-Wicks expressed a different view: refer to Transcript of Kathrine Morgan-Wicks, 9 September 2022, 3849 [2]–3850 [15].

166 Transcript of Paul Turner, 8 July 2022, 2674 [38]–2675 [3].

167 Transcript of Paul Turner, 8 July 2022, 2674 [38]–2675 [6].

168 Refer, for example, to Office of the Solicitor-General, *Model Litigant Guidelines* (2019) cl 9(c). x.

169 Statement of Ginna Webster, 29 April 2022, 4 [25].

170 Elise Archer, 'New State Litigation Office to Support Victim-Survivors' (Media Release, 1 March 2023) <https://elisearcher.com.au/new-state-litigation-office-to-support-victim-survivors/>.

171 Elise Archer, 'New State Litigation Office to Support Victim-Survivors' (Media Release, 1 March 2023) <https://elisearcher.com.au/new-state-litigation-office-to-support-victim-survivors/>.

172 The name 'Alex' is a pseudonym; Order of the Commission of Inquiry, restricted publication order, 30 August 2023; Transcript of 'Alex', [date redacted] 1681 [6–9], 1682 [20–22].

173 Transcript of Katrina Munting, 10 May 2022, 712 [46]–714 [22]; Statement of Katrina Munting, 5 April 2022, 11 [55].

174 Statement of Katrina Munting, 5 April 2022, 11 [55].

175 Statement of Katrina Munting, 5 April 2022, 11 [55].

176 Transcript of Katrina Munting, 10 May 2022, 716 [24–25].

177 Transcript of Katrina Munting, 10 May 2022, 716 [33–40].

178 Transcript of Azra Beach, 16 June 2022, 1450 [32–37].

179 Transcript of Azra Beach, 16 June 2022, 1450 [39–45].

180 Transcript of Angela Sdrinis, 12 May 2022, 1031 [2–14].

181 Peter Gutwein, 'No Stone Must Be Left Unturned in Protecting Our Most Vulnerable' (Media Release, 26 February 2021) <https://www.premier.tas.gov.au/site_resources_2015/additional_releases/no_stone_must_be_left_unturned_in_protecting_our_most_vulnerable>; Darren Hine, 'Outcomes of Tasmania Police Griffin Review Released' (Media Release, 26 February 2021) <https://www.police.tas.gov.au/news-events/media-releases/outcomes-of-tasmania-police-griffin-review-released/>; David Killick, 'Premier and Police Chief Apologise over Griffin Investigation Failings', *The Mercury* (online, 26 February 2021) <https://www.themercury.com.au/news/tasmania/premier-and-police-chief-apologise-over-griffin-investigation-failings/news-story/e47718cab59ce5c6eafae15c14e82667>; Rob Inglis and Jessica Willard, 'Police Review into James Geoffrey Griffin Handed Down', *The Examiner* (online, 26 February 2021) <https://www.examiner.com.au/story/7144073/police-review-finds-deficiencies-in-handling-of-griffin-allegations/>.

182 Tasmania, *Parliamentary Debates*, House of Assembly, 2 March 2021, 4 (Peter Gutwein, Premier).

183 Tasmania, *Parliamentary Debates,* House of Assembly, 11 November 2021, 6 (Peter Gutwein, Premier).

184 In November 2021, following the release of the *Independent Inquiry into the Department of Education's Responses to Child Sexual Abuse* Report, Timothy Bullard, Secretary, Department of Education, made a public apology that included the following: 'As an organisation we are deeply sorry for the historical abuse that happened in our schools and apologise unreservedly to the victims and survivors'. Refer to Transcript of Timothy Bullard, 11 May 2022, 893 [43]–894 [6]. Ginna Webster, Secretary, Department of Justice, apologised to victim-survivors in her statement to our Commission of Inquiry. Refer to Statement of Ginna Webster, 10 June 2022, 1 [3]. Kathrine Morgan-Wicks, Secretary, Department of Health, also apologised to victim-survivors. Refer to Transcript of Kathrine Morgan-Wicks, 5 July 2022, 2375 [33]–2378 [4]. Mr Michael Pervan, the then Secretary of the Department of Communities, repeated the words of the Premier that 'We are so terribly sorry that we failed those people, our system failed those people'. He also apologised to Azra Beach, who had given evidence, and to other witnesses who had given evidence to our Inquiry about what had happened to them. Refer to Transcript of Michael Pervan, 17 June 2022, 1589 [23–44].

185 Tasmania, *Parliamentary Debates*, House of Assembly, 8 November 2022, 29–39 (Jeremy Rockliff, Premier; Rebecca White, Leader of the Opposition; Cassy O'Connor, Leader of the Greens; Kristie Johnston; David O'Byrne).

186 Tasmania, *Parliamentary Debates,* House of Assembly, 8 November 2022, 29–32 (Jeremy Rockliff, Premier).

187 Tasmania, *Parliamentary Debates*, House of Assembly, 8 November 2022, 31 (Jeremy Rockliff, Premier).

188 Statement of Angela Sdrinis, 5 May 2022, 12 [52].

189 Transcript of Angela Sdrinis, 12 May 2022, 1031 [2–14]. Refer also to Statement of Warren Strange, 28 April 2022, 23 [75(c)].

190 *Civil Liability Act 2002* s 7(1). An 'apology' is defined as 'an expression of sympathy or regret, or of a general sense of benevolence or compassion, in connection with any matter, which does not contain an admission of fault in connection with the matter': s 7(3).

191 *Civil Liability Act 2002* ss 3B(1)(a), 6A.

192 For example, Ms Munting emailed the Premier on 15 December 2022 to point out that, following the Tasmanian Parliament's apology to victim-survivors of child sexual abuse in Tasmanian Government institutions, no settlement was reached in her case, which had been set down for trial in March 2023, as a result of which she would have to submit to cross-examination again. She said she considered the apologies made by the secretaries of the Tasmanian Government departments and the Premier were empty words.

193 Statement of Ginna Webster, 10 June 2022, 47 [305].

194 The *Civil Liability Act 2002* defines 'child abuse' for the purposes of section 49H (the 'duty of care' provision) and section 49J (vicarious liability claims) as '(a) sexual abuse, or physical abuse, of the child; and (b) any psychological abuse of the child that arises from the sexual abuse or physical abuse'. Thus, the provision is not confined to child sexual abuse.

195 Some aspects of support for victims of crime are also discussed in relation to criminal justice responses in Chapter 16.

196 *Victims of Crime Assistance Act 1976* s 6A. These figures relate to 'primary victims', that is, those who are directly harmed. The cap of $30,918 applies up to 30 June 2023 and is now indexed to the Consumer Price Index. Refer to *Victims of Crime Assistance Regulations 2010* reg 4. There is also provision for family members and others to obtain compensation if the primary victim has died.

197 *Victims of Crime Assistance Act 1976* s 6A(4).

198 Department of Justice, *Victims Support Services* (Web Page) <https://www.justice.tas.gov.au/victims>.

199 Department of Justice, *Victims of Crime Service* (Web Page, 4 April 2022) <https://www.justice.tas.gov.au/victims/services/victims-of-crime-service>.

200 Department of Justice, *Victims of Crime Service* (Web Page, 4 April 2022) <https://www.justice.tas.gov.au/victims/services/victims-of-crime-service>.

201 Statement of Catherine Edwards, 4 July 2022, 3 [14–15], 10 [70].

202 Department of Justice, *Victims of Crime Service* (Web Page, 4 April 2022) <https://www.justice.tas.gov.au/victims/services/victims-of-crime-service>.

203 Department of Justice, *Eligible Persons Register* (Web Page, 4 April 2022) <https://www.justice.tas.gov.au/victims/services/eligible-persons-register>.

204 Department of Justice, *Victims of Crime Service* (Web Page, 4 April 2022) <https://www.justice.tas.gov.au/victims/services/victims-of-crime-service>.

205 Department of Justice, *Victims of Crime Service* (Web Page, 4 April 2022) <https://www.justice.tas.gov.au/victims/services/victims-of-crime-service>.

206 Statement of Catherine Edwards, 4 July 2022, 3 [20].

207 Statement of Catherine Edwards, 4 July 2022, 9 [62–63].

208 Statement of Catherine Edwards, 4 July 2022, 3 [22].

209 Statement of Catherine Edwards, 4 July 2022, 3–4 [23].

210 Statement of Catherine Edwards, 4 July 2022, 17 [120], 18 [124–125].

211 Letter from anonymous to Attorney-General, 19 January 2021, produced by the Department of Justice in response to a Commission notice to produce, 2. Section 7(5) of the *Victims of Crime Assistance Act 1976* also permits a Commissioner to direct that a person appears before them; however, Ms Edwards told us she could not recall the provision ever being used in the time she was employed at the Victims Support Services: refer to Statement of Catherine Edwards, 4 July 2022, 21 [147–149].

212 Statement of Catherine Edwards, 4 July 2022, 19 [129–132].

213 Statement of Catherine Edwards, 4 July 2022, 4 [25–26].

214 Statement of Catherine Edwards, 4 July 2022, 4 [27].

215 Department for Education, Children and Young People, *Procedural Fairness Response*, 16 March 2023, 13.

216 *Victims of Crime Assistance Act 1976* s 4(1). The provision also applies where the other person had some other justification for that act or where they were injured assisting a police officer to make an arrest or to prevent a crime from being committed.

217 *Victims of Crime Assistance Act 1976* s 5(2).

218 *Victims of Crime Assistance Act 1976* s 4(2). Different matters are covered where the applicant is the family member of a victim who has died. We do not discuss these matters here.

219 *Victims of Crime Assistance Act 1976* s 7(1A), (1B).

220 *Victims of Crime Assistance Act 1976* s 7(1C).

221 Submission 014 Anonymous, 48–49.

222 Statement of Catherine Edwards, 4 July 2022, 9 [64].

223 *Victims of Crime Assistance Act 1976* s 7(1D) as amended by the *Justice Miscellaneous (Royal Commission Amendments) Act 2022* s 45.

224 *Victims of Crime Assistance Act 1976* s 5(3).

225 *Victims of Crime Assistance Act 1976* s 5(3A).

226 Statement of Catherine Edwards, 4 July 2022, 19 [133–138].

227 *Victims of Crime Assistance Act* s 5(4).

228 *Victims of Crime Assistance Act 1976* s 10. An application for judicial review, on grounds including error of law, can be made under the *Judicial Review Act 2000*, but the merits of a decision cannot be reviewed.

229 *Victims of Crime Assistance Act 1976* (Vic) s 59(1).

230 *Victims of Crime (Financial Assistance Scheme) Act 2022* (Vic) s 46.

231 *Victims Rights and Support Act 2013* (NSW) ss 40(7), 51.

232 Submission 014 Anonymous, 45.

233 Submission 014 Anonymous, 46.

234 Submission 014 Anonymous, 33.

235 Submission 014 Anonymous, 33.

236 Submission 014 Anonymous, 33.

237 Statement of Catherine Edwards, 4 July 2022, 6 [39].

238 Statement of Catherine Edwards, 4 July 2022, 7 [45].

239 Statement of Catherine Edwards, 4 July 2022, 6 [40]–7 [44].

240 Statement of Catherine Edwards, 4 July 2022, 7 [46].

241 Transcript of Ginna Webster, 8 July 2022, 2699 [29–36], as modified by Department for Education, Children and Young People, *Procedural Fairness Response*, 16 March 2023.

242 Administrative decisions currently subject to merits review by the Tasmanian Civil and Administrative Tribunal include decisions under the *Motor Accidents (Liabilities and Compensation) Act 1973*, *Workers' (Occupational Diseases) Relief Fund Act 1954* and *Workers Rehabilitation and Compensation Act 1988*.

243 For a discussion of the importance of access to information for victim-survivors of child sexual abuse in institutional contexts, refer to *Royal Commission into Institutional Responses to Child Sexual Abuse* (Final Report, December 2017) vol 8, 87–88. Refer also to Statement of Warren Strange, 28 May 2022, 30 [100], which discusses the importance of records to people who have few records of childhood, noting: 'They may assist in restoring a sense of who an individual is, where they came from, why they went into care, and may help re-establish family connections'.

244 *Right to Information Act 2009* s 7. Refer also to *Personal Information Protection Act 2004* sch 1, cl 6. For an overview of rights to information and privacy legislation in Australia, refer to *Royal Commission into Institutional Responses to Child Sexual Abuse* (Final Report, December 2017) vol 8, 88–92.

245 As discussed above, victim-survivors may also obtain some information about offenders through the Eligible Persons Register. There are also civil litigation procedures, such as discovery, which can be used to obtain government information.

246 Transcript of Samuel Leishman, 13 May 2022, 1062 [1–8].

247 For definitions and descriptions of the stages of record keeping, refer to *Royal Commission into Institutional Responses to Child* Sexual *Abuse* (Final Report, December 2017) vol 8, 40–41.

248 *Royal Commission into Institutional Responses to Child Sexual Abuse* (Final Report, December 2017) vol 8, 30. For an overview of the impact of poor records and record keeping on victim-survivors of child sexual abuse in institutional contexts, refer to *Royal Commission into Institutional Responses to Child Sexual Abuse* (Final Report, December 2017) vol 8, 42–43.

249 *Royal Commission into Institutional Responses to Child Sexual Abuse* (Final Report, December 2017) vol 8, 108–109, Recommendation 8.4.

250 *Royal Commission into Institutional Responses to Child Sexual Abuse* (Final Report, December 2017) vol 8, 108–109, Recommendation 8.4.

251 *Royal Commission into Institutional Responses to Child Sexual Abuse* (Final Report, December 2017) vol 8, 10.

252 *Royal Commission into Institutional Responses to Child Sexual Abuse* (Final Report, December 2017) vol 8, 22, Recommendations 8.1, 8.2 and 8.3.

253 *Royal Commission into Institutional Responses to Child Sexual Abuse* (Final Report, December 2017) vol 8, 22, Recommendation 8.1.

254 *Royal Commission into Institutional Responses to Child Sexual Abuse* (Final Report, December 2017) vol 8, 22, Recommendations 8.2 and 8.3.

255 Office of the State Archivist, *Disposal Schedule for Records Relating to Child Abuse: Disposal Authorisation DA2520* (December 2019).

256 Office of the State Archivist, *Disposal Schedule for Records Relating to Child Abuse: Disposal Authorisation DA2520* (December 2019) 2.

257 Office of the State Archivist, *Notice of a Disposal Freeze on Records Relating to Children* (December 2019) 1.

258 Department of Justice, *Fifth Annual Progress Report and Action Plan 2023: Appendix A* (Report, December 2022) 23.

259 Department of Justice, *Fifth Annual Progress Report and Action Plan 2023: Appendix A* (Report, December 2022) 23. Refer also to Office of the State Archivist, *Information and Records Management Standard* (28 October 2020).

260 Department of Justice, *Fifth Annual Progress Report and Action Plan 2023: Appendix A* (Report, December 2022) 23.

261 Department of Justice, *Fifth Annual Progress Report and Action Plan 2023: Appendix A* (Report, December 2022) 23–24.

262 Department of Communities, 'Item 15', 13 September 2021, 3, produced by the Department of Communities in response to a Commission notice to produce.

263 Submission 107 knowmore, 4.

264 Statement of Michael Pervan, 14 June 2022, 96 [529].

265 Statement of Michael Pervan, 14 June 2022, 87 [472].

266 Statement of Kathrine Morgan-Wicks, 24 May 2022, 48 [412].

267 Statement of Kathrine Morgan-Wicks, 24 May 2022, 49 [415–416].

268 Statement of Timothy Bullard, 10 May 2022, 64 [403].

269 Statement of Michael Pervan, 14 June 2022, 86 [472], 96 [529].

270 Statement of Kathrine Morgan-Wicks, 24 May 2022, 49 [415–416]; Department of Justice, *Fifth Annual Progress Report and Action Plan 2023: Appendix A* (Report, December 2022) 24.

271 Department for Education, Children and Young People, *Procedural Fairness Response*, 16 March 2023, 2.

272 Department for Education, Children and Young People, *Procedural Fairness Response*, 16 March 2023, 2.

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275 The name 'Rachel' is a pseudonym; Order of the Commission of Inquiry, restricted publication order, 11 May 2022; Transcript of 'Rachel', 11 May 2022, 823 [10-12].

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277 Department for Education, Children and Young People, *Procedural Fairness Response*, 16 March 2023, 15.

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284 *Right to Information Act 2009* s 7.

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286 *Right to Information Act 2009* ss 44, 45.

287 *Personal Information Protection Act 2004*.

288 *Personal Information Protection Act 2004* sch 1, cl 6.

289 *Personal Information Protection Act 2004* sch 1, cl 6(1). 'Personal information custodian' means: a public authority; any body, organisation or person who has entered into a personal information contract relating to personal information; or a prescribed body: *Personal Information Protection Act 2004* s 3.

290 *Royal Commission into Institutional Responses to Child Sexual Abuse* (Final Report, December 2017) vol 8, 93.

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309 Ombudsman Tasmania, *Annual Report 2021–2022* (Report, 2022) 30.

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312 Statement of Angela Sdrinis, 5 May 2022, 3 [14].

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315 Statement of Warren Strange, 28 May 2022, 30 [101]–32 [107].

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318 *Right to Information Act 2009* s 3(4)(b).

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320 Refer to *Freedom of Information Act 1982* (Vic) s 29 (documents containing matter communicated by any other State) and s 30 (internal working documents). Section 36 contains an exemption due to a 'disclosure contrary to public interest'; however, this exemption is confined to matters affecting the economy of Victoria, business and financial affairs and council documents.

321 *Right to Information Act 2009* sch 1. Schedule 2 lists matters that are irrelevant to assessment of public interest.

322 Refer to, for example, *Government Information (Public Access) Act 2009* (NSW) s 14; *Right to Information Act 2009* (Qld) sch 4.

323 It should be noted that the exemptions in the *Right to Information Act 2009* sch 1 include a broad range of matters, not all of which are relevant to the issues discussed in our Inquiry. For example, these include business information and information relating to law enforcement.

324 *Personal Information Protection Act 2004* sch 1, cl 6(1)(a).

325 *Personal Information Protection Act 2004* sch 1, cl 6(1)(b).

326 Consultation with Ombudsman Tasmania, 2 September 2021.

327 *Personal Information Protection Act 2004* sch 1, cl 6(1)(a).

328 Refer to, for example, *Privacy and Data Protection Act 2014* (Vic) sch 1, cl 6; *Privacy and Personal Information Act 1998* (NSW) s 14; *Information Privacy Act 2014* (ACT) sch 1, cl 12.1 and *Information Act 2002* (NT) sch 2, cl 6.1.

329 *Right to Information Act 2009* s 36(1).

330 For a discussion of the approach to a third party's privacy, refer to *Royal Commission into Institutional Responses to Child Sexual Abuse* (Final Report, December 2017) vol 8, 89—90.

331 *Privacy and Data Protection Act 2014* (Vic) sch 1, cl 6.1(b). Refer also to *Information Act 2002* (NT) sch 2, cl 6.1(c).

332 *Right to Information Act 2009* s 36(2).

333 *Right to Information Act 2009* s 36(3), (4).

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335 Statement of Warren Strange, 28 May 2022, 31 [102].

336 Transcript of Warren Strange, 12 May 2022, 1033 [27–28].

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339 Transcript of Samuel Leishman, 13 May 2022, 1062 [1–8].

340 Transcript of Samuel Leishman, 13 May 2022, 1062 [37–46].

341 Transcript of Timothy Bullard, 13 May 2022, 1071 [26–27].

342 Transcript of Timothy Bullard, 13 May 2022, 1071 [32–34].

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344 Transcript of Samuel Leishman, 12 May 2022, 1063 [9–10].

345 *Right to Information Act 2009* s 15(1).

346 *Right to Information Act 2009* s 15(5). The timeframes for consultation, notification and review in these instances mean the process may require more time than the additional 20 days. Refer to the timeframes for these processes in the *Right to Information Act 2009* ss 36, 37.

347 *Right to Information Act 2009* s 15(4).

348 *Personal Information Protection Act 2004* sch 1, cl 6(1)(b).

349 Statement of Angela Sdrinis, 5 May 2022, 2–3 [13]. Refer also to Transcript of Angela Sdrinis, 12 May 2022, 1034 [12–19].

350 Statement of Warren Strange, 28 May 2022, 31 [105]. Refer also to Transcript of Warren Strange, 12 May 2022, 1033 [34–38].

351 Transcript of Angela Sdrinis, 12 May 2022, 1034 [3–5].

352 Submission 068 Care Leavers Australasia Network, 7. A submission from Shine Lawyers also noted that it can take months, sometimes in excess of a year, for victim-survivors to be provided with personal records: Submission 048 Shine Lawyers, 5–6.

353 Transcript of 'Rachel', 11 May 2022, 822.

354 Transcript of Ann Moxham, 12 May 2022, 1023 [46]–1024 [11].

355 Transcript of Emily Baker, 5 May 2022, 463 [37–40].

356 Transcript of Emily Baker, 5 May 2022, 464 [3–4].

357 Transcript of Emily Baker, 5 May 2022, 463 [47].

358 Information and Privacy Commission New South Wales, *National Dashboard – Utilisation of Information Access Rights – 2020–21* (Web Page) <https://www.ipc.nsw.gov.au/sites/default/files/2022-06/OGP_Metrics_all_jusridictions_all_years_June_2022.pdf>.

359 Queensland did not supply information on this metric: Information and Privacy Commission New South Wales, *National Dashboard – Utilisation of Information Access Rights – 2020–21* (Web Page) <https://www.ipc.nsw.gov.au/sites/default/files/2022-06/OGP_Metrics_all_jusridictions_all_years_June_2022.pdf>.

360 Ombudsman Tasmania, *Annual Report 2021–2022* (Report, 2022) 28.

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362 Refer to, for example, Transcript of Timothy Bullard, 13 May 2022, 1073 [18]–1074 [30]; Statement of Gina Webster, 10 June 2022, 41 [258–261]; Statement of Kathrine Morgan-Wicks, 24 May 2022, 46 [396]–47 [398]; Statement of Michael Pervan, 14 June 2022, 88 [475]–89 [483].

363 Transcript of Timothy Bullard, 13 May 2022, 1074 [11–12].

364 Transcript of Timothy Bullard, 13 May 2022, 1074 [28–30].

365 Statement of Ginna Webster, 10 June 2022, 41 [258].

366 Statement of Kathrine Morgan-Wicks, 24 May 2022, 46 [394]

367 Statement of Ginna Webster, 10 June 2022, 42 [265]; Statement of Kathrine Morgan-Wicks, 24 May 2022, 47–48 [402]; Statement of Timothy Bullard, 10 May 2022, 61 [387].

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370 Transcript of Ann Moxham, 12 May 2022, 1023 [46]–1024 [11].

371 Statement of Ginna Webster, 10 June 2022, 42 [265–269].

372 Statement of Angela Sdrinis, 5 May 2022, 2–3 [13].

373 The application fee is 25 fee units: *Right to Information Act 2009* s 16(1). Refer also to: *Fee Units Act 1997* ss 5, 6. The value of a fee unit in 2023–2024 is $1.78: Department of Treasury and Finance, *Fee Units* (Web Page, 15 February 2023) <https://www.treasury.tas.gov.au/economy/economic-policy-and-reform/fee-units>.

374 *Right to Information Act 2009* s 16(2).

375 For a description, refer to *Royal Commission into Institutional Responses to Child Sexual Abuse* (Final Report, December 2017) vol 8, 89.

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379 Ombudsman Tasmania, *Annual Report 2021–2022* (Report, 2022) 31.

380 Ombudsman Tasmania, *Annual Report 2021–2022* (Report, 2022) 31.

381 Ombudsman Tasmania, *Annual Report 2021–2022* (Report, 2022) 31. A media report in February 2023 also suggested that filling staff vacancies continues to be a challenge: Alex Treacy, 'Ombudsman Tasmania: Three-Year Wait for Review Has Labor Fuming', *The Mercury* (online, 10 February 2023) <https://www.themercury.com.au/news/tasmania/ombudsman-tasmania-threeyear-wait-for-review-has-labor-fuming/news-story/2d4c760bb36f286940f77f3d99fcd43b>.

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387 Alex Treacy, 'Ombudsman Tasmania: Three-Year Wait for Review Has Labor Fuming', *The Mercury* (online, 10 February 2023) <https://www.themercury.com.au/news/tasmania/ombudsman-tasmania-threeyear-wait-for-review-has-labor-fuming/news-story/2d4c760bb36f286940f77f3d99fcd43b>.

388 This is also the case for other Ombudsman decisions, but it causes particular problems in the context of release of information.

389 Consultation with Ombudsman Tasmania, 2 September 2021.

390 Refer to, for example, *Freedom of Information Act 1982* (Vic) pt VI, div 3; *Government Information (Public Access) Act 2009* (NSW) pt 5, div 4.

391 Statement of Warren Strange, 28 May 2022, 31 [103].

392 Statement of Warren Strange, 28 May 2022, 31 [103].

393 Transcript of Warren Strange, 12 May 2022, 1033 [18–25].

394 Statement of Warren Strange, 28 May 2022, 31 [105].

395 Submission 086 Angela Sdrinis, 75.

396 Refer to, for example, Statement of Warren Strange, 28 May 2022, 31 [104].

397 Statement of Kathrine Morgan-Wicks, 24 May 2022, 46 [391].

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401 Department of Premier and Cabinet, *Keeping Children Safer Implementation Status Report* (Report, 31 May 2023); Department of Premier and Cabinet, 'Keeping Children Safer Implementation Status Report', *Keeping Children Safer* (Policy Document, 31 May 2023) Action 2 <https://www.dpac.tas.gov.au/keepingchildrensafer>.

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Commission of Inquiry into the Tasmanian Government's Responses to Child Sexual Abuse in Institutional Settings

Who was looking after me? Prioritising the safety of Tasmanian children

Volume 8: Oversight, coordination and therapeutic support

August 2023

Commission of Inquiry into the Tasmanian Government's Responses to Child Sexual Abuse in Institutional Settings Report

Volume 8
Oversight, coordination and therapeutic support

The Honourable Marcia Neave AO
President and Commissioner

Professor Leah Bromfield
Commissioner

The Honourable Robert Benjamin AM SC
Commissioner

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Introduction to Volume 8

In this volume—Volume 8—we consider how the Tasmanian Government can better coordinate and strengthen its approach to addressing child sexual abuse. The recommendations we make in the chapters of this volume are relevant to all the institutions we consider in detail across our report, as well as institutions that we did not consider in detail. There are six chapters in this volume, as well as appendices to our report.

In Chapter 18—Overseeing child safe organisations, we consider the community-wide child sexual abuse prevention strategies recommended by the National Royal Commission. We also consider the Tasmanian Government's investment in ensuring that staff and volunteers who work within child-facing organisations have a good baseline knowledge of child sexual abuse and how to respond to it. We recommend a new Commission for Children and Young People. The new Commission would subsume the functions of the current Commissioner for Children and Young People, which include advocating for, and promoting the wellbeing of, all children in Tasmania. The new Commission would also be responsible for:

- educating relevant organisations on the Child and Youth Safe Standards
- overseeing and enforcing compliance with those standards
- administering, overseeing and monitoring the Reportable Conduct Scheme.

We make recommendations to support the independence of the Commissioner for Children and Young People. We recommend the Ombudsman, the Integrity Commission, the Registrar of the Registration to Work with Vulnerable People Scheme and the new Commission for Children and Young People clarify and formalise their respective functions and information-sharing arrangements and ensure these are clear to the community.

In Chapter 19—A coordinated approach, we describe what is required to ensure there is a united approach to child safety issues across the Tasmanian Government. We recommend the development of a child sexual abuse reform strategy and action plan to bring together an extensive reform agenda, hold government and government funded agencies and statutory bodies to account for their responsibilities in implementing child sexual abuse reforms, and provide information to victim-survivors and their families, the community and government and non-government agencies about what is being done to address child sexual abuse in Tasmania. We recommend this strategy and action plan is overseen by a strong governance structure led by the Department of Premier and Cabinet and ensure children and young people and adult victim-survivors of child sexual abuse take part. We also recommend improving whole of government information sharing, coordination and response.

In Chapter 20—State Service disciplinary processes, we consider the disciplinary processes that apply when an employee of a government institution is the subject of an allegation of child sexual abuse or related conduct. We outline many problems with the State Service's disciplinary framework in responding to allegations of child sexual abuse and related conduct, including in relation to the State Service Code of Conduct and employment directions. We propose reforms relating to the application and implementation of the Code itself, and to the employment directions related to suspensions, breaches of the Code of Conduct and inability to perform duties. Fundamentally, we are calling for a shift in the focus of this disciplinary framework to allow for the safety of children to be prioritised. It will take significant commitment and culture change to achieve this outcome. We invite unions to support these reforms.

In Chapter 21—Therapeutic services, we review the support services available to children, young people and adults who have experienced child sexual abuse in an institutional setting. We also consider the support needs of children and young people who have engaged in harmful sexual behaviours and require an additional level of specialised intervention to address those behaviours. We recommend the Tasmanian Government:

- provides leadership, and funds the development of a therapeutic service system with optimal maximum waiting periods
- ensures that funding agreements with non-government specialist services have appropriate governance requirements, sexual abuse service standards, service evaluation and child safe accreditation built into them. They should require that services meet the needs of all victim-survivors and children who have displayed harmful sexual behaviours, irrespective of their gender, background, culture or identity
- establishes and funds a peak body for the sexual assault service system, distinct from and working collaboratively with the family violence peak body
- develops a statewide framework and plan for preventing, identifying and responding to harmful sexual behaviours. This framework should ensure the Government provides ongoing and increased funding for specialist therapeutic interventions for abusive and violent harmful sexual behaviours.

In Chapter 22—Monitoring reforms, we note the Tasmanian Government has committed to implementing our recommendations and propose that the Government establishes an implementation monitor to ensure the recommendations of our Commission of Inquiry result in:

- sustained systemic improvements towards preventing child sexual abuse in institutions
- improved institutional responses to such abuse
- victim-survivors receiving the supports they need.

In a final chapter of this volume and of our report, Chapter 23—Afterword, we outline challenges we have faced due to the legislation that applied to our Commission of Inquiry. We make suggestions to address these challenges for the benefit of future commissions of inquiry.

18 Overseeing child safe organisations

1 Introduction

Across our report, we have focused on prevention and responses to child sexual abuse in government institutions, particularly within government schools and health services, the out of home care system, and youth detention. We also have considered the systems that respond to abuse, including the criminal and civil law justice systems and psychological and support services. We make a range of recommendations specific to those institutions and systems. This chapter focuses on the oversight of a child safe system across Tasmania more broadly.

Every member of the Tasmanian community has a role to play in keeping children safe. Whether in their role as staff member, volunteer, parent or carer, trusted family friend or bystander—we consider it is critical that everyone has at least a basic understanding of child sexual abuse, including the factors that increase its likelihood and the signs that it may have occurred.

This foundational understanding must counteract common myths and misconceptions about sexual abuse, the credibility of children, and the nature of perpetrators. It must equip everyone in the community with the skills to respond to disclosures of abuse—including awareness of who to report to and how to offer a supportive response.

The National Royal Commission directed most of its community-wide prevention recommendations to the Australian Government. However, we consider the Tasmanian Government has a role to make sure national prevention investment benefits and is accessible to Tasmania, and to ensure it also invests in addressing the specific community educational needs of Tasmanians. We consider community-wide education will give staff and volunteers who enter child-facing organisations a good baseline of knowledge that can then be further built upon.

We welcome the Tasmanian Government's Child and Youth Safe Organisations Framework, which will see Tasmania implement recommendations from the National Royal Commission to legislate Child Safe Standards (called Child and Youth Safe Standards in Tasmania) and a Reportable Conduct Scheme overseen by an Independent Regulator. These complementary regulatory schemes are designed to ensure organisations that engage with children have embedded the essential requirements to maximise child safety, including:

- robust policies and practices
- appropriate training and professional development
- clear strategies to reduce risks of abuse
- effective and transparent processes for escalating and addressing child safety concerns.

We consider the effective implementation of these schemes to be the most important strategy to prevent abuse within organisations and to improve responses to complaints, when made.

We broadly endorse the *Child and Youth Safe Organisations Act 2023* ('Child and Youth Safe Organisations Act'). However, we recommend the functions of the Independent Regulator sit with a new Commission for Children and Young People in Tasmania, with expanded functions to oversee and monitor child safety (particularly within the out of home care and youth justice systems). We consider the Commissioner for Children and Young People should be the Independent Regulator.

While we consider a new Commission for Children and Young People should be the primary body to oversee the management of child safety concerns in organisational settings, we recognise there may be situations where other oversight bodies—including the Ombudsman, Integrity Commission and Registrar of the Registration to Work with Vulnerable People Scheme—will have a shared interest or responsibility for addressing risks to children in organisations. Recognising that each body has a role in receiving information and/or investigating complaints relating to misconduct or unlawful

behaviour of individuals working within public bodies, we recommend clarifying roles and responsibilities between these bodies. We also recommend formalising information-sharing arrangements under a memorandum of understanding and, where necessary, legislative change.

2 Community-wide prevention strategies

Improving community awareness and understanding of child sexual abuse is a fundamental requirement to protect children from harm. Institutions exist within the community and comprise individuals who may bring their own attitudes and understanding of child safety issues which, individually or taken together, can determine how an institution responds to risks of child sexual abuse.

Professor Ben Mathews, Research Professor, Queensland University of Technology leads the Australian Child Maltreatment Study, and told us community awareness of child sexual abuse was an important element of strengthening 'the protective social fabric' of our society.[1] He added: 'In the long-term, this [awareness] would be of more value than anything else. Whilst it is not an easy solution, this is the foundation of everything else'.[2]

Despite the significant awareness the National Royal Commission raised and the recent development of the *National Strategy to Prevent and Respond to Child Sexual Abuse* (described further in Section 2.1), it is clear there is much to be done to increase and improve community understanding of child sexual abuse. The Australian Childhood Foundation, together with Monash University, has conducted periodic studies tracking community attitudes relating to child sexual abuse since 2003 across Australia. Its most recent study in 2021 found little progress in the state of awareness and appreciation of the nature and gravity of child abuse amongst participants. The study described awareness of such matters being 'virtually identical' to earlier studies. The 2021 study showed that:

- Just over one in three respondents did not believe child abuse was a problem they needed to be personally concerned about.
- 32 per cent of respondents believed children make up stories of abuse.
- Seven out of 10 respondents could not remember seeing or hearing anything about child abuse in the media in the preceding 12 months.
- One in five respondents were 'not at all' confident on what to do if they suspected a child was being abused or neglected.[3]

The report noted:

> The community lacks all of the building blocks required to prevent child abuse and adequately act to protect them from abuse and neglect. They are not aware of the true scale and impact of child abuse. They do not believe it is as widespread as it really is. They have a shallow definition of how it is defined, what its components are, how it develops … They lack confidence about when, what and why they should take action when exposed to information that children are being abused and neglected … These attitudes have been there for at least eighteen years and they have not changed.[4]

These findings, while shocking, did not surprise us. They reflect many of the views and attitudes that became apparent across different institutional settings through our Inquiry. We discuss some of these further in relation to community attitudes in Tasmania in Section 2.2.

The National Royal Commission made several recommendations relating to community-wide prevention, which were directed at the Australian Government. These included developing a national strategy to prevent child sexual abuse that encompassed a range of initiatives, including:

- social marketing campaigns targeting community awareness to increase knowledge of child sexual abuse—including challenging problematic attitudes that reflect myths and misconceptions
- prevention programs in preschools and schools and other community settings for children and young people, noting that such education can be linked with the existing Australian curriculums, such as respectful relationships and sexuality education
- online safety education for children, parents and other community members, supported by the Office of the eSafety Commissioner
- increased prevention education on child sexual abuse and harmful sexual behaviours for tertiary students entering child-related occupations
- help-seeking services targeting individuals who feel they may be at risk of sexually abusing children
- information on pathways to seek help if child sexual abuse is disclosed or suspected.[5]

The National Royal Commission recommended the Australian Government ensures prevention initiatives:

- align with relevant strategies relating to child maltreatment
- be appropriately tailored and targeted to reach different communities

- involve and engage children and young people in their design and development
- be based on best practice evidence of what works to prevent child sexual abuse and harmful sexual behaviours.[6]

2.1 National reforms relating to prevention

Since the National Royal Commission, the Australian Government has undertaken initiatives relevant to community-wide prevention of child sexual abuse, including:

- establishing the National Office for Child Safety on 1 July 2018, tasked with leading and implementing recommendations from the National Royal Commission, including the development of a national strategy[7]
- releasing the *National Strategy to Prevent and Respond to Child Sexual Abuse 2021–2030* ('National Strategy') on 27 October 2021, supported by $307.5 million in implementation funding[8]
- delivering the initial five-year funding for establishing the National Centre for the Prevention of Child Sexual Abuse (ultimately named the National Centre for Action on Child Sexual Abuse ('National Centre')), which is a joint venture between Blue Knot Foundation, The Healing Foundation and the Australian Childhood Foundation, announced in October 2021.[9]

This National Centre is designed to 'commission critical research, evaluate interventions and therapeutic programs, raise community awareness, reduce stigma and provide training'.[10] In June 2023, the National Centre released *Here for Change: Five Year Strategy 2023–2027*, which is intended to transform the way child sexual abuse is understood and responded to in Australia.[11]

2.1.1 National Strategy to Prevent and Respond to Child Sexual Abuse

The National Strategy is an initiative of the Australian and state and territory governments. It is divided into four categories:

- National Strategy to Prevent and Respond to Child Sexual Abuse
- First National Action Plan
- Commitments
- Evaluation Reporting.[12]

The First National Action Plan and First Commonwealth Action Plan cover the period 2021–24, with subsequent three-year action plans scheduled for 2025–27 and 2028–30.[13] The former Premier, the Honourable Peter Gutwein MP, was a signatory to the National Strategy, alongside the then Prime Minister and other state and territory leaders.

The National Strategy seeks to set up a nationally coordinated and consistent way to prevent and respond to child sexual abuse, including within families, by other people, in organisations and online.[14] It is based on a public health approach. The prevention measures include:

- primary (aimed at the whole community and addressing the underlying causes)
- secondary (addressing the early warning signs that change the result for those at risk of being victims or perpetrators)
- tertiary (aimed at responding to child sexual abuse and preventing it from happening again)
- quaternary (evaluating the effectiveness of tertiary interventions).[15]

The First National Action Plan (which reflects the current priorities) has five themes. Most relevantly, preventing child sexual abuse is Theme 1, which covers 'Awareness-raising, education and building child safe cultures'. Under this theme, there are six measures that the National Office for Child Safety leads. These measures are:

- implementing and promoting the National Principles for Child Safe Organisations (described in Section 3.2.1)
- setting up ongoing national reporting for non-government organisations to report against their progress on creating and maintaining child safe cultures
- enhancing national information-sharing arrangements relating to child safety and wellbeing
- supporting educational resources to ensure children and young people learn about wellbeing, relationships and safety (including online safety)
- working with the National Centre for Action on Child Sexual Abuse on education and the skills and capabilities of the workforces to respond to child sexual abuse
- delivering a national awareness raising campaign on child sexual abuse.[16]

2.2 Community awareness and attitudes in Tasmania

Through our Commission of Inquiry, we saw how a lack of awareness and understanding of child sexual abuse contributed to poor prevention and responses to it within government service systems and organisations. The most common problems we saw across all the different organisational contexts included a limited appreciation for the many and varied strategies perpetrators rely on to identify, groom and coerce their victims. We also saw how such strategies can sometimes enthral victims of abuse and make children and adolescents compliant and loyal towards the person who is abusing them, rather than fearful and avoidant.

Kathryn Fordyce, Chief Executive Officer of sexual assault service Laurel House, highlighted grooming as a particular area requiring further education in Tasmania, noting there are 'considerable misconceptions' around it that make 'victim-blaming attitudes' all too common:[17]

> We need to educate people to identify the components of grooming and act on red flags and boundary breaches … this can be achieved by educating the community about what grooming looks like, providing examples and educating people to identify these components.[18]

We also observed simplistic understandings of 'consent'—including a tendency to conflate concepts of consent with compliance and an absence of physical resistance from a victim. We sometimes observed a lack of appreciation of the many ways in which 'consent' is usually irrelevant in the context of child sexual abuse and the significant power disparity that often arises where adults are in a position of trust and authority over a young person.[19] For example, in our commissioned research on children's experiences of safety within Tasmanian organisations, two high school focus group participants argued that if a young person consented to a sexual relationship with a teacher it 'might be OK', which generated much debate within the focus group more broadly.[20]

The July 2022 report commissioned by the Sexual Assault Support Service, *Sexual Violence in Southern Tasmania: Research Report for Sexual Assault Support Service Tasmania*, considered 'the scale of sexual violence, its nature, barriers to seeking help, and potential solutions' in Tasmania.[21] This also included some discussion of sexual abuse of children and young people.

This report highlighted a common narrow and simplistic understanding of consent and sexual abuse in the community, with the researchers noting:

> Discussion of consent was rarely framed by stakeholders or community participants as positive, affirming, and enthusiastic agreement; instead, participants defined sexual violence in terms of the absence of consent.[22]

This report also highlighted how abusive relationships can sometimes be normalised, with one participant in the study reporting:

> It's not frowned upon for a 15- or 16-year-old to date someone in his mid-20s and be impregnated by him. … I mean, two of my siblings, are the children of what I would deem paedophilia. My father was 27, and that woman 14, for one of my brothers, and he was 29 and the girl 15 for my sister. I have siblings literally born of paedophilia. Yeah, and it was completely normalised. Their families didn't care. They never thought it was weird. I didn't realise it was weird until I grew up … it is horrific, and it is everywhere.[23]

The most troubling area in which we saw confusion regarding consent was for children in out of home care who were being sexually exploited by adults outside the service system, to which they were sometimes seen—including by Child Safety Services and Tasmania Police—as consenting, which is discussed in Chapter 9.

We also discuss how the language of consent in criminal justice proceedings relating to child sexual abuse contributes to distress and confusion for participants and the broader public in Chapter 16.

Across several institutional settings, we observed a limited understanding of what constitutes harmful sexual behaviours, the harm it causes victims and the most appropriate way to manage the risks associated with a young person using such behaviours. We discuss these in more detail in Volumes 3, 4, and 5 (relating to children in schools, out of home care and youth detention).

We also observed a tendency to doubt and downplay the complaints of children, with particular scepticism reserved for complaints made by young people who are considered to be 'bad' or 'troubled' (for example, in complaints handling in the context of Ashley Youth Detention Centre, discussed in Chapter 11). There often exists a corresponding predisposition to sympathise and believe the accounts of adults. This trust in adults contributed to misguided blame and responsibility, with an undue scrutiny and focus on the actions and behaviours of a victim-survivor rather than the conduct of their alleged abuser (refer for example to 'Katrina's experience' in Chapter 5 or Case study 2 relating to Dr Tim (a pseudonym) in Chapter 14).[24] It also included an undue concern for reputational and other impacts on a person accused of abuse or misconduct and inadequate care and consideration extended to the suffering and support needs of a victim-survivor (refer to Chapter 20 on State Service disciplinary processes).

We also saw failures to recognise that child sexual abuse is often perpetrated by everyday people working in positions of trust within the community. Dr Michael Guerzoni, Indigenous Fellow, University of Tasmania with expertise in criminology, described a common lack of sophistication in community understanding (in Tasmania and more broadly): '[P]erpetrators of child sexual abuse are [commonly] understood as sexual deviants and "bad apples", and may be readily distinguished from other, "normal" people'. Dr Guerzoni told us this was a problem because:

> [W]hen there is a fixed understanding as to what an offender is, that will colour all of the interpretations of institutional policy and procedure towards child sexual abuse and, in turn, it may lead to non-compliance with what is written down in the policies and procedures.[25]

Victim-survivor, Robert Boost, told us of the importance of not making assumptions about who is likely (or unlikely) to perpetrate abuse, noting the inherent power difference between adults and children:

> Society needs to see every adult as being 'capable' of abusing children because of their relative positions of power towards children. This is made even more acute when an adult is in a position of power relative to other adults … We as a society need to recognise that real danger in order to protect our children, even if it means some adults' lives will be made more difficult. We need to stop worrying about hurting adults, and look at the damage that is being done to children.[26]

We discuss 'situational' perpetrators of abuse (and related prevention strategies) in Section 3.1.

The *Sexual Violence in Southern Tasmania: Research Report for Sexual Assault Support Service Tasmania* report commissioned by the Sexual Assault Support Service also highlighted how sexual violence (and the attitudes that enable it) could be amplified in isolated and close-knit communities.[27] As Mr Boost reminded us: 'In a close-knit place like Tasmania, relationships often influence outcomes'.[28]

Michael Salter, Scientia Associate Professor of Criminology, School of Social Sciences, University of New South Wales, told us that rather than acting as a barrier to prevention of child abuse, Tasmania's relatively small population and close-knit features could be a 'resource that should be capitalised on'.[29] Dr Salter cited bystander intervention programs (where members of an institution or community receive training on how to detect the signs of abuse and intervene effectively) and community mobilisation programs (which build community-wide connections to services and agencies to respond to social problems) as examples of prevention strategies that are well-suited to discrete communities.[30]

2.2.1 Tasmanian prevention initiatives

While we recognise National Royal Commission recommendations relating to primary prevention were directed largely at the Australian Government, we agree with the National Children's Commissioner, Anne Hollonds, who noted the National Strategy (as well as the implementation of the National Principles for Child Safe Organisations, discussed in Section 3.2.1) are 'important steps and will require the commitment of all federal, state and territory governments to be fully implemented'.[31]

In line with our terms of reference, our key recommendations for preventing child sexual abuse in Tasmania include implementing:

- a mandatory child sexual abuse prevention curriculum from early learning programs to year 12 students, drawing on expert evidence of best practice (refer to Recommendation 6.1 in Chapter 6)
- legislated Child and Youth Safe Standards for Tasmanian organisations engaging with children, overseen by an Independent Regulator (which has been implemented through the Child and Youth Safe Organisations Act and is discussed in Section 4.3).

However, we also consider it is important for the Tasmanian community to receive the full benefit of any national community education and awareness initiatives by ensuring they are fit-for-purpose and suited to the needs of Tasmanians.

We also consider it may be necessary for the Tasmanian Government to complement national initiatives by developing specific local content for Tasmanians. We understand the Department for Education, Children and Young People is working on a 'tell someone' website and accompanying public campaign, although we have limited information on this initiative.[32]

Dr Charlie Burton, Manager Policy, Tasmanian Council of Social Services, emphasised the importance of a public health approach to address child sexual abuse:

> This means looking beyond practices in particular institutions or organisations and taking a whole-of-community lens, with action along the continuum from universal prevention, early intervention and targeted tertiary responses, as well as trauma informed support for recovery.[33]

Dr Burton recommended the Tasmanian Government work to translate national initiatives (such as those connected to the National Centre for Action on Child Sexual Abuse) to the Tasmanian context, guided by victim-survivors and Tasmanian organisations with expertise in sexual assault.[34] Dr Burton also felt the Tasmanian Government had a clear role in funding general prevention programs itself:

> In particular, it needs to drive change to address a societal culture that minimises or dismisses behaviours that escalate to child sexual abuse. It needs to invest in understanding the evidence of what works in prevention and early intervention and follow that up with resources and action.[35]

Ms Fordyce, whose organisation Laurel House currently designs and delivers a range of prevention programs in schools, workplaces and the broader community, told us her service could expand prevention initiatives with increased funding, rather than being 'predominantly reactive service':[36]

> We could focus additional efforts towards preventing the occurrence of child sexual abuse by educating people working in and interacting with institutions where there are high incidences of abuse. We would like to be more visible in schools and the community so we can supplement formal training opportunities with incidental conversations with people who work with children to help them understand the critical role they play in preventing, identifying, responding to and reporting sexual abuse, and other forms of violence.[37]

Jillian Maxwell, Chief Executive Officer, Sexual Assault Support Service, which also delivers primary prevention programs, described some of the challenges for Tasmanian organisations to get funding for particular initiatives (for example, under the National Strategy). Ms Maxwell recognised the importance of being accountable for funding but described how 'red tape' associated with Commonwealth funding management was

onerous.[38] Ms Maxwell said such problems did not exist for state-based funding, which often benefited from closer relationships with ministers, advisors and grant managers that made managing such funding more straightforward as you 'get a chance to talk them through the issues'.[39]

We consider it is important the Tasmanian Government ensures Tasmanians receive the full benefit of national prevention initiatives, by advocating to federal counterparts on the specific needs of Tasmanians to ensure such measures translate to tangible and meaningful change. We also consider the Tasmanian Government may need to invest in its own targeted community awareness initiatives to complement national strategies, where practical, using and drawing upon Commonwealth-funded materials and resources. Such programs should be developed to meet the Tasmanian context.

Recommendation 18.1

The Tasmanian Government should continue to advocate for Tasmania to receive the full benefit of Australian Government prevention strategies, including under the *National Strategy to Prevent and Respond to Child Sexual Abuse 2021–2030*.

3 Creating child safe organisations

Across our Commission of Inquiry, we have heard how some of the most trusted organisations have not been safe places for children. Many times, child sexual abuse could have been prevented or identified earlier if the organisation in question had taken a more proactive, targeted approach to identifying and addressing risks of abuse. This includes having an organisational culture vigilant to potential harms to children and that encourages and empowers anyone with child safety concerns to report them, with confidence that such reports will be taken seriously.

Earlier in this chapter, we discussed prevention initiatives designed to educate the entire Tasmanian community. However, we consider organisations that engage directly with children have additional responsibilities to prevent and address risks of abuse.

In this section, we discuss some of the evidence we received about how organisations can (and should) adopt 'situational prevention' strategies to reduce risks of child sexual abuse. Such strategies make organisations less vulnerable to motivated perpetrators who may actively seek environments in which they can abuse children. However, such strategies can also reduce the likelihood of abuse or harm from 'situational' perpetrators who may—under unsafe and permissive conditions—engage in inappropriate conduct with children.

The value of situational prevention is reflected in the National Principles for Child Safe Organisations. In Tasmania, these are reflected in the Child and Youth Safe Standards legislated through the Child and Youth Safe Organisations Act. As discussed in Section 4, this legislation requires child-facing and other in-scope organisations to take active steps to prevent harms to children through robust policies, practices and a child-centred culture. We support this legislative reform and consider its successful implementation a key pillar to prevent abuse within Tasmanian organisations.

Tasmania's proposed Reportable Conduct Scheme, which complements the Child and Youth Safe Standards, will strengthen independent oversight for the response of an organisation to complaints or concerns, improving the mitigation of risk to children and young people. We expect organisations to examine the circumstances that contribute to reportable conduct they investigate, and work to further strengthen and refine their child-safe practices over time. In this sense, a reportable conduct scheme is a mechanism to ensure appropriate responses to reports of harm to children. It also offers a clear opportunity for organisations to learn, improve and prevent similar occurrences into the future.

3.1 Situational prevention of abuse within organisations

We sought evidence from relevant experts on how organisations can reduce the likelihood of child sexual abuse occurring. This included considering the features of organisations that were more, or less, likely to enable abuse to occur.

Dr Guerzoni defined situational crime prevention as 'a theory of criminology that argues that crime occurs due to the interconnection of individual and environmental factors; it is not solely a matter of premeditated desires of this offender'.[40] He noted the benefit of adopting a situational crime prevention model is that 'it moves consideration away from endless debates about abuse causation … to emphasis on what can be done by organisations to prevent abuse based on empirical criminological research'.[41]

As foreshadowed, not all perpetrators of child sexual abuse have a pre-existing motivation to offend. Professor Donald Palmer, Graduate School of Management, University of California has expertise in organisational misconduct (including child sexual abuse) and told us some individuals only develop the motivation to offend against children after they have joined an organisation, describing them as 'situational offenders'.[42] Professor Palmer told us that situational offending can occur due to 'individual psychological factors' but also noted that 'organisational structures and processes also can influence the likelihood that organisational participants will become situational child sexual abusers'.[43]

Professor Palmer noted situational offenders will abuse when they think children will be vulnerable to their advances and they are unlikely to be detected and punished. He stated:

> For this reason, most situational prevention measures focus on creating conditions under which potential offenders believe that their advances will be rejected (for example, child sexual abuse training of children and youth) and believe that if successful, their advances will be detected (for example, prohibition of one-on-one staff/child interactions) and addressed (for example, staff training).[44]

Because some offenders are situational, Dr Guerzoni highlighted flaws with organisations adopting a 'bad apples' mentality, which has the organisation looking out for characteristics assumed to align with motivated sex offenders. Instead, it is more effective to consider the factors that are more likely to give rise to abuse. Dr Guerzoni gave some examples of the factors that may be relevant for organisations to consider:

> [E]nvironments where few other persons are present, rooms without surveillance, professions which enable isolated interactions with minors or remote locations. Such situational factors tend to manifest in the circumstances of the profession. For example, helping the child change after sport, a consultation with a child in one's office, staying behind after class, or driving a child home. These isolated environments are known to both create opportunity for offending, as well as precipitate thoughts of offending amongst perpetrators.[45]

The *Independent Inquiry into the Tasmanian Department of Education's Responses to Child Sexual Abuse* undertaken by Professors Stephen Smallbone and Tim McCormack discussed how the physical environment of schools could heighten risks of abuse to students.[46] We discuss this in greater detail in Volume 3.

Professor Mathews described the challenge of responding to grooming and boundary violations. He noted that, properly construed, grooming is an intentional act of cultivating a relationship to enable child sexual abuse. However, he noted:

> A boundary violation could take place without an intention to sexually abuse the child in any proximate time. It may for example be an isolated mistake that could be the subject of positive intervention, such as an inappropriate comment in a text message or email. These types of instances involving adults should be easily remedied through proper education, policies and codes of conduct.[47]

Professor Palmer described how the dynamics of an organisation can shape and influence a person's attitudes and behaviour, noting that '[a] person's behaviour is subject to much more control within an organisation, when compared to other settings'.[48] He said that organisations should invest in ensuring their policies, practices and culture prioritise child safety, rather than relying only on the goodwill and capabilities of the individuals within it.

Dr Guerzoni described the best approach as a partnership between the individual and the institution:

> In that partnership, organisations must be willing to be aware and active in their monitoring of child safety matters. This should extend to ensuring staff are supported to make complaints (including that they are given time to make such complaints), staff are required or encouraged to undertake relevant professional development, and that matters of child safety are framed as a present (as opposed to historical) risk that is to remain consistently on the agenda.
>
> Simultaneously, individuals must be willing to monitor the environment and their colleagues for risks or signs of grooming and victimisation. This includes being open to, and aware of, the fact that if that individual is not careful, they may put themselves in a position where they may be more susceptible to criminal decision making. Individuals must also be willing and open to raising complaints or concerns.[49]

Dr Guerzoni described how organisations can strengthen their policies by:

- recognising a criminal record check is not enough to determine the potential risk a person may pose to children
- considering child safety in interview and recruitment processes
- challenging myths (that sexual offending against children is only perpetrated by paedophiles) and helping staff to understand the situational factors that may contribute to abuse
- introducing requirements that minimise isolated interaction with children and try to mitigate situational risk factors.[50]

Robert Ryan, Executive Lead, Strategy and External Engagement, Life Without Barriers, described that organisation's whole of organisation approach to child safety in its *We Put Children First* child sexual abuse prevention strategy:

> The strategy is based on a situational prevention approach, which recognises that the risk of child sexual abuse can be reduced by making environmental and cultural changes within an organisation, rather than only focusing on the risk presented by particular individuals. To reduce the risk of child sexual abuse, organisations need to create conditions where offending is difficult, the risk of detection is high, environmental cues that can trigger offending are removed and permissibility is reduced.[51]

While Professor Palmer agreed these factors are important, he explained organisations are often looking for a 'free lunch' when attempting to become safer for children and young people.[52] Policies go some way but are not a 'comprehensive solution' for the following reasons, stating: 'They don't address culture, they don't address power, they don't address informal groups, they don't address socialisation'.[53]

Professor Palmer said there is much work to be undertaken by an organisation to 'truly embed child safe practices in an organisation'.[54] Professor Palmer described the first step for an organisation is to outline its mission and goals and assess the extent to which

they conflict with child safety objectives 'and then deal with that conflict in an honest fashion'.[55] Professor Palmer gave an example of this tension in schools, where a balance needs to be struck between the benefit of fostering close student/teacher relationships that improve a child's learning and development, and the risk that such dynamics can be open to abuse by teachers.[56] Dr Guerzoni agreed on the importance of striking the right balance in managing risks to children as '[s]trict approaches to child safety may cause adults to not pursue proper or nurturing relationships with young people … for fear of not doing the right thing'.[57]

Associate Professor Tim Moore, Deputy Director, Institute of Child Protection Studies, Australian Catholic University, also cautioned against such situational prevention strategies having 'unintended consequences' by making adults reluctant to engage with children due to fears of how such behaviour would be perceived—for example, workers in residential care units being wary of hugging children in their care.[58] A disproportionate emphasis on the risks adults can pose could also erode children and young people's trust in those engaging with them.[59] Associate Professor Moore told us of the importance of ensuring children and young people have the benefit of healthy connections with adults, using the example of the out of home care system:

> Again, if you look at some of the lives of some of these children and young people who have been potentially sexually abused or physically harmed in their family environments, we put them through a system that discourages children and young people to have their intimacy needs met. When I'm talking about intimacy I'm not talking about sexual intimacy necessarily, I'm talking about to feel loved and cared for, to be hugged, you know, to feel like someone's demonstrating their care and love for you in this physical kind of way. Kids are often denied that within the system and therefore don't know what's okay and what's not okay and how to express themselves.[60]

We agree it is important that organisations are careful when assessing risks but must ensure their risk mitigation is proportionate and appropriate to their specific context and operating environment. It is also important that staff and volunteers are clear on appropriate standards of behaviour towards the children and young people they engage with. This is to limit the potential for inadvertent boundary breaches that may arise from a lack of experience or clarity on appropriate professional boundaries within the context of a particular organisation. Children and young people can benefit greatly from the services and care offered by organisations they interact with. The overwhelming majority of adults who provide services to children do so with their best interests at the forefront of their minds.

Striking the appropriate balance is entirely consistent with implementing Child and Youth Safe Standards, which encourage organisations to design and embed child safe practices suited to the services and care they provide. We discuss this in the next section.

3.2 Child Safe Standards

A note on language

Child Safe Standards is a term used by the National Royal Commission and adopted by certain jurisdictions. We use 'Child Safe Standards' where we specifically refer to the National Royal Commission or jurisdictions, such as Victoria, that use that term.

We use the term 'Child and Youth Safe Standards' when we refer to Tasmania's implementation of these Standards, as this is the term adopted in the Child and Youth Safe Organisations Act. When we use this term, we intend for it to also encompass the Universal Principle, which is an additional Tasmanian requirement for organisations to protect Aboriginal cultural safety. Where Tasmanian witnesses have used 'Child Safe Standards' we have not altered the language.

Child Safe Standards reflect a set of principles and requirements that, taken together, articulate what constitutes a child safe organisation.[61] The National Royal Commission developed ten Child Safe Standards and described them as interrelated, overlapping and of equal importance, noting they should be 'dynamic and responsive' rather than 'static and definitive'.[62] The National Royal Commission noted:

> The standards are designed to be principle-based and focused on outcomes and changing institutional culture as opposed to setting prescriptive rules that must be followed or specific initiatives that must be implemented. This is to enable the standards to be applied to, and implemented by, institutions in a flexible way, informed by each institution's nature and characteristics. The risk of child sexual abuse varies from institution to institution. Therefore, every institution needs to consider each standard and take time to identify risks that may arise in their context, and find ways to mitigate or manage those risks.[63]

3.2.1 National Principles for Child Safe Organisations

Following the release of the National Royal Commission report, the Australian Government tasked the former National Children's Commissioner, Megan Mitchell, to lead the development of National Principles for Child Safe Organisations, which were ultimately endorsed by members of the Council of Australian Governments in February 2019, including the Tasmanian Government.[64] These draw heavily on the Child Safe Standards the National Royal Commission developed but are framed to apply to a broader set of harms to children. National Children's Commissioner, Anne Hollonds explained:

> The National Principles cover all forms of potential harms, and adopt a child rights, strengths-based approach to organisational development. Applied collectively, they demonstrate that a child safe organisation is one that creates a culture that empowers and values children and young people, engages families and the broader community, adopts suitable strategies and takes appropriate action to promote child safety and wellbeing.[65]

National Principles for Child Safe Organisations

1. Child safety and wellbeing is embedded in organisational leadership, governance and culture.
2. Children and young people are informed about their rights, participate in decisions affecting them and are taken seriously.
3. Families and communities are informed and involved in promoting child safety and wellbeing.
4. Equity is upheld and diverse needs respected in policy and practice.
5. People working with children and young people are suitable and supported to reflect child safety and wellbeing values in practice.
6. Processes to respond to complaints and concerns are child focused.
7. Staff and volunteers are equipped with the knowledge, skills and awareness to keep children and young people safe through ongoing education and training.
8. Physical and online environments promote safety and wellbeing while minimising the opportunity for children and young people to be harmed.
9. Implementation of the national child safe principles is regularly reviewed and improved.
10. Policies and procedures document how the organisation is safe for children and young people.

The National Principles have informed and underpin many of the recommendations we have made in the chapters that relate to specific organisations.

Since the development of the National Principles, resources and guidance material have been created to support organisations to implement them. These include:

- a draft child and wellbeing policy template
- an example code of conduct

- an introductory self-assessment tool for organisations
- a checklist relating to online safety.[66]

SNAICC – National Voice for Our Children, Victorian Aboriginal Child Care Agency and the National Office for Child Safety have also developed a guide specifically designed to support organisations to embed cultural safety for Aboriginal children and young people within organisations, in line with the National Principles.[67] Resources have also been developed at state and territory level, such as the Victorian and New South Wales guides to enabling children's participation in decision making.[68]

As we discuss in Section 4.1, these National Principles largely form the basis of Tasmania's legislated Child and Youth Safe Standards and will become mandatory for institutions that provide services to, or engage with, children from 2024 onwards.[69]

We heard of varied approaches to implementing the National Principles across the Tasmanian Government. This includes the following (non-exhaustive) initiatives:

- In the context of education, the relatively newly established Office of Safeguarding Children and Young People has been tasked with mapping the Department's activities against the National Principles. Secretary, Department for Education, Children and Young People, Timothy Bullard, told us 'this includes understanding where there may be overlap with work underway in response to recommendations of the [National] Royal Commission and the [Department of Education independent] inquiry, where there are gaps and the key areas in which work must be prioritised'.[70] We note that since the education hearings, the Office of Safeguarding has broadened the remit of its work within an expanded Department for Education, Children and Young People to develop a whole of department framework for safeguarding children and young people that aligns with the National Principles.[71]
- In the context of health, the Child Safe Organisations Project team was established in 2021 to implement the National Principles and evaluate the Department of Health's performance against them. The Tasmanian Government told us the Department of Health has since made progress implementing those National Principles, including delivering:
    - a signed Statement of Commitment to child safety and wellbeing by members of the Health Executive
    - a new Child and Young Person Advisory Panel to provide a process for seeking the views of children and young people on changes across the Department that affect them

    - a Child Safety and Wellbeing Policy that establishes the requirement to comply with the National Principles and children's rights, and the roles and responsibilities of executive and senior leaders, and all staff in the Department of Health
    - a new Child Safety and Wellbeing Service to support the promotion of child safety and wellbeing, prevention of harm, analysis to identify trends, patterns and red flags, compliance and performance monitoring, and managing risks
    - increased mandatory child safeguarding training, clearer guidance to staff on recognising signs of harm and responding to disclosures of harm by children, and improvements to incident reporting to capture any child safeguarding concerns, among other initiatives.[72]

- In the context of youth justice, former Secretary of the Department of Communities, Michael Pervan, told us work was undertaken in 2021 to 'contemporise all [Ashley Youth Detention Centre] policies and procedures to be compliant with Child Safe Standards' alongside the commencement of a Learning and Development Framework.[73] A commitment to the National Principles is also referenced in the Draft Youth Justice Blueprint 2022–2032.[74]
- In the context of out of home care, in July 2019, the Tasmanian Government created a policy obliging all government funded non-government organisations with significant liabilities under the National Redress Scheme to demonstrate they were engaging in child safe practices. This included mapping the services and existing standards and regulatory regimes against the National Principles. It also included developing a self-assessment tool the community sector could use.[75]

We note that much of this effort and initiative began during our Commission of Inquiry. We also observe that despite the Tasmanian Government's commitment to the National Principles in 2019, their implementation within Tasmanian Government departments is in its relative infancy.

While the obligations imposed by Tasmania's Child and Youth Safe Standards start from 2024, there has been nothing preventing an institution from adopting these requirements voluntarily. Indeed, the National Royal Commission recommended all organisations implement its Child Safe Standards to uphold the rights of the child, as required by Article 3 of the United Nations Convention on the Rights of the Child.[76] While our terms of reference limit our recommendations to government (or government funded) organisations, we consider all organisations committed to the safety of children should take steps to apply the National Principles, whether they are legislatively bound to or not. Organisations that will be legislatively mandated to comply from 2024 may also wish to take steps to comply with the requirements before they are legislatively required to do so.

Recommendation 18.2

All organisations engaging in child-related activities should voluntarily comply with the National Principles for Child Safe Organisations (as reflected in Tasmania's Child and Youth Safe Standards) to the greatest extent possible, regardless of whether they are legislatively bound to do so or when their legislative obligations commence.

3.2.2 Legislated Child Safe Standards

The National Royal Commission recommended Child Safe Standards be legislated and apply to a range of organisations that engage with children. These include health, disability, education services, youth detention, out of home care, childcare, and coaching and tuition services, among others.[77] It recommended compliance with these requirements be overseen and enforced by an independent body.[78]

New South Wales, Victoria and South Australia have implemented legislated Child Safe Standards, although there is some variation in the approach and model adopted by different jurisdictions.[79] At the time of writing, Western Australia and the Australian Capital Territory were considering legislated Child Safe Standards.[80] Different governments (and departments) in Queensland, the Northern Territory and the Australian Capital Territory have 'committed' to the National Principles, but have not, at the time of writing, legislated compliance with them.[81]

Because it is one of the more advanced legislated models (having been introduced in 2016), we sought evidence from Victoria about its approach to legislating, monitoring and enforcing Child Safe Standards. The implementation of Victoria's Child Safe Standards was also reviewed in 2019. This information is reflected in the following box.

Victoria's implementation of legislated Child Safe Standards

Victoria has had legislated mandatory Child Safe Standards since 2016, adopting a staged approach to implementation. Some organisations were required to comply from January 2016 and a broader range of organisations from January 2017.[82] The Commission for Children and Young People in Victoria assumed its formal functions in relation to the Child Safe Standards in January 2017.[83]

Principal Commissioner, Commission for Children and Young People (Victoria), Liana Buchanan, shared with us her view of the importance of Victoria's Child Safe Standards:

> As a mandatory set of standards with a very broad reach, the Child Safe Standards are very important in terms of changing the way children are seen in organisations, changing awareness in organisations about children and child safety issues and about supporting organisations to have all of the systems and processes necessary to keep children safe.[84]

Emily Sanders, Director, Regulation, Victorian Commission for Children and Young People told us: 'The focus on prevention of abuse and the capability building elements of the Child Safe Standards are key elements'.[85]

The operation of Victoria's Child Safe Standards was reviewed in 2018 by Victoria's then Department of Health and Human Services. This review found strong support for the Child Safe Standards among regulated organisations but described implementation as resource intensive and difficult.[86] The review also found strong support for harmonisation with the National Principles and that oversight and compliance functions needed to be clarified and strengthened.[87] This review informed several amendments and refinements to Victoria's model.

Since 1 July 2022, Victoria's Child Safe Standards largely mirror the 10 National Principles, with an additional Standard that requires '[o]rganisations establish a culturally safe environment in which diverse and unique identities and experiences of Aboriginal children and young people are respected and valued'.[88] A detailed guide supports Victoria's 11 Child Safe Standards, which includes the minimum requirements that an organisation must meet (which reflect the key action areas of the National Principles). The guide also includes 'compliance indicators' (what the Commission will look for to assess compliance), as well as advice and information on how to be compliant and create a child safe organisation.[89]

When asked to reflect on the successful features of Victoria's Child Safe Standards, Ms Buchanan described how the Commission's functions supported their implementation. Ms Buchanan told us that most organisations 'demonstrate goodwill and preparedness to implement the Child Safe Standards' but benefit from support and guidance to do so.[90] She explained the Commission's functions supported it to do a range of activities, including:

- developing educational guides and tools
- running information sessions
- supporting a Child Safe Standards Community of Practice
- engaging with peak bodies and sector leads
- providing targeted support and guidance to organisations to support their compliance.[91]

Ms Buchanan told us of the value of having recourse to stronger compliance functions, when warranted. This includes the Commission for Children and Young People having powers to:

- issue notices to produce and notices to comply
- attend and inspect premises to enable the Commission to speak to staff and volunteers
- request further information to assess compliance.[92]

Ms Buchanan said these powers are important where organisations are uncooperative, repeatedly fail to comply or where significant risks to children have been identified. She added: 'In many cases, the fact that organisations know we can resort to enforcement measures is sufficient to prompt action'.[93]

Since 1 January 2023, the Commission has had additional enforcement powers to:

- enter premises with consent (without notice)
- enter with a warrant
- search premises
- seize information and documents.[94]

The Commission can also now:

- issue official warnings for non-compliance
- accept enforceable undertakings (legally enforceable agreements that describe what an organisation will do to comply)
- issue infringement notices
- seek a range of court orders, including injunctions and adverse publicity orders (in which an organisation is required to publicise their failure to comply with the Standards and the consequences of those failures).[95]

Ms Buchanan foreshadowed these amendments to us when she gave evidence in May 2022 and welcomed them, observing the changes would help to 'address some of the gaps needed in instances where we are unable to support organisations to comply, and need further powers to ensure compliance, especially where children are at risk'.[96] From 1 January 2023, the Commission for Children and Young People shares responsibility with Victorian government departments, the Victorian Registration and Qualifications Authority and the Wage Inspectorate for promoting and supporting compliance with the Child Safe Standards.[97]

The Commission for Children and Young People has a graduated approach to enforcement, which it describes as follows (noting this pre-dates some of its newer enforcement powers):

- inform and educate (including general awareness raising and guidance materials)
- support to comply (including providing specific advice and guidance where non-compliance is identified)
- monitor compliance (including inspecting an organisation's premises and documents, investigating non-compliance or conducting an own motion investigation, sharing information with other regulators)
- enforce the law (including issuing a 'Notice to Comply' with the Standards to compel action, applying to court for a declaration of non-compliance or naming organisations, where appropriate, when publishing information relating to the operation of the Standards).[98]

In 2021–22, the Commission initiated action against 33 organisations for potential non-compliance with the Child Safe Standards.[99] Since commencing the Child Safe Standards, non-compliance actions have been initiated against 250 organisations.[100]

Ms Buchanan also stated oversight of the Child Safe Standards has led to a 'large improvement' in the Commission's understanding of the organisations and sectors at risk, which 'has in turn informed the Victorian Government and others through formal submissions, inquiries and other information sharing processes'.[101]

We discuss Victoria's implementation of its Reportable Conduct Scheme further in Section 3.3.

3.2.3 Tasmania's implementation of legislated Child Safe Standards

In 2018, the Tasmanian Government accepted in principle the National Royal Commission recommendations related to Child Safe Standards. In doing so, the Tasmanian Government expressed support for the 'aspirational principles as the architecture of the National Framework' but noted jurisdictions may differ in their implementation approach due to their existing systems and that consistency would be achieved over time, where possible.[102] As noted before, the Government endorsed the National Principles for Child Safe Organisations in February 2019.

In late 2020, the Tasmanian Government released a draft Child Safe Organisations Bill 2020 for consultation.[103] Ginna Webster, Secretary, Department of Justice, explained the delay to us in her statement as follows:

> By way of context it is important to note that some of the delays in relation to drafting the Child Safe Organisations Bill 2020 were due to urgent legislation required to manage the COVID-19 pandemic. This is not to say that the Bill was not a priority for Government however the capacity of the Office of Parliamentary Counsel (OPC) and the State Service in a state the size of Tasmania presents some limitations.[104]

Feedback from stakeholders through that consultation showed general support for implementing the National Royal Commission recommendations relating to regulating organisations that provide services to children, with an acknowledgment that some organisations (particularly those that are smaller or volunteer run) may need help and support to comply.[105]

However, the Tasmanian Government received critical feedback from stakeholders, including that:

- Tasmania's proposed Child Safe Standards did not align adequately with the National Principles.
- The scope of the obligations (particularly which organisations would and would not be captured) was not clear.
- There was a lack of clarity around the role, powers and the designated body to undertake independent oversight.[106]

Secretary Webster gave her reflections on the feedback received:

> The feedback received on the Child Safe Organisations Bill supported the acceleration of the project to include independent regulation of the Child Safe Standards and a reportable conduct scheme. Despite intentions to align the Bill with the Principles for Child Safe Organisations endorsed by First Ministers at the Council of Australian Governments, during the drafting of the Bill some drafting changes were made to accommodate the structure of the Bill. Many stakeholders provided feedback about the departure from the wording of the Principles.[107]

Secretary Webster told us in her 10 June 2022 statement that the lack of consistency with the National Principles would be 'resolved in future drafts'.[108]

We consider it unfortunate the Tasmanian Government's initial attempt to progress implementation of Child Safe Standards was hampered by significant deficiencies in the 2020 Bill, as this represented a substantial loss of time and wasted effort.

Consistent with the feedback provided to the Department of Justice in response to its 2020 Bill, several individuals and organisations voiced support for implementing legislated Child Safe Standards, overseen by a strong and effective independent regulator, in our consultations and public submissions.[109] Tasmania's Commissioner for Children and Young People, Leanne McLean, told us:

> In my view, Tasmania can and should implement a best practice child safe system, including mandatory legislated child safe standards accompanied by a reportable conduct scheme with child-centred independent oversight consistent with the recommendations of the [National] Royal Commission.[110]

This ultimately occurred with the development and passage of the Child and Youth Safe Organisations Act, which introduced legislated Child and Youth Safe Standards and a reportable conduct scheme.

3.3 Reportable conduct schemes

The National Royal Commission described a reportable conduct scheme as 'a legislated scheme that requires reporting, investigation and oversight of child protection-related concerns that arise in certain government and non-government institutions that provide services to, or engage with, children'.[111]

A reportable conduct scheme is intended to ensure complaints or allegations relating to the abuse or neglect of a child by institutions are managed robustly and transparently. The National Royal Commission described the key features of such a scheme as follows:

- the head of an institution must notify an oversight body of any reportable allegation, conduct or conviction involving its staff (we describe how this relates to sexual abuse below)[112]
- the institution is generally responsible for appropriately managing reportable conduct matters (for example, by assessing and managing risk and conducting investigations) unless the oversight body directs otherwise or conducts its own investigation[113]
- the oversight body monitors and scrutinises the institution's handling and investigation of any allegation, complaint or notification[114]
- the oversight body can audit an institution's policies and procedures to help them improve their systems and practices for responding to complaints or allegations.[115]

Reportable conduct schemes do not apply to children who have displayed harmful sexual behaviours.[116]

The National Royal Commission recommended that state and territory governments establish reportable conduct schemes.[117] Four jurisdictions currently have a reportable conduct scheme: Victoria, New South Wales, Western Australia and the Australian Capital Territory.[118]

Conduct reportable under a reportable conduct scheme includes the abuse or neglect of a child, including sexual abuse (including sexual misconduct), physical abuse and psychological abuse.[119] Importantly, sexual misconduct is intended to capture behaviour that may not meet the threshold of a sexual offence, including crossing professional

boundaries, sexually explicit or other overtly sexual behaviour or grooming.[120] This creates far greater opportunity to identify and address concerning behaviours at an early stage. It also overcomes some of the paralysis that can arise when organisations are confronted with conduct that is concerning but may not meet reporting thresholds to police or child protection, by giving a mandated lever for some action to be taken at an early stage.

Ms Fordyce felt that creating an environment for complaints and concerns to be acted upon at an early stage was important for minimising risks of abuse, noting at present, in Tasmania, organisations often only acted in response to child sexual abuse once a serious incident had occurred.[121] Ms Fordyce added:

> Low reporting thresholds are important in protecting children from child sexual abuse. If minor issues are identified, corrected and dealt with constantly and consistently, this deters perpetrators of child sexual abuse from committing child sexual abuse because they are aware that the system will be able to identify them.[122]

Stephen Kinmond, recently appointed as the New South Wales Children's Guardian, reflected on his experience overseeing New South Wales' Reportable Conduct Scheme in a former role as New South Wales Deputy Ombudsman (Human Services). Mr Kinmond also highlighted how a reportable conduct scheme could allow for earlier intervention in response to high-risk behaviours. He noted the importance of broad definitions of sexual misconduct, as these provide an opportunity for the organisation and oversight body to closely assess the risk posed by the person who is the subject of the allegation, recognising it can be difficult to initially determine the nature and extent of the conduct at the initial report.[123] Broad definitions for sexual misconduct also reflect that substantiating criminal charges, particularly for complex conduct such as grooming, can be difficult. Mr Kinmond added:

> I believe it is important to recognise that the threshold for taking action must be different to the threshold required to sustain a finding in a criminal matter. This need to proactively identify and respond to risk is vital to ensuring that we can take appropriate risk management action for the safety of children.[124]

As with the Child Safe Standards, we asked Victorian experts to describe the operation of its Reportable Conduct Scheme. This is described in the following box.

Overview of operation of Victoria's Reportable Conduct Scheme

Victoria's Reportable Conduct Scheme commenced in July 2017. Its scheme requires certain organisations to provide mandatory notifications relating to alleged child abuse and certain child-related misconduct to Victoria's Commission for Children and Young People.[125] A failure to do so without reasonable excuse is a criminal offence.[126] Ms Sanders told us:

> This means that, from the start of the investigative process to the outcome of the investigation, the CCYP [Commission for Children and Young People] is aware of the allegation and is able to independently and transparently scrutinise the organisation's investigation into that allegation. The CCYP can also educate and guide the organisation.[127]

The Reportable Conduct Scheme applies to organisations with a high level of responsibility for children and is not as broad as the category of organisations captured under the Child Safe Standards. It includes schools, disability and mental health services, hospitals, out of home care, religious bodies, occasional care providers and other prescribed entities (that could be zoos, libraries, museums and so forth).[128] In Victoria, the scheme was introduced in three tranches over 18 months, with different types of organisations captured by the scheme in each phase.

The Reportable Conduct Scheme in Victoria imposes obligations on the heads of relevant organisations to notify the Commission of a 'reportable allegation' within three business days of becoming aware of it.[129] In addition to the requirements of the Child Safe Standards (described in Section 3.2.2) it also requires the head of an entity to have systems in place to prevent reportable conduct and ensure it is reported and investigated where it does occur.[130] The 'head' of an organisation is defined in the Act to generally be the Secretary (where the entity is a department) or as otherwise prescribed in regulations, and in any other case the chief executive officer, the principal officer or otherwise a person nominated and approved by the Commission.[131]

'Reportable conduct' is defined broadly in Victoria to include:

- a sexual offence committed against, with or in the presence of a child (whether or not a criminal proceeding has been commenced or concluded)
- sexual misconduct committed against, with or in the presence of a child (defined as 'behaviour, physical contact or speech or other communication of a sexual nature, inappropriate touching, grooming behaviour and voyeurism')
- physical violence committed against, with or in the presence of a child

- any behaviour that causes significant emotional or psychological harm to a child
- significant neglect of a child.[132]

Under the scheme, allegations that may constitute criminal offences should also be reported to Victoria Police. A police investigation has priority, with any investigations by an organisation to be suspended or not started until police advise that it may proceed.[133] Guidance material from the Commission states that criminal allegations should be 'immediately reported' to police, in addition to the Commission.[134]

As soon as possible and within 30 calendar days after becoming aware of the reportable allegation, the organisation must provide the Commission with:

- detailed information about the reportable allegation
- whether or not any disciplinary action is proposed and reasons why (or why not)
- any written submissions made to the head of the organisation that the relevant employee wished to have considered in determining disciplinary or other action.[135]

As soon as possible after completing the investigation, the head of the organisation must provide the Commission with a copy of the investigation findings and information about actions.[136]

A snapshot of a head of organisation's obligations under reportable conduct

Source: Commission for Children and Young People Victoria, Information Sheet 1 'About the Victorian Reportable Conduct'.

Failure to notify the Commission of the reportable allegation, or to keep the Commission updated on actions taken to investigate and respond within 30 calendar days, is an offence.[137] The head of the entity must investigate the allegation (or engage another body, such as the Commission to investigate) and, as soon as possible after the investigation concludes, provide a copy and reasons for findings, details of disciplinary and other action to be taken and an explanation if no disciplinary or other action is proposed.[138]

The Commission can request information or documents relating to a reportable allegation or investigation at any time. The head of the entity must comply with the request.[139] The Commission can visit an entity to inspect any document related to the reportable allegation or conduct an interview.[140]

The Commission also has own motion powers to investigate a reportable allegation where:

- it receives information about a reportable allegation and believes on reasonable grounds that reportable conduct may have been committed and considers it in the public interest to investigate the reportable allegation
- it is advised the organisation will not or cannot investigate the reportable allegation or engage an independent investigator
- it is concerned there has been inappropriate handling of (or response to) a reportable allegation and considers it in the public interest to investigate itself.[141]

Affected parties can seek internal review of some decisions the Commission makes. This includes decisions to issue a notice to produce regarding the Reportable Conduct Scheme or findings by the Commission in an own motion investigation, for example.[142] Some internal review decisions can be further reviewed by the Victorian Civil and Administrative Tribunal.

The Commission for Children and Young People published *Guidance for Organisations: Investigating a Reportable Conduct Allegation* in June 2019. Key points from this guide include:

- Decision-makers in reportable conduct investigations must apply the 'balance of probabilities' standard of proof (whether more likely than not the reportable conduct happened). In so doing, the decision-maker must apply the 'Briginshaw test', which requires that the more serious the allegation and gravity of a substantiated finding, the more comfortably satisfied on the evidence they should be.[143]

- An independent investigator must be used, defined as an 'independent body or person (who can come from within the organisation) with appropriate qualifications, training or experience to investigate reportable allegations'.[144] The guide describes situations where an external investigator should be considered, including where the matter is complex or there is a conflict of interest.[145]
- An alleged victim and the subject of an allegation should be interviewed, unless there are good reasons not to (these should be documented). The guide includes the factors to consider when interviewing a child, including their age and developmental stage, whether they have been interviewed already and the nature of the allegations.[146] It also states that 'careful thought and planning' is required to enable a child to describe their experience, where appropriate, 'being mindful to avoid causing any further trauma to the child'.[147] The Commission for Children and Young People has developed the *Guide for including children and young people in reportable conduct investigations*, alongside other resources (including mock interviews). These provide specific guidance on how to ensure interviews are trauma-informed, including for Aboriginal children and young people.[148]
- A worker or volunteer who is the subject of a reportable allegation is entitled to receive natural justice (often called procedural fairness). The guide identifies the factors that will facilitate such fairness (including the provision of a notice on the nature and scope of allegations, ability to have a support person present, have reasonable opportunity to respond and have this considered before any final decisions are made).[149]
- The importance of organisations managing risks to children while investigations are conducted, with regard to the nature and seriousness of the reportable allegation, the vulnerability of the children and the position and duties of the subject of the allegation (including whether they have unsupervised access to children).[150]

In addition to the powers above, the Commission has specific functions in administering the scheme. This broadly includes:

- educating and providing advice to organisations to support compliance
- overseeing the investigation of reportable allegations (and in some instances, investigating the allegations itself)
- monitoring compliance

- exchanging information with Victoria Police, other regulators and Working with Children Check Victoria (we discuss information sharing in the context of New South Wales' Reportable Conduct Scheme below)
- reporting to the Minister and Parliament on trends.[151]

Ms Buchanan told us the Commission for Children and Young People works closely with many regulatory bodies and it has implemented formal memoranda of understanding with some of these bodies.[152] Ms Buchanan said this enhances the safety and wellbeing of children by ensuring relevant information is shared, while also reducing duplication of effort in responding to matters.[153]

Ms Buchanan said the Commission shares information with co-regulators and other agencies to help them perform their role regulating organisations or individuals in relation to child safety.[154] It can refer a substantiated allegation to the Working with Children Check Unit or a professional accreditation body (for example, Victorian Institute of Teaching or the Australian Health Practitioner Regulation Agency).[155] It can also bring agencies together to share information about a matter and support each regulator to fulfil its roles and responsibilities in addressing child safety issues, while minimising duplication.[156]

Where Victoria Police investigates a matter that falls within the scope of the Reportable Conduct Scheme, the Commission can request information about the matter from Victoria Police and share it with a relevant organisation.[157] Ms Buchanan said placing a police officer within the Commission during the first two years of operation of the Reportable Conduct Scheme helped the Commission to establish processes to effectively manage information and information requests between the two agencies. This resulted in an increase in intelligence about potential abuse being shared with Victoria Police to assist criminal investigations. The Commission now routinely shares with and requires considerable information from Victoria Police. Victoria Police also shares reportable conduct allegations with the Commission that may not have otherwise come to light.[158]

New South Wales was the first jurisdiction to establish a reportable conduct scheme. We asked Mr Kinmond to describe the features of the New South Wales model, including its lessons in implementation. Mr Kinmond described in detail the significance of a reportable conduct scheme in providing central oversight of high-risk individuals and strong collaboration with police and child protection agencies to actively manage the risks these individuals posed. We describe the New South Wales experience relating particularly to information-sharing in the following box.

Information sharing under the New South Wales Reportable Conduct Scheme

New South Wales implemented a reportable conduct scheme in 1999, originally sitting within the New South Wales Ombudsman before being administered by the Office of the Children's Guardian from 1 March 2020.[159] The regulator has responsibility for overseeing the handling of child abuse and neglect allegations against employees of more than 7,000 government and non-government agencies.[160]

Stephen Kinmond was appointed to lead the Employment-Related Child Protection Division within the New South Wales Ombudsman in 2010 and had responsibility for the Reportable Conduct Scheme. Mr Kinmond recognised the importance of an oversight body of this nature 'value adding' and being proactive in the management of risks to children.[161] He stated that before he joined the Office of the Ombudsman, it had 'reflected a more passive traditional oversight model'.[162] He described the action he took:

> [I] immediately went about establishing standard operating procedures with the police, getting access to the police system, getting access to the child protection system, ensuring that in fact we were proactive in our response.[163]

Increasing 'in-house' access to databases held by police and child protection enabled the Ombudsman to 'obtain a holistic understanding of the prevailing risks in particular matters and to better inform [its] assessment of any action that may be required' to supplement its own information gleaned through reportable conduct notifications.[164] This provided a 'helicopter view' of critical information.[165]

Chapter 16A of the *Children and Young Persons (Care and Protection) Act 1998* (NSW) ('Children and Young Persons (Care and Protection) Act') provides significant scope for the regulator of the Reportable Conduct Scheme, as well as other prescribed bodies, to proactively share risk-related information to promote the safety, welfare and wellbeing of children.[166] Section 245C states:

1. A prescribed body (the provider) may provide information relating to the safety, welfare or well-being of a particular child or young person or class of children or young persons to another prescribed body (the recipient) if the provider reasonably believes that the provision of the information would assist the recipient:
    a. To make any decision, assessment or plan or to initiate or conduct any investigation, or to provide any service, relating to the safety, welfare or well-being of the child or young person or class of children or young persons ...
    b. To manage any risk to the child or young person (or class of children or young persons) that might arise in the recipient's capacity as an employer or designated agency.
2. Information may be provided under this section regardless of whether the provider has been requested to provide the information.[167]

Provisions under the Act also permit an agency to request information relating to the safety, welfare or wellbeing of children from another prescribed body and provide protection from liability to those who provide information under provisions set out in the Act.[168] Prescribed bodies for the purposes of the Act include New South Wales Police, public service agencies or public authorities, government or registered non-government schools, TAFEs, public health organisations, private health facilities and persons or bodies prescribed in regulations.[169]

On a regulator's approach to information sharing, Mr Kinmond said:

> I took the view that an Ombudsman's Office should err on the side of disclosure, given the importance of ensuring the Office of the Children's Guardian was provided with relevant risk related information to carry out their functions. My approach was always to think about what the community's views would be on a failure to act in a particular situation, including failing to provide information that indicated an individual may pose a risk to children. I find this to be a simple but helpful test.[170]

The provisions in the Children and Young Persons (Care and Protection) Act seek to overcome agency concerns about breaching individual privacy.[171] Mr Kinmond said that a reportable conduct scheme regulator must take an active role to ensure relevant information is shared with appropriate agencies and acted on.[172] This is best achieved through broad information sharing powers.[173] He said the reportable conduct scheme regulator must also model proactive information exchange in its own practice to send a clear message to agencies and sectors that there is a 'collective responsibility' to share information to promote the safety, welfare and wellbeing of children.[174]

Mr Kinmond said the regulator of a reportable conduct scheme must assess the information it gathers and form a view about whether it can be exchanged with other prescribed bodies consistent with promoting the safety, welfare and wellbeing of a child or class of children.[175] This requires an assessment of the nature and quality of the information and ensuring the exchange of information beyond what is permitted by legislation does not occur.[176]

Mr Kinmond provided us with a submission the NSW Ombudsman made to the National Royal Commission in 2016 that cited an example where a historical child sexual abuse case was reopened by police after the Ombudsman identified an individual having two different 'unlinked' names within the police database.[177]

Mr Kinmond told us of the importance of regulators and oversight bodies being proactive in the context of overseeing a reportable conduct scheme:

> It's not an acceptable situation to have an oversight body that understands that risks are in play in relation to matters that are reported to it and remains passive, and so, in that respect it's perhaps different than other oversight arrangements because, if there is an unacceptable risk to children – or a child or children … the oversight body has to respond.[178]

Mr Kinmond stressed the importance of providing for capacity building for organisations through training, education and guidance, recognising that smaller agencies in particular often lacked the knowledge and experience to handle reportable allegations properly.[179] Failures to build capacity could also undermine the level and quality of reporting to the regulator.[180]

We consider that many of the problems we observed in responses to allegations or complaints of child sexual abuse or sexual misconduct in our Inquiry could have been prevented through a reportable conduct scheme, underpinned by proactive information-sharing arrangements and a supportive approach to helping organisations to manage investigations effectively. This is particularly the case for conduct that may not meet the threshold for more serious interventions (for example, not meeting the threshold for police reporting).

We consider that, had Tasmania adopted a reportable conduct scheme earlier, a range of problems we describe throughout our report may have been prevented, including:

- failures to notify other agencies of complaints or concerns relating to child sexual abuse (such as police, professional regulators or the Registrar of the Registration to Work with Vulnerable People Scheme) and to share information appropriately to ensure risks to children are properly assessed and mitigated (refer to, for example, Volumes 3, 4, 5 and 6)
- failures to investigate complaints or concerns, or investigate them adequately, and in a trauma-sensitive way (particularly in adopting best practice approaches to interviewing children and young people) (refer to, for example, Volumes 3, 4, 5, 6 and Chapter 20 in Volume 8)
- a tendency to prioritise the perceived rights and interests of the person accused of the conduct and the reputation of the organisation ahead of the safety of children by failing to ensure investigations were transparent, trauma-informed, appropriately included the accounts and perspectives of affected children and young people, and ensured risks associated with particular individuals were appropriately managed (refer to, for example, Volumes 3, 4, 5, 6 and Chapter 20 in Volume 8).

As noted, the Tasmanian Government released a consultation draft of the Child Safe Organisations Bill in 2020. This Bill did not provide for a reportable conduct scheme, as this was proposed to occur after the National Principles for Child Safe Organisations had been legislated.[181] As we noted earlier, Secretary Webster told us feedback on the draft Bill showed support for a reportable conduct scheme.[182] In her submission to us, Commissioner McLean outlined her 'strong view' that Tasmania should have both Child Safe Standards and a reportable conduct scheme.[183]

We agree and consider the value of a reportable conduct scheme lies in addressing a significant gap in responding to institutional responses to child sexual abuse and sexual misconduct. We note the child protection system is primarily focused on the care and protection of individual children and responding to risks of harm within the familial setting.

As we discuss in the next section, the Tasmanian Government has implemented a reportable conduct scheme in its Child and Youth Safe Organisations Act, which is due to commence in 2024. Secretary Webster told us:

> Once established, the Reportable Conduct Scheme … will be a central repository for reportable conduct and the investigation outcomes related to child sexual abuse in organisations, government and nongovernment. The Reportable Conduct Scheme will have an important role in data collection and monitoring the incidence of child sexual abuse.[184]

4 Child and Youth Safe Organisations Act 2023

In September 2022, the Government released a revised draft Child and Youth Safe Organisations Bill for public consultation. This consultation included an invitation for the views of children and young people, who could participate in a short survey about their ideas. Public consultation closed on 1 October 2022.[185] The revised Bill introduced a more comprehensive child safe organisation framework than the 2020 Bill. It was introduced into the Tasmanian Parliament on 22 November 2022.[186] The Child and Youth Safe Organisations Act was passed by the Tasmanian Parliament in May 2023 and commenced on 1 July 2023 (with some legislative obligations commencing in a phased manner in 2024).[187]

We summarise the key features of the Act in the following section.

4.1 Child and Youth Safe Standards and Universal Principle

As previously outlined, the Child and Youth Safe Organisations Act introduces Child and Youth Safe Standards that mirror the National Principles certain organisations must comply with, as part of the broader Child and Youth Safe Organisations Framework. Organisations must also comply with an embedded Universal Principle that requires a regulated entity to 'ensure that the right to cultural safety of children who identify as Aboriginal or Torres Strait Islander is respected'.[188] The Universal Principle has the same status as the Child and Youth Safe Standards, with the Independent Regulator's powers (including enforcement powers) identical to those of the Standards.[189] As we noted earlier, our references to Child and Youth Safe Standards should be read as inclusive of the Universal Principle.

A range of organisations must comply, including health, educational, accommodation providers, youth justice workers, recreational clubs and businesses that provide services to children.[190] The Act stipulates that local councils, legal practitioners providing services to children, government agencies and the Parliament of Tasmania must also comply.[191]

The Independent Regulator is given broad functions regarding the Child and Youth Safe Standards that relate to education and advice on compliance, oversight and enforcement, information sharing, data collection and analysis, and public reporting.[192] The Independent Regulator also has enforcement powers that extend to:

- requesting documents and information
- inspecting premises
- sharing information
- issuing relevant notices to an organisation (to produce a document or to comply with requirements the Child and Youth Safe Standards impose).[193]

Penalties apply to non-compliance with the legislation.[194]

4.2 Reportable Conduct Scheme

The Child and Youth Safe Organisations Act also introduces a reportable conduct scheme, which requires the head of a relevant entity to notify the Independent Regulator within three business days of becoming aware of reportable conduct. Most relevantly for our purposes, reportable conduct includes a range of sexual offences as well as sexual misconduct, which is defined to include inappropriate behaviour, physical contact and voyeurism when performed in a sexual manner or with a sexual intention.[195] The head

of an entity is required, as soon as practicable and no later than 30 days after becoming aware of the reportable allegation, to notify the Independent Regulator of information received, action taken, and any submissions received by parties related to the matter.[196]

The Reportable Conduct Scheme applies to a slightly narrower cohort of organisations than the proposed Child and Youth Safe Standards (which is consistent with the recommendations of the National Royal Commission) and includes all government agencies, out of home care and accommodation providers, youth justice, health services and schools, among others.[197]

The Independent Regulator has a range of functions to administer and oversee the scheme, including educating and advising entities, monitoring investigations of reportable conduct (and conducting own motion investigations), monitoring compliance with the scheme, facilitating appropriate information sharing, collecting and analysing data, and public reporting.[198]

As with the Child and Youth Safe Standards, the Independent Regulator has a range of powers, including to request documents or information, enter premises, conduct interviews and share information.[199]

4.3 Independent Regulator and Deputy Independent Regulator

The Child and Youth Safe Organisations Act provides for the Governor to appoint an Independent Regulator and Deputy Independent Regulator (one of whom must be known to be Aboriginal or Torres Strait Islander).[200] The Act makes it explicit the Independent Regulator and Deputy Independent Regulator are 'not subject to the direction or control of the Minister' and 'must act independently, impartially and in the public interest' when exercising their functions or powers.[201]

The Act also makes provision for 'entity regulators', which the Independent Regulator is to determine.[202] Entity regulators can exercise certain functions the Independent Regulator delegates, including powers to inspect premises, interview persons or give a notice to produce a document.[203]

At the time of writing, it is unclear how the Independent Regulator, Deputy Independent Regulator and the Child and Youth Safe Organisations Framework, including the Reportable Conduct Scheme, will be operationalised. The Tasmanian Government has stated its intention to establish a new entity led by the Independent Regulator 'focused on the institutional safety and wellbeing of children and young people' to administer the Child and Youth Safe Organisations Framework.[204] Recruitment for the role of the Independent Regulator is underway at the time of writing, with appointment of the Deputy Independent Regulator to follow.[205]

We consider the Tasmanian Government should establish a new and appropriately resourced Commission for Children and Young People (discussed further in Section 5.2), which should also administer the Child and Youth Safe Standards and the Reportable Conduct Scheme.

4.4 Information-sharing provisions

The Child and Youth Safe Organisations Act includes several provisions designed to facilitate appropriate information sharing between agencies. These provisions are expansively drafted to empower the Independent Regulator to obtain, record, disclose and otherwise use information for a broad range of purposes, including for:

- promoting and protecting the safety of children
- supporting investigations by law enforcement
- employment and disciplinary processes.[206]

It also provides that a range of persons and bodies may disclose information or documents relating to compliance with the Child and Youth Safe Standards or matters relating to reportable conduct between different organisations. This includes:

- heads of organisations
- entity regulators
- police (including police in other jurisdictions)
- the Registrar of the Registration to Work with Vulnerable People Scheme
- ministers
- an independent investigator (where necessary)
- the Chief Commissioner of the Integrity Commission
- others, including persons or bodies that can be prescribed.[207]

We note the Ombudsman is not listed as a body that can take part in information sharing. We are unclear on the reasons for this. We consider it important and necessary that the Ombudsman be expressly empowered to share information with the Independent Regulator, alongside those listed, given its complaints-handling and oversight functions.

The State has agreed with this position and committed to prescribing the Ombudsman within the regulations to bring it within information-sharing provisions under the Act, and to confer investigative functions on the Ombudsman as an entity regulator under the Reportable Conduct Scheme.[208]

Recommendation 18.3

The Tasmanian Government should ensure the Ombudsman is prescribed as an entity for the purposes of disclosure of information under section 40 of the *Child and Youth Safe Organisations Act 2023*.

4.5 Other matters

The Child and Youth Safe Organisations Act has a commencement date of 1 July 2023, with staggered commencement of the requirements in 2024.[209] The first tranche of organisations will be required to comply with the Child and Youth Safe Standards (including government agencies such as schools, health services, out of home care and youth justice) from 1 January 2024. A second tranche will be required to comply from 1 July 2024 (mostly private and commercial business, such as party services or talent and beauty competitions).[210] A similar logic applies to phasing the implementation of the Reportable Conduct Scheme, recognising some variation in the organisations subject to the scheme.[211]

A table outlining the organisations regulated by the Child and Youth Safe Standards and the Reportable Conduct Scheme and relevant commencement dates for compliance can be found at Table 18.1.

Table 18.1: Organisations regulated under the Child and Youth Safe Organisations Act 2023[212]

Type of organisation	Child and Youth Safe Standards	Reportable Conduct Scheme	Date must start to comply
Accommodation and residential services for children, including housing services and overnight camps	Yes	Yes	1 January 2024
Activities or services of any kind, under the auspices of a particular religious denomination or faith through which adults have contact with children	Yes	Yes	1 January 2024
Child care and commercial baby sitting services	Yes	Yes	1 January 2024
Child protection services and out-of-home care, including contact services	Yes	Yes	1 January 2024
Health services for children, including organisations that provide counselling services*	Yes	Yes	1 January 2024
An organisation that provides early intervention or disability support services	Yes	Yes	1 January 2024
Justice and detention services for children*	Yes	Yes	1 January 2024
Education services for children	Yes	Yes	1 January 2024
Tasmanian Government and Local Government	Yes	Yes	1 January 2024
Tasmanian Parliament	Yes	Yes	1 January 2024
Government House	Yes	Yes	1 January 2024
Neighbourhood Houses	Yes		1 July 2024
A club, association or cadet organisation that has a significant membership of, or involvement by, children	Yes	Yes	1 July 2024
An entity that provides a coaching or tuition service to children	Yes	Yes	1 July 2024
An entity that provides commercial services to children	Yes		1 July 2024
A transport service specifically for children	Yes		1 July 2024

Source: Department of Justice, 'Child and Youth Safe Organisations Framework'.

The Act also provides for a review of the first three years of its operation, with a report on the review outcomes to be tabled in Parliament.[213]

4.6 Stakeholder feedback

As foreshadowed, the Department of Justice released a consultation draft of the Child and Youth Safe Organisations Bill in September 2022. The Department of Justice published 11 submissions from stakeholders in response to the consultation draft, all of which reflected broad support for the objectives, aims and provisions of the Bill.[214] Some of the key themes emerging from the submissions included:

- recommendations that the Tasmanian Commissioner for Children and Young People assumes the functions of the Independent Regulator for the Child and Youth Safe Standards and Reportable Conduct Scheme.[215] The importance of ensuring the Independent Regulator was appropriately resourced was also emphasised[216]

- support for explicit consideration of cultural safety for Aboriginal children but recommending this align to the approach adopted in Victoria by introducing an additional Standard (rather than a Universal Principle)[217]
- some support for expanding the scope of the Reportable Conduct Scheme to capture all organisations that would be bound by the Child and Youth Safe Standards (acknowledging this goes beyond what the National Royal Commission recommended).[218]

Stakeholders who provided feedback on the consultation draft also made a range of technical and drafting suggestions.

The CREATE Foundation, the national consumer body for children and young people with an out of home care experience, also consulted a group of young people in September 2022 on the draft Bill. The feedback from this group was broadly positive. They suggested the Child and Youth Safe Standards should be accessible and understood by young people.[219]

As part of its consultation process, the Department of Justice established a range of advisory panels to support the implementation of the new requirements, including a:

- Lived Experience Advisory Panel—with members who have lived experience of child sexual abuse in institutional settings or are family members or friends who are victim-survivor advocates.
- Sector Implementation Advisory Panel—which brings together representatives from sectors likely to be affected by the reforms, including a range of services and organisations, businesses, clubs, associations, local government and private organisations (such as non-government schools).
- Interdepartmental Implementation Advisory Panel—chaired by the Department of Justice with representatives from the Department for Education, Children and Young People, the Department of Health, the Department of State Growth, the Department of Police, Fire and Emergency Management, the Department of Natural Resources and Environment Tasmania and the Department of Premier and Cabinet.[220]

4.7 Supporting the implementation of Tasmania's child safe regulatory framework

We welcome the Tasmanian Government's introduction of the Child and Youth Safe Organisations Act and consider it has appropriately responded to stakeholder feedback by:

- aligning with the National Principles for Child Safe Organisations
- reflecting the need for all organisations to take active steps to ensure they feel safe and welcoming for Aboriginal children
- capturing a wide range of organisations that must manage the most acute risks of harms to children in both the Child and Youth Safe Standards and Reportable Conduct Scheme
- facilitating and explicitly enabling robust information sharing between key agencies that prioritises the safety of children and young people
- embedding the independence of the Independent Regulator and Deputy Independent Regulator
- providing for a review of the operation of the legislation after three years.

We also welcome the adoption of broad definitions of reportable conduct. However, we note these rely on staff and volunteers to be sufficiently skilled to identify reportable conduct (for example, inappropriate boundary violations or breaches).

We are particularly pleased Tasmania Police will become a regulated entity for the Child and Youth Safe Standards and Reportable Conduct Scheme. We consider this appropriate, as police occupy unique positions of trust within the community and can wield significant power and authority over children and young people.

We consider there has been a significant delay in implementing the National Royal Commission recommendations as they relate to the Child and Youth Safe Standards and the Reportable Conduct Scheme. The Child Safe Standards in the 2020 draft of the Bill were not fit for purpose and had to be abandoned, while a reportable conduct scheme was only proposed in the draft Bill of 2022. The unfortunate effect of these delays is the opportunity to reduce any risks that children and young people may be subject to was missed. Valuable time was lost to start the necessary consultation, capacity building and preparation within regulated organisations needed to ensure the success of their implementation.

Given the broad alignment with the key features of interstate models, and the extensive delays to date, we do not propose revisiting the substance of the Act, beyond our recommendation regarding the inclusion of the Ombudsman as an information-

sharing entity (outlined in Section 4.4). In the interests of realising the benefits of these regulatory schemes as soon as possible, we encourage the Tasmanian Government to be considered and thoughtful with its implementation in order to maximise the success and impact of the regulatory schemes. We also recommend the issues we would like considered in the statutory review of the operation of the Act.

Other jurisdictions, such as New South Wales and Victoria, have substantially progressed implementation of these schemes and can offer valuable insight to guide Tasmanian implementation. It was clear from the evidence from these jurisdictions that close collaboration with other agencies with relevant information and responsibilities (such as police), including access to their information holdings, was an important enabler for effective information sharing. Tasmania can now leverage resources and guidance materials that have been developed at the national level to support organisations and regulators alike. These will greatly assist during the implementation process and avoid the need for Tasmania to 'reinvent the wheel'.

Recommendation 18.4

The Tasmanian Government, in implementing the *Child and Youth Safe Organisations Act 2023*, should ensure:

a. the functions of the Independent Regulator and Deputy Independent Regulator under the Act are embedded within the new Commission for Children and Young People (Recommendation 18.6)

b. the Commission is sufficiently resourced to enable it to effectively perform these regulatory functions

c. the Commission has access to government data systems such as those held by Tasmania Police, Child Safety Services and the Registrar of the Registration to Work with Vulnerable People Scheme to enable systematic and proactive monitoring and that those agencies have access to the Commission's data, where appropriate.

We note that section 64 of the Child and Youth Safe Organisations Act allows the Minister to initiate a review of the Act covering the three years since the Act started and to ensure a report of the review outcomes is tabled in Parliament within four years of commencement. We welcome this provision but offer recommendations in the next section regarding considerations we consider should guide this review, which we consider should be undertaken by an independent entity.

Recommendation 18.5

The Tasmanian Government should ensure its independent three-year review of the *Child and Youth Safe Organisations Act 2023* has a particular focus on:

a. whether the Independent Regulator is sufficiently resourced and empowered to perform its functions effectively, and new or additional resourcing, functions and powers are necessary to support compliance

b. how effectively the Independent Regulator is working with other agencies, including the Ombudsman or other oversight bodies, Registrar of the Registration to Work with Vulnerable People Scheme, Tasmania Police, professional regulatory bodies and other peak bodies, to support compliance, share information and manage active risks to children and young people

c. how organisations captured by the Child and Youth Safe Standards and the Reportable Conduct Scheme have experienced the new regulatory requirements, and in particular whether they have felt sufficiently supported to comply

d. analysing data emerging from the operation of the schemes, particularly as they relate to complaints and notifications and trends within and across sectors

e. whether the Universal Principle requiring organisations to uphold cultural safety is achieving its intended objective, and whether it should become an additional Child and Youth Safe Standard, mirroring the approach in Victoria

f. whether any further legislative changes are required to ensure appropriate information sharing between the Independent Regulator and other agencies.

4.8 The appointment of the Independent Regulator

The Child and Youth Safe Organisations Act does not specify the body that will assume the functions of the designated Independent Regulator and Deputy Independent Regulator. Secretary Webster told us:

> 'the establishment of an independent statutory oversight body will require the analysis of current legislation in Tasmania to identify the best placement and analysis around what existing functions of current statutory officers may need to be reviewed'.[221]

She noted Tasmania's relatively small size will need to be considered when examining how other jurisdictions have approached independent regulation.[222]

The Child and Youth Safe Organisations Project Plan states the Tasmanian Government is committed to establishing a 'dedicated independent oversight body' to oversee the Child and Youth Safe Standards and the Reportable Conduct Scheme.[223]

As noted in Section 4.3, the Government has stated its intention to establish a new entity led by the Independent Regulator to administer the Child and Youth Safe Organisations Framework.[224] Recruitment for the role of the Independent Regulator is underway at the time of writing, with appointment of the Deputy Independent Regulator to follow.[225]

The National Royal Commission contemplated that existing children's commissioners and guardians could assume responsibilities for Child Safe Standards and Reportable Conduct Schemes.[226] We agree these responsibilities should be assumed by an oversight body focused exclusively on children and young people. We consider the person or body appointed as Independent Regulator should:

- be independent of government
- have specialist knowledge of children
- be accessible to children and their parents/carers, as they may wish to make a reportable allegation
- have a child-centred focus and processes
- have appropriate regulatory skills, which could be built over time.

In a small jurisdiction such as Tasmania, it is also important the appointment of the Independent Regulator avoid duplication of work with existing roles and entities.

As described earlier, in Victoria, the Commission for Children and Young People administers its Child Safe Standards and Reportable Conduct Scheme, which also performs other important functions. As discussed in Chapter 9, these functions include:

- conducting inquiries into the safety and wellbeing of an individual vulnerable child or group of vulnerable children[227]
- undertaking systemic inquiries into the provision of services to vulnerable children[228]
- monitoring serious incidents in the out of home care and youth justice systems[229]
- administering an independent visitors scheme for children in youth justice centres.[230]

As outlined in Sections 3.2 and 3.3, we heard evidence from Ms Buchanan and Ms Sanders, about the Commission for Children and Young People Victoria.[231] We were impressed at the considerable knowledge and expertise the Victorian Commission for Children and Young People has built as a regulator of Child Safe Standards and Reportable Conduct Scheme since 2017.

Ms Buchanan believed there was benefit in the Commission for Children and Young People holding the role as regulator, as it is a body with 'specialised knowledge and understanding of children, children's development and child sexual abuse', noting that this knowledge and expertise continues to grow.[232] Ms Buchanan said:

> So, one of the really important aspects of performing an oversight function here is, [number one], you have to be an organisation that has and continues to develop a very good understanding of children, of risks to children, of the patterns of child abuse and harm to children and about what organisations need to have in place to prevent and appropriately respond to child abuse, so that knowledge, that expertise, that specialisation in children and harms to children is very, very important.[233]

Ms Sanders stated how Child Safe Standards and a reportable conduct scheme are complementary:

> The Child Safe Standards are about systems, while the [Reportable Conduct Scheme] is about more specific and detailed management of investigations by organisations. They work together as part of the same overall child safety framework. We consider that these are two key aspects of the safeguarding system that seeks to prevent and respond to child sexual abuse.[234]

Ms Buchanan and Ms Sanders pointed to benefits in one regulator overseeing both the Child Safe Standards and the Reportable Conduct Scheme.[235] These benefits are summarised as follows:

- The number and nature of reportable allegations received under the Reportable Conduct Scheme can offer intelligence as to the organisation's level of compliance with Child Safe Standards (where the number or nature of these reports is inconsistent with expected trends).[236]
- An assessment of how well an organisation is implementing Child Safe Standards can guide how the regulator may wish to oversee the management of a reportable allegation. For example, if there are compliance concerns arising from the Child Safe Standards relating to an organisation or sector, this may encourage the regulator to be more proactive in working with the organisation in its investigation into reportable conduct.[237]
- There are no information barriers to overcome as the information held about both the Child Safe Standards and Reportable Conduct Scheme are held by the one regulator.[238] This means the Commission's internal teams can use information gleaned in regulating one scheme to inform its approach or action in relation to the other.[239]

Commissioner McLean supported Tasmania's regulator overseeing both schemes, as occurs in Victoria.[240] She noted:

> I believe the Victorian child safe model provides a particularly useful example of how we could take the steps needed to further protect the safety and wellbeing of children and young people in Tasmanian institutional contexts.[241]

As outlined earlier, in New South Wales, Child Safe Standards and the Reportable Conduct Scheme are administered by the Office of the Children's Guardian.[242] The New South Wales Ombudsman was initially responsible for the Reportable Conduct Scheme, however this responsibility was transferred to the Office of the Children's Guardian in March 2020.[243]

We are pleased to see the Child and Youth Safe Organisations Act proposes the same entity regulates the Child and Youth Safe Standards and the Reportable Conduct Scheme.

With its specialist knowledge of matters relating to children and its child-centred processes, we consider our proposed new Commission for Children and Young People (discussed in Section 5.2) to be the logical choice for the functions of the Independent Regulator. This organisation, as the successor to the current Commissioner for Children and Young People, will have the benefit of being known to children and families in Tasmania as an organisation that can help with concerns relating to children and young people. It will also ensure there is one oversight body in Tasmania with a focus on the safety and wellbeing of children and young people. We consider this recommendation takes account of Tasmania's relatively small size and the need for regulation to be effective and efficient.

While we acknowledge it will take some time to fully establish the new Commission for Children and Young People, the implementation of the Child and Youth Safe Standards and Reportable Conduct Scheme should progress with some urgency.

5 Oversight and safeguards supporting a child safe system

A healthy and robust system of oversight is a critical pillar to improving children's safety in Tasmanian organisations. This is because well-regulated organisations are more likely to have the features of child safe organisations—including clear policies and procedures, healthy and protective work cultures, skilled and motivated staff and a culture of collaboration, reflection and continuous improvement. Organisations that tolerate poor practice, fail to properly address misconduct, and lack transparency and accountability are more likely to have heightened risks of abuse of children. In this section, we outline our recommendation to strengthen the oversight and regulation of child safety in Tasmania by establishing a new Commission for Children and Young People, which expands the current functions of the Commissioner for Children and Young People.

5.1 A confused and complex oversight system

In Chapter 2, we outline the current child sexual abuse system and identify that Tasmania has a range of oversight and integrity bodies (including professional regulators) that have some responsibility relating to child safety. In particular, the current oversight and integrity system in Tasmania is complex and confusing. The Ombudsman, Integrity Commission and the Commissioner for Children and Young People have certain highly specific (and often narrow) functions that relate to managing child safety.

Commissioner McLean acknowledged that Tasmania's oversight system lacks coordination, stating:

> In Tasmania we currently have a disconnected patchwork of systems and processes which do not provide an integrated and systematic approach to keeping children safe from abuse in institutional settings. The flow-on effects of the current system are that navigation by the public and agencies is difficult, there is limited coordination or communication between regulatory agencies, there is no central body with responsibility for systemic oversight …[244]

During our hearings, we convened a panel comprising the Chief Executive Officer, Integrity Commission, Michael Easton, the Ombudsman, Richard Connock, and Commissioner McLean to explain how their respective bodies work together in receiving and responding to complaints and concerns relating to child safety. Their evidence revealed what appeared to us to be a complex and confused integrity and oversight model in Tasmania, including:

- The Ombudsman's powers in relation to publicly funded private entities 'depends on the relationship between the private entity and the government'—which may create a lack of clarity for some out of home care providers, depending on their status.[245]
- The decision to initiate (or not initiate) disciplinary processes are administrative decisions but are not, in most cases, subject to the Ombudsman's jurisdiction.[246] We note the Integrity Commission has powers relating to misconduct by public officers.[247]
- The Commissioner for Children and Young People has individual advocacy functions for children and young people detained under the *Youth Justice Act 1997*, but no individual advocacy functions for children and young people in out of home care.[248] This means they cannot advocate on behalf of an individual child in the out of home care system or investigate a specific organisation providing care services, for example.[249] We discuss problems with these lack of powers in Chapter 9 relating to children in out of home care.

- The Commissioner for Children and Young People currently cannot, on their own motion, investigate decisions made about children and young people in detention. The Commissioner can only advocate on a child or young person's behalf (for example, to facilitate a complaint to the Ombudsman about their treatment).[250]
- The Commissioner for Children and Young People, the Ombudsman, the Custodial Inspector and the Tasmanian National Preventive Mechanism appointed under the United Nations Optional Protocol to the Convention Against Torture (noting the latter three roles are held by Mr Connock) all have functions relating to youth detention. For the Commissioner, this extends to visiting and advocating for children and young people in detention. For the Ombudsman, this relates to investigating administrative decisions made by the Department overseeing youth detention. For the Custodial Inspector, this relates to inspecting detention facilities against established standards.[251] The Integrity Commission may also be involved where there is misconduct by a staff member if, after considering whether the alleged misconduct could be a criminal offence and any necessary consultation with Tasmania Police, it considers that involvement to be appropriate regarding the principles set out in section 8(1)(l) of the *Integrity Commission Act 2009* ('Integrity Commission Act').
- Referral pathways could sometimes lead to potentially unintended outcomes—for example, if a young person shared a concern with the Commissioner for Children and Young People about their treatment in detention and they were fearful of making a formal complaint because of concerns about reprisal, it is possible the Commissioner for Children and Young People could still make a complaint to the Integrity Commission regarding the misconduct concerns. The Integrity Commission could refer the complaint back to the Department responsible for youth justice to investigate.[252] The young person in question would not necessarily know how their privately expressed concern was being managed.
- Only public officers or contractors who have entered into a contract with a public body can make public interest disclosures under the *Public Interest Disclosures Act 2002*, which limits who can receive the protections under the Act—for example, private individuals who may hold relevant information to the operation of a public body.[253] The Integrity Commission does not have such limitations as to who can make a complaint to it.[254]

In unpacking the various roles and responsibilities, how they intersect (and how they do not) Counsel Assisting posed questions for Mr Connock, Mr Easton and Commissioner McLean:

> Q [Counsel Assisting]: Would you each agree with me that this is a complex system … ?
>
> A [Ms McLean]: Yes.
>
> Q [Counsel Assisting]: Ombudsman?
>
> A [Mr Connock]: Yes.
>
> Q [Counsel Assisting]: Mr Easton?
>
> A [Mr Easton]: Yes.
>
> Q [Counsel Assisting]: Is it a difficult system for lay people to navigate, Commissioner?
>
> A [Ms McLean]: In my experience, yes, people are often confused about my role.
>
> Q [Counsel Assisting]: Mr Ombudsman?
>
> A [Mr Connock]: It can be, yes.
>
> Q [Counsel Assisting]: Mr Easton?
>
> A [Mr Easton]: I think it's difficult for people to understand the complexities, but they know—my sense is the layperson would know they could come to us about misconduct …[255]

All three oversight heads reported very few complaints (or public enquiries, in the case of the Commissioner for Children and Young People, who does not have a complaint handling function) relating to child sexual abuse.[256] Mr Connock seemed unable to explain why complaints about child sexual abuse, or whistleblowing complaints relating to misconduct were so low, but was cautious to attribute it to barriers to reporting.[257] In later hearings regarding Ashley Youth Detention Centre, Mr Connock reflected that there may be inadequate recognition of the protections for complaints-handling (including against reprisal), and that better publicising complaints avenues (and related protections) may help.[258]

Mr Easton was more willing to draw conclusions about barriers to reporting during our first week of hearings, stating:

> … it's our view based on our experience that people will not report things for fear of retribution or for fear of ostracisation as a whistleblower … But equally people won't report things because they don't understand the process within their agency of reporting things, or they won't report things because they don't think they have to.[259]

Mr Easton suggested there had been an uptick in such notifications since the establishment of our Commission of Inquiry.

Mr Kinmond, reflecting on his former role as New South Wales Deputy Ombudsman (Human Services) with responsibilities for a reportable conduct scheme, told us the absence of complaints should be a source of concern for a regulator:

> Q [Counsel Assisting]: [W]e can take it as read that the society that we live in has a problem with child sexual abuse and so, if it's not being reported, that itself indicates that something needs to happen?
>
> A [Mr Kinmond]: Absolutely, or if it has been reported and things aren't being handled appropriately, then the community would take a very dim view of an oversight body failing to act.[260]

We consider there is a lack of clarity about respective roles and responsibilities for oversight bodies as they relate to the safety of children in organisations. This makes it difficult for members of the public—including children, young people and their parents—to understand where they can make a complaint or seek help if they have concerns about their treatment within organisations. It renders the complaints process dependent on the judgment of the oversight bodies.

5.2 A new Commission for Children and Young People

As foreshadowed, we consider it is important that the prevention and management of child sexual abuse is overseen by a body with specialist skills in, and knowledge of, children's rights and safety. We consider a new Commission for Children and Young People in Tasmania—with appropriate independence, powers and resourcing—would achieve a clearer and more cohesive system of oversight of children's safety than exists currently.

It is not clear whether the Tasmanian Government has contemplated the establishment of a Commission for Children and Young People with expanded powers and responsibility for monitoring and oversight of the Child and Youth Safe Organisations Framework. While the Tasmanian Government has announced and made some progress towards appointing a new Independent Regulator, we consider these functions should ultimately be performed by the new Commissioner for Children and Young People.

The Commission for Children and Young People would subsume the current functions of the Commissioner for Children and Young People, which are to:

- advocate for all children and young people in Tasmania
- act as advocate for children and young people in youth detention
- research, investigate and influence policy development on matters relating to children and young people generally
- promote, monitor and review the wellbeing of children and young people generally
- promote and empower the participation of children and young people in the making of decisions, or the expressing of opinions on matters, that may affect their lives

- help ensure the State satisfies its national and international obligations regarding children and young people generally
- encourage and promote the establishment by organisations of appropriate and accessible mechanisms for the participation of children and young people in matters that may affect them
- perform any other prescribed functions.[261]

However, the Commission for Children and Young People would also have several new and expanded functions to support recommendations in other parts of our report. In Chapters 9 and 12, we examine the oversight of the out of home care and youth detention systems respectively. In those chapters, we discuss oversight functions exercised regarding individual children in out of home care and youth detention, and, more broadly, regarding the out of home care and youth detention systems.

Regarding individuals, we distinguish between advocacy on behalf of an individual child—including visiting a child in out of home care or youth detention, assisting them to raise any concerns about their experiences and seeking resolution of those concerns—and the formal investigation of a complaint made by a child or young person about out of home care or youth detention. We also consider systemic advocacy by oversight bodies—for example, making recommendations to government to improve the out of home care and youth detention systems.

In Chapters 9 and 12, we make several recommendations to improve individual advocacy for children in out of home care and youth detention, and to strengthen oversight of those systems. We recommend (among other matters):

- establishing a Commissioner for Aboriginal Children and Young People to advocate for Aboriginal children and young people in out of home care and youth detention, and more broadly (Recommendation 9.14)
- establishing an independent community visitor scheme for children in out of home care, youth detention and other residential youth justice facilities (Recommendations 9.34 and 12.36)
- establishing an independent Child Advocate to advocate on behalf of children and young people in out of home care and youth detention, with the power to make a complaint to the Ombudsman on behalf of a child or young person in out of home care or youth detention, and to apply to the Tasmanian Civil and Administrative Tribunal to review departmental decision-making in relation to a child in out of home care (Recommendations 9.33, 9.34 and 9.35)
- expanding external monitoring and oversight of the out of home care and youth justice systems (Recommendations 9.38 and 12.38).

In addition to the current functions of the Commissioner for Children and Young People set out here, the functions of the new Commission for Children and Young People would therefore include:

- educating relevant entities on the Child and Youth Safe standards, overseeing and enforcing compliance with those standards and related functions under the Child and Youth Safe Organisations Act, with reference to the Victorian child safe organisational framework and underlying legislative framework[262]
- administering, overseeing and monitoring the Reportable Conduct Scheme and related functions under the Child and Youth Safe Organisations Act with reference to the Victorian child safe organisational framework and underlying legislative framework[263]
- administering the independent community visitor scheme for children in out of home care, youth detention and other residential youth justice facilities (Recommendations 9.34 and 12.36)
- advocating for individual children in out of home care and youth detention, including supporting children to make complaints to the Ombudsman and (for children in out of home care) to apply for an independent review of departmental decision-making (Recommendations 9.35 and 9.36)
- monitoring the operation of the out of home care and youth justice systems and the provision of out of home care and youth justice services to children, by analysing data on those systems regularly provided by the Department for Education, Children and Young People and conducting own motion systemic inquiries into aspects of those systems and/or the services received by an individual child or group of children in those systems (Recommendations 9.38 and 12.38)
- recommending improvements to government for the out of home care and youth justice systems
- promoting the participation of children in the out of home care and youth justice systems in decision-making that affects their lives
- upholding and promoting the rights of children in the out of home care and youth justice systems.

The new Commission for Children and Young People should have all powers necessary for it to perform these functions.

We also make some specific recommendations relating to oversight bodies in particular organisational contexts across our report. This includes recommendations relating to strengthening and clarifying the role of the Teachers Registration Board (refer to Chapter 6).

In the next section, we outline the key statutory roles required to support the new Commission for Children and Young People, the need to clarify regulatory and advocacy roles, and several measures to ensure the independence of the new Commission from government.

5.3 Statutory roles

Legislation establishing the new Commission for Children and Young People should provide for the appointment by the Governor of three statutory roles, each for a term of five years:

- Commissioner for Children and Young People, who would also be the Independent Regulator of the Child and Youth Safe Standards and the Reportable Conduct Scheme
- Commissioner for Aboriginal Children and Young People (recommended in Chapter 9)
- Child Advocate (Deputy Commissioner) (recommended in Chapter 9).

As is currently the case for the Commissioner for Children and Young People, the legislation should permit the reappointment of a person appointed to any of the above roles for a further five-year term.[264]

We note there are different models in Australian jurisdictions for establishing a Commissioner for Aboriginal Children and Young People. For example, in Victoria, the *Commission for Children and Young People Act 2012* (Vic) establishes a Commission for Children and Young People, which is constituted by the 'Principal Commissioner'. The Principal Commissioner has all the functions and powers of the Commission.[265] The Victorian Commissioner for Aboriginal Children and Young People is appointed by the Governor in Council as an 'additional Commissioner' under that Act but does not have separate statutory functions or powers.[266] The Principal Commissioner may delegate relevant functions and powers to an additional Commissioner.[267]

In practice, the activities of the Victorian Commission for Children and Young People relating to Aboriginal children are led by the Commissioner for Aboriginal Children and Young People, however the Commissioners consult each other on 'key policy or strategic issues'.[268] Ms Buchanan and the former Commissioner for Aboriginal Children and Young People, Justin Mohamed, have previously expressed the view that the Victorian legislation should include clearly defined functions and powers for the Commissioner for Aboriginal Children and Young People.[269]

In South Australia, the Commissioner for Children and Young People and the Commissioner for Aboriginal Children and Young People are appointed under the *Children and Young People (Oversight and Advocacy Bodies) Act 2016* (SA), and each has their own separate legislated functions and powers.[270] These include the power to employ staff.[271]

A 2021 report of Western Australia's parliamentary Joint Standing Committee on the Commissioner for Children and Young People noted the potential for duplication and overlap with the South Australian model.[272] The committee did not recommend adopting the South Australian model, but suggested features of the South Australian legislation 'may be worth exploring' in the event of implementation of an Aboriginal children's commissioner in Western Australia.[273] We agree that the Commissioner for Children and Young People and the Commissioner for Aboriginal Children and Young People should work together and avoid duplication.

As outlined in Chapter 9, we recommend the role of Commissioner for Aboriginal Children and Young People be given its own, clearly defined statutory functions and powers to promote the safety and wellbeing of Aboriginal children. These functions and powers should be equivalent to those of the Commissioner for Children and Young People. However, we acknowledge it would not be practical to vest regulatory functions regarding the Child and Youth Safe Standards and the Reportable Conduct Scheme in two separate statutory roles. We therefore recommend the regulatory functions of the new Commission for Children and Young People be the responsibility of the Commissioner for Children and Young People, although they should consult with the Commissioner for Aboriginal Children and Young People where appropriate.

A further question arises about the relationship between the new Child Advocate and the Commissioner for Aboriginal Children and Young People. In Chapter 9, we recommend the new Commission for Children and Young People be given the function of advocating for individual children in out of home care and youth detention, primarily through an independent community visitor scheme (Recommendation 9.34). Under this scheme, independent community visitors would regularly visit children in out of home care, youth detention and other residential youth justice facilities, help them raise any concerns they may have with the Department for Education, Children and Young People, and seek to have those concerns resolved on the child's behalf. We also recommend appointing at least one Aboriginal visitor, who would be available to visit Aboriginal children in out of home care and youth detention where possible.

In Chapter 9, we also recommend the individual advocacy function of the new Commission for Children and Young People be supported by a small number of legally trained child advocacy officers, who would be available to help children in out of home care or youth detention with more complex matters or concerns, such as applying for a review of a departmental decision about out of home care (Recommendation 9.36). The new Child Advocate would be responsible for appointing community visitors and child advocacy officers and administering these programs.

Given the substantial over-representation of Aboriginal children in out of home care and youth detention (refer to Chapters 9 and 12), it would be extremely beneficial for Aboriginal children in those systems to have access to a senior Aboriginal person

to advocate on their behalf. The South Australian Guardian for Children and Young People, Penny Wright, told us that only an Aboriginal advocate can help foster strong connection to culture and identity for Aboriginal children in custody in a meaningful way.[274] Accordingly, in addition to the appointment of Aboriginal visitors, we recommend the Commissioner for Aboriginal Children and Young People undertakes individual advocacy for Aboriginal children in out of home care or youth detention who request the Commissioner's assistance.

Recommendation 18.6

1. The Tasmanian Government should establish a statutory Commission for Children and Young People, which includes the following roles, each appointed for a term of five years:
    a. a Commissioner for Children and Young People
    b. a Commissioner for Aboriginal Children and Young People
    c. a Child Advocate (Deputy Commissioner).
2. The Commission for Children and Young People should, in addition to the functions of the current Commissioner for Children and Young People under the *Commissioner for Children and Young People Act 2016*, have the following functions:
    a. educating relevant entities on the Child and Youth Safe Standards and overseeing and enforcing compliance with those standards as Independent Regulator under the *Child and Youth Safe Organisations Act 2023*
    b. administering the Reportable Conduct Scheme as Independent Regulator under the *Child and Youth Safe Organisations Act 2023*
    c. administering the independent community visitor scheme for children in out of home care, youth detention and other residential youth justice facilities (Recommendations 9.34 and 12.36)
    d. advocating for individual children in out of home care, youth detention and other residential youth justice facilities
    e. monitoring the operation of the out of home care and youth justice systems and the provision of out of home care and youth justice services to children (Recommendations 9.38 and 12.38)
    f. conducting inquiries into the out of home care and youth justice systems and the services provided to individual children in those systems, including own motion inquiries (Recommendations 9.38 and 12.38)

g. making recommendations to government for out of home care and youth justice system improvements

h. promoting the participation of children in out of home care and youth justice in decision making that affects their lives

i. upholding and promoting the rights of children in the out of home care and youth justice systems.

3. The Commission for Children and Young People should have all necessary powers to perform its functions.

5.4 Separation of regulatory and advocacy functions

As outlined earlier, the new Commission would have individual advocacy functions for vulnerable children, and systemic monitoring and oversight functions for the out of home care and youth justice systems, as well as being responsible for administering the Child and Youth Safe Standards and the Reportable Conduct Scheme.

As discussed, the Victorian Commission for Children and Young People regulates organisations subject to the Child Safe Standards and Reportable Conduct Scheme, while also undertaking systemic monitoring and oversight functions in relation to the out of home care and youth justice systems. While it does not have an explicit individual advocacy function under its enabling legislation, the Victorian Commission for Children and Young People administers an independent community visitor program for children in youth justice centres.[275] It also has an arrangement whereby children in youth justice centres can contact the Commission for Children and Young People directly via the Youth Justice telephone system to raise concerns.[276] In practice, the Victorian Commission for Children and Young People undertakes individual advocacy for children in custody.

In addition, in June 2022, the Victorian Government introduced a Bill to confer power on the Victorian Commission for Children and Young People to advocate for individual children in out of home care or in contact with the child protection system.[277] This suggests that there is no inherent obstacle to a single body undertaking advocacy for individual children, performing systemic monitoring and oversight functions, and administering Child Safe Standards and a reportable conduct scheme.

Still, we acknowledge there may appear to be a tension or conflict between the performance of individual advocacy functions and regulatory functions by a single entity. For example, a situation may arise in which the new Commission for Children and Young People is undertaking advocacy on behalf of a child in out of home care who is the subject of a reportable allegation and, at the same time, monitoring the investigation of that allegation. Commissioner McLean indicated that if the Tasmanian Commissioner

for Children and Young People was tasked with the oversight and administration of Child Safe Standards and a reportable conduct scheme, there would be a need to consider 'the appropriateness or otherwise of the Commissioner retaining an individual advocacy role' for children in youth detention.[278]

However, we consider this tension could be overcome by ensuring:

- functions in respect of the Child and Youth Safe Standards and Reportable Conduct Scheme are performed by the Commissioner for Children and Young People, supported by a separate regulatory team within the Commission for Children and Young People
- individual advocacy functions for children in out of home care and youth detention are performed by the new Child Advocate and (where Aboriginal children are concerned) the Commissioner for Aboriginal Children and Young People, supported by independent community visitors and child advocacy officers.

5.5 The importance of independence

The United Nations' Paris Principles for establishing national human rights organisations require such organisations to be independent of government.[279] The *Commissioner for Children and Young People Act 2016* ('Commissioner for Children and Young People Act)' requires the Commissioner for Children and Young People to act 'independently, impartially and in the public interest' when performing a function or exercising a power, 'unless otherwise specified'.[280]

Ms Buchanan observed that independence was crucial for her role as Principal Commissioner of the Victorian Commission for Children and Young People:

> I simply can't imagine performing my regulatory functions to improve child safety without that independence. My role, both as an oversight body in terms of youth justice and out of home care, but also in terms of a regulator of organisations to improve child safety often requires that I am having to consider what powers I have at hand, I'm having to engage and persuade, but ultimately I'm having to make decisions about, if an organisation is not doing what I think needs to be done, what the law and certain standards require, then my independence means that I can make a clear objective decision about what powers and functions might need to be exercised: that's what independence means to me.[281]

Ms Buchanan also referred to the inherent tension involved in maintaining 'good, open but robust' relationships with the bodies regulated by the Victorian Commission for Children and Young People, but taking action where a risk to a child or children requires it:

> … I cannot imagine overlooking an issue for the sake of a relationship; I need to be able to kind of engage constructively, collaboratively, work with organisations and leaders of organisations, but that only works if there's a mutual respect for our roles and if, to be frank, the organisation with which I'm working understands that at any point I may need to take some stronger and more formal action; that's kind of the way that I work.
>
> … all of our work really, whether it's oversight work or our regulatory work, is risk-based, so we kind of assess how significant is the risk, what are the issues for either the individual child or children more broadly, and we make our decisions on what action is needed based very much on that.[282]

Similarly, Mr Kinmond told us:

> And so, there is that aspect of being in no doubt that whilst on the one hand you seek to facilitate and work in a constructive relationship with bodies with a common aim of protecting children, your calling, your responsibility, is to act always in the public interest, and the moment you lose sight of that you probably should go and find employment elsewhere.[283]

We were impressed by the level of independence clearly shown in such comments.[284]

We also heard about the importance of adequate resourcing to support the independence of regulatory and oversight bodies. South Australian Guardian for Children and Young People, Penny Wright, told us the legislative independence of her roles as Guardian and Training Centre Visitor can be constrained if adequate resources are not provided to fulfil the statutory functions of those offices.[285] Similarly, Mr Kinmond commented that without institutional independence, and sufficient powers and resourcing to enable an integrity body to carry out its statutory functions, its aims are likely to go largely unrealised.[286]

Kim Backhouse, Chief Executive Officer, Foster and Kinship Carers Association, observed the role of Tasmanian Commissioner for Children and Young People has been 'a chequered portfolio' in the past, as it has been held by individuals from interstate who have 'clashed with the government'.[287] The role has been held by 10 individuals (including Commissioner McLean) since it was first established in 2000.[288]

Andrea Sturges, Chief Executive Officer, Kennerley Children's Homes, expressed the view that the Commissioner for Children and Young People 'should not be a political appointment'.[289] While we are aware some initial concerns were expressed at the time of Commissioner McLean's appointment about the appropriateness of an individual moving from a political role to an independent statutory office, the Commissioner indicated she had not experienced political interference during her term.[290]

Former Commissioner for Children and Young People, Mark Morrissey, told us that in 2017 he was asked to 'back off' advocating for changes at Ashley Youth Detention Centre by a senior government politician, and to 'cease writing' to the then Minister for Child Protection by a senior member of the Minister's staff.[291] According to Mr Morrissey, this appeared to be a request to change his relationship with the Minister and Parliament, to instead direct correspondence through the Department.[292]

Mr Morrissey also referred to 'several subtle factors' that can bring pressure to bear on the independence of the role of Commissioner for Children and Young People.[293] These include the Department delaying recruitment to staff vacancies and applying efficiency dividends, which Mr Morrissey described as 'turn[ing] the resourcing tap down, by increments and delay'.[294] He also observed that relying on the Department for human resources, information technology, finance and other corporate support can limit the efficacy of the role and may create 'real or perceived conflicts of interest', whereby the Commissioner for Children and Young People is required to hold to account the Department it relies on for operational support.[295] The Integrity Commission agreed with this observation, telling us '[a]s a small agency, it is inevitable that we be reliant on administrative and technological support from another department, and we are not sufficiently resourced to operate otherwise'.[296]

Ms Buchanan highlighted the importance of operational independence, observing that:

> I, as the Commissioner, need to be able to make decisions about the source of advice, make decisions about how I and we at the Commission approach our legislative functions. I need to make decisions, as I can, about who I employ, they need to be my employees, not employees of a department, all of those are very important aspects to my independence and my ability to perform my role.[297]

5.6 Transparency of statutory appointments

In Western Australia, the Governor appoints the Commissioner for Children and Young People on the recommendation of the Premier.[298] Before making a recommendation for appointment, the Premier must:

- advertise throughout Australia for expressions of interest from people with professional qualifications and substantive experience in matters affecting children
- consult with the leader of any political party that has at least two members in either house of parliament.[299]

The *Commissioner for Children and Young People Act 2006* (WA) also specifies that children and young people must be involved in the selection process.[300] We understand this requirement could be met through having a children's selection panel, as well as an adult selection panel, for example.

We note that the process for appointment of the Chief Commissioner of the Tasmanian Integrity Commission by the Governor requires the Attorney-General to consult first with the Joint Standing Committee on Integrity of the Tasmanian Parliament.[301] This is a multi-party committee comprising three members of the Legislative Council and three members of the House of Assembly, required to be appointed at the commencement of the first session of each parliament.[302]

The Integrity Commission Act also provides for the appointment of a chief executive officer of the Integrity Commission by the Governor on the recommendation of the Premier, following consultation with the Joint Standing Committee on Integrity.[303]

We recommend further safeguards to the integrity of appointments to the new Commission for Children and Young People, as described below.

Recommendation 18.7

The Tasmanian Government should ensure the process for appointing future Commissioners and Deputy Commissioners for Children and Young People adopts the following:

a. future Commissioners and Deputy Commissioners be appointed following an externally advertised merit-based selection process to ensure they have relevant professional qualifications and substantive experience in matters affecting vulnerable children

b. the recruitment process for these roles include a non-partisan adult selection panel with at least one member external to the Tasmanian State Service, and a separate children's selection panel

c. the adult and children's selection panels for the role of Commissioner for Aboriginal Children and Young People have a majority of Aboriginal members

d. before making a recommendation to the Governor for an appointment to the Commission for Children and Young People, the Minister be required to consult with the leader of any political party with at least two members in Parliament.

5.7 Funding and employment of staff

According to the Paris Principles, a national human rights organisation must have adequate funding to enable it to have its own staff and premises, and not be 'subject to financial control which might affect its independence'.[304] It is essential that the new Commission for Children and Young People receives enough funding to enable it to perform its various functions.

The funding allocated to the Commissioner for Children and Young People for 2021–22 was $1,386,000.[305] Commissioner McLean told us her budget flowed through the former Department of Communities, rather than being a separate appropriation.[306] In contrast, the Ombudsman, Mr Connock, told us he had a separate appropriation for funding and was therefore in control of his own budget, which was 'helpful'.[307] The Office of the Ombudsman has a service-level agreement with the Department of Justice for the provision of human resources and information technology support.[308]

As outlined in Chapter 9, Commissioner McLean told us that resourcing constraints have limited her ability to fulfil her current functions.[309] In particular, she told us in April 2022, the resourcing of her office seriously limited her ability to undertake 'own motion' investigations or inquiries.[310] Despite this, in December 2022, Commissioner McLean announced she would undertake an own motion investigation into the allocation of child safety officers for children in out of home care in Tasmania, under the new out of home care case management model.[311] Commissioner McLean told us that the decision to undertake an own motion investigation was 'not made lightly' as it diverted resources from and delayed other core reporting, research and advisory activities of her office.[312]

The Commissioner for Children and Young People Act provides that a person may be employed under the *State Service Act 2000* ('State Service Act') 'for the purpose of enabling the Commissioner to perform his or her functions' under the Act.[313] A person so employed may serve the Commissioner for Children and Young People in any capacity 'in conjunction with State Service employment'.[314] Commissioner McLean told us this 'creates an inherent conflict', as her staff are State Service employees employed to implement the Government's policies and programs, while the Commissioner 'sometimes communicates different policy views to those of the Government'.[315] In April 2022, Commissioner McLean told us she was supported by nine staff with several new positions recently established but not yet filled.[316]

It is not clear that having staff who are State Service employees necessarily creates a conflict for a regulatory or oversight body. Staff of the Tasmanian Integrity Commission and Ombudsman are appointed in line with the State Service Act.[317] Similarly, staff of the Victorian Commission for Children and Young People are employed under the *Public Administration Act 2004* (Vic), while staff of the Queensland Family and Child Commission are employed under the *Public Service Act 2000* (Qld).[318]

Ms Wright told us the funding for the South Australian Guardian for Children and Young People comes from the Department of Education, and her staff are Department of Education employees rather than employees of the Department of Child Protection.[319] She described this as 'a very effective arrangement' as 'a conflict of interest could well arise if the overseen body is determining the funding and employment arrangements of the oversight body'.[320] Ms Wright indicated it was 'not acceptable to have to rely on "goodwill" from the Departments or Ministers who are subject to … oversight'.[321]

In contrast, employees of the South Australian Commissioner for Children and Young People and Commissioner for Aboriginal Children and Young People are deemed not to be public service employees, other than for the purposes of the *Public Sector (Honesty and Accountability) Act 1995* (SA).[322]

In our view, the new Commission for Children and Young People should be funded via separate appropriation, like the Ombudsman, rather than through the Department for Education, Children and Young People. The Commission for Children and Young People should have the power to control its own budget and hire its own staff. While we acknowledge Commissioner McLean's concerns about the status of her staff as State Service employees, we do not consider this would have a material bearing on the independence of the new Commission for Children and Young People, if the other protections that we recommend in this chapter were implemented. If human resource and information technology support are needed, this should be achieved through a service agreement with a department the Commission does not have a regulatory relationship with.

Recommendation 18.8

The Tasmanian Government should ensure the Commission for Children and Young People is separately and directly funded, rather than through the Department for Education, Children and Young People. Any funding arrangements or conditions should be structured to ensure the Commission has power to control its budget and staffing.

5.8 Oversight of the new Commission for Children and Young People

In Western Australia, the work of the Commissioner for Children and Young People is monitored and examined by the Joint Standing Committee on the Commissioner for Children and Young People of the Western Australian Parliament, appointed under the *Commissioner for Children and Young People Act 2006* (WA).[323] This committee comprises two members appointed by the Legislative Assembly and two members appointed by the Legislative Council.[324]

The functions of this committee are to:

- monitor, review and report to parliament on the exercise of the functions of the Western Australian Commissioner for Children and Young People

- examine the reports of the Western Australian Commissioner for Children and Young People
- consult regularly with the Western Australian Commissioner for Children and Young People.[325]

Similarly, in New South Wales, the Committee on Children and Young People—a parliamentary joint committee established under the *Advocate for Children and Young People Act 2014* (NSW)—oversees the work of the Children's Guardian.[326] Mr Kinmond indicated it was useful for a regulatory body to report to a 'Parliamentary oversight body' as an 'important check and balance'.[327]

In Tasmania, the Integrity Commission, Ombudsman and Custodial Inspector—referred to in the Integrity Commission Act as 'integrity entities'—are monitored by the Joint Standing Committee on Integrity of the Tasmanian Parliament.[328] The functions of this committee are to:

- monitor and review the performance of the functions of integrity entities
- examine the annual reports or any other report of an integrity entity
- report to both houses of parliament on matters relevant to an integrity entity.[329]

To maximise independence, we consider the performance of the functions of the new Commission for Children and Young People should be monitored by a joint standing committee of the Tasmanian Parliament—whether by the Joint Standing Committee on Integrity or by another joint standing committee established for this purpose, as in Western Australia.

The Ombudsman and the Integrity Commission should have the power to receive and investigate complaints about the new Commission for Children and Young People as a 'public authority' under the *Ombudsman Act 1978* ('Ombudsman Act') and the Integrity Commission Act respectively.[330]

Recommendation 18.9

A joint standing committee of the Tasmanian Parliament should oversee the performance and proper execution of functions of the Commission for Children and Young People.

6 Other oversight and regulatory bodies

While we expect the Commission for Children and Young People would be the primary gateway for child safety matters, we acknowledge there may be instances where complaints and concerns about how an organisation is working to protect children may fall within the jurisdiction of other oversight bodies—for example, where there is staff misconduct (Integrity Commission) or where there is a complaint about the administrative action of a public authority or a public interest disclosure (the Ombudsman).

While the Reportable Conduct Scheme will also ensure appropriate scrutiny and oversight of the management of child safety complaints in the most high-risk organisations in Tasmania, not all departments and organisations will be legally captured by these schemes where they are not directly involved with providing services to children. In addition, the Commission for Children and Young People may identify systemic concerns that fall outside its area of responsibility.

Even with a new Commission for Children and Young People with expanded functions, the Ombudsman would retain a role in investigating complaints about public authorities and public interest disclosures. The Integrity Commission would retain responsibility for promoting and enhancing standards of ethical conduct by public officers through education, dealing with and assisting public authorities in handling misconduct and making findings and recommendations regarding its investigations and inquiries. To achieve a cohesive and effective oversight system, we recommend greater clarity in how these bodies work together—and suggest that each should be proactive in encouraging any complaints or concerns that are within their powers to investigate and resolve. Once such complaints are received, these oversight bodies should work together seamlessly to achieve the best possible outcome that promotes the safety and wellbeing of children and young people—particularly through clear and enabling information sharing arrangements.

The Registrar of the Registration to Work with Vulnerable People Scheme also plays a role in managing the risks posed by staff and volunteers in a range of organisational settings.

In this section, we discuss the roles and functions of these other integrity and oversight bodies and make recommendations for improvements. Regarding the Registrar of the Registration to Work with Vulnerable People Scheme, we recommend statutory guidance on how they undertake an assessment of risk of harm.

6.1 Integrity Commission and Ombudsman

In Section 5.2, we propose a new Commission for Children and Young People that will support and oversee Tasmania's introduction of Child and Youth Safe Standards and the Reportable Conduct Scheme. These measures will go a long way to reducing the need for recourse to other oversight bodies, such as the Ombudsman and Integrity

Commission, as most matters relevant to children and young people will be within the remit of the new Commission. Organisations with the greatest risk factors for abuse will also be legislatively compelled under the Reportable Conduct Scheme to proactively notify the new Commission (as our recommended Independent Regulator) of any reportable complaints, which can then oversee and monitor the organisation's investigation and response to that complaint to ensure it is appropriate. This increased transparency and scrutiny (alongside the capacity building that will occur as the new Commission supports and guides organisations in their responses) will increase the integrity and quality of organisational responses over time. However, these other oversight bodies will still play a role in protecting the integrity and good administration of the State Service.

We hold concerns that oversight bodies have sometimes inappropriately referred matters back to departments to investigate complaints against them. While referring complaints back to an entity is standard practice, judgment must be exercised in deciding whether this is appropriate, and the oversight body should retain oversight of the department's subsequent actions.

The Integrity Commission told us it receives very few complaints about child sexual abuse.[331] Where it does so, it would generally liaise with Tasmania Police and would be unlikely to take further action if a police investigation were to occur, unless the complaint raised broader concerns, for example, relating to poor reporting structures or procedures.[332] We consider this appropriate, although note that in the future the complaint should also be referred to the Independent Regulator of the Reportable Conduct Scheme.

However, in Chapter 14, we discuss the Integrity Commission's handling of a whistleblower complaint about Launceston General Hospital management's response to child safety concerns relating to a registered nurse, James Griffin. In that complaint, the Integrity Commission conducted an initial assessment before referring it to the Department of Health to investigate. This departmental investigation was ultimately undertaken by the human resources team led by an individual who had a direct conflict of interest. Despite some reservations, the Integrity Commission ultimately accepted this investigation (which we now know was flawed) without further action. In that chapter, we find the Integrity Commission's monitoring of the Department's response to the complaint was insufficient.

In Chapter 11, Case study 7 we discuss how in the mid-2010s the Office of the Ombudsman referred a serious complaint made by a detainee back to Ashley Youth Detention Centre for response, without adequate monitoring and oversight. While we were told this was an error, this example shows why appropriate independent oversight over youth detention is important.

We consider it important that the Integrity Commission and Ombudsman clarify (and publicise) the circumstances in which it will be appropriate for complaints related to child sexual abuse to be referred back to an agency, and when it is not. We consider this guidance should consider the following matters:

- the significance of the matter being alleged or complained about and the risks associated with that conduct
- the potential for actual or perceived conflicts of interest in the relevant department or agency
- the capacity of the department or agency to undertake a robust and quality investigation
- the risks associated with retribution and reprisal toward the complainant and of their anonymity being compromised
- public considerations, including the importance of preserving public confidence in Tasmania's integrity and oversight regime
- whether the complaint goes to matters relevant to multiple public authorities, which may benefit from a more global, systemic review by the entity.

Where possible, the Integrity Commission and Ombudsman should consult the complainant on the intended approach to managing the complaint (particularly if the oversight body wishes to send the complaint back to the relevant department or agency) to enable that individual to give their views on the suitability of this approach. This is particularly important if the complainant is seeking to maintain anonymity or is fearing reprisal.

Recommendation 18.10

1. The Integrity Commission and Ombudsman should develop a publicly available policy for complaints related to child sexual abuse which explains the circumstances in which complaints may be referred back to the agency that is the subject of the complaint for investigation.
2. The Integrity Commission and Ombudsman should consult the complainant on the intended approach to handling the complaint, including referring the complaint back to the relevant agency.

The Reportable Conduct Scheme will not capture all departments and organisations, which may leave a role for the Integrity Commission in overseeing the management of allegations of child sexual abuse in some situations. The Integrity Commission

told us that currently, public authorities are not required to notify the Integrity Commission when they are responding to an allegation of misconduct (including serious misconduct). This means it 'may not be aware of matters involving child sexual abuse'.[333] Recommendation 11 of the *Independent Five Year Review of the Integrity Commission Act 2009* requires public authorities to notify the Integrity Commission of any allegations of serious misconduct.[334] The Integrity Commission advocated the Tasmanian Government implement this recommendation.[335] We agree this should occur, where the agency does not have an obligation to notify the Commission for Children and Young People of the allegation under the Reportable Conduct Scheme.

Recommendation 18.11

The Tasmanian Government should implement Recommendation 11 of the Independent Reviewer's 2016 Report *Independent Review of the Integrity Commission Act 2009*, which would oblige public authorities to notify the Integrity Commission of any allegations of serious misconduct.

6.2 Registrar of the Registration to Work with Vulnerable People Scheme

Registration to work with vulnerable people requirements are an important regulatory safeguard, as they provide for screening and monitoring of staff or volunteers who work with vulnerable people, including children. Tasmania requires individuals undertaking certain 'regulated activities', including a range of services to children (such as health, education and youth justice), to hold registration to work with vulnerable people.[336]

The importance of the role of the Registrar of the Registration to Work with Vulnerable People Scheme cannot be overstated. Although their office is small, it is pivotal to the administrative structures designed to protect children against sexual abuse. Any comments in this section should not be seen as criticism of the Registrar or the staff of their office.

6.2.1 Opportunities for reform

The former Registrar of the Registration to Work with Vulnerable People Scheme ('Registrar'), Peter Graham, told us in his statement that, as at 31 July 2022, there were 147,878 people who held registration.[337] Since establishing the scheme in 2014, there have been 2,204 people who have had their application for registration rejected (or have withdrawn their application after past conduct was queried), with a further 397 people having surrendered their registration (or having had it suspended or cancelled) in response to information reported to the Registrar.[338]

However, Mr Graham told us there were opportunities to strengthen the Registration to Work with Vulnerable People Scheme:

- ensuring a consistent understanding of reporting and notification requirements to make certain the Registrar receives information relevant to their decision making[339]
- all State Service agencies undertaking a systemic review of past complaints or investigations[340]
- amending the *Registration to Work with Vulnerable People Act 2013* ('Registration to Work with Vulnerable People Act') to enable determinations to suspend or cancel registration to be the subject of review by the Tasmanian Civil and Administrative Tribunal[341]
- creating statutory guidance regarding the power of the Registrar to suspend a person's registration.[342]

We heard that the Registrar is not consistently receiving information relevant to their decision-making, including from Child Safety Services.[343] Mr Graham said he was, however, optimistic about the ability of the Child and Youth Safe Organisations Framework to help reinforce the obligations of agencies and other organisations to report behaviour.[344]

Mr Graham told us that he considered it 'likely' that a systematic review by State Service agencies of past complaints or investigations would reveal information that should be reported to the Registrar.[345] In Chapter 11, we discuss examples of departments (including the Department of Justice and the former Department of Communities) not consistently reporting allegations of child sexual abuse received about current or former Ashley Youth Detention Centre staff. For this reason, we recommend in Chapter 12 an independent audit of past complaints and redress claims to ensure the Registrar has all relevant information they need to assess risk.

The Registration to Work with Vulnerable People Act requires that applications for the review of any decision or determination by the Registrar be made to the Administrative Appeals Division of the Magistrates Court.[346] Mr Graham told us he would support change to enable determinations to suspend or cancel registration be reviewed by the Tasmanian Civil and Administrative Tribunal.[347] We agree with this suggestion.

The Tribunal was created after the Registration to Work with Vulnerable People Act was introduced and we consider that its expertise in administrative law and its ability to provide appropriately qualified members to hear reviews makes it a more appropriate jurisdiction than the Magistrates Court for administrative reviews of determinations under the Registration to Work with Vulnerable People Act.[348] The introduction of a tribunal review process would also make Tasmania's approach consistent with that of other states and territories.[349]

Accordingly, we recommend that the Registration to Work with Vulnerable People Act be amended so that administrative reviews under the Act are undertaken by the Tasmanian Civil and Administrative Tribunal, instead of the Administrative Appeals Division of the Magistrates Court. Any legislative amendment should also require Tribunal members hearing administrative reviews of decisions under the Act to have the knowledge, skills, experience and aptitude to deal with each matter, including in relation to child sexual abuse, neglect and family violence.

We are aware that, where an applicant applies for a review of a determination of the Registrar to suspend, refuse or cancel their registration under the Registration to Work with Vulnerable People Act, there may be no person who opposes that application, whether the application is in the Magistrates Court or the Tasmanian Civil and Administrative Tribunal. We did not examine this issue in detail, and we are not making a formal recommendation about it. It is unclear to us whether the Registrar should be empowered to argue for such refusal, suspension or cancellation. This, however, may be an area where consideration could be given to providing a child affected by the registration, that child's representative, the Commission for Children and Young People or a government agency the authority to intervene and oppose such review applications.

In Chapter 11, we find that occasionally, the Registrar of the Registration to Work with Vulnerable People Scheme adopted too high an evidentiary threshold in assessing whether Ashley Youth Detention Centre staff with allegations against them posed an unacceptable risk to children. Mr Graham also told us there is a lack of statutory guidance regarding the power of the Registrar to suspend a person's registration. The Registrar is required to conduct an additional risk assessment of a registered person if they believe, on reasonable grounds, there is 'new, relevant information about that person'.[350] The Registrar is also empowered to suspend a person's registration while this risk assessment is undertaken, but there is no guidance on when and how that action should be taken.[351] Mr Graham told us he generally reserved this suspension power for situations where the new and additional information would likely prevent registration (for example, relating to a relevant criminal offence) or where he formed the view that the person posed an unacceptable risk and a suspension was justified while the cancellation process took place.[352]

The suspension of registration to work with vulnerable people can provide grounds for the termination of employment and Mr Graham reported that, at times, the Registrar has been pressured by agencies to suspend a person who is subject to an additional risk assessment.[353] Mr Graham accepted sometimes this was a desirable outcome but also often meant that employment direction investigations may cease before completion.[354] Mr Graham told us:

> The existence of such a power, the absence of clear legal test and the lack of appeal mechanism has caused confusion and had unintended behavioural responses from agencies.[355]

In Chapter 20, we discuss a tendency by departments to prefer managing concerns about conduct of staff through Employment Direction No. 6—Inability, which allows for a determination that an employee is unable to perform their duties because of a loss of registration, instead of managing concerns by conducting misconduct investigations.

We also discussed the response of the Registrar to information received about staff at Ashley Youth Detention Centre in Chapter 11. While we accept the Registrar was often working with limited or incomplete information, we saw examples of what we consider a high evidentiary threshold adopted in relation to suspensions. We make a finding in that case study that, on occasion, the Registrar of the Registration to Work with Vulnerable People Scheme appeared to adopt too high an evidentiary threshold in assessing whether staff at the Centre with allegations against them posed an unacceptable risk to children.

The Registration to Work with Vulnerable People Act is clear that the Registrar's assessment of whether a person poses an unacceptable risk to vulnerable persons is a predictive exercise to assess future risk to vulnerable persons, based on known facts and present circumstances.[356] Such an assessment does not need to be based on proof of previous harm to vulnerable persons. For example, the Registrar may consider a past allegation of child sexual abuse in their assessment despite not having substantiated, or being able to substantiate, that that allegation occurred 'on the balance of probabilities'.[357]

The broader understanding of a risk assessment under the Registration to Work with Vulnerable People Act is supported by the Second Reading Speech for the Registration to Work with Vulnerable People Bill which became the Act, which states that the Bill provides for a:

> … broader basis on which to conduct background checking that includes a person's criminal history, non-conviction information, relevant offences and other pertinent information.[358]

The concept of risk assessment and its predictive nature is not novel. It involves the evaluation of the likelihood of an event occurring, alongside gauging the magnitude of harm which may occur if the event occurs. The Registrar should decrease their threshold to determine whether to exercise their power under the Registration to Work with Vulnerable People Act to refuse or cancel registration as the risk that a person poses to vulnerable persons increases. That threshold should be lowered further in relation to a suspension of registration to protect vulnerable persons who may be at risk of harm while a comprehensive assessment of risk is undertaken.

We recommend that the Tasmanian Government provides the Registrar with guidelines for how risk assessments should be conducted. We further recommend that the Act be amended to provide that the principles outlined by the Federal Circuit and Family Court of Australia in the case named *Isles and Nelissen* regarding risk assessments be applied

by the Registrar in determinations of risk relating to registration, suspension and cancellation of registration under the Registration to Work with Vulnerable People Act.[359] That case considered the test relating to unacceptable risk under the Commonwealth *Family Law Act 1975* (Cth). It referred to:

> ...two separate questions ... on the one hand, whether or not allegations of abuse are proven on the balance of probabilities; and on the other, whether or not an unacceptable risk of harm is demonstrated, regardless of the finding made in respect of the frank allegations of abuse.[360]

That decision further held that the 'tendency rule has no work to do when assessing risk'.[361] This means the decision maker should not be precluded from considering evidence that might suggest a tendency of a person to abuse when assessing risk.

In Chapter 11, we also discuss instances where the Registrar had formed negative views about the complainants or sources of information to his office (in that instance, former detainees), including in some instances that complainants colluded or were financially motivated in seeking redress.[362] While we accept the Registrar is entitled and indeed required to apply judgment and discretion when assessing and weighing information, we consider it beneficial for this to be clearly guided by statute to limit the risks of personal value judgments (some of which may be based on myths and misconceptions or reflect societal stigma) in making assessments relating to child safety.

Recommendation 18.12

1. The Tasmanian Government should introduce legislation or regulations to provide statutory guidance to the Registrar of the Registration to Work with Vulnerable People Scheme on the factors to be considered when conducting risk assessments in respect of applications for registration, suspension or cancellation pursuant to the *Registration to Work with Vulnerable People Act 2013*.
2. The statutory guidance should provide that (among other things):
    a. the assessment of unacceptable risk is a predictive exercise that is not necessarily capable of empirical proof nor subject to a particular standard of proof such as 'the balance of probabilities'
    b. the assessment of unacceptable risk of harm to a child or children requires determination of two separate questions, without conflation, namely
        i. whether or not an allegation or allegations of previous harm to vulnerable people are proven on the balance of probabilities, and

ii. whether or not an unacceptable risk of harm is demonstrated regardless of whether there is a finding, on the balance of probabilities, that previous harm occurred

c. the Registrar is not limited in the factors they can consider in assessing unacceptable risk, including information that suggests a person's tendency to cause harm, as the ultimate determination of unacceptable risk is a predictive exercise

d. when the Registrar is considering suspending a person's registration, the focus on the prospective risk that a person may pose to children should have a lower evidentiary threshold, noting further assessment will likely occur prior to a decision to cancel registration or otherwise

e. once the Registrar makes a determination that a person poses an unacceptable risk to a child or young person, irrespective of other factors (such as employment or mental health), that person's registration must be refused, suspended or cancelled (as the case may be).

Recommendation 18.13

1. The Tasmanian Government should introduce legislation to amend the *Registration to Work with Vulnerable People Act 2013* and related statutory instruments to replace the Administrative Appeals Division of the Magistrates Court with the Tasmanian Civil and Administrative Tribunal as the forum for administrative reviews of decisions under the Act.
2. The Tasmanian Government should:

   a. introduce legislation or regulations to require the Tasmanian Civil and Administrative Tribunal to support Tribunal members who hear administrative reviews of decisions under the *Registration to Work with Vulnerable People Act 2013* to have the knowledge, skills, experience and aptitude to deal with each matter, including in relation to child sexual abuse, neglect and family violence

   b. provide sufficient funding to the Tribunal to support members to gain this knowledge, skills, experience and aptitude.

6.3 Coordinating oversight and regulation

As discussed, even with the establishment of the new Commission for Children and Young People, there will be instances where other bodies may need to assume responsibilities as they relate to child safety. For this reason, we recommend all these agencies work together to develop clear and user-friendly guidance describing their roles and responsibilities to help members of the public, and children and young people, to understand how they can raise concerns with these agencies and what to expect when they do. A single resource, including user friendly infographics, should be developed to support public understanding of the different roles and responsibilities of Tasmanian oversight bodies in relation to child safety. This includes reassurance and public commitment to a 'no wrong door' approach to complaints. This resource should be adapted for children and young people and form part of each agency's community education activities as they relate to promoting the safety of children and young people within Tasmanian organisations.

Recommendation 18.14

1. The Commission for Children and Young People, the Registrar of the Registration to Work with Vulnerable People Scheme, the Integrity Commission and the Ombudsman should work jointly to develop a user-friendly guide for the general public, which describes:
    a. how each of these agencies can assist with complaints and concerns about how organisations respond to child sexual abuse
    b. the process these agencies will adopt in responding to reports, complaints and concerns, including what outcomes these agencies are empowered to achieve
    c. how information provided by a person lodging a report, complaint or concern will be shared and managed
    d. that agencies are committed to a 'no wrong door' approach to complaints, so people are reassured that all reports, complaints and concerns will receive a response from an agency
    e. pathways for raising concerns about the way any of these agencies respond to reports, complaints or concerns.
2. A child and youth-friendly version of the guide should also be developed and should be publicised and distributed widely in schools, out of home care, youth justice and health settings.

3. Both guides should be available on each of the agencies' websites and form part of their child safety community education and engagement activities.
4. While the Commission for Children and Young People should be promoted as the key agency for receiving reports, complaints or concerns relating to conduct towards children, people should be able to raise reports, complaints or concerns with any of these agencies and these agencies should ensure the matter is appropriately referred (the 'no wrong door' approach).

6.4 Effective information sharing between oversight bodies

Effective information sharing is a crucial component of any child-centred system—not only to ensure risks to children and young people are effectively managed, but also to make certain responses by oversight or other agencies are clear and coordinated.

We examined the existing powers of the Commissioner for Children and Young People, Ombudsman and Integrity Commission to share information relevant to child safety, which we describe below:

- The Commissioner for Children and Young People is empowered to provide and request non-identifying information relating to a child or young person to and from an information-sharing entity.[363] An information-sharing entity may also, on its own initiative, provide the Commissioner with non-identifying information.[364] An 'information-sharing entity' is defined in the Commissioner for Children and Young People Act as having the same meaning as in the *Children, Young Persons and Their Families Act 1997*, and for our purposes includes a State Service officer or employee and other organisations providing health, disability and community services.[365] 'Non-identifying information' is defined as 'information in relation to a person that does not contain identifying details for the person or enable the identity of the person to be ascertained or discovered'.[366] An individual who provides this information does not breach professional standards or incur any criminal or civil liability.[367]
- The Ombudsman Act contains provisions that enable information disclosure. A person may disclose information to the Ombudsman's office where it relates to preliminary inquiries being made by the Ombudsman or to the making of a complaint or investigation by the Ombudsman.[368] The Ombudsman may also disclose information to a person exercising similar functions in another Australian jurisdiction, the Integrity Commission and the Custodial Inspector.[369] Protections are also available to the Ombudsman and its staff from criminal and civil proceedings for actions carried out in good faith under the Act.[370] There do not appear to be similar protections for complainants.

- The Integrity Commission Act contains provisions relating to referring and exchanging information. The Integrity Commission may refer a complaint to a public authority, integrity agency, Parliamentary integrity agency, the Commissioner of Police or any other person the Integrity Commission thinks appropriate for investigation and action.[371] 'Personal information custodians' are also authorised to disclose personal information to the Integrity Commission under the *Personal Information Protection Act 2004*.[372] The definitions provide that 'personal information custodians' include government agencies.[373]
- The Registration to Work with Vulnerable People Act contains provisions allowing the Registrar of the Registration to Work with Vulnerable People Scheme to require a range of Tasmanian entities, as well as certain bodies outside Tasmania, with information it reasonably considers relevant to its powers and functions.[374] The Registrar is also empowered to disclose particular information to a registering authority or prescribed entity (for example, agencies within the meaning of the State Service Act and Tasmania Police).[375]

We heard there are no consistent formal arrangements for information sharing between the Commissioner of Children and Young People, the Ombudsman and the Integrity Commission, with the determination of who is best placed to deal with a particular complaint often managed on a case-by-case basis.[376] Mr Easton said the Integrity Commission has memoranda of understanding with various entities, including Tasmania Police and the Auditor-General. For information sharing between the Integrity Commission and the Ombudsman, Mr Connock and Mr Easton said they would generally resolve informally which of their agencies are best placed to manage a complaint where their interests intersect.[377] Mr Connock felt informal information-sharing arrangements worked well: 'So we have a good idea, having been doing it for a while, where things should go'.[378]

While we do not underestimate the benefit of informal and practical approaches to information sharing between agencies, we consider it a risk for information of such importance to be left to the experience and good judgment of individuals. This creates a risk that complaints or enquiries fall between the cracks where they do not neatly fit the definitions of this complex model, or they are considered in a fragmented or piecemeal manner by several entities, limiting the ability to give appropriate visibility to the risks to child safety posed overall. We consider there is benefit in the Ombudsman, Integrity Commission, Registrar of the Registration to Work with Vulnerable People Scheme and the new Commission for Children and Young People to have clear and formalised information-sharing agreements to underpin their informal practices. This is particularly the case if the new Commission for Children and Young People receives oversight functions and powers under our recommendations and under the Child and Youth Safe Organisations Act, which has extensive information-sharing provisions in Part 5.

Generally (and considering the views of a complainant), we consider:

- The Commission for Children and Young People should lead matters that relate to its responsibilities to monitor and enforce the Child and Youth Safe Standards and the Reportable Conduct Scheme for relevant organisations and its responsibilities to oversee and monitor incidents in the youth detention and out of home care systems.
- The Integrity Commission should lead the response to complaints about misconduct and serious misconduct by public officers (which may include child sexual abuse) that are not otherwise captured by the Commission for Children and Young People's functions (for example, relating to agencies that are not legislatively required to comply with Child and Youth Safe Standards or the Reportable Conduct Scheme).
- The Ombudsman should lead the management of formal individual complaints about the administrative actions of a public authority that do not constitute reportable allegations.
- The Registrar of the Registration to Work with Vulnerable People Scheme should assess the suitability of individuals to work with, and alongside, children and young people. This assessment should be ongoing and subject to any additional information received about a registered individual.

Recommendation 18.15

The Commission for Children and Young People, the Integrity Commission, the Ombudsman and the Registrar of the Registration to Work with Vulnerable People Scheme should develop a formal memorandum of understanding relating to the management and oversight of reports, complaints and concerns relating to child sexual abuse and information sharing. The memorandum of understanding should:

a. define the roles, responsibilities, functions and limitations of each agency and describe where these overlap or intersect

b. require consultation prior to the initiation of systemic reviews or inquiries where the subject of that inquiry relates to areas of common interest or intersecting functions

c. provide for permissive and enabling information-sharing practices that prioritise the safety and welfare of children for individual matters and ensure each party receives from others de-identified trend data necessary to perform its functions.

7 Conclusion

Our Commission of Inquiry has established that Tasmanian children and young people are not as safe as they could be within organisations tasked with their care—including schools, health services, out of home care and youth detention. We recommend addressing specific risks and problems we identified in those specific settings, but firmly consider the foundations of child safety within organisations needs to improve across the board.

The primary objective for organisations should be to prevent child sexual abuse occurring in the first place. We consider this is best achieved through a combination of strategies, which includes robust community-wide education about the dynamics and risk factors associated with sexual abuse. We recommend the Tasmanian Government continues to work with the Australian Government to maximise the benefit of national prevention initiatives and ensure they are fit for purpose in Tasmania. In our chapter on children in the education system, we recommended specific preventative programs targeting school students.

We also consider that organisations must be proactive in developing policies and practices that target the specific risks of sexual abuse that arise in their setting, and consider legislated Child and Youth Safe Standards to be the best mechanism to ensure this occurs and endures.

We accept that no child safe system will be perfect. For this reason, it is critical to have robust and transparent processes to ensure any complaints and concerns that arise within organisations are dealt with quickly and prioritise the safety and wellbeing of children and young people. Responding to child safety concerns is not easy. Organisations will benefit from guidance and support. To ensure this occurs, and to ensure the integrity of investigative processes, we consider a reportable conduct scheme—which ensures there is appropriate support and oversight into organisational responses to complaints or concerns—is also an essential element to improving safety for organisations with the most direct contact with children and young people.

Working in tandem, we consider these regulatory schemes will improve safety for Tasmanian children and young people and build community trust and confidence in processes to register complaints and concerns individuals may have about the safety of children.

Having an empowered, well-resourced and suitably skilled Independent Regulator will be integral to the success of these schemes. We heard from experts in Victoria and New South Wales about the factors that made those jurisdictions' implementation of Child Safe Standards and a reportable conduct scheme successful. We also learned about the necessary functions and features of an effective oversight body in the context of child safety.

We consider the best way to support Tasmanian organisations to be safe for children and to provide oversight and scrutiny to particularly high-risk groups (including those in the out of home care system and within youth detention) is for Tasmania to establish a new Commission for Children and Young People, with a broader suite of powers and functions than those of the current Commissioner for Children and Young People. We also recommend establishing a dedicated role to promote the interests, wellbeing and cultural safety of Aboriginal children and young people.

A new Commission for Children and Young People should assume the monitoring and oversight functions of the Independent Regulator for the Child and Youth Safe Organisations Act. It should have specific powers to monitor and investigate concerns relating to the out of home care and youth justice systems. The new Commission should be fiercely independent, appropriately resourced and sufficiently empowered to lead genuine change across Tasmania. We make several recommendations directed at supporting this goal.

We consider the Child and Youth Safe Standards and the Reportable Conduct Scheme operating in tandem and overseen by a well-resourced and empowered Independent Regulator, will go a long way towards reducing the need for recourse to other oversight bodies, such as the Integrity Commission and the Ombudsman. However, these bodies may still play a role, particularly in addressing specific complaints and targeting broader systemic risk factors within organisations that can increase risks of abuse, particularly as they relate to misconduct, poor decision-making and tolerance for poor behaviour and practice. We consider it will likely increase the level and quality of information available to inform decisions of the Registrar of the Registration to Work with Vulnerable People Scheme. For this reason, we recommend the Ombudsman, Integrity Commission, Registrar of the Registration to Work with Vulnerable People Scheme and a new Commission for Children and Young People clarify and formalise their respective functions and information-sharing arrangements, and ensure these are clear to the community. We also recommend further clarifying the powers of the Registrar of the Registration to Work with Vulnerable People Scheme to suspend individuals when taking additional risk assessments relating to registered individuals.

We hope that over time, recourse to oversight bodies will be reduced, as organisations' proactive efforts to prevent abuse greatly reduce harm to children and ensure any complaints and concerns are managed quickly and effectively by the organisation at the earliest opportunity. We expect this to occur as Child and Youth Safe Standards and the Reportable Conduct Scheme become more thoroughly embedded across Tasmanian organisations. However, we consider there will always be a need for oversight bodies to be vigilant to risks to child safety and responsive to concerns about managing those risks.

Notes

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21 Jess Rodgers et al, *Sexual Violence in Southern Tasmania: Research Report for Sexual Assault Support Service Tasmania* (Tasmanian Institute of Law Enforcement Studies, University of Tasmania and Sexual Assault Support Service, July 2022) viii.

22 Jess Rodgers et al, *Sexual Violence in Southern Tasmania: Research Report for Sexual Assault Support Service Tasmania* (Tasmanian Institute of Law Enforcement Studies, University of Tasmania and Sexual Assault Support Service, July 2022) 46.

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42 Statement of Donald Palmer, 12 April 2022, 6 [25].

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45 Statement of Michael Guerzoni, 29 April 2022, 10 [33].

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111 *Royal Commission into Institutional Responses to Child Sexual Abuse* (Final Report, 2017) vol 7,51.

112 *Royal Commission into Institutional Responses to Child Sexual Abuse* (Final Report, 2017) vol 7,19, 51, 105, 242, 247.

113 *Royal Commission into Institutional Responses to Child Sexual Abuse* (Final Report, 2017) vol 7, 57; see for example s 16O of the *Child Wellbeing and Safety Act 2005* (Vic), which provides the Commission for Children and Young People in Victoria powers to investigate reportable conduct on its own motion.

114 *Royal Commission into Institutional Responses to Child Sexual Abuse* (Final Report, 2017) vol 7,19, 51, 242, 247.

115 *Royal Commission into Institutional Responses to Child Sexual Abuse* (Final Report, 2017) vol 7,249.

116 *Royal Commission into Institutional Responses to Child Sexual Abuse* (Final Report, 2017) vol 7, 84.

117 *Royal Commission into Institutional Responses to Child Sexual Abuse* (Final Report, 2017) vol 7, 24, 7.9.

118 *Child Wellbeing and Safety Act 2005* (Vic) pt 5A; *Children's Guardian Act 2019* (NSW) pt 4; *Parliamentary Commissioner Act* 1971 (WA) div 3B; *Ombudsman Act 1989* (ACT) pt 2.

119 *Royal Commission into Institutional Responses to Child Sexual Abuse* (Final Report, 2017) vol 7, 247.

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121 Statement of Kathryn Fordyce, 3 May 2022, 26 [83].

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123 Statement of Stephen Kinmond, 29 March 2022, 11 [49–50].

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128 *Child Safety and Wellbeing Act 2005* (Vic) schs 3–5.

129 This is defined to include reportable conduct or misconduct that may involve reportable conduct, whether or not that was alleged to have occurred within the person's employment: *Child Safety and Wellbeing Act 2005* (Vic) s 3.

130 *Child Safety and Wellbeing Act 2005* (Vic) s 16K.

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134 Commission for Children and Young People Victoria, *Guidance for Organisations: Investigating a Reportable Conduct Allegation* (June 2018) 8.

135 *Child Safety and Wellbeing Act 2005* (Vic) s 16M(1)(b).

136 *Child Safety and Wellbeing Act 2005* (Vic) s 16N(3).

137 *Child Safety and Wellbeing Act 2005* (Vic) s 16M(4).

138 *Child Safety and Wellbeing Act 2005* (Vic) s 16N.

139 *Child Safety and Wellbeing Act 2005* (Vic) s 16N(2).

140 *Child Safety and Wellbeing Act 2005* (Vic) s 16P.

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143 *Briginshaw v Briginshaw* (1938) 60 CLR 336.

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153 Statement of Liana Buchanan, 4 May 2022, 24 [90].

154 Statement of Liana Buchanan, 4 May 2022, 20 [69(a)].

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156 Statement of Liana Buchanan, 4 May 2022, 20 [69(c)].

157 Statement of Liana Buchanan, 4 May 2022, 21 [72].

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161 Statement of Stephen Kinmond, 29 March 2022, 12 [57].

162 Transcript of Stephen Kinmond, 6 May 2022, 518 [33–34].

163 Transcript of Stephen Kinmond, 6 May 2022, 518 [42–47].

164 Statement of Stephen Kinmond, 29 March 2022, Attachment SK-02 (NSW Ombudsman, 'Extract of submission to the National Royal Commission relating to its reportable conduct scheme', undated) 1.

165 Statement of Stephen Kinmond, 29 March 2022, Attachment SK-02 (NSW Ombudsman, 'Extract of submission to the National Royal Commission relating to its reportable conduct scheme', undated) 10.

166 Statement of Stephen Kinmond, 29 March 2022, 5 [19].

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171 Statement of Stephen Kinmond, 29 March 2022, 5 [20].

172 Statement of Stephen Kinmond, 29 March 2022, 8 [35].

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192 *Child and Youth Safe Organisations Act 2023* s 16.

193 *Child and Youth Safe Organisations Act 2023* s 17.

194 *Child and Youth Safe Organisations Act 2023* pt 6.

195 *Child and Youth Safe Organisations Act 2023* s 7.

196 *Child and Youth Safe Organisations Act 2023* s 34.

197 *Child and Youth Safe Organisations Act 2023* sch 3.

198 *Child and Youth Safe Organisations Act 2023* s 22.

199 *Child and Youth Safe Organisations Act 2023* s 23.

200 *Child and Youth Safe Organisations Act 2023* ss 11, 12.

201 *Child and Youth Safe Organisations Act 2023* s 13.

202 *Child and Youth Safe Organisations Act 2023* ss 3, 9.

203 *Child and Youth Safe Organisations Act 2023* s 10(2).

204 Department of Justice, 'Information Package - Independent Regulator - Child and Youth Safe Organisations Framework', *Expressions of Interest* (Web Page) <https://www.justice.tas.gov.au/eoi/previous_adverts/independent-regulator-child-and-youth-safe-organisations-framework/information-package>.

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207 *Child and Youth Safe Organisations Act 2023* s 40.

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209 *Child and Youth Safe Organisations Act 2023* s 2; State of Tasmania, *Procedural Fairness Response*, 20 June 2023, 6.

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234 Statement of Emily Sanders, 5 May 2022, 4 [18].

235 Statement of Liana Buchanan, 4 May 2022, 24 [87]; Statement of Emily Sanders, 5 May 2022, 4 [19].

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280 *Commissioner for Children and Young People Act 2016* s 8(3).

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289 Statement of Andrea Sturges, 16 June 2022, 24–27 [102].

290 Commissioner for Children and Young People, *Procedural Fairness Response*, 1 June 2023, 7–8.

291 Statement of Mark Morrissey, 9 August 2022, 19 [120], 26 [169].

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296 Integrity Commission, *Procedural Fairness Response*, 23 May 2023, 3.

297 Transcript of Liana Buchanan, 6 May 2022, 523 [9–16].

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299 *Commissioner for Children and Young People Act 2006* (WA) s 7(2).

300 *Commissioner for Children and Young People Act 2006* (WA) s 7(3).

301 *Integrity Commission Act 2009* s 15(1), (2).

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303 *Integrity Commission Act 2009* s 17(1), (2).

304 United Nations, *Principles Relating to the Status of National Institutions*, GA Res 48/134, UN Doc A/RES/48/134 (20 December 1993) ('The Paris Principles').

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307 Transcript of Richard Connock, 5 May 2022, 429 [37–39].

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312 Commissioner for Children and Young People, *Procedural Fairness Response*, 1 June 2023, 9.

313 *Commissioner for Children and Young People Act 2016* s 6(2).

314 *Commissioner for Children and Young People Act 2016* s 6(3).

315 Statement of Leanne McLean, 12 April 2022, 11 [38]. Commissioner McLean referred to a principle under the *State Service Act 2000* according to which the State Service must be 'responsive to the Government in providing honest, comprehensive, accurate and timely advice and in implementing the Government's policies and programs': *State Service Act 2000* s 7(1)(e).

316 Statement of Leanne McLean, 12 April 2022, 10–11 [34].

317 *Integrity Commission Act 2009* s 20; *Ombudsman Act 1978* s 9.

318 *Commissioner for Children and Young People Act 2016* (Vic) s 21(1); *Family and Child Commission Act 2014* (Qld) s 24(2).

319 Statement of Penny Wright, 6 June 2022, 37 [171].

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322 *Children and Young People (Oversight and Advocacy Bodies) Act 2016* (SA) ss 12(2), 20F(2).

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324 Joint Standing Committee on the Commissioner for Children and Young People, *Annual Report 2020–2021* (Report 1, 16 September 2021) 5.

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326 *Children's Guardian Act 2019* (NSW) s 8AC.

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328 *Integrity Commission Act 2009* s 24(1)(a)–(c).

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334 Tasmanian Government Response, *Independent Review of the Integrity Commission Act 2009* (Report, November 2016) 14.

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336 Statement of Peter Graham, 15 August 2022, 1.

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342 Statement of Peter Graham, 15 August 2022, 10.

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345 Statement of Peter Graham, 15 August 2022, 10.

346 *Registration to Work with Vulnerable People Act 2013* s 53.

347 Transcript of Peter Graham, 24 August 2022, 3230 [31–39].

348 *Tasmanian Civil and Administrative Tribunal Act 2020*.

349 *Child Protection (Working with Children) Act 2012* (NSW) s 27; *Worker Screening Act 2020* (Vic) s 105; *Working with Children (Risk Management and Screening) Act 2000* (QLD) s 354; *Child Safety (Prohibited Persons) Act 2016* (SA) s 43; *Working with Children (Screening) Act 2004 (WA)* s 26; *Working with Vulnerable People (Background Checking) Act 2011 (ACT)* s 63.

350 Statement of Peter Graham, 15 August 2022, 10.

351 Statement of Peter Graham, 15 August 2022, 10.

352 Statement of Peter Graham, 15 August 2022, 10.

353 Statement of Peter Graham, 15 August 2022, 10.

354 Statement of Peter Graham, 15 August 2022, 10.

355 The existence of such a power, the absence of clear legal test and the lack of appeal mechanism has caused confusion and led to unintended behavioural responses from agencies.

356 *Registration to Work with Vulnerable People Act 2013* ss 2A(c), 25, 49.

357 Refer to the decision of the Federal Circuit and Family Court of Australia in *Isles and Nelissen*, which considered the test relating to unacceptable risk under the related Commonwealth legislation, the *Family Law Act 1975* (Cth). That decision referred to 'two separate questions … on the one hand, whether or not allegations of abuse are proven on the balance of probabilities; and on the other, whether or not an unacceptable risk of harm is demonstrated, regardless of the finding made in respect of the frank allegations of abuse': *Isles and Nelissen* [2022] FedCFamC1A 97 at [83]. That decision further held that the 'tendency rule has no work to do when assessing risk'; *Isles and Nelissen* [2022] FedCFamC1A 97 at [104].

358 Tasmania, *Parliamentary Debates*, House of Assembly, 14 November 2013, 120 (Cassy O'Connor, Minister for Human Services).

359 *Isles and Nelissen* [2022] FedCFamC1A 97. Refer also to the English case of *H & Ors* [1996] AC 563, which concerned the question of whether a particular child was 'likely to suffer significant harm' pursuant to a risk assessment under the *Children Act 1989* (UK). In his dissenting opinion, Lord Browne-Wilkinson concluded that such a risk assessment 'does not require the court to find that such harm is more likely than not: it is enough if the occurrence of such harm is a real possibility': *H & Ors* [1996] AC 563, 572. Lord Browne-Wilkinson went on to state that 'to be satisfied that an event has occurred or is occurring the evidence has to show on balance of probabilities that such event did occur or is occurring. But in order to be satisfied that there is a risk of such an occurrence, the ambit of the relevant facts is in my view wider': *H & Ors* [1996] AC 563, 572.

360 *Isles and Nelissen* [2022] FedCFamC1A 97 at [83].

361 *Isles and Nelissen* [2022] FedCFamC1A 97 at [104].

362 Statement of Peter Graham, 15 August 2022, Annexure D, 5.

363 *Commissioner for Children and Young People Act 2016* s 16(2).

364 *Commissioner for Children and Young People Act 2016* s 16(3).

365 *Children, Young Persons and Their Families Act 1997* s 3.

366 *Commissioner for Children and Young People Act 2016* ss 4, 16(1).

367 *Commissioner for Children and Young People Act 2016* s 16(4).

368 *Ombudsman Act 1978* s 17.

369 *Ombudsman Act 1978* s 26(3)–(3B).

370 *Ombudsman Act 1978* s 33.

371 *Integrity Commission Act 2009* ss 39, 40, 41, 42, 43.

372 *Integrity Commission Act 2009* s 102.

373 *Personal Information Protection Act 2004* s 3; *Right to Information Act 2009 s* 3.

374 *Registration to Work with Vulnerable People Act 2013* ss 52A(1), 52A(3).

375 *Registration to Work with Vulnerable People Act 2013* ss 52B(2)(3).

376 Transcript of Richard Connock, Michael Easton and Leanne McLean, 5 May 2022, 422 [35]–423 [45].

377 Transcript of Richard Connock and Michael Easton, 5 May 2022, 422 [42–43], 423 [21–27].

378 Transcript of Richard Connock, 5 May 2022, 423 [17–18].

19 A coordinated approach

1 Introduction

An effective approach to preventing, identifying and responding to child sexual abuse in institutions requires a coordinated and sustained commitment across government and government funded agencies and statutory bodies. In this chapter, we outline what we consider is needed to ensure there is a united approach to child safety issues across the Tasmanian Government. We recommend developing a child sexual abuse reform strategy and action plan to:

- bring together an extensive reform agenda
- hold government, government funded agencies and statutory bodies to account for their responsibilities in implementing child sexual abuse reforms
- help victim-survivors and their families, the community, and government and non-government agencies understand what is being done to address child sexual abuse in Tasmania.

We also recommend strengthened leadership, accountability and governance mechanisms to oversee this strategy and action plan, which, among other things, will ensure children and young people and adult victim-survivors of child sexual abuse can inform government policy and reform work.

We also discuss the challenge of sharing information and coordination between agencies relating to child safety issues in Tasmania. We recommend any legislative barriers that hinder the sharing of information to protect the safety and wellbeing of children be identified and removed. To address cultural barriers to information sharing and further support responses to child safety issues, we also recommend the development of child safety information sharing, coordination and response guidelines that clearly set out the roles and responsibilities of agencies in responding to child safety concerns.

2 A fragmented system

As part of our inquiries, we asked the Tasmanian Government to describe its current service system—including services, initiatives, policies and procedures—related to preventing, identifying, reporting and responding to allegations or incidents of child sexual abuse in institutional contexts.[1] Rather than receiving one coordinated response to this request that described the system across the whole of government, we received separate and varied responses from individual government departments including the:

- former Department of Communities, which produced a summary document and 109 attachments[2]
- former Department of Education (now the Department for Education, Children and Young People), which produced a summary document and 35 attachments[3]
- Department of Health, which produced a summary document and no attachments[4]
- Department of Justice, which produced a summary document and one attachment[5]
- Department of Police, Fire and Emergency Management, which produced a summary document and 18 attachments.[6]

Our observations following a review of these responses were that:

- they listed or summarised policy documents and initiatives without explaining how they intersected or operated in practice, which made it difficult for us to understand the linkages between policies or to situate initiatives within the Government's broader system response to child sexual abuse[7]
- most material referred to in the responses appeared to be directed towards child abuse and neglect more broadly, particularly familial abuse, and there was limited material within the responses that specifically contemplated child sexual abuse in institutional contexts

- a proportion of the material supplied as part of the responses, particularly policies, was past its stated review date or did not have a review date, so it was not clear whether the material remained operational, had been superseded by new material, or was no longer in use[8]
- some source material supplied as part of the responses was not signed or dated, which made it difficult for us to know whether particular documents had been executed and when they came into operation.[9]

Our concern extends beyond the format in which the information was provided. Our overall conclusion after reviewing the responses is that the Government could not clearly articulate a cohesive system for preventing, identifying, reporting and responding to allegations and incidents of child sexual abuse in institutions. Instead, it described elements of a service system without setting out how the system is intended to operate across the whole of government and intersect with other service systems, recognising the issues affecting children and young people do not occur in a silo and often cut across several portfolios.[10] We acknowledge that many of the policies Tasmanian Government departments initially produced to our Commission of Inquiry have since been or are being updated.

Leanne McLean, Commissioner for Children and Young People, expressed a similar view to ours, describing the features of Tasmania's current system response to institutional child sexual abuse as:

> … a disconnected patchwork of systems and processes which, despite their good intent, fail to provide an integrated and systemic approach to keeping children safer from abuse in institutional settings. The flow on effects of the current system are that navigation by the public and agencies is difficult, there is little to no coordination or communication between regulatory agencies and there is no central body with responsibility for systemic oversight.[11]

Similarly, in consultations where we asked what was working well in the system that responds to child sexual abuse, participants expressed frustration that there was no system, or that the system was not well coordinated.[12]

We outline in Chapter 2 what we understand to be the current system for responding to child sexual abuse in institutional contexts. It took considerable work on our part to decipher this system. As described in that chapter, we understand the system covers:

- organisations, including:
    - the Child Safety Service
    - Tasmania Police
    - Registration to Work with Vulnerable People Scheme

- professional registration bodies, including:
    - Australian Health Practitioner Regulation Agency ('Ahpra')
    - Teachers Registration Board
- oversight bodies, including:
    - Commissioner for Children and Young People
    - Ombudsman
    - Integrity Commission
    - Auditor-General.

The system for responding to child sexual abuse in institutional contexts also encompasses sexual assault support services, the criminal justice system and the civil justice system, which includes the National Redress Scheme. Lastly, the system includes the processes through which specific government institutions—such as schools, out of home care, youth detention and health services—prevent, identify and respond to child sexual abuse.

3 Developing a child sexual abuse reform strategy and action plan

In Chapter 2, we discussed several national strategies and frameworks relevant to child safety and child sexual abuse. We also identified Tasmanian strategies, frameworks and action plans that outline whole of government approaches to issues affecting children and young people, including their safety and wellbeing. These national and local strategies and frameworks should inform Tasmania's approach to child sexual abuse, including in government institutions. In this section, we outline the Tasmanian Government's current policy approach to child sexual abuse. We recommend a child sexual abuse reform strategy and action plan be developed to bring together an extensive reform agenda, provide information and guidance to victim-survivors and their families and the community about what is being done by the Government to specifically address child sexual abuse in Tasmania, and to hold government and government funded agencies and statutory bodies to account for their responsibilities in implementing child sexual abuse reforms. As Kathrine Morgan-Wicks, Secretary, Department of Health, told us:

> Successful reform will require a multi-faceted and integrated response across Government, strong leadership, and clear governance and accountability on a whole of government level. Clear and consistent information and advice must be provided across government.[13]

These sentiments were echoed by Jan Shuard PSM, Family Violence Reform Implementation Monitor for the Victorian Royal Commission into Family Violence:

> I consider that, to avoid reliance on a single person for change, responsibility for reform needs to go beyond ministers and portfolios or agencies and be driven by a 'whole of government' approach across institutional settings, culture, procedure and policy.[14]

As we have acknowledged elsewhere in our report, cultural change is central to protecting children from child sexual abuse in institutions and ensuring that if it occurs, it is responded to appropriately.

3.1 Tasmania's Family and Sexual Violence Action Plan

The Tasmanian Government's primary policy approach to child sexual abuse and harmful sexual behaviours is its Family and Sexual Violence Action Plan. There have been three iterations of this plan since 2015:

- *Safe Homes, Safe Families: Tasmania's Family Violence Action Plan 2015–2020*[15]
- *Safe Homes, Families, Communities: Tasmania's Action Plan for Family and Sexual Violence 2019–2022*[16]
- *Survivors at the Centre: Tasmania's Third Family and Sexual Violence Action Plan 2022–2027* ('Survivors at the Centre').[17]

The first plan focused solely on family violence. However, the second and third iterations have included 'sexual violence', which is broadly defined in the following way:

> Sexual violence is a behaviour of a sexual nature directed towards a person that makes them feel uncomfortable, distressed or threatened, and to which they have not consented. Sexual violence includes a wide range of unwanted, non-consensual, traumatic and harmful sexual behaviours.
>
> Sexual violence includes sexual harassment, technology facilitated abuse, unwanted kissing or sexual touching, coercion, sexual assault including rape, child sexual abuse and child sexual exploitation, and stealthing (removal of a condom without consent).[18]

The family and sexual violence plans are accompanied by annual 'responding and reporting' reports, which outline key achievements under the plans.[19] There is also a practice guide, which primarily focuses on adult victim-survivors and perpetrators of family and sexual violence. The guide provides some information about support pathways for children and young people, mostly in relation to family violence.[20]

The Government has indicated the family and sexual violence plans address the implementation of many of the National Royal Commission's recommendations about responding to child sexual abuse in institutions and harmful sexual behaviours.[21]

The most recent plan, Survivors at the Centre, was released in November 2022. It represents the Government's response to the *National Plan to End Violence Against Women and Children 2022–2032* ('National Family Violence Plan').[22]

3.2 Developing a strategy for child sexual abuse

Survivors at the Centre states it 'has been developed in the context of the Commission of Inquiry into the Tasmanian Government's Response to Child Sexual Abuse in Institutional Settings' and that the 'Tasmanian Government is deeply committed to learning from the past, hearing the stories of victim-survivors, and ensuring that children and young people are safeguarded now and into the future'. However, our review of the plan and earlier iterations reveals that many of its actions do not specifically respond to or address child sexual abuse, child sexual abuse in institutional settings or harmful sexual behaviours.[23] Of the 38 actions in Survivors at the Centre, only the following actions appear to directly relate to child sexual abuse:

- Pilot the establishment of two Multidisciplinary Centres in the North and South of the State to provide survivor-centred, holistic and integrated responses to family and sexual violence.[24]
- Provide historic increased core funding to Tasmania's specialist family and sexual violence services with five-year contracts to enable funding certainty.[25]
- Effectively embed Respectful Relationships and Consent Education in Tasmanian schools and develop a suite of resources informed by key stakeholders and children and young people that builds understanding of consent, coercive control and grooming in the Tasmanian community.[26]
- Continue to deliver the Harmful Sexual Behaviours Program for children and young people.[27]
- Establish Tasmania's first victim-survivor advisory council, which will include victim-survivors of family and sexual violence and adults who may have experienced child sexual abuse as well as family and friends of victims who have lost their lives to family and sexual violence.[28]

Other actions that could affect the response to child sexual abuse, depending on how the action is interpreted, include:

- Expand the scope of the Safe Families Coordination Unit to undertake whole of government data coordination and integration for family and sexual violence.[29]
- Provide next generation technology and instruments for forensic scientists to ensure higher quality evidence for court proceedings, and increase capacity for storage of evidence, including sexual evidence kits.[30]
- Establish a family and sexual violence liaison service within the Tasmanian Health Service, which will provide Family Violence Liaison Officers statewide to support clients who identify as experiencing family and sexual violence to access services.[31]

- Investigate the establishment of a Tasmanian Family and Sexual Violence Peak to improve coordination of family and sexual violence services and advice on policy development and service design.[32]
- Continue to provide legal assistance to people experiencing family and sexual violence.[33]
- Deliver funding for community-based projects to support inclusion, access and equity to support diverse Tasmanians who experience barriers for accessing support for family and sexual violence.[34]
- Continue the Hearing Lived Experience 2022 Survey of Victim-Survivors of Family and Sexual Violence to inform implementation of the action plan and provide a comprehensive data set of victim-survivor experiences.[35]

Survivors at the Centre also commits to a program of measurement, evaluation and learning, which will be formalised into an Outcomes Framework that will be 'co-designed with victim-survivors, the family and sexual violence service system and community members, and will be delivered in the second year of [the] Action Plan'.[36] The current plan does not outline the governance arrangements in place to oversee the implementation of actions in the plan, despite such arrangements having appeared in an earlier iteration.[37]

In our view, Survivors at the Centre, in its current form, is not sufficiently targeted towards child sexual abuse, child sexual abuse in institutions and harmful sexual behaviours. It does not contemplate reform work the Government announced in response to our Commission of Inquiry, including:

- the Premier's priorities for action to keep children safe (also known as the *Keeping Children Safer Actions* that are summarised in Chapter 2)
- establishing the Child and Youth Safe Standards
- establishing the Reportable Conduct Scheme

These are key elements of a response to child sexual abuse in institutions.[38]

The plan also does not align with a contemporary understanding of child sexual abuse and family violence. The National Family Violence Plan acknowledged that 'many of the risk factors and experiences of child abuse and neglect align closely with violence against women and children'.[39] However, the National Family Violence Plan recognised the need for two distinct approaches to family violence and child sexual abuse because:

> Sexual violence perpetrated against children below the age of consent is child sexual abuse. Although these issues are interrelated, the Commonwealth's child sexual abuse response is covered by the National Strategy to Prevent and Respond to Child Sexual Abuse 2021–2030. *The drivers and impacts of child sexual abuse can be vastly different to those of adult sexual abuse, and they require different responses* [emphasis is ours].[40]

As a result, the Australian Government has two separate approaches to these issues that sit side-by-side:

- *National Plan to End Violence Against Women and Children 2022–2032*
- *National Strategy to Prevent and Respond to Child Sexual Abuse 2021–2030.*[41]

This latter strategy encompasses all child sexual abuse, regardless of the context in which it occurs. We consider Tasmania should take a similar approach and develop its own child sexual abuse reform strategy. The Australian Childhood Maltreatment Study has shown the scale of the problem of child sexual abuse (including child sexual abuse in institutions) in Australia. This study found an overall national prevalence of child sexual abuse in Australia of 28.5 per cent, and a prevalence of child sexual abuse in Australia of 25.7 per cent among those surveyed who were aged 16–24.[42] We consider a standalone strategy is not only justified but warranted. We note that in developing a separate reform strategy to respond to child sexual abuse, Tasmania would model a best practice whole of government response to child sexual abuse for other states and territories in Australia.

Tasmania's child sexual abuse reform strategy should align with the National Strategy to Prevent and Respond to Child Sexual Abuse and existing strategies and frameworks relating to children and young people that the Government has already developed. Taking this approach will provide information and guidance to victim-survivors and their families, the community and government and government funded agencies and statutory bodies on what is being done to address and respond to child sexual abuse, child sexual abuse in institutions and harmful sexual behaviours in Tasmania. It will ensure these agencies and statutory bodies meet their obligations. It will also ensure the different drivers associated with child sexual abuse (including in institutional settings) and harmful sexual behaviours are being appropriately addressed and are not lost within a much broader approach to family and sexual violence. Importantly, it will act as a safety net for the Government to be self-assured it has a coordinated whole of government approach to creating, monitoring and improving its response to child sexual abuse.

The Government has committed to an extensive reform agenda in relation to child sexual abuse in institutions. This reform agenda includes implementing:

- recommendations from the *National Royal Commission*
- recommendations from the *Independent Inquiry into the Tasmanian Department of Education's Responses to Child Sexual Abuse*
- *Keeping Children Safer Actions*
- recommendations from the *Child Safe Governance Review of the Launceston General Hospital and Human Resources* and the *Launceston General Hospital Community Recovery Initiative*
- recommendations from our Commission of Inquiry.[43]

These reforms should be captured in the child sexual abuse reform strategy.

This strategy should outline a 'theory of change', that is, the system for preventing, identifying and responding to child sexual abuse that Tasmania is seeking to achieve, including the component parts of that system, how Tasmanians will know it is working, and the role of different reforms and recommendations in achieving the intended outcomes.

The strategy should address many of the matters we raise across our report or that are essential elements of a whole of government strategy. These elements include:

- identifying guiding principles
- ensuring empowerment of children
- defining key concepts
- addressing diversity
- outlining key reform agendas.

The development of the child sexual abuse reform strategy and action plan will benefit from consultation. In Chapter 21, we recommend establishing a peak body for the sexual assault service system. In developing the strategy and action plan, the Government should consult with the:

- peak body
- Premier's Youth Advisory Council
- adult victim-survivors of child sexual abuse advisory group we recommend be established later in this chapter.

3.3 Developing an action plan for child sexual abuse reform

Implementing an extensive reform agenda requires coordinated planning and prioritisation across the whole of government.

Tim Cartwright APM, inaugural Family Violence Reform Implementation Monitor for the Victorian Royal Commission into Family Violence from August 2016 until August 2019, told us that although there is often a degree of urgency to implementing recommendations after a royal commission, implementation must be undertaken in a way that is designed to 'build a path to sustainable change'.[44] A key step in this process is developing a detailed implementation plan.[45]

Mr Cartwright told us, in relation to implementing royal commission recommendations, it was important for an implementation plan to identify:

- intended completion dates for each recommendation
- the agency or government department responsible for each recommendation
- any milestones, dependencies and priority actions.[46]

Mr Cartwright said that in his role as the inaugural Family Violence Reform Implementation Monitor, '[t]he absence of this information made it very difficult to report on progress against individual recommendations'.[47] We consider similar principles also apply to implementing a reform strategy.

Ms Shuard emphasised the importance of understanding the intended outcomes of proposed reforms and the various roles that many departments play in achieving those reforms:

> Reform requires the involvement of multiple agencies and departments. Implementing change is about everybody understanding how new elements fit into the overall existing system to achieve the desired outcomes. A whole lot of actions are required to make a specific recommendation work beyond just the specific reform. So there is a need to clearly identify and understand the intended outcomes.[48]

Mr Cartwright told us that responsibility for implementation 'is best given to agencies that have a track record in program delivery and implementation'.[49] Agencies allocated responsibility for implementing recommendations must have a track record for engaging stakeholders and the community, and be open to receiving scrutiny and criticism, including from an implementation monitor.[50]

In our view, the Tasmanian Government should develop a well-considered action plan that outlines how all the individual reforms comprising key reform initiatives identified in the child sexual abuse reform strategy, are to be prioritised for implementation over the short-, medium- and long-term. The action plan should consider the timeframes we propose for the implementation of our recommendations is Chapter 22. It should also assign responsibility for implementing the reforms to an agency and role holder, and include a transparent process for reporting against the implementation of recommendations. While we recognise the action plan may need to evolve over time due to changes in factors affecting the successful implementation of reform, at the outset, we consider it should contain several elements that we identify in Recommendation 19.1.

The child sexual abuse reform strategy and action plan should be overseen and reviewed under a strong governance structure, which includes representation from children and young people and victim-survivors of child sexual abuse (refer to Recommendation 19.5). The Child Sexual Abuse Reform Implementation Monitor we recommend in Chapter 22 (refer to Recommendation 22.1) should monitor the Government's progress against the strategy and action plan.

Recommendation 19.1

1. The Tasmanian Government should develop a whole of government child sexual abuse reform strategy for preventing, identifying and responding to child sexual abuse, including child sexual abuse in institutions and harmful sexual behaviours. The strategy should:

    a. describe the system that Tasmania seeks to achieve, including the component parts of that system, how Tasmanians will know it is working, and the role of key initiatives, reforms and recommendations in achieving the intended outcomes

    b. be separate from, but complement, the Government's Family and Sexual Violence Action Plan

    c. be informed by the voices of children and young people and adult victim-survivors of child sexual abuse (Recommendation 19.5)

    d. include agreed definitions of child sexual abuse, institutional child sexual abuse and harmful sexual behaviours

    e. set out guiding principles and objectives to inform preventing, identifying and responding to child sexual abuse

    f. identify the agencies, including statutory bodies and non-government organisations, involved in preventing, identifying and responding to child sexual abuse

    g. set out processes through which government agencies, statutory bodies and non-government organisations can consult on child sexual abuse reform

    h. set out considerations relevant to particular cohorts of children and young people, including Aboriginal children, children with disability, children with mental illness, children who identify as LGBTQIA+ and children from culturally and linguistically diverse communities

    i. outline the sources of funding for key initiatives and reforms set out in the strategy

    j. outline the governance, monitoring, review and evaluation arrangements for child sexual abuse reform, including that the Secretary of the Department of Premier and Cabinet, as Chair of the Secretaries Board, is responsible for endorsing, overseeing, coordinating and reporting on the strategy and action plan (Recommendation 19.3).

2. The Tasmanian Government should develop an action plan for the implementation of the child sexual abuse reform strategy. The action plan should:
    a. prioritise all recommendations and reforms for implementation over the short, medium and long term and include expected timeframes for implementing each recommendation
    b. identify the role holders and agencies that have responsibility for implementation of each recommendation and reform
    c. describe the actions to be taken to implement the recommendations and reforms, including any milestones, sequencing and dependencies
    d. identify the status of each recommendation and reform (that is, complete, under way or not commenced) and whether it is progressing on time
    e. be endorsed and overseen by the governance structure identified in the strategy.
3. The child sexual abuse reform strategy and action plan should be:
    a. tabled in each House of Parliament
    b. published on a dedicated website
    c. supported by a communication plan that seeks to inform and provide visibility of reform work to stakeholders and the community
    d. periodically reviewed and updated by the Secretaries Board through the Department of Premier and Cabinet.

3.4 Ensuring the system for preventing, identifying and responding to child sexual abuse is trauma-informed

The National Royal Commission identified that all human services should respond to the needs of victim-survivors of child sexual abuse and 'should be trauma-informed and have an understanding of institutional child sexual abuse'.[51] It recommended:

> The Australian Government and state and territory government agencies responsible for the delivery of human services should ensure relevant policy frameworks and strategies recognise the needs of victims and survivors and the benefits of implementing trauma-informed approaches.[52]

Research commissioned by the National Royal Commission defined trauma-informed approaches as:

- recognising the impact of trauma on a victim-survivor
- understanding their behaviour in the context of their past trauma
- interacting in a way that supports recovery and reduces the possibility of re-traumatisation.[53]

The term 'trauma-informed' refers specifically to 'the *context* in which services are offered' (emphasis in original), as distinguished from 'trauma-specific treatment services', which refers to clinical treatments for the trauma itself.[54] Both are essential.

In Tasmania, several victim-survivors and those who worked with them told us how their experiences with government services—such as the Child Safety Service, Tasmania Police, Director of Public Prosecutions, the Teachers Registration Board and hospitals—had not been trauma-informed. In some cases, we heard these services increased the harm caused by the abuse.[55] Kathryn Fordyce, Chief Executive Officer, Laurel House, observed that first contact with services is a particular challenge for victim-survivors of institutional abuse because their confidence that an institution will act in their best interests has already been 'damaged'.[56] Jillian Maxwell, Chief Executive Officer, Sexual Assault Support Service, said victim-survivors report that they have often tried to disclose their abuse and seek help and 'either feel not heard, believed or silenced'.[57] She expressed concern that there was 'a lack of or sufficient trauma-informed training about child sexual assault in some government settings and facilities'.[58]

The child sexual abuse reform strategy we recommend the Tasmanian Government develops (refer to Recommendation 19.1) should require all relevant staff to undertake regular professional development in responding to trauma.

We note that 'relevant staff' is a broad category and includes:

- many government and government funded staff of human service organisations including employees, volunteers, contractors and sub-contractors
- staff involved in direct responses to child sexual abuse such as the police, health workers and counsellors
- staff working in services in which child sexual abuse survivors are disproportionately represented, such as drug and alcohol, health, housing, legal services and prisons
- staff who are tasked with developing policy and are empowered to make decisions about people affected by trauma
- staff working within statutory bodies (such as the Commissioner for Children and Young People) who may have contact with child sexual abuse victim-survivors.

We note that as part of the *Keeping Children Safer Actions*, the Government made the following commitments:

- investigate rolling out trauma-informed training across the State Service with those in leadership positions, including Heads of Agencies[59]
- review the structure and processes across civil litigation to ensure the approach is trauma-informed and that legal practitioners recognise evidence-based understandings of the nature and impact of child sexual abuse[60]
- require mandatory professional development for all Department for Education, Children and Young People staff[61]
- make trauma-informed practice training mandatory for investigators and other state servants involved in misconduct investigation processes.[62]

These commitments have been marked as complete, except for the third, which has an expected delivery date of September 2023.[63]

In several other volumes and chapters of our report we have also made context-specific recommendations regarding mandatory minimum knowledge about child sexual abuse, grooming, professional boundary breaches, harmful sexual behaviours, reporting and responding. Regarding mandatory education, the Government's overall aim should be to ensure the delivery of appropriate mandatory education to as many people as possible in the most cost-effective way. Some roles will require a more advanced level of knowledge and skill (for example, child safety officers), or professional development tailored to elevated risks in a specific context, such as residential care, youth detention or policing. However, there will also be a minimum level of knowledge in child sexual abuse, grooming, professional boundary breaches and harmful sexual behaviours that is common across sectors. We recognise the Department of Health and the Department for Education, Children and Young People have recently developed and started rolling out mandatory reporter training. To help in cost efficiency and consistency of understanding, we suggest that state-owned and developed child sexual abuse professional development materials be collated and made available when new training is being developed by state agencies. In the future, consideration should also be given to whether any of these training offerings can be consolidated.

Recommendation 19.2

The Tasmanian Government should develop a whole of government approach to professional development on responding to trauma within government and government funded services, as well as statutory bodies, that provide services to children and young people or adult victim-survivors of child sexual abuse.

4 Establishing leadership, accountability and governance for child safety

The successful implementation of reform requires strong and sustainable leadership, accountability and governance mechanisms. The Tasmanian Government will need to establish these mechanisms before starting the reform work included in the child sexual abuse reform strategy and accompanying action plan.

4.1 Leadership and accountability for child safety

At the beginning of our Inquiry, we were concerned there was an absence of clear leadership, responsibility or accountability for child safety across the Tasmanian Government.

In week one of our hearings, Jenny Gale, Secretary, Department of Premier and Cabinet and Head of the State Service, and Ginna Webster, Secretary, Department of Justice, gave evidence on system responses, accountability and the implementation of the National Royal Commission recommendations.[64] Secretary Webster is responsible for the Child Abuse Royal Commission Response Unit, which coordinates the Government's response to, and implementation of, the National Royal Commission's recommendations. This Unit also develops the annual progress reports and action plans that indicate Tasmania's progress against these recommendations.[65] Responsibility for implementing specific recommendations has also been allocated to the Department of Justice and other government departments and agencies, including the:

- former Department of Communities
- former Department of Education (now the Department for Education, Children and Young People)
- Department of Police, Fire and Emergency Management
- Department of Premier and Cabinet
- Office of the Director of Public Prosecutions.[66]

The Department of Health does not have responsibility for implementing any recommendations, although we note it is now leading the response to the *Child Safe Governance Review of the Launceston General Hospital and Human Resources* and the *Launceston General Hospital Community Recovery Initiative* (which we discuss in Chapter 15).

We had anticipated that both Secretaries would jointly or individually be able to outline the cross-government system for preventing, identifying and responding to child sexual abuse and the role and responsibilities of the various government agencies within this system.

Secretary Gale gave evidence that the prevention and detection of child sexual abuse in institutions was a priority for the State of Tasmania but did not articulate how this prioritisation was being achieved in practice. She deferred to Secretary Webster on the question of implementing the National Royal Commission's recommendations.[67] Secretary Gale conceded that child safety had not previously been a focus of her department under her leadership.[68]

Secretary Webster explained that the Department of Justice was responsible for compiling information about other departments' progress in implementing reforms but not for holding them to account:

> … the department leads the whole of government response to those recommendations, and whilst we wouldn't be responsible for other agencies and their implementation, we would certainly be responsible for getting information about how progressed they are; assisting in terms of any barriers that might exist in its implementation, and compiling the report, the reporting process that's required.[69]

Secretary Webster indicated she did not have capacity to direct other Heads of Agencies or government departments in relation to implementing the recommendations.[70] However, she clarified that, as the Chair of the interdepartmental committee established in relation to implementing the National Royal Commission recommendations, she could raise the progress of a recommendation with the relevant agency member on the committee, Head of Agency or Deputy Secretary.[71]

Secretary Webster agreed she had accountability and oversight regarding the implementation of some of the National Royal Commission's recommendations but limited power to actually influence the progression of recommendations that sat outside of her own department.[72] When asked by Counsel Assisting our Inquiry whether she was satisfied with the progress of implementing the National Royal Commission's recommendations, Secretary Webster said she was 'very comfortable that it is a priority for our department and that we are taking the action we need to take; of course, I'd always like things to move a lot faster than they do in lots of areas'.[73]

We also learned during our Commission of Inquiry that Heads of Agencies across the Government, including those with responsibility for direct service provision to children, did not have any direct or specific accountability for safeguarding children or accountability regarding child sexual abuse as part of their performance agreements.[74]

4.2 Efforts to improve leadership and accountability for child safety and reform

Through the course of our Inquiry, we saw significant improvement in whole of government leadership, including in relation to reform regarding child sexual abuse in institutions.

4.2.1 Establishment of the Secretaries Board

The *Independent Review of the Tasmanian State Service* ('State Service Review') (published in July 2021) considered whether the governing framework for the State Service was fit for purpose. The review made 77 recommendations to improve the overall operation of the State Service.[75]

The Secretaries Board was established in early 2022 in response to the State Service Review.[76] It comprises 'every departmental Secretary'.[77] Secretary Gale chairs the Secretaries Board and meets on a monthly basis.[78] Secretary Gale told us the Secretaries Board is guided by terms of reference that require the identification of priorities for the Tasmanian State Service. It is also guided by regular updates and discussion on whole of government implementation of these priorities.[79] This reflects a significant shift in whole of government accountability, noting that Tasmania's previous arrangements for Heads of Agencies meetings were informal and not subject to terms of reference or formalised reporting requirements.[80]

Secretary Gale told us the Secretaries Board would provide improved governance and accountability for reforms relating to preventing, identifying, reporting and responding to child sexual abuse in institutional contexts. Secretary Gale explained that the Secretaries Board now has collective oversight of the *Keeping Children Safer Actions*.[81] She said the Premier had tasked the Department of Premier and Cabinet with responsibility for leading reporting to Cabinet on implementation progress in relation to these actions.[82] Although specific actions have been tasked to different government agencies for implementation, as Chair of the Secretaries Board, Secretary Gale is accountable for this work.[83] We consider this responsibility should extend to the oversight and accountability for the child sexual abuse reform strategy and action plan (refer to Recommendation 19.1).

4.2.2 Changes to Head of Agency Performance Agreements

During our Inquiry, Heads of Agency Performance Agreements have been changed to 'clarify expectations and improve accountability [for] making sure child safety and wellbeing is embedded in organisational leadership, governance and culture'.[84]

This was made possible due to changes in response to the State Service Review. The review observed that for the Tasmanian State Service to 'function well' the 'reporting and decision-making responsibilities between ministers, ministerial staff, Heads of Agencies and senior executives must be clearly stated' and that 'all parties must understand their role and their accountabilities, particularly in the case of statutory and legislative responsibilities'.[85] The review observed that the:

- existing performance management process did not always effectively hold departmental secretaries to account for whole of government initiatives[86]
- performance assessment processes for Heads of Agencies should be reshaped to ensure that whole of government outcomes feature alongside portfolio-based accountabilities, and that the Premier is more centrally involved in the process[87]
- performance agreement for Heads of Agencies should explicitly set out the responsibility of Heads of Agencies to contribute to cross-portfolio programs (including whole of government priorities) and whole of government capability development as well as that of their own agencies.[88]

The review made three recommendations to improve performance agreements and assessments for departmental secretaries:

> **Recommendation 7**
>
> That the Secretary of the Department of Premier and Cabinet, in full consultation with relevant portfolio ministers and the Premier, develop and undertake departmental secretaries' annual performance agreements and assessments.[89]
>
> **Recommendation 8**
>
> That the Premier undertake the annual performance agreement and assessment of the Secretary of the Department of Premier and Cabinet, informed by discussions with ministers (as the Premier sees appropriate) and consolidated advice from other departmental secretaries.[90]
>
> **Recommendation 9**
>
> Consider [Heads of Agencies] contribution to developing the [Tasmanian State Service] as a genuinely single state service, including the delivery of cross-portfolio outcomes (such as whole-of-government priorities) and whole-of-government capability development, in agency heads' performance assessments.[91]

Secretary Gale told us this new approach to developing departmental secretaries' annual performance agreements and assessments enables common themes to be included in performance agreements. These themes include shared accountability for the safety of Tasmanian children in government institutions, particularly for secretaries whose departments engage in child-related work.[92]

Secretary Gale spoke about what these changes mean in relation to departmental secretaries' performance agreements and her own performance agreement:

> Every Head of Agency's performance agreement with the Premier will commit them to identify and take action within their own department and across the service that will keep children safer. This commitment applies regardless of whether that agency engages directly in child-related work.
>
> In my own performance agreement I commit to being accountable for facilitation and coordination of the suite of actions known as, Keeping Children Safer Actions....

> I also commit to continuing to roll out more trauma-informed training across the [State Service] and to supporting improvements that will see trauma-informed complaints handling processes across the [State Service].[93]

4.2.3 Our observations

We consider the reforms we recommend regarding child sexual abuse in institutions should be a whole of government priority. As such, the Secretary of the Department of Premier and Cabinet, as Chair of the Secretaries Board, should be responsible for endorsing, overseeing, coordinating and reporting on the child sexual abuse reform strategy and action plan.

All relevant secretaries, as members of the Secretaries Board, should be responsible for actioning particular reforms under the child sexual abuse reform strategy and action plan within their portfolio responsibilities. These responsibilities should be included in their performance agreements and reviewed annually.

We also consider that accountability for implementing the child sexual abuse reform strategy and action plan should be extended to the performance agreements of other relevant State Service executives. Over time, the statements of duties for relevant departmental staff, particularly those who provide services to children and young people, should also reflect their responsibilities in relation to the strategy and action plan. This signifies that everyone has a responsibility for keeping children and young people safe within government institutions.

Recommendation 19.3

The Secretary of the Department of Premier and Cabinet, as Chair of the Secretaries Board, should be responsible for endorsing, overseeing, coordinating and reporting on the child sexual abuse reform strategy and action plan.

Recommendation 19.4

1. The Premier should, through their performance agreements, ensure Heads of Agencies are responsible for reforms under the child sexual abuse reform strategy and action plan within their portfolio responsibilities.
2. Heads of Agencies should ensure relevant State Service executives are also responsible for implementing the strategy and action plan.
3. The statements of duties for relevant departmental staff should refer to their responsibilities in relation to the strategy and action plan.

4.3 Existing governance structures for child safety reform

At our hearings, Ms Shuard told us that a governance structure must be inclusive of a 'whole range of agencies' to ensure coordination and that no one is left behind in relation to reform work.[94] Ms Shuard said reporting mechanisms are also important for ensuring there is a shared understanding of what's happening across all the reforms.[95] She was of the view that system-wide risks should be brought to the attention of the Secretaries Board.[96] She also emphasised the importance of hearing the voices of children and young people:

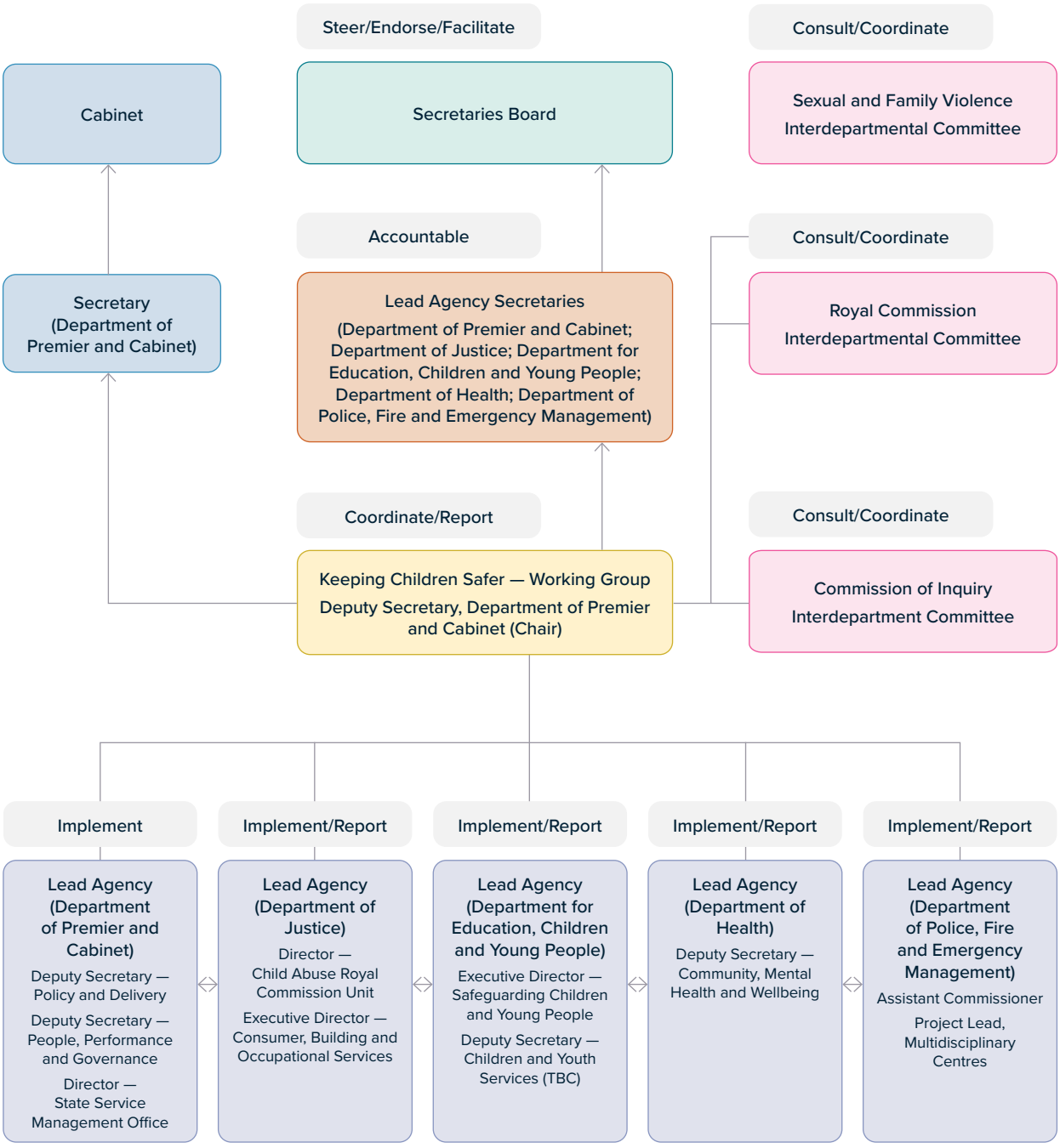
> Their voice must be heard in these arrangements, otherwise we design around our old constructs and forget what that might mean for children and young people, so the peak bodies or advocates for children and young people are essential voices to be heard ...[97]

The Tasmanian Government has established a governance structure for overseeing and implementing the *Keeping Children Safer Actions*. This structure comprises:

- **Department of Premier and Cabinet**, which is responsible for coordinating, monitoring and reporting on the *Keeping Children Safer Actions*.[98] The Department drafts monthly briefings and implementation status reports for Cabinet.[99]
- **Departmental secretaries and Heads of Agencies**, who have been allocated responsibility for implementing the *Keeping Children Safer Actions* by the Premier (either as a sole agency or with another agency or agencies).[100] Departmental secretaries are accountable to the Premier for implementing the *Keeping Children Safer Actions* under performance management instruments.[101] Department leads prepare fortnightly reports for the *Keeping Children Safer Working Group*.[102]
- ***Keeping Children Safer Working Group***, which comprises Deputy Secretaries and Directors from across government and has been established to coordinate and oversee implementation activity regarding the *Keeping Children Safer* actions, provide authoritative advice and endorse fortnightly implementation status reports and reports to Cabinet.[103] The Working Group is guided by terms of reference and meets fortnightly.[104] It also has access to advice and consultation from subject matter experts as needed.[105] The Working Group reports to the Secretaries Board through written reports after each meeting.[106] The Working Group is supported by a Secretariat from the Policy Branch within the Department of Premier and Cabinet.[107]
- **Secretaries Board**, which steers implementation activity, helps resolve barriers to implementation and endorses implementation plans and status reports.[108]
- **Cabinet**, which receives and endorses monthly implementation status reports prepared by the Department of Premier and Cabinet.[109]

The governance structure for the *Keeping Children Safer Actions* is shown in the following figure.

Figure 19.1: Governance structure for the Keeping Children Safer Actions[110]



Source: Statement of Jenny Gale, 23 November 2022.

Secretary Gale also told us:

- The Children, Young People and Families Safety and Wellbeing Cabinet Committee oversees policies and programs that focus on family and sexual violence and the safety and wellbeing of children, young people and their families in Tasmania.[111] Their work includes overseeing the implementation of the *Safe Homes, Families, Communities* initiative, *Strong Families Safe Kids* initiative and the *Child and Youth Wellbeing Strategy*.[112] The Committee is supported by a 'senior officials' committee', which is chaired by Secretary Gale.[113]
- The Department of Premier and Cabinet has responsibility for developing and delivering whole of government policies relating to child safety and wellbeing, including stewardship of the *It Takes a Tasmanian Village: Tasmania's Child and Youth Wellbeing Strategy* and the *Safe Homes, Safe Families: Tasmania's Family Violence Action Plan 2015–2020*.[114]

We consider this governance structure provides a strong foundation for overseeing and implementing the child sexual abuse reform strategy and action plan. In the following sections, we discuss how this governance structure could be strengthened by providing a mechanism for children and young people and adult victim-survivors of child sexual abuse to influence the system designed to benefit them.

We also consider this governance structure could be strengthened by ongoing sector engagement with agencies outside of government. Throughout our report, we have identified the key role of non-government agencies, including in relation to providing out of home care services and sexual assault counselling. These entities will be a good measure of the success of reforms and should be consulted when developing the strategy and action plan.

We also observe that there does not appear to be any governance arrangements in place to provide an ongoing voice to government from children and young people, such as through the Premier's Youth Advisory Council, or from adult victim-survivors of child sexual abuse. There are no arrangements to ensure representation from diverse communities in Tasmania, including the Aboriginal community, people with disability, people with mental illness, LGBTQIA+ people, and culturally and linguistically diverse communities. We discuss the inclusion of these voices in the following section of this chapter.

4.4 Empowering children and young people and adult victim-survivors of child sexual abuse

Children and young people and adult victim-survivors of child sexual abuse should be empowered to participate in regular discussion on issues that directly affect them and contribute to change and reform. They should also be able to advise the Tasmanian Government on the best ways to coordinate and implement reform work.[115] The participation of children and young people and adult victim-survivors of child sexual abuse ensures the voices of service users and affected populations can contribute to designing and implementing a system that meets the needs of service users, service providers and the Government.[116]

The Australian Human Rights Commission report *Keeping Kids Safe and Well—Your Voices* (released on 6 April 2022) was based on consultations led by Anne Hollonds, National Children's Commissioner, Australian Human Rights Commission, to inform the Australian Government's Actions Plans on *Safe and Supported: The National Framework for Protecting Australia's Children 2021–2031.*[117] In relation to the consultations that informed the report, Ms Hollonds said:

> Overwhelmingly, children, young people and families told us how important it is that governments and service providers listen to them when making decisions that affect them.[118]

At our hearings, Ms Hollonds also said:

> … my experience has been that actually when kids are at the table they're surprisingly insightful and refreshing in all of their wisdom, and they actually bring something that adults don't bring to the conversation …[119]

We note that steps to involve children and young people as well as adult victim-survivors of child sexual abuse have already been taken by some government agencies regarding child sexual abuse reform activity.

For example, children and young people and adult victim-survivors of child sexual abuse were engaged when developing the Child and Youth Safe Organisation Framework—comprising the Child and Youth Safe Standards and Reportable Conduct Scheme—being implemented by the Department of Justice.[120] Secretary Webster told us advisory panels were established relating to developing the framework and included a Lived Experience Advisory Panel comprising adult victim-survivors of child sexual abuse in institutional settings and family and friends of victim-survivors.[121]

A suite of consultation methods was also used to capture the views and opinions of children and young people in the community, including children and young people with experience of the out of home care system.[122]

Secretary Webster also told us:

> People with lived experience of child sexual abuse in institutional settings and children and young people are critical stakeholders in the project to develop and implement the Framework. Their expertise gained through lived experience will be a valuable contribution to the policy development and implementation planning for the Framework. Genuine engagement with children and young people and victim-survivor advocates through the project cycle also reflects the Government's commitment to the Child Safe Standards.[123]

As noted above, the Government is also establishing its first Victim-Survivor Advisory Council as an action under its most recent Family and Sexual Violence Action Plan—Survivors at the Centre.[124] The Council will include victim-survivors of family and sexual violence, including adults who may have experienced child sexual abuse, and family and friends of victims who lost their lives to family and sexual violence. It will provide an ongoing voice to government.[125] However, it is not clear how many members will have lived experience of child sexual abuse, or whether the Council will be consulted about reform work falling outside the actions identified in Survivors at the Centre, including reforms relating to child sexual abuse in institutions. We consider victim-survivors of child sexual abuse to have distinct experiences and needs that differentiate them from adult victim-survivors of family and sexual violence.

In our view, the Government must show an ongoing preparedness to hear the voices of children and young people and adult victim-survivors of child sexual abuse, including child sexual abuse in institutions, at a broader whole of government level and across all reforms. We recommend the governance structures for the child sexual abuse reform strategy and action plan incorporate the voices of children and young people and adult victim-survivors of child sexual abuse, including child sexual abuse in institutions. Sustained and ongoing engagement of children and young people and adult victim-survivors of child sexual abuse is crucial to building an understanding of issues relating to child safety, child sexual abuse (including child sexual abuse in institutions) and harmful sexual behaviours. It is also crucial for ensuring policy and reform work meets service user needs. We consider the Government can achieve this governance structure through the already established Premier's Youth Advisory Council and through the establishment of an adult-victim survivors of child sexual abuse advisory group.

The Premier's Youth Advisory Council comprises a group of young people aged between 12 and 25 years. It provides an opportunity for 'young people to inform the Tasmanian Government on issues and policies that affect them and their peers' through meetings with the Premier and the Minister for Education, Children and Youth 'several times a year'.[126]

We consider the adult victim-survivors of child sexual abuse advisory group should comprise some members who have experienced child sexual abuse in institutions.

These groups should be representative of the diverse communities in Tasmania, including the Aboriginal community, people with disability, people with mental illness, LGBTQIA+ people and culturally and linguistically diverse communities.

The issues we consider each advisory group can contribute to include:

- the therapeutic service system that supports victim-survivors and their families and carers
- whole of government policies relating to child safety
- strategies to raise awareness about child safety, including in government institutions
- resources for children and young people in relation to the prevention, identification and response to child sexual abuse
- forms of engagement with children and young people and adult victim-survivors of child sexual abuse
- initiatives designed to improve and respond to the safety of children and young people and harmful sexual behaviours, including initiatives designed for particular cohorts of children
- professional development initiatives to promote trauma-informed practices across government
- recruiting senior leadership roles focused on children and safety (for example, the Commissioner for Children and Young People).

Each advisory group should be promoted across government as a key mechanism through which to test ideas, policies and reform initiatives relating to child safety.

In other chapters of our report, we also recommend establishing advisory groups for specific institutional contexts, such as out of home care, Ashley Youth Detention Centre and health services (refer to Recommendations 9.6, 12.8 and 15.7). We considered whether, for efficiency, there could be one advisory group to meet these different purposes. However, in our view, these specific institutional contexts require specialist knowledge, gained through lived experience, about those systems. We consider these institution-specific advisory groups should also be consulted on policy and reform work when this is appropriate. In contrast, given the lower level of vulnerability of most children and young people in schools, we consider the Premier's Youth Advisory Council, and other existing broad student representative voice mechanisms, should be engaged regarding policy and reform work in schools.

We also recommend that the mechanisms for engaging with children and young people and adult victim-survivors of child sexual abuse, including child sexual abuse in institutions, be set out in the child sexual abuse reform strategy (Recommendation 19.1).

Promoting these mechanisms through the strategy will build awareness of the mechanisms and ensure they are consistently and regularly engaged in policy design and reform work as standard practice across government.

Recommendation 19.5

1. The Tasmanian Government should ensure, in setting out the governance structure for the child sexual abuse reform strategy and action plan, that children and young people and adult victim-survivors of child sexual abuse are part of this governance structure through:
    a. the Premier's Youth Advisory Council
    b. the establishment of an advisory group comprising adult victim-survivors of child sexual abuse, including child sexual abuse in institutions, of different ages, backgrounds, cultures, gender identities and geographical locations and parents of child victim-survivors.
2. The Department of Premier and Cabinet should report on the activities of these advisory groups in its annual report.
3. These advisory groups should:
    a. be guided by clear terms of reference that have been developed in consultation with the advisory groups
    b. have a clear purpose and objectives in terms of how they can contribute across the whole of government
    c. receive secretarial support and be adequately funded and resourced
    d. ensure trauma-informed processes apply in their interactions
    e. support and enable members' attendance by covering the costs of travel and expenses, and providing honorariums where appropriate.

5 Improving information sharing and cross-agency coordination for child safety

To prevent, identify, report and respond to child sexual abuse in institutions, it is essential government and government funded agencies and statutory bodies work effectively with one another. As outlined, many agencies have a role in addressing child sexual abuse in institutions. However, to achieve an effective response, agencies must be clear on the scope of their role and responsibilities and maintain strong communication.[127]

In this section, we summarise some problems we heard about information sharing and coordination across agencies relating to child safety issues, and the steps the Tasmanian Government is taking to address these issues. We recommend that any legislative barriers that hinder the sharing of information to protect the safety and wellbeing of children in Tasmania's legislation be identified and removed.

To further support effective responses to child safety issues, we also recommend the development of child safety information sharing, coordination and response for government and government provided agencies and statutory bodies. These guidelines should clearly articulate the roles and responsibilities of collaborating agencies in responding to child safety issues, including their information sharing obligations.

5.1 The National Royal Commission

The National Royal Commission defined 'information sharing' or 'information exchange' in the following way:

> 'Information sharing' and 'information exchange' refers to the sharing or exchange of information, including personal information, about, or related to, child sexual abuse in institutional contexts. The terms refer to the sharing of information between (and, in some cases, within) institutions, including non-government institutions, government and law enforcement agencies, and independent regulatory or oversight bodies. They also refer to the sharing of information by and with professionals who operate as individuals to provide key services to or for children.[128]

The National Royal Commission considered that information sharing between institutions with responsibilities for the safety of children is important to 'identify, prevent and respond to incidents and risks of child sexual abuse'.[129] It also considered the exchange of information to be important in ensuring the 'proper functioning of reportable conduct and Working With Children Check schemes'.[130] It noted that no single institution collects all the relevant information that can protect children, which is why information must be shared across institutions to enable effective responses to incidents and risks of child sexual abuse.[131]

As a matter of principle, we consider information sharing should occur when there is a concern about a risk of harm (including of child sexual abuse) to a child or a group of children, such as those in a particular institutional context. We also consider information should be shared with any entity that could act to address this risk now or in the future.

5.1.1 Recommendations on information sharing

The National Royal Commission observed the exchange of information relating to child safety often involves personal and sensitive information (such as information about a child's harmful sexual behaviours or information about adults who pose a potential risk to children), which is often protected by legislation.[132] It noted that even where legislation permits the exchange of this information for child safety, there may be a reluctance to share such personal and sensitive information due to concerns about privacy, confidentiality, defamation and confusion about the application of complex and inconsistent laws.[133] It also observed the exchange of information may be inhibited due to institutional cultures, poor leadership and weak or unclear governance arrangements.[134]

The National Royal Commission recommended a nationally consistent information sharing scheme between key agencies and institutions be developed and implemented to improve information sharing in relation to the safety and wellbeing of children within and across jurisdictions and sectors.[135] It said the scheme should:

a. enable direct exchange of relevant information between a range of prescribed bodies, including service providers, government and non-government agencies, law enforcement agencies, and regulatory and oversight bodies, which have responsibilities related to children's safety and wellbeing

b. permit prescribed bodies to provide relevant information to other prescribed bodies without a request, for purposes related to preventing, identifying and responding to child sexual abuse in institutional contexts

c. require prescribed bodies to share relevant information on request from other prescribed bodies, for purposes relating to preventing, identifying and responding to child sexual abuse in institutional contexts, subject to limited exceptions

d. explicitly prioritise children's safety and wellbeing and override laws that might otherwise prohibit or restrict disclosure of information to prevent, identify and respond to child sexual abuse in institutional contexts

e. provide safeguards and other measures for oversight and accountability to prevent unauthorised sharing and improper use of information obtained under the information exchange scheme

f. require prescribed bodies to provide adversely affected persons with an opportunity to respond to untested or unsubstantiated allegations, where such information is received under the information exchange scheme, prior to taking adverse action against such persons, except where to do so could place another person at risk of harm.[136]

The National Royal Commission considered the core group of institutions that should be considered to include in the information exchange scheme to be:

- accommodation and residential services for children
- childcare services
- child protection and out of home care services
- disability services and supports for children with disability
- education services for children
- health services for children
- justice and detention services for children
- state and territory government agencies and public authorities
- law enforcement agencies
- Working With Children Check screening agencies
- regulatory and oversight agencies (including, for example, teacher registration authorities)
- Australian Government agencies that may hold information relating to the safety and wellbeing of children
- professionals who provide key services and supports to children as individual service providers, rather than through agencies or organisations (such as medical practitioners and psychologists)
- professional and disciplinary bodies that oversee professional practice in the institutions set out above.[137]

It also indicated that religious institutions, sport and recreation institutions and non-government organisations that provide particular services to adults (such as drug, alcohol and mental health services) be considered for inclusion.[138]

The National Royal Commission also recommended strengthening information sharing in the education and out of home care sectors. These recommendations provide for the sharing of information about:

- teachers regarding teacher registration across jurisdictions
- students who move schools and may, for example, have exhibited harmful sexual behaviours
- carers as part of introducing carers' registers across jurisdictions to collect information about carers who have applied to work or do work at various out of home care agencies.[139]

Work has commenced to implement some of these recommendations in Tasmania, and some have already been implemented.[140] However, as we outline in the following section, we still heard of problems relating to sharing child safety information.

Secretary Webster told us reform that related to improving access to and the sharing of information to protect children is a difficult area.[141] She said although the National Royal Commission undertook significant work on the issue, it 'fell short of providing definitive guidance about balancing privacy and risk to children'.[142]

5.2 Legislation governing the sharing of information about child safety in Tasmania

Legislation governing the exchange of information regarding the safety of children includes general privacy legislation and specific legislative schemes. In Tasmania, specific legislative schemes that govern the exchange of information between agencies about the safety of children in particular situations include:

- *Children, Young Persons and Their Families Act 1997* ('Children, Young Persons and Their Families Act')
- *Youth Justice Act 1997* ('Youth Justice Act')
- *Registration to Work with Vulnerable People Act 2013* ('Registration to Work with Vulnerable People Act').

The *Personal Information Protection Act 2004* ('Personal Information Protection Act') regulates general information sharing between government agencies that falls outside of a legislative scheme. We discuss key pieces of legislation in the following sub-sections.

5.2.1 Personal Information Protection Act

The Personal Information Protection Act regulates the collection, maintenance, use, correction and disclosure of personal information relating to individuals. 'Personal information' encompasses any information or opinion in any recorded format about an individual whose identity is apparent or is reasonably ascertainable from the information or opinion. That individual must be alive or not have been dead for more than 25 years.[143]

A 'personal information custodian', which includes a government department, must comply with the Personal Information Protection Principles.[144] These Principles state that a personal information custodian must not use or disclose personal information about an individual for a purpose other than the purpose for which it was collected unless, among other things:

- the personal information custodian reasonably believes that the use or disclosure is necessary to lessen or prevent a serious threat to an individual's life, health, safety or welfare, or a serious threat to public health or public safety
- the personal information custodian has reason to suspect that unlawful activity has been, is being or may be engaged in, and uses or discloses the personal information as a necessary part of its investigation of the matter or in reporting its concerns to relevant persons or authorities
- the use or disclosure is required or authorised by or under law
- the personal information custodian reasonably believes the use or disclosure is reasonably necessary for the prevention, detection, investigation, prosecution or punishment of criminal offences or breaches of a law imposing a penalty or sanction by or on behalf of a law enforcement agency
- the personal information is to be used as employee information in relation to the suitability of the individual for appointment or the suitability of the individual for employment held by the individual
- the personal information is employee information that is being transferred from one personal information custodian to another personal information custodian for use as employee information relating to the individual.[145]

When a provision in the Personal Information Protection Act is inconsistent with a provision in another piece of legislation, the provision in the other legislation prevails.[146]

5.2.2 Children, Young Persons and Their Families Act

The Children, Young Persons and Their Families Act provides for the care and protection of children in Tasmania. It sets out responsibilities and obligations regarding reporting concerns to the Child Safety Service about the abuse or neglect of children.[147] It states that an adult who 'knows, or believes or suspects on reasonable grounds' that a child is suffering or is likely to suffer abuse or neglect has a responsibility to act to prevent the abuse. This action includes informing the relevant Secretary or the Strong Families Safe Kids Advice and Referral Line.[148]

Specific professionals, including state servants, also have mandatory reporting obligations. They must inform the relevant Secretary or the Strong Families Safe Kids Advice and Referral Line if, in carrying out official duties or in the course of their work, they know or believe or suspect on reasonable grounds that a child has been or is being abused.[149] While there has been some confusion across the Tasmanian Government about whether mandatory reporting obligations arise when information suggests a potential risk to children generally, rather than a risk to a specifically identified child, we consider it best practice to make a report even when this uncertainty exists.

The Children, Young Persons and Their Families Act also provides for information exchange between the Child Safety Service and an 'information-sharing entity' for the safety, welfare or wellbeing of a person who is the subject of a notification to, or under an order of, the Child Safety Service (a relevant person).[150] An 'information-sharing entity' includes a:

- mandatory reporter
- state servant
- person in charge of specified health and disability services
- person in charge of an organisation that receives a referral from the Child Safety Service.[151]

The Secretary may provide information to, or require information from, any of these entities.[152] The information-sharing entity may, if satisfied that information in its possession relates to the safety, welfare or wellbeing of a relevant person, provide the Secretary with this information as well as another information-sharing entity if they are involved with, or are likely to be involved with, the relevant person or a significant person to the relevant person.[153]

The Children, Young Persons and Their Families Act provides that a person who receives a report from a notifier, or who becomes aware of the identity of a notifier of a report, as a result of administering the Act must not disclose the notifier's identity to another person unless the disclosure is made:

- in the course of their official duties under the Act to another person who is acting in the course of their official duties
- with the consent of the notifier
- by way of evidence adduced with leave granted by the court
- to a law enforcement agency (since 2 October 2019).[154]

Although an individual engaged in administering the Act is obliged to maintain confidentiality, they may divulge information where, among other things, it is necessary or appropriate for the proper administration of the Act or they are legally authorised or required to do so.[155] Individuals are protected from liability when performing or exercising functions and powers under the Act, including the disclosure of information.[156] A similar protection is provided to the police.[157]

Since 1 March 2021, there have also been exceptions to the duty to maintain confidentiality for providing:

- relevant personal information for criminal and civil actions against alleged perpetrators who are the subject of the personal information

- information to agencies undertaking an employment screening or review process, or disciplinary investigations or proceedings, against a current or prospective employee or a volunteer.[158]

These 1 March 2021 exceptions apply if sharing the information does not disclose the identity of, or lead to the identification of, a person other than the person who is the subject of the civil or criminal proceedings or employment screening or disciplinary investigation or proceeding.[159] Using this information is subject to the rules of procedural fairness.[160]

5.2.3 Youth Justice Act

The Youth Justice Act provides for the treatment and sanctioning of young people who have offended. It contains provisions relating to confidentiality. Specifically, the Youth Justice Act provides that, subject to some exceptions, a person must not publish any information regarding any action or proceeding that is to be, is being or has been taken against a young person and may lead to the identification of the youth, victim or another person involved who has not consented to publishing the information.[161]

5.2.4 Registration to Work with Vulnerable People Act

The Registration to Work with Vulnerable People Act establishes a screening and monitoring system for people who work with vulnerable people, including children and young people.[162] A 'reporting body', which includes a State Service agency and the police service, that becomes aware by any means, or suspects on reasonable grounds that a person registered under the Act has engaged, or may have engaged, in reportable behaviour, must notify the Registrar of the Registration to Work with Vulnerable People Scheme, as soon as practicable, of the name and other identifying details of the person and the behaviour.[163] 'Reportable behaviour' is behaviour that poses a risk of harm to vulnerable persons, whether by neglect, abuse or other conduct.[164]

The Registration to Work with Vulnerable People Act also contemplates the Registrar receiving information about reportable behaviour other than through the duty that a reporting body has to notify the Registrar. However, there is no specific legislative provision for receiving this information.[165] There is nothing in the Registration to Work with Vulnerable People Act preventing an entity, including a government department or any individual, from notifying the Registrar of concerning behaviour involving any person. However, they would need to ensure they are not in breach of the general prohibition on the use or disclosure of personal information under the Personal Information Protection Act. Sharing relevant information with the Registrar would generally be for determining whether the person is suitable to:

- be registered under the Registration to Work with Vulnerable People Scheme (through a risk assessment)
- stay registered under the Scheme (through an additional risk assessment).

These purposes are for the broader purpose of protecting public safety or for the assessment of the suitability of the person for employment. Both purposes are exceptions to the general prohibition on the use or disclosure of personal information in the Personal Information Protection Act. Our view is that the Registration to Work with Vulnerable People Act should be amended to clarify that any person can notify reportable behaviour to the Registrar of the Registration to Work with Vulnerable People Scheme.

When the Registrar of the Registration to Work with Vulnerable People Scheme reasonably considers that an 'entity', which includes an individual, public authority or another body, may have information relevant to their functions and powers under the Registration to Work with Vulnerable People Act, they may require the entity to provide this information.[166] The entity must comply with the request or provide a reasonable excuse for its failure to comply.[167] Information the Registrar obtains arising from a request may only be used to administer the Registration to Work with Vulnerable People Act.[168]

Peter Graham, former Registrar of the Registration to Work with Vulnerable People Scheme, described the obligation to notify the Registrar of 'reportable behaviour' as the 'backbone of the scheme' because 'it forms the basis of information available to the Registrar to consider when conducting a risk assessment [of a person applying for registration] or additional risk assessment [of a person who is already registered]' under the Scheme.[169]

Mr Graham said notifications made under this obligation give the Registrar of the Registration to Work with Vulnerable People Scheme 'significantly more information' when undertaking risk assessments than is contemplated by the National Standards for Working with Children Checks. The information available to the Registrar includes criminal intelligence and other information provided by reporting bodies, including allegations that have not been tested by an investigation (unsubstantiated allegations).[170]

The Registrar of the Registration to Work with Vulnerable People Scheme and their staff must not use or disclose information about a person that has been disclosed or obtained as part of the performance or exercise of a function or power under the Registration to Work with Vulnerable People Act, unless it is divulged under the Act, another Act or corresponding law, or with the person's consent.[171] The Registrar may disclose the result of a risk assessment, that the registration of a person has been suspended or cancelled, or other information relating to a registered person to another registering authority that has similar functions under another corresponding law.[172]

The Registrar of the Registration to Work with Vulnerable People Scheme may also disclose this information to specified bodies or a person if they consider it appropriate to protect vulnerable persons or a class of vulnerable person from a risk of harm.[173] We were told it is 'typical' for the Registrar to advise a State Service agency of a negative risk assessment regarding an individual, but not share the underlying information or grounds for the assessment. This is because it will generally have been informed by information that is available to the Registrar but not available to the State Service agency (that is, through criminal intelligence information).[174]

Recommendation 19.6

The Tasmanian Government should introduce legislation to amend the *Registration to Work with Vulnerable People Act 2013* to clarify that, in addition to the duty to report in certain circumstances, any person can notify reportable behaviour to the Registrar of the Registration to Work with Vulnerable People Scheme.

5.3 Barriers to information sharing and coordination in Tasmania

During our Inquiry, we heard information sharing and coordination between agencies is not always done in a way that prioritises the safety and wellbeing of children and young people. We also heard it does not always support the needs of victim-survivors of child sexual abuse in institutions. While some of these barriers were explained to us in terms of legislative barriers, we consider culture to be the main barrier to appropriate information sharing and a coordinated response to child safety concerns.

Regarding mandatory reporting to the Child Safety Service and the Registrar of the Registration to Work with Vulnerable People Scheme, we make findings in relation to or heard about the following barriers to information sharing:

- We find in Chapter 14, Case study 3, relating to James Griffin that Launceston General Hospital had no clear system or process in place to support complaints to external agencies and, as a result, staff were not aware of their reporting obligations, including to the Child Safety Service and Ahpra. We also highlighted in Chapter 15 that the Tasmanian Health Service Protocol – Complaint or Concern about Health Professional Conduct (November 2020) included an expectation that staff would not make a mandatory report without executive leadership approval.
- In Chapter 11, Case study 7, we find the Department of Justice does not have an appropriate process to ensure that information in National Redress Scheme applications is shared in a timely manner to protect children. We also discuss how

poor information sharing between agencies increased the risk of child sexual abuse at Ashley Youth Detention Centre.

- Tasmania Police told us in its submission that 'because different classes of people are required to report different types of conduct to different departments, the system is vulnerable to information exchange breakdown and consequent delays in investigation'.[175]
- Mr Graham told us it is clear there is a varied understanding of the reporting obligations under the Registration to Work with Vulnerable People Act across the State Service.[176] Previously, legal advice provided to the Department of Justice was based on a narrow interpretation of the use of the word 'finds' regarding the reporting of reportable behaviour under the Act. This advice influenced agencies to not report to the Registrar until after a misconduct investigation had made a 'finding' of misconduct against a staff member.[177] Since 1 February 2021, the wording in the Registration to Work with Vulnerable People Act in relation to this point has been clarified.[178]
- Secretary Webster told us that outside of Tasmania Police and the Child Safety Service, it has taken longer for other agencies to understand and meet their obligations of reporting to the Registrar of the Registration to Work with Vulnerable People Scheme.[179]

We also heard the following in relation to the sharing of information between Tasmania Police and the Child Safety Service:

- Until the 2021 *Keeping Children Safe Memorandum of Understanding*, Tasmania Police sometimes had to seek warrants to obtain information from the Child Safety Service.[180] Both the memorandum and accompanying *Keeping Children Safe Handbook* now state: 'Warrants are not required in order to facilitate the release of information relating to the safety of a child from either party and warrants will not be requested by either party in relation to the provision of such information'.[181]

Regarding State Service disciplinary processes, we heard of the following problems:

- Secretary Bullard told us the general prohibition in the Personal Information Protection Act restricted the former Department of Education's ability to share information about a teacher that had been obtained through an investigation into a breach of the State Service Code of Conduct (referred to as an Employment Direction No. 5—Breach of Code of Conduct investigation), including with the Teachers Registration Board.[182] Secretary Bullard said this was based on advice that the purpose the information had been collected for (employee disciplinary processes by the Department) was different from the purpose the information was sought to be disclosed (determining good character and fitness to teach

by the Teachers Registration Board).[183] It is unclear to us why the public safety or employment reasons exceptions in the Personal Information Protection Act would not apply.

- Secretary Bullard and Secretary Gale both indicated the Personal Information Protection Act is a barrier to keeping complainants and victim-survivors informed about how abuse complaints are managed and the status of investigations.[184]
- Based on legal advice about the privacy provisions in the Children, Young People and Their Families Act and Youth Justice Act, the former Department of Communities had not provided un-redacted material (specifically the files of children who had been in Ashley Youth Detention Centre and Unit Diaries from the Centre) to investigators undertaking Employment Direction No. 5—Breach of Code of Conduct investigations.[185] As outlined before, these legislative provisions prevent publishing information about care and protection proceedings as well as court proceedings, formal or informal cautions or community conferences in particular circumstances regarding children and young people.[186]

In our view, these information sharing failures have placed children at risk by not ensuring relevant agencies or entities have the adequate information they need to perform their functions and fulfil their obligations to protect children. We agree with Secretary Bullard's observation that information sharing is critical to assessing risk and ensuring the necessary supports are in place for the safety and wellbeing of children and young people.[187]

We acknowledge that some told us information sharing problems stem from legislative barriers. For example, Mr Graham told us a general exemption should be included in the Personal Information Protection Act that enables information about the safety of children to be shared, noting it would combat the reluctance some people have in sharing information because the Personal Information Protection Act is often used as a barrier to information exchange.[188]

Similarly, Secretary Bullard embraced including such a legislative provision in the Personal Information Protection Act. He queried whether such a provision should be mandatory or permissive.[189] Secretary Bullard said making it mandatory would likely be easier because this removes the need for deliberation and judgment.[190]

In our view, the Personal Information Protection Act already contains sufficient exemptions which would, if interpreted in a way that seeks to promote the safety and wellbeing of children and young people, enable information about the safety of children to be shared, particularly where:

> … the personal information custodian reasonably believes that the use or disclosure [of personal information] is necessary to lessen or prevent … a serious threat to an individual's life, health, safety or welfare; or a serious threat to public health or public safety.[191]

These provisions reflect provisions in other jurisdictions, including the Australian Privacy Principles.[192]

As noted, Secretary Webster told us it was her belief that one of the most difficult areas of reform will be improving access to and sharing information.[193] Secretary Webster explained this particularly in relation to any legislative changes required:

> These reforms impinge on the existing privacy rights of individuals. Legislative reforms to information sharing and erosion of privacy protections can be fraught and controversial. I fully support the need to significantly increase the rights of children to be safe and understand the processes that have affected them, but I note that these reforms will need to be carefully considered and balanced. I also note that these reforms will be complex drafting exercises because of the numerous Tasmanian statutes that contain confidentiality provisions for a [sic] various policy reasons.[194]

Secretary Bullard said changing information sharing practices requires 'sustained change management' including clarity about what information agencies hold, what information can and should be shared, purposes for which it can be shared and with whom.[195] He said it then requires a concerted effort to understand and address underlying beliefs or assumptions about what information should or should not be shared.[196] He said it also requires an understanding of legal and other barriers to change and a willingness to make legislative amendments as required.[197] Despite this challenge, Secretary Bullard said information sharing between departments, independent statutory bodies and with victim-survivors needs to be improved within the bounds of what is legally permissible.[198]

Where there are legislative barriers, these should be removed. We recommend confidentiality and secrecy provisions in Tasmanian legislation be reviewed. Where these provisions create specific legislative barriers to the sharing of information to protect the safety and wellbeing of children and young people, these barriers should be removed.

We consider, however, that many failures to share information stem from a culture within parts of the State Service, including those providing advice. This advice preferences a person's right to privacy over the protection of the safety and wellbeing of children. There is also a lack of understanding of mandatory reporting obligations and staff ability to share information to protect children. These cultural barriers must be addressed. We discuss measures to address cultural barriers to information sharing in the following section.

Recommendation 19.7

The Tasmanian Government should review confidentiality and secrecy provisions in Tasmanian legislation, including the *Personal Information Protection Act 2004*, to identify any specific legislative barriers that hinder the sharing of information necessary to protect the safety and wellbeing of children and young people and remove these barriers.

5.4 Existing guidance on information sharing, coordination and responses for child safety

Given the cultural resistance to sharing information, it is fundamental that there is clear guidance about how information can and should be shared to protect children, and to facilitate a coordinated response to child safety concerns. Further, it is critical that information affecting children's safety is purposefully shared and leads to action by appropriate entities and services.

Darren Hine AO APM, former Commissioner, Tasmania Police, told us several formal documents guide Tasmania Police on information sharing and coordinating investigations and responding to child sexual abuse. These documents include:

- ***Tasmania Police Manual***, which provides guidance to police officers on performing their duties, including in relation to child sexual abuse, and the types of notifications they must make to external agencies, including (but not limited to) the Strong Families Safe Kids Advice and Referral Line, Registrar of the Registration to Work With Vulnerable People Scheme, Ahpra and the Teachers Registration Board.[199]
- ***Tasmania Police Initial Investigation and Notification of Child Sexual Abuse Guidelines***, which provide 'policy and practice guidance to Tasmania Police officers in responding to children and young people who have, or may have been, sexually abused'.[200] The guidelines outline objectives, procedures (including reporting), roles and responsibilities (including initial response, interviews, forensics and information sharing requirements) and relevant legislation and policy documents.
- ***Registration to Work with Vulnerable People Information Sharing Protocol between the Department of Justice and Tasmania Police***, which outlines the process for Tasmania Police to share information with the Registration to Work with Vulnerable People Unit in the Department of Justice.[201] Since 2016, an interface between both agencies has supported the exchange of information under the protocol where information is shared daily with the Registration to Work with Vulnerable People Unit from Tasmania Police's information systems.[202] A similar information-sharing arrangement has also been in place for the Child Safety Service to share information daily with the Registration to Work with Vulnerable People Unit since 2017.[203]

- **Memorandums of Understanding** between Tasmania Police and various government departments, which includes the *Keeping Children Safe Memorandum of Understanding* that guides the relationship between Tasmania Police and the Child Safety Service regarding statutory responses to suspected child abuse and neglect.[204] This Memorandum designates Tasmania Police as the lead agency in all child safety matters when an offence is disclosed and the Child Safety Service as the lead agency in matters relating to the care and protection of a child.[205] Joint responses under the Memorandum are to be coordinated in a way that ensures the interests and safety of a child are paramount.[206] The Memorandum is accompanied by the *Keeping Children Safe Handbook*, which provides additional context and guidance to staff about fulfilling their roles and responsibilities under the Memorandum.[207] It also includes forms and templates for use in cross-agency coordination to ensure there is consistent practice between both agencies.[208] Both documents explicitly state: 'Information will be exchanged freely as requested between the parties in relation to the protection of children, facilitating the complete picture of a child's experience, enabling decisive and effective action'.[209]

We do not consider that the Memorandum or the Handbook responds specifically to the issue of information sharing or coordination of responses to child sexual abuse in institutions.

During our Commission of Inquiry, some government agencies also developed memorandums of understanding with Tasmania Police to clarify their roles and responsibilities in preventing and responding to child sexual abuse in institutions.[210] These memorandums are similar and address the following topics:

- purpose
- shared operating principles
- management of incidents or disclosures of child sexual abuse in education and health settings, including reporting, investigation, communication and information sharing
- governance.[211]

We received no evidence that any formal documents had been developed to specifically guide government or government funded agencies or statutory bodies regarding responses to child sexual abuse in institutions. This includes when a staff member is the subject of an allegation or incident of child sexual abuse.

5.5 Efforts to improve information sharing and coordination of responses to child sexual abuse in institutions

During our Commission of Inquiry, the Tasmanian Government started or committed to undertake several projects to improve information sharing across agencies. We summarise this work in the following sub-sections.

5.5.1 Keeping Children Safer Actions

As part of the *Keeping Children Safer Actions*, the Tasmanian Government is considering 'legislative solutions and other initiatives that will make it easier to share information about risks to children, including looking at whether issues of custom, practice and culture are creating unnecessary barriers'.[212] The Department of Premier and Cabinet is leading this work. The Government has indicated that legislative options will be developed for it to consider.[213] This action has an expected delivery date of March 2024.[214]

In the final week of our hearings, Secretary Gale told us the Department of Premier and Cabinet is planning reforms to facilitate government-wide information sharing, in the form of 'overarching legislation that would be superior to … all other … legislation in relation to that information'.[215] When asked whether a positive obligation to share information about child safety needed to be considered as part of the Department's work, Secretary Gale said: 'if we need to make it absolutely clear by making it mandatory that we share information, then we will certainly consider that strongly'.[216] Secretary Webster told us the Department of Justice is helping with this work and information was prepared for Cabinet at the end of 2022.[217]

When questioned in the final week of our hearings about professional development for staff to ensure they understand their child safety information sharing obligations, Secretary Gale said information sharing is 'largely driven by custom and practice':[218]

> … even though we know that there is no barrier to sharing that information between agencies, it has been difficult. And I think this gets to the cultural piece that will need to be a very significant part of the work that we do … it's one thing to enable through processes, legislation, and so on, but it is another to change the way in which people behave.[219]

Also related to this work is the *Keeping Children Safer* action of developing clear information about the circumstances in which agencies can and should share information about the status of investigations and/or investigative material.[220] We understand this work forms part of a broader project to build shared capability across government agencies for serious disciplinary investigations and is expected to be completed in October 2023.[221] We support this work and encourage the Government to develop a plan to ensure this information is known and accessible to relevant staff across agencies.

In the final week of our hearings, Secretary Gale also told us the Department is working on developing procedures to keep complainants informed about Employment Direction No. 5—Breach of Code of Conduct investigations within the parameters of the Personal Information Protection Act.[222] She said this will involve exploring how the Act can be changed to enable complainants to be kept better informed about these types of investigations.[223] We have not received further information about this initiative but support its continuation.

5.5.2 Child and Youth Safe Organisations Act

One of the *Keeping Children Safer Actions* is to develop a Child and Youth Safe Organisations Framework including Child and Youth Safe Standards and a Reportable Conduct Scheme.[224] Introducing child safe standards and a reportable conduct scheme were recommendations the National Royal Commission made in December 2017.[225]

On 22 November 2022, the Child and Youth Safe Organisations Bill 2022 was introduced into the Tasmanian Parliament. The Bill received Royal Assent and commenced as the *Child and Youth Safe Organisations Act 2023* ('Child and Youth Safe Organisations Act') on 1 July 2023. Implementation of the Child and Youth Safe Organisations Framework, which comprises the Child and Youth Safe Standards and Reportable Conduct Scheme, is now underway and has an expected delivery date of July 2024.[226]

We discuss the Child and Youth Safe Organisations Act in detail in Chapter 18 but, for current purposes, Part 5 of the Act provides for information sharing. In addition to giving the Independent Regulator under the Child and Youth Safe Organisations Act broad information-sharing powers (described further in this chapter and in Chapter 18), the Act also provides for sharing information between specified individuals and organisations. This includes powers to share information between:

- the Independent Regulator (of the Child and Youth Safe Standards and Reportable Conduct Scheme)
- an entity regulator (this can include government agencies or other bodies that assume regulatory functions related to the Reportable Conduct Scheme—the Independent Regulator is to determine these)
- the head of an entity (which would include a Secretary of a Department) (including in relation to contractors)
- the Commissioner of Police, a police officer, or police from other Australian jurisdictions
- an independent investigator, in some situations
- the Registrar of the Registration to Work with Vulnerable People Scheme

- the Integrity Commissioner
- a Minister
- any other roles prescribed by regulations.[227]

In Chapter 18, we recommend the Ombudsman be included in the entities required to share information (refer to Recommendation 18.3). Information that can be shared by and between these bodies relates to information or documents relating to the Child and Youth Safe Standards and Reportable Conduct Scheme (noting that the Standards are broad in scope). This includes:

- information or documents relating to concerns about compliance with the Standards and Universal Principle
- information relating to reportable allegations and associated investigations, including findings and outcomes relating to reportable conduct.[228]

The disclosure of information relating to these matters must relate to:

- the purposes of the Child and Youth Safe Organisations Act
- the promotion of the safety and wellbeing of children
- a prescribed purpose.[229]

If there is any inconsistency with other legislation (for example, restrictions imposed by the Personal Information Protection Act or the *Right to Information Act 2009* ('Right to Information Act')) the permissive information sharing powers of the Child and Youth Safe Organisations Act are intended to apply and override them.[230]

The Independent Regulator can also obtain information, make a record of information, disclose information to *any* person, and otherwise use information in situations where such an action is taken:

- to protect and promote the safety and wellbeing of children
- to enable the investigation or the enforcement of a law
- for investigatory, disciplinary or employment-related purposes related to the safety and wellbeing of children
- to share information with other jurisdictions and child safety oversight bodies to collect, publish and analyse data on approaches to child safety
- to perform a function or exercise a power in the Act
- for a prescribed purpose.[231]

The Child and Youth Safe Organisations Act also allows the Independent Regulator to disclose information relating to the administration of the Reportable Conduct Scheme, including:

- the details of an allegation, investigation and findings to a worker the subject of an allegation
- children and young people involved in an allegation and their guardian in particular situations.[232]

The Independent Regulator must also notify the Registrar of the Registration to Work with Vulnerable People Scheme of information relating to a 'relevant finding' made regarding reportable conduct. This includes:

- the fact that a finding has been made
- an outline of the finding and the reasons for it
- the name (including former names or aliases, if known) of the worker who is the subject of the finding
- the worker's date of birth (if known).[233]

The Act also offers protections relating to disclosing information that would identify a child or a person who has disclosed reportable conduct.[234]

Secretary Webster told us that allowing the flow of information between the Independent Regulator and a range of entities by overriding elements of the Right to Information Act and Personal Information Protection Act helps to ensure the safety of children is at the centre of information sharing.[235] We discuss the Right to Information Act in more detail in Chapter 17.

5.5.3 Department for Education, Children and Young People

We were also told that merging the former Department of Communities and the Department of Education into the Department for Education, Children and Young People on 1 October 2022 may help overcome some barriers to information sharing. We discuss the structure of the new Department in Chapter 7.

Secretary Bullard said that he saw this change as:

> … an opportunity to build closer links across all areas working to safeguard and protect Tasmania's children and young people; thereby building a more effective process for sharing information and taking a holistic approach to the prevention, identification and response to child sexual abuse in an institutional context.[236]

Secretary Gale also told us that 'putting the key functions relating to children in the one Agency will help to breakdown cultural and systems-based barriers to information

sharing that could keep children safe'.[237] These views were echoed by Secretary Webster who indicated the new department would help ensure a more coordinated and consistent approach to child safety across key child services provided by government.[238]

The Department for Education, Children and Young People has established an oversight committee and advisory group comprising departmental staff to identify and advise about opportunities to, among other things:

- build mechanisms for coordinated decision-making, action and accountability
- improve the information staff have available to make better decisions about the safety, wellbeing and learning of children and young people.[239]

We support these efforts.

5.5.4 Our observations and recommendations

We consider, if successfully implemented, the work already underway across Tasmanian Government departments will go some way to improving information sharing and coordination of responses to child safety issues in Tasmania, including to child sexual abuse in institutions. However, we consider a key element missing from this work across government is the existence of clear and concise information about child safety information sharing obligations and the roles and responsibilities of staff in coordinating responses to child safety issues. We were told there is no publicly available memorandums or statements that set out how the Government manages information sharing internally (including as it relates to child safety).[240]

To address this gap, we recommend government and government funded agencies and statutory bodies work together to develop child safety information sharing, coordination and response guidelines. These guidelines must provide clear direction on the roles and responsibilities of agencies and staff in responding to child safety issues. The guidelines should be drafted to give effect to the guiding principle that the safety and wellbeing of children is paramount.

Aspects of a response we consider should be covered by the guidelines include:

- clarifying the lead agency in responses to child safety issues and their role and responsibilities
- clarifying the role and responsibilities of supporting agencies, including how to ensure the ongoing safety of children within the care of an agency, that any risks to children have been addressed, and that there has been timely fulfilment of relevant reporting and notification obligations and information sharing requirements
- clarifying the role and responsibilities of receiving agencies when information is shared

- developing processes for keeping affected children, families, carers and the community informed about responses to child safety issues
- developing processes for providing support to affected children and their immediate family and carers
- considering the use of disciplinary processes in parallel with any investigations undertaken by police and other regulators and professional bodies such as the Registrar of the Registration to Work with Vulnerable People Scheme, Ahpra or the Teachers Registration Board
- developing processes for responding to reports of child safety issues when they are connected to another government or government funded agency or statutory body, including alerting the relevant agency of the report
- developing escalation and dispute resolution processes to resolve disagreements that may arise between agencies in responses to child safety issues.

Where necessary, the guidelines can be further supplemented with agency-specific information and resources. For example, in Chapter 21 we recommend that the Tasmanian Government, in collaboration with key stakeholders, should develop a statewide framework and plan for preventing, identifying and responding to harmful sexual behaviours (refer to Recommendation 21.8).

We also consider it important that agencies and statutory bodies examine the professional development needs of staff in relation to responding to child safety issues and the scope of their reporting and information sharing obligations. In a submission to our Commission of Inquiry, Laurel House said:

> There is a need for training and capacity building opportunities to be provided to institutions to ensure that all employees, regardless of their position, understand their role in keeping children safe. All employees and decision makers who work within services that support children should be required to undergo mandatory training that alerts them to the warning signs of childhood sexual abuse, to make them vigilant to grooming behaviours and other sexual misconduct, and to understand their reporting obligations and the risks that failing to act places on children, the employee, the workplace and the community.[241]

We note that one of the *Keeping Children Safer Actions* is to '[e]ncourage and support staff to raise child safety concerns'.[242] We also note the *Keeping Children Safer Working Group* (discussed in Section 4.3) has started mapping government agency resources relating to child safety so they can be tailored to departmental needs and support staff training and wider cultural change across the State Service.[243] This work is expected to be delivered in December 2023.[244] We are also aware that individual government departments (particularly the Department for Education, Children and Young People and the Department of Health) have made additional training available to staff on

these issues.[245] We consider the guidelines should also identify relevant resources and professional development opportunities available to staff regarding responding to child safety issues.

As a whole of government initiative, the Department of Premier and Cabinet should lead the development of the child safety information sharing, coordination and response guidelines. It should also lead efforts to promote their use across government and government funded agencies and statutory bodies. This work will require a large culture change element, which the Government should fund.

Recommendation 19.8

1. The Department of Premier and Cabinet should lead the development of child safety information sharing, coordination and response guidelines to support government and government funded agencies and statutory bodies to respond to child safety issues. The guidelines should:
    a. set out the principles which guide information sharing, cross-agency coordination and the roles of different services and entities in responding to child safety issues, and require that staff are trained on these issues
    b. identify a process for nominating a lead agency for cross-agency responses to individual child safety issues and set out the lead agency's role and responsibilities
    c. identify a process for setting out the roles and responsibilities of collaborating agencies in responding to child safety issues
    d. explain child safety information-sharing obligations and responsibilities and how staff can fulfil them
    e. set out an escalation and dispute resolution process to resolve disagreements that may arise across agencies
    f. identify resources and professional development opportunities for staff in relation to responding to child safety issues
    g. be subject to periodic review to ensure they remain up to date and accurately reflect best practice cross-agency information sharing and coordination arrangements.
2. The Tasmanian Government should fund the culture change work required to achieve good information-sharing practices.

The Tasmanian Government should fund the culture change work required to achieve good information sharing practices.

6 Conclusion

An effective approach to preventing, identifying, reporting and responding to child sexual abuse in institutions requires a coordinated and sustained commitment across government and government funded agencies and statutory bodies. This starts with developing a clear strategy that directs how Tasmania intends to respond to child safety issues, including child sexual abuse in institutions. This strategy should be accompanied by an action plan to implement child sexual abuse reform over the short, medium, and long-term. The strategy and action plan should be supported by strong governance structures, including input from children and young people and adult victim-survivors of child sexual abuse.

Staff working within government and government funded agencies and statutory bodies must also be empowered and supported to respond to child safety issues. This requires that they are clear on how they are expected to act when information is received and can confidently share information to protect the safety and wellbeing of children and young people. Legislation must be clear on when this can occur and should not hinder information sharing when it is necessary to address risks to child safety. Staff within government and government funded agencies and statutory bodies must also understand their broader roles and responsibilities to safeguard children, including how to:

- address risks to other children
- support victim-survivors
- escalate disagreements in relation to responses across agencies.

We consider the recommendations that we make in this chapter will help to create a united and coordinated whole of government approach to child sexual abuse that prioritises the safety and wellbeing of children in Tasmania.

Notes

1 Notice to produce served on the State of Tasmania, 20 July 2021, 5 [4].

2 Department of Communities, 'Tasmanian Government's Current Service System', 22 September 2021, produced by the Tasmanian Government in response to a Commission notice to produce.

3 Department of Education, 'Policies and Procedures: Tasmanian Government's Current Service System', 16 September 2021, produced by the Tasmanian Government in response to a Commission notice to produce.

4 Department of Health, Department of Justice, 'Policies and Procedures', 9 September 2021, produced by the Tasmanian Government in response to a Commission notice to produce.

5 Department of Justice, 'Policies and Procedures', 9 September 2021, produced by the Tasmanian Government in response to a Commission notice to produce; Department of Justice, 'RWVP Year to Date Stats as at 17/09/2021', 17 September 2021, produced by the Tasmanian Government in response to a Commission notice to produce.

6 Department of Police, Fire and Emergency Management, 'Tasmanian Government's Current Service System', 3 August 2021, produced by the Tasmanian Government in response to a Commission notice to produce.

7 Refer to, for example, Department of Education, 'Policies and Procedures', 9 September 2021, 1-3, produced by the Tasmanian Government in response to a Commission notice to produce; Department of Health, 'Policies and Procedures', 9 September 2021, 4–5 [g], produced by the Tasmanian Government in response to a Commission notice to produce.

8 Refer to, for example, Children and Youth Services, 'Practice Advice – Identifying and Assessing Risk and Protective Factors in cases of Reported Child Abuse and Neglect', 29 August 2016, produced by the Tasmanian Government in response to a Commission notice to produce; Child Safety Service, 'Procedure – Assessing and Responding to Sexual Abuse', 4 November 2016, produced by the Tasmanian Government in response to a Commission notice to produce; Department of Health and Human Services, 'Investigations of Severe Abuse or Neglect of a Child in Out of Home Care (Schedule 2)', 1 June 2013, produced by the Tasmanian Government in response to a Commission notice to produce.

9 Refer to, for example, Department of Communities, 'Complaint Factsheet: How to Resolve Your Concern', undated, produced by the Tasmanian Government in response to a Commission notice to produce.

10 Transcript of Anne Hollonds, 2 May 2022, 60 [3–12].

11 Submission 074 Commissioner for Children and Young People, 8.

12 Hobart consultation, 13 August 2021; Launceston consultation, 19 August 2021; Queenstown consultation, 27 August 2021.

13 Statement of Kathrine Morgan-Wicks, 24 May 2022, 57 [479].

14 Statement of Jan Shuard, 4 September 2022, 8 [39].

15 Tasmanian Government, *Safe Homes, Safe Families: Tasmania's Family Violence Action Plan 2015–2020* (August 2015).

16 Tasmanian Government, *Safe Homes, Families, Communities: Tasmania's Action Plan for Family and Sexual Violence 2019–2022* (July 2019).

17 Tasmanian Government, *Survivors at the Centre: Tasmania's Third Family and Sexual Violence Action Plan 2022–2027* (November 2022).

18 Tasmanian Government, *Survivors at the Centre: Tasmania's Third Family and Sexual Violence Action Plan 2022–2027* (November 2022) 25.

19 Department of Premier and Cabinet, 'Family and Sexual Violence', *Community Partnerships and Priorities* (Web Page, undated) <https://www.dpac.tas.gov.au/divisions/cpp/community-policy-and-engagement/family-and-sexual-violence>.

20 Tasmanian Government, *Safe Homes, Families, Communities: Responding to Family and Sexual Violence – A Guide for Service Providers and Practitioners in Tasmania* (Report, January 2021) 3.

21 Department of Justice, 'Tasmanian Government Response to the National Royal Commission's Recommendations', 20 September 2021, produced by the Tasmanian Government in response to a Commission notice to produce.

22 Tasmanian Government, *Survivors at the Centre: Tasmania's Third Family and Sexual Violence Action Plan 2022–2027* (November 2022) 10.

23 Tasmanian Government, *Survivors at the Centre: Tasmania's Third Family and Sexual Violence Action Plan 2022–2027* (November 2022).

24 Tasmanian Government, *Survivors at the Centre: Tasmania's Third Family and Sexual Violence Action Plan 2022–2027* (November 2022) 13 (Action 1).

25 Tasmanian Government, *Survivors at the Centre: Tasmania's Third Family and Sexual Violence Action Plan 2022–2027* (November 2022) 16 (Action 12).

26 Tasmanian Government, *Survivors at the Centre: Tasmania's Third Family and Sexual Violence Action Plan 2022–2027* (November 2022) 19 (Action 24).

27 Tasmanian Government, *Survivors at the Centre: Tasmania's Third Family and Sexual Violence Action Plan 2022–2027* (November 2022) 20 (Action 28).

28 Tasmanian Government, *Survivors at the Centre: Tasmania's Third Family and Sexual Violence Action Plan 2022–2027* (November 2022) 22 (Action 31).

29 Tasmanian Government, *Survivors at the Centre: Tasmania's Third Family and Sexual Violence Action Plan 2022–2027* (November 2022) 13 (Action 2).

30 Tasmanian Government, *Survivors at the Centre: Tasmania's Third Family and Sexual Violence Action Plan 2022–2027* (November 2022) 13 (Action 4).

31 Tasmanian Government, *Survivors at the Centre: Tasmania's Third Family and Sexual Violence Action Plan 2022–2027* (November 2022) 14 (Action 5).

32 Tasmanian Government, *Survivors at the Centre: Tasmania's Third Family and Sexual Violence Action Plan 2022–2027* (November 2022) 16 (Action 14).

33 Tasmanian Government, *Survivors at the Centre: Tasmania's Third Family and Sexual Violence Action Plan 2022–2027* (November 2022) 17 (Action 18).

34 Tasmanian Government, *Survivors at the Centre: Tasmania's Third Family and Sexual Violence Action Plan 2022–2027* (November 2022) 22 (Action 32).

35 Tasmanian Government, *Survivors at the Centre: Tasmania's Third Family and Sexual Violence Action Plan 2022–2027* (November 2022) 23 (Action 35).

36 Tasmanian Government, *Survivors at the Centre: Tasmania's Third Family and Sexual Violence Action Plan 2022–2027* (November 2022) 24.

37 Tasmanian Government, *Safe Homes, Families, Communities: Tasmania's Action Plan for Family and Sexual Violence 2019–2022* (July 2019) 31.

38 Department of Premier and Cabinet, *Tasmanian Government's Interim Response to the Commission of Inquiry* (Report, 30 June 2023); Solicitor-General of Tasmania, *Procedural Fairness Response*, 20 June 2023, 1; *Royal Commission into Institutional Responses to Child Sexual Abuse* (Final Report, December 2017) vol 6, 211, (Recommendation 6.4); *Royal Commission into Institutional Responses to Child Sexual Abuse* (Final Report, December 2017) vol 7, 283 (Recommendation 7.9).

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40 Department of Social Services, *National Plan to End Violence Against Women and Children 2022–2032* (Commonwealth of Australia, 2022) 22.

41 Department of Social Services, *National Plan to End Violence Against Women and Children 2022–2032* (Commonwealth of Australia, 2022); Department of the Prime Minister and Cabinet, *National Strategy to Prevent and Respond to Child Sexual Abuse 2021–2030* (Commonwealth of Australia, 2021).

42 Divina Haslam et al, *The Prevalence and Impact of Child Maltreatment in Australia: Findings from the Australian Child Maltreatment Study: Brief Report* (Report, Australian Child Maltreatment Study, Queensland University of Technology, 2023) 17–18.

43 Department of Justice, *Fifth Annual Progress Report and Action Plan 2023* (Report, December 2022) 11; Department of Premier and Cabinet, *Tasmanian Government's Interim Response to the Commission of Inquiry* (Report, 30 June 2023); 'Updates on Implementation of Recommendations from the Child Safe Governance Review', *Department of Health* (Web Page, 23 February 2023) <https://www.health.tas.gov.au/news/health-alerts/updates-implementation-recommendations-child-safe-governance-review>.

44 Statement of Timothy Cartwright, 22 August 2022, 4 [18].

45 Statement of Timothy Cartwright, 22 August 2022, 4 [19–21].

46 Statement of Timothy Cartwright, 22 August 2022, 4 [20].

47 Statement of Timothy Cartwright, 22 August 2022, 4 [20].

48 Statement of Jan Shuard, 4 September 2022, 8 [37].

49 Statement of Timothy Cartwright, 22 August 2022, 9 [49].

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20 State Service disciplinary processes

1 Introduction

A key element of an institution's response to child sexual abuse is the action they can take when there is an allegation of child sexual abuse or related conduct (such as boundary breaches or grooming behaviour) against a staff member within their organisation, including any disciplinary action. Within the State Service, the *State Service Act 2000* ('State Service Act'), the State Service Code of Conduct and the Employment Directions that relate to suspensions, misconduct investigations and the ability of an employee to perform their role, form the central components of the State Service disciplinary system.[1]

Throughout our Inquiry, we heard there were significant problems with the Tasmanian State Service disciplinary system, particularly as it relates to matters involving child sexual abuse or related conduct. Problems with the disciplinary system resulted in slow or inadequate responses to concerning staff behaviour, leaving children to be cared for or supervised by people who posed a potential threat to their safety. To address these problems, we make recommendations in this chapter to:

- clarify and strengthen the articulation of expected and acceptable behaviour of state servants, including conduct outside of their employment
- improve the disciplinary processes that Heads of Agencies can follow in response to concerning staff behaviour, including considering child safety and a complainant's needs

- encourage the Tasmanian Industrial Commission to consider the special requirements that should apply when addressing child sexual abuse in relation to employment matters.

We also make observations about the role of unions in promoting child safety and invite their support in reforming the disciplinary process.

In this chapter, we set out how State Service disciplinary processes fit within the broader institutional response to allegations and concerns about child sexual abuse and related conduct.

We explain how the main mechanisms of the State Service disciplinary system—including unions and the industrial system—operate. We discuss the problems and failures we heard about the disciplinary system when it is used to address matters involving child sexual abuse, and recommend improvements.

In this chapter, while the focus is on the disciplinary provisions within the State Service Act and associated policies and procedures (the 'State Service disciplinary system'), we acknowledge obligations on the State arising from the broader employment framework. This framework includes the *Industrial Relations Act 1984* and registered awards and agreements. While we do not explicitly refer to these broader frameworks in this chapter, we tested our recommendations with relevant stakeholders and experts. We understand the delicate and, at times, difficult balance incumbent on the State between exercising a duty of care to ensure the safety of children and complying with obligations to an employee in matters relevant to child sexual abuse.

We consider that, in exercising this balance, the duty of care to children has too often been compromised because of barriers within the existing disciplinary framework and its practical application. In this chapter, we seek to identify and address these barriers.

Our proposed reforms require a significant shift in how the State approaches this process and may require changes to awards and agreements. We consider that prioritising child safety justifies this approach.

2 Institutional responses to child sexual abuse

In Chapter 18, we discuss the obligation of Tasmanian Government departments that provide services to children to become child-safe organisations. This includes having child-focused processes for complaints and concerns. The National Royal Commission noted that responses to complaints of child sexual abuse encompass a range of actions that institutions should take. These actions include:

- Identifying complaints—child or adult victim-survivors who disclose possible child sexual abuse should be taken seriously.
- Assessing risk—potential safety issues for victim-survivors and other parties should be identified and action taken to ensure their safety (including for the subject of the complaint where necessary).
- Reporting—all relevant bodies and institutions should be informed of the complaint, including, for example, the police, the Registrar of the Registration to Work with Vulnerable People Scheme, the Strong Families, Safe Kids Advice and Referral Line, and any relevant professional oversight body.
- Communicating and providing support—departments may be required to communicate with all affected parties and must assess the need for, and be able to provide, support for those involved, including complainants, parents, employees and other affected children.
- Investigating—this process should begin after a complaint is received and risk assessment completed. Some actions, for example, ensuring the integrity of a location as soon as possible after a complaint is received, can be crucial to an investigation.
- Maintaining records—institutions should maintain relevant records, including of investigation processes.
- Completing a root cause analysis—where required, review the circumstances of the complaint to identify possible systemic factors that may have contributed to the incident.
- Monitoring and reviewing—have policies and procedures to help continually improve the 'protection of children for whom the institution has responsibility'.[2]

In Chapter 6, we recommend establishing a Child-Related Incident Management Directorate. This Directorate would support agencies to meet the requirements outlined by the National Royal Commission, as would our recommendations for improved complaints policies and processes in each of our focus institutions: education, out of home care, youth detention and health (refer to Recommendations 6.6, 6.7, 6.8, 9.31, 9.32, 12.35, 15.16, 15.17). The Directorate would be responsible for three core functions comprising:

- support for local-level responses through case management
- investigations
- legal review of the investigation, and recommendations to the Secretary.

The State Service's disciplinary system would control management of child sexual abuse-related misconduct matters by the Directorate, including procedures for an investigation and the recommendations made at the end of an investigation.

3 State Service disciplinary system

The State Service disciplinary system has remained largely unchanged for more than 20 years. This section provides a brief outline of the system's main features, key elements of which we discuss in more detail throughout this chapter.

If an allegation of child sexual abuse is made against a staff member, a preliminary assessment is conducted to decide whether the matter should be investigated to determine if there has been a breach of the State Service Code of Conduct. We understand preliminary assessments are sometimes carried out before the Head of Agency is aware of the allegation.[3]

Once the preliminary assessment is complete, the information is transmitted to the Head of Agency who then decides how to respond to the allegations. The response may include:

- suspension
- investigation for a breach of the State Service Code of Conduct
- terminating employment when an employee no longer holds minimum requirements for employment (such as a loss of Registration to Work with Vulnerable People).

These processes are guided by Employment Directions issued by the Premier.

If the Head of Agency has reasonable grounds to believe a breach of the State Service Code of Conduct may have occurred, then the Head of Agency is required to appoint an investigator to investigate and determine whether the employee has breached the State Service Code of Conduct.[4]

At the end of the investigation, if the Head of Agency determines there has been a breach of the State Service Code of Conduct, they may apply sanctions, including counselling, a reprimand, reassignment of duties or termination of employment.[5]

We note the State has a continued duty of care to an employee who is alleged to have breached the Code the Conduct during the relevant Employment Direction process.

Unions play a role in this process by:

- providing information and support to their members
- ensuring procedures are adhered to throughout the disciplinary process.

Unions can also support members to appeal to the Tasmanian Industrial Commission against adverse decisions.

4 Problems with disciplinary processes

In this section, we outline the problems we heard that relate to disciplinary processes in the State Service.

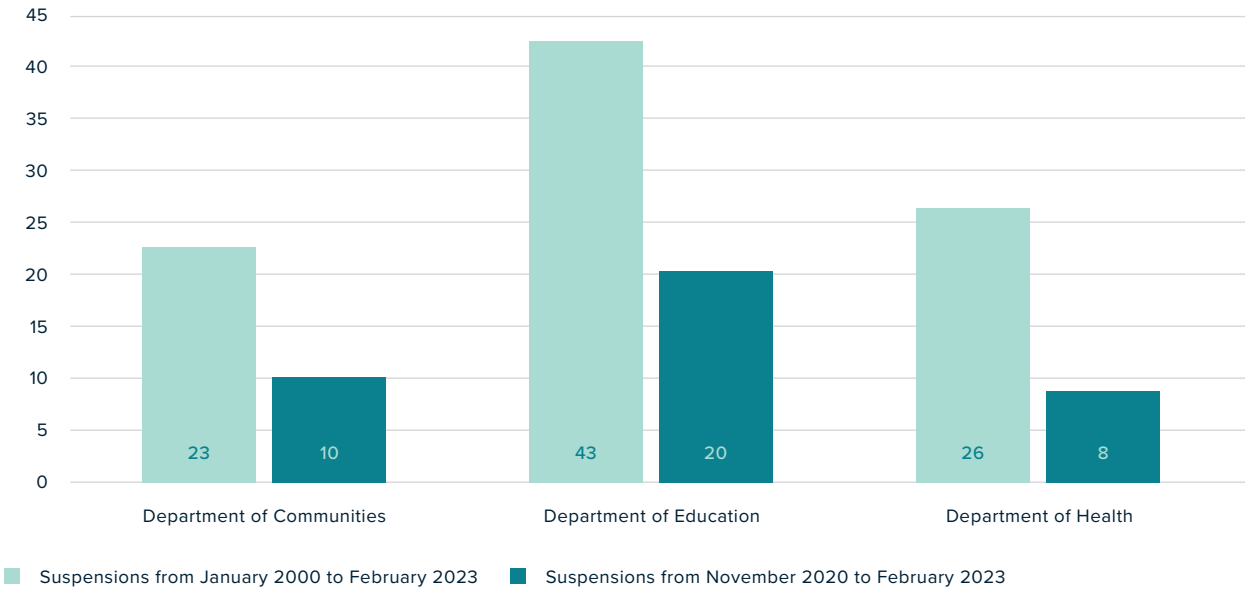
We examine the sudden increase in the number of state servant suspensions by respective departments, which was one factor that instigated the establishment of our Inquiry. It is possible such disciplinary action had been avoided previously because of the inadequacy of the disciplinary processes we heard about and the difficulties in terminating the employment of staff in matters pertaining to child sexual abuse.

4.1 Suspensions in the State Service

As discussed in Chapter 1, an increasing number of state servant suspensions due to concerns about child sexual abuse contributed to establishing our Commission of Inquiry.

By February 2023, we were aware there had been 92 state servants suspended from their employment since 1 January 2000 in relation to allegations of child sexual abuse or related conduct in the then Department of Communities, the then Department of Education and the Department of Health. These are outlined in Figure 20.1 and in more detail below.[6]

Figure 20.1: Suspensions by department for the period January 2000 to February 2023 and for the period November 2020 to February 2023[7]



Source: Tasmanian Government, *ED trackers* produced by the Tasmanian Government in response to Commission notices to produce, 2023.

4.1.1 Department of Communities

Of the 23 suspensions reported by the former Department of Communities (now the Department for Education, Children and Young People), 10 occurred since or just before the announcement of our Inquiry in November 2020.[8] Nineteen suspensions related to employees staff at Ashley Youth Detention Centre.[9] In Chapter 11, Case study 7, we consider the Department's response to allegations of child sexual abuse made against staff at Ashley Youth Detention Centre. In that case study, we describe instances where employees remained on site despite the Department being aware of allegations through redress claims, civil litigation and other complaints.

Within the 23 suspensions, there were four suspensions in relation to Child Safety Services since 2000.[10] Two of these suspensions occurred during our Inquiry. We discuss this concerningly low number of suspensions in Chapter 8.

The Department acknowledged that poor record keeping and inaccurate data collection affected the reliability of the data the Department provided in relation to Ashley Youth Detention Centre and out of home care.[11] Some staff were suspended multiple times without being dismissed. The Department did not routinely report matters to the Registrar of the Registration to Work with Vulnerable People Scheme, Child Safety Services and Tasmania Police.

4.1.2 Department of Education

In the former Department of Education, records provided to us indicate there had been 43 suspensions relating to allegations of child sexual abuse or related conduct between January 2000 and February 2023, with 20 of these occurring since the announcement of our Inquiry.[12] In Chapter 5, we discuss some of these cases and the effects of the Department's initial investigations on victim-survivors. In this chapter, we discuss some problems with disciplinary processes highlighted by these case studies. The Department's record keeping in the period set by our terms of reference was much better than that of other departments, although we were told of issues with its record keeping outside this period.

4.1.3 Department of Health

There were 26 suspensions in the Department of Health since January 2000 to February 2023, with eight of these occurring since the announcement of our Inquiry.[13] Our review of the information on suspensions the Department provided suggest the Department routinely notified the Registrar of the Registration to Work with Vulnerable People Scheme when it suspended employees in relation to alleged child sexual abuse. However, the Department was not consistent in how it reported matters to police or other regulatory bodies such as the Australian Health Practitioner Regulation Agency ('Ahpra') or the Strong Families, Safe Kids Advice and Referral Line.[14]

4.2 Inadequacy of disciplinary processes

Through submissions, sessions with a Commissioner, stakeholder consultations, roundtable discussions and public hearings, we identified difficulties with State Service disciplinary processes and procedures. Criticisms and concerns about disciplinary processes as they relate to allegations of child sexual abuse came not only from victim-survivors and their families and supporters but, also, government officials tasked with administering disciplinary processes—from human resources staff to departmental secretaries.

In summary, these problems included:

- A one-size-fits-all approach under the disciplinary system means the investigative processes used in cases of serious misconduct, such as child sexual abuse, are the same as those used for lower-level misconduct.
- There is no ability to immediately terminate employees in cases of serious misconduct where it is overwhelmingly clear the misconduct occurred or the employee admits to the misconduct.
- The basis for, and timing of, suspending employees is unclear following an allegation or incident of child sexual abuse.
- The process for terminating employment is unnecessarily difficult in situations where an employee no longer possesses the certification or accreditation necessary to perform their role.
- The State Service provides insufficient guidance on issues and considerations regarding disciplinary processes.

More specifically, we heard wide-ranging criticisms of and concerns about disciplinary processes regarding each of the institutions we examined.

In the context of children in schools, we received evidence that:

- Narrow and legalistic interpretations of the State Service Code of Conduct meant that despite information suggesting that children might be at risk, the behaviour did not result in disciplinary action. This was particularly the case when behaviour occurred outside school grounds.[15]
- Investigations tended to consider each individual allegation in a complaint separately rather than assessing whether the allegations reflected a pattern of behaviour consistent with sexual abuse or boundary breaches such as grooming.[16]
- Investigation processes were slow, not trauma-informed, did not reflect good practice when interviewing children (where this occurred), and did not appear to understand grooming behaviours.[17]

- Some departmental responses lacked an understanding of child sexual abuse and related concerns.[18]
- Investigations ended if a teacher resigned.[19]
- There was not enough support, care and communication with children, parents, staff and the school community.[20]
- Preliminary assessments appear to have been treated as mini-investigations and developed as a way to deal with disciplinary matters before engaging with the more involved Employment Direction No. 5—Breach of Code of Conduct process.[21]

Regarding children in out of home care, we observed:

- Low numbers of disciplinary processes. Because of poor record keeping, it was difficult to determine whether there had been more disciplinary action than that reported to us or whether the Department had been slow to take action against staff for concerning behaviour.[22]

Regarding children in youth detention, we make the following findings and observations in Chapter 11:

- The State Service disciplinary framework was not suited to managing risks associated with child sexual abuse.[23]
- There were problems with the preliminary assessment process, including:
    - applying a high threshold to the initiation of a disciplinary investigation and, instead, conducting a proxy investigation through preliminary assessment processes
    - a lack of clarity in the process for initiating a preliminary assessment regarding a conflict of interest, including identifying a suitable decision maker
    - unacceptable delays in the process risked exposing children to ongoing harm.[24]
- The Department adopted informal practices of 'putting allegations' to alleged perpetrators for response.[25]
- The Department showed a reluctance to consider the cumulative impact of multiple allegations.[26]
- At times, serious complaints were being investigated by staff at Ashley Youth Detention Centre and not being appropriately escalated.[27]
- At times, the Department did not adequately and appropriately investigate complaints in a timely manner, including complaints made by staff and detainees, and allegations made through redress schemes.[28]

- There were real or perceived challenges in responding to allegations of child sexual abuse against staff due to industrial pressures.[29]
- One of the limitations on the Department's ability to investigate complaints or take disciplinary action regarding allegations of child sexual abuse or related conduct by staff was the absence of provisions in the State Service Code of Conduct relating directly to child safety or child abuse.[30]
- At least until late 2020, due to legal advice or a practice that had developed, no disciplinary action was taken regarding allegations about staff from redress schemes without the Department seeking a sworn statement from a complainant.[31]
- In late 2020, the Department changed its approach to taking disciplinary action against staff who had allegations of child sexual abuse against them and started to place appropriate weight on public interest considerations.[32]
- Despite improvements over the last few years, there continues to be significant delays in taking disciplinary action against staff with allegations of child sexual abuse against them.[33]
- There appeared over time to be a tension or 'push-pull' between the prioritisation of risks to child safety and risks to staff morale and wellbeing. We saw periods where concerns about child safety appeared to be dominant, but over time as the Department attempted to respond to safety concerns emerging from staff culture and conduct, the wellbeing of staff would reemerge as a dominant consideration.[34]

Regarding children in health services, we make the following findings or observations in Chapter 14:

- Investigators examining child sexual abuse allegations in health services should have access to relevant expertise and provide victim-survivors with the option to take part in an investigation.[35]
- There were perceived limitations on taking disciplinary action against a staff member under the State Service Code of Conduct because the requirement that employees abide by Australian law was assumed to require evidence that a person has been convicted of a crime.[36]
- There is a need to apply independent and rigorous investigatory and disciplinary processes to complaints in health settings and for these processes to use trauma-informed practices to minimise trauma for complainants.[37]
- Launceston General Hospital failed to consider the cumulative effect of complaints about James Griffin.[38]
- None of the many concerns raised with Mr Griffin were responded to with a disciplinary response harsher than a letter, education and direction. A disciplinary

process was only recommended when there was no other option but to do so, namely, when Mr Griffin was unable to perform his duties when his Registration to Work with Vulnerable People was suspended on 31 July 2019.[39]

- Launceston General Hospital's response to Will Gordon's 2017 Safety Reporting and Learning System complaint did not comply with the requirements of a State Service Code of Conduct investigation.[40]
- Standards of behaviour for staff working in child-facing roles should have been in place, so Mr Griffin's conduct could be transparently assessed and disciplinary action triggered in response to his repeated failures to comply with the standards. The State Service Code of Conduct is not sufficient to assess child safety complaints given its general nature.[41]
- The disciplinary process into Mr Griffin was aborted when he resigned. This practice means the institution does not have the opportunity to learn from any systemic issues that may arise by examining the alleged conduct. Once such a process stops, there is no record preventing the ex-employee from being re-employed to the State Service at a later date.

4.3 Difficulties with terminating employment

Terminating the employment of an employee from the Tasmanian State Service is difficult. We were told this difficulty stems from the provisions of the State Service Code of Conduct and the processes for terminating employment such as Employment Direction No. 5—Breach of Code of Conduct.

According to the interim report of the *Independent Review of the Tasmanian State Service*, terminations of employment from the State Service for breaches of the State Service Code of Conduct are difficult and, therefore, rare.[42] The Independent Review's final report, published in 2021, examined (among other things) the Tasmanian State Service's misconduct and disciplinary framework. The Independent Review's remit was all types of breaches of the State Service Code of Conduct, not only matters involving child sexual abuse. It reported 320 allegations of breaches of the State Service Code of Conduct in the five years before the report's publication. Of these allegations, just over half, 165 (52 per cent), were confirmed breaches, of which only 11 (about 4 per cent) resulted in termination of employment.[43] Stakeholders told the Independent Review that 'the overly prescriptive nature of procedures associated with separations in the [Tasmanian State Service] may be impacting on rates at which employees are terminated for breaches of the Code of Conduct or underperformance'.[44] The Independent Review found, compared with the proportion of terminations of employment for misconduct in the Australian Public Service, terminations of employment for Code of Conduct violations in the Tasmanian State Service were much lower.[45]

Similarly, a 2021 report for the Department of Premier and Cabinet, *Critical Analysis Report on Termination in the State Service,* noted the disciplinary system in Tasmania was heavily prescriptive compared with other states and territories, and that this resulted in lower resolution rates for misconduct matters and longer times to resolve such matters.[46] The report concluded that the low turnover rate in the Tasmanian State Service was:

> caused by the prescriptive nature of procedures in the [Tasmanian State Service]. Because a failure to strictly adhere to each step could result in the termination being alleged to have been mismanaged, extensive time is taken to ensure everything is covered and every step is taken.
>
> This focus, internally, on form over substance then unduly narrows the focus of the [Tasmanian Industrial Commission]. The [Tasmanian Industrial Commission] is reviewing strict procedures which already burden the [Tasmanian State Service] system and is not empowered, through legislation, to take a more practical or discretionary view of matters.[47]

The Independent Review's interim report observed that stakeholders had expressed concerns that 'employer-initiated terminations are rarely used in the [Tasmanian State Service] … termination is very difficult, even for very clear examples of underperformance or misconduct'.[48] Stakeholders noted that the reasons for this included:

- misconduct procedures were difficult
- natural justice requirements could be overly burdensome
- there are 'general sensitivities around terminations'.[49]

Some people who engaged with our Commission of Inquiry made similar observations about difficulties associated with misconduct and disciplinary procedures. For example, Michael Easton, Chief Executive Officer, Integrity Commission, said public sector agencies in Tasmania were generally 'overly risk averse' when contemplating taking action against employees.[50] In Mr Easton's view, this stemmed from an approach in government agencies that over-emphasised privacy and confidentiality, and agencies' desire to 'avoid employees being reinstated by the Tasmanian Industrial Commission'.[51]

Likewise, Eric Daniels, former Chief Executive, Hospitals North/North West in the Department of Health, told us he thought there was a 'conservative industrial environment' in the Tasmanian State Service.[52] Mr Daniels said, in his experience:

> [n]ot associated with child sexual abuse but associated with other what I consider to be reasonably significant matters in relation to the practice of individuals, are treated with quite significant delicacy, for want of a better word, to ensure procedural fairness.[53]

When asked whether it was fair to say there was a focus on industrial relations rather than on child safety when managing concerns about employees, Mr Daniels hypothesised that he believed this was the case.[54]

A further general observation about the nature of employment in the Tasmanian State Service is that Tasmania's relatively small population may contribute to the 'general sensitivities' about terminations of employment. For example, Professor Richard Eccleston, University of Tasmania, told us that '[g]iven the broader community dynamics in Tasmania, there is also a risk that obligations to colleagues might trump obligations to uphold high ethical standards in the workplace'.[55] Professor Eccleston went on to say:

> [t]here are strong social and professional connections among the population and among many employees of the [Tasmanian State Service]. These interdependencies make it particularly difficult to maintain integrity and a commitment to process and ethical conduct.[56]

We are concerned that a culture of not addressing poor professional conduct, of any nature, may embolden child sexual abuse offenders in the workplace.

5 Amending the State Service Code of Conduct

5.1 State Service Code of Conduct

The State Service Act governs the conduct of Tasmanian State Service employees. The Act's provisions set out the standards and conduct expected of State Service employees and the consequences for engaging in misconduct. Relevant to employee misconduct, the Act includes:

- the State Service Code of Conduct[57]
- sanctions for breaches of the State Service Code of Conduct[58]
- provisions regarding the termination of employment.[59]

Section 9 of the State Service Act outlines the State Service Code of Conduct. The State Service Code of Conduct outlines the required behaviour of all state servants. It is broad in nature, which means it does not contain specific provisions about child sexual abuse. This reflects a similar approach across most Australian states and territories.[60] Still, depending on the situation, child sexual abuse and related conduct could constitute a breach of several provisions of the State Service Code of Conduct.

Relevant to matters that involve child sexual abuse and related conduct, several provisions in the State Service Code of Conduct require that all State Service employees conduct themselves in particular ways 'in the course of State Service employment'. For example, employees must, in the course of their employment:

- behave honestly and with integrity[61]
- act with care and diligence[62]
- treat everyone with respect and without harassment, victimisation or discrimination[63]
- comply with the law[64]
- behave in a way that upholds the State Service Principles.[65] (These principles include that the State Service performs its functions 'in an impartial, ethical and professional manner'.)[66]

State Service employees also 'must at all times behave in a way that does not adversely affect the integrity and good reputation of the State Service'.[67] This requirement captures conduct that does not occur in the course of employment but has a sufficient nexus between the conduct and the employee's State Service employment (this is discussed in Section 5.3).

State Service employees must also comply with any lawful and reasonable direction given by a person having authority to give the direction.[68]

Depending on the situation, child sexual abuse and related conduct (including boundary breaches and grooming behaviours) may contravene the State Service Code of Conduct by:

- breaching the State Service Principle of ethical and professional behaviour
- being a breach of applicable law
- victimising children
- adversely affecting the integrity and good reputation of the State Service.

A finding that an employee has breached the State Service Code of Conduct can result in sanctions, including:

- counselling
- a reprimand
- reassignment of duties
- termination.[69]

However, as explained, we understand that termination of employment is seldom used in relation to sanctions imposed for breaches of the State Service Code of Conduct and that it can be difficult to terminate employees from the Tasmanian State Service.

5.2 Suitability for child safety

Several people told us the State Service Code of Conduct is not suitable for taking disciplinary action in relation to child sexual abuse or related conduct. Timothy Bullard, Secretary of the Department for Education, Children and Young People, said the State Service Code of Conduct 'is not a framework well suited to the determination of allegations of child abuse'.[70]

Kathrine Morgan-Wicks, Secretary of the Department of Health, considered the State Service Code of Conduct should be amended to include a specific provision aimed at prohibiting specific behaviours.[71] Michael Pervan, then Secretary of the former Department of Communities, said the State Service Code of Conduct was ill-suited to investigating evidence from redress applications and allegations of child sexual abuse in general.[72]

Professors Stephen Smallbone and Tim McCormack, who conducted the Independent Education Review, observed that the generic nature of the Code's provisions meant it was 'ill-suited to the particular contexts of schools' in that it could not 'adequately deal with allegations of child sexual abuse made against Department of Education employees'.[73]

These comments about the general unsuitability of the State Service Code of Conduct to deal with matters involving child sexual abuse or child safety were affirmed by Ginna Webster, Secretary, Department of Justice, and Jenny Gale, Secretary, Department of Premier and Cabinet and Head of the State Service, both of whom indicated that the State is considering reforms to the State Service Code of Conduct.[74]

5.3 A Code of Conduct that responds to risks of child sexual abuse

It is apparent there are deficiencies and problems with the application or interpretation of the State Service Code of Conduct, particularly when it is used to address matters involving child sexual abuse. These problems contribute to the difficulty in taking disciplinary action against employees. They include the fact the State Service Code of Conduct and/or its narrow interpretation gives insufficient weight to the risk that a state servant's behaviour may place children in danger of sexual or other forms of abuse. These problems arise from the interpretation of the following requirements of the State Service Code of Conduct that:

- an employee must comply with all applicable Australian law
- an employee must at all times uphold the integrity and good reputation of the State Service
- conduct must be 'in the course of employment' or have a 'nexus' to employment.

These interpretations are discussed in the following sections.

The application of these provisions is guided by advice from the Office of the Solicitor-General. As discussed in Chapter 17, there are limits to a government department's ability to seek legal advice from external lawyers. Heads of departments are required to follow the advice of the Solicitor-General.

5.3.1 Comply with Australian law

As noted, State Service employees must comply with all applicable Australian law in the course of their employment.[75] Child sexual abuse is a breach of the law and, if the perpetrator was found guilty in a court, this would constitute a breach of this provision of the State Service Code of Conduct. Further, given that disciplinary processes attract a lower standard of proof, if it was determined on the balance of probabilities that an employee was likely to have committed a criminal act of sexual abuse, the employee would have contravened the Code requirement to comply with all applicable Australian law.[76]

However, there appears to be a 'historical and cultural' application which means this provision has not been applied unless there has been a proven breach of an Australian law (to the criminal standard).[77]

Secretary Morgan-Wicks told us that the Australian law requirement:

> is considered to be applicable only where the relevant offending of child sexual abuse has been proven in an Australian court of law (i.e. an offender has been found not to have complied with an applicable Australian law) and not where there is only an investigation, or charges only have been laid, or court proceedings are pending or underway.[78]

Similarly, Secretary Bullard observed that 'where a prosecution does not proceed or is unsuccessful', the Head of Agency will rely on other provisions of the Code of Conduct to take disciplinary action, which are normally those relating to behaving with honesty and with integrity, acting with care and diligence, or acting with respect and without harassment, victimisation or discrimination.[79] These provisions relate to conduct that is in the course of employment.

The Tasmanian State Service Code of Conduct is based on the Australian Public Service Code of Conduct.[80] The latter's guidance for the equivalent provision—must comply with all applicable Australian law—makes it clear that the decision maker does not need to wait until a breach of the law has been proven in a court for the provision to apply.[81]

Noting that criminal prosecutions often do not proceed for reasons unrelated to whether the perpetrator committed the offence (including, for example, when the alleged victim is very young or is unwilling to give evidence in a criminal trial), we suggest the broader interpretation, based on the balance of probabilities that criminal conduct has occurred, would allow for a focus on child safety. As a matter of principle, we assume the Government would wish to be able to ensure that state servants who are likely to have committed a child sexual abuse offence can be removed from the State Service.

5.3.2 Uphold the integrity and good reputation of the State Service

Section 9(14) of the State Service Code of Conduct requires an employee to 'at all times behave in a way that does not adversely affect the integrity and good reputation of the State Service'. This provision appears to be broad and allow the Head of Agency to take disciplinary action against an employee who had been involved in sexual activity or related conduct with a child or young person, irrespective of where that conduct occurred. Unlike many of the other relevant requirements in the State Service Code of Conduct, it does not state that the conduct must be in the 'course of employment'.

The Office of the Solicitor-General has provided advice on the interpretation of the integrity and good reputation provision, suggesting 'integrity' or 'good reputation' in this section are not concerned with:

> ...general considerations relating to the private behaviour, morality or fitness of character of a particular employee, unless there can be said to be a nexus between the behaviour and employment in the [Tasmanian State Service], in the context of accountability to the government, the parliament and the public. Whether there is a nexus requires an evaluative judgement, in the particular circumstances of the case.[82]

Under this interpretation of section 9(14), there is still a requirement for there to be a nexus between the employee's behaviour and their employment in the State Service (in the context of accountability to the Government, the Parliament and the public) for the provision to apply. Presumably, this limitation reflects the view that some aspects of private behaviour should not attract a disciplinary sanction. For example, historically, this could have protected state servants from sanctions simply because they were living with a person outside marriage or had unusual political opinions.

In the context of child sexual abuse, we consider that a better approach is to specifically deal with behaviour that places children at risk, rather than relying on value judgments about whether there is a nexus between the conduct complained of and its propensity to adversely affect the integrity and good reputation of the State Service. In other words, where a state servant works with children or young people and the alleged conduct involves a child or young person, this should supply the necessary nexus or link between that conduct and the disciplinary processes that apply under the State Service Code of Conduct.

In other jurisdictions, similar requirements that state servants not behave in ways that can adversely affect the State Service are defined in ways that may avoid this issue. For example, in Queensland, misconduct is defined in section 187 of the *Public Service Act 2008* (Qld) as:

> (a) inappropriate or improper conduct in an official capacity; or (b) inappropriate or improper conduct in a private capacity that reflects seriously and adversely on the public service.

The Code of Conduct for the public service in Queensland also states that state servants will 'ensure our private conduct maintains the integrity of the public service and our ability to perform our duties'.[83]

Further, we note that in the Australian Public Service ('APS') Code of Conduct, employees are required to behave in a way that upholds 'the integrity and good reputation of the employees' Agency and the APS' *at all times*.[84] This requirement is explained as follows:

> 2.28. Under s.13(11), employees must at all times uphold the Values and Employment Principles and behave in a way that upholds the integrity and good reputation of their agency and the APS. This means that APS employees' behaviour outside work is subject to the Code to the extent that:
>
> - it could reasonably be viewed as failing to uphold the integrity and good reputation of the employee's agency or the APS, or
> - it could reasonably call into question the employee's capacity to comply with the Values and Employment Principles in their work—for example, their ability to be impartial or respectful.[85]

This requirement of the Australian Public Service Code of Conduct is interpreted as applying to an employee's conduct 'outside normal work hours and at non-work premises'.[86] The Australian Public Service advice on interpreting section 13(11) of the Code of Conduct further states that while there is no explicit requirement for conduct to be connected to the employee's employment, in practice, however, a finding that conduct has breached the code 'will generally require some degree of connection to the employee's employment'.[87]

The Tasmanian legislation should make clear that the requirement that employees are to behave in a way that does not 'adversely affect the integrity and good reputation of the State Service' in section 9(14) includes employee conduct outside work where the relevant behaviour means that children and young people are at risk of harm.

5.3.3 Conduct in the course of employment

The term 'in the course of State Service employment' is used in several subsections of the State Service Code of Conduct. Based on evidence at our hearings and the materials provided to us, we consider that the term does not adequately protect children from sexual abuse.[88] The present application of 'in the course of employment' can result in conduct such as grooming behaviour that occurs outside of work situations not being regarded as misconduct under the State Service Code of Conduct, when it should. Secretary Bullard told us:

> It's important to note that these subsections directly relate to conduct that is 'in the course of State Service employment'. In other words, misconduct that occurs outside the work context (e.g. at a weekend social event or after a young person has left the school where the alleged perpetrator is teaching), would not naturally invoke

> the [disciplinary] process [to investigate whether the Code of Conduct has been breached] as it would not amount to 'in the course of State Service employment'.[89]

Secretary Webster made similar observations about these restrictions in the State Service Code of Conduct:

> The current Code of Conduct is largely limited to investigations within 'the course of employment' or 'in connection with employment'. There are limitations on investigations under [the Code of Conduct] where the alleged conduct occurs outside the workplace, and where the threshold for a criminal investigation or prosecution is not reached.[90]

In 2021, the State Service Management Office provided the Department of Health with an interpretation of the meaning of the phrase 'in the course of State Service employment' in relation to the State Service Code of Conduct, stating that this would include conduct 'directly associated with and expected of an employee at work and in the course of their duties and can include travelling for work purposes'.[91] This interpretation is based on workers compensation law cases that have discussed the meaning of 'in the course of employment' in an industrial relations context.[92] We consider the test for a connection to employment in the context of workers compensation should differ from that applied in connection with disciplinary matters related to the conduct of state servants towards children.

The Office of the Solicitor-General has also provided advice to Department of Health staff on the meaning of 'in the course of employment', arriving at an equally narrow interpretation, but based on High Court authority on vicarious liability, not workers compensation law.[93] The meaning of the words 'in the course of employment' in the context of a civil compensation claim, in which it is argued the State should be held vicariously liable for the behaviour of a state servant, may differ from the way it should be interpreted in deciding whether a state servant should be disciplined for their behaviour that places children at risk of harm.[94]

This narrow interpretation of 'in the course of employment' has meant that, in some cases, inappropriate behaviours towards children and young people were deemed not to have occurred in the course of employment. For example, we heard in victim-survivor Rachel's (a pseudonym) case, the 2006 investigation into the conduct of her teacher, Wayne (a pseudonym), which included saying she had 'a nice arse', drawing a penis with a pen on her ankle and providing her with alcohol, found that he had not breached the State Service Code of Conduct as the relevant conduct had occurred during a non-school sports trip.[95] (Rachel's case is discussed in Case study 'Wayne' in Chapter 5.) The investigation concluded that although these incidents had occurred, they did not occur in the course of Wayne's employment with the Department of Education.[96] This conclusion was based on advice from the Office of the Solicitor-General.[97] When asked about this advice, Sarah Kay SC, the Solicitor-General, told us:

> I wasn't asked there about whether action could be taken or what action could be taken, it was a question about the construction of a phrase in the statute. And, they are the words of the statute, so whether something might be considered inappropriate or not objectively is a separate matter to considering the scope of the words that we're dealing with in section 9 of the State Service Act.[98]

We acknowledge that if the situation that arose in Rachel's case were to arise in 2023, it would most likely be handled differently. Secretary Bullard explained that, in 2022, a sufficient nexus would be drawn between Wayne's conduct and his employment for the purpose of the State Service Code of Conduct:

> Ongoing conduct, even outside of school hours, can be held to account and therefore included in the [disciplinary] process where the conduct occurred because of a relationship that had developed out of the employee/student relationship.
>
> ...
>
> If allegations such as those raised by Rachel were raised today, the Department would review all allegations in light of there being such a nexus between the allegations and being 'in the course of employment'.[99]

Secretary Bullard told us that, in 2022, the student-teacher relationship would be relevant *at all times*, not just while on school grounds or during school hours. [Emphasis added.][100]

However, we note that the State Service Code of Conduct has not changed. Secretary Bullard acknowledged that the requirement for conduct to be 'in the course of employment' is an ongoing issue: '[t]he need to establish a nexus between the alleged conduct and it being "in the course of employment" means that the Department remains exposed to failings and criticism'.[101] The Solicitor-General also told us she had not observed any change in the way her Office views 'course of employment'.[102]

Regarding the Department of Health, Secretary Morgan-Wicks told us she had been notified of matters involving allegations against Department employees where there were questions about the nexus between the conduct and the employee's employment.[103] Secretary Morgan-Wicks told us, in these cases, she had applied a low threshold and had suspended employees while an investigation was undertaken despite the conduct in question having occurred outside the workplace.[104] She said this was done to place 'child safety absolutely at the centre'.[105] We support this approach.

In our view, the requirement that there be a nexus between conduct and employment will continue to compromise the safety of children in government institutions. To ensure their safety, the State Service Code of Conduct should be able to hold state servants accountable for behaviours associated with child sexual abuse, wherever those behaviours occur, including outside of the workplace or after working hours. Where an employee has contact with children or young people through their work, and an allegation is made against that employee, the fact that the connection between the employee and the child or young person is through the employee's work should be enough to warrant disciplinary action to ensure all children and young people in that workplace are protected.

We considered other Australian jurisdictions to determine if there was guidance for the Tasmanian Government on how to address the issue of a nexus to employment. In the Northern Territory, an employee will commit a breach of discipline if the employee 'in the course of employment or in circumstances having a relevant connection to his or her employment, conducts himself or herself in an improper manner'.[106] The meaning of 'relevant connection' in this context is not defined, but it may capture a broader range of behaviour as being connected to employment.

In the Australian Capital Territory, section 9 of the *Public Sector Management Act 1994* (ACT) sets out conduct requirements for public servants, some of which relate to conduct 'when acting in connection with the public servant's job'.[107] While 'acting in connection with' is not defined, the Australian Capital Territory Public Sector Standards Commissioner guidelines state that, in relation to the definition of misconduct, '[t]here is no restriction on where or when this conduct occurs and [it] may relate to behaviour that occurs outside of the workplace'. The guidance then notes this may particularly be the case where 'there is a clear connection between the employee's out-of-hours conduct and their employment'.[108]

However, without access to legal advice such as that obtained through our inquiries in relation to the Tasmanian State Service Code of Conduct, it is difficult to draw conclusions about other jurisdictions. As a general observation, other jurisdictions appear to emphasise the need to always uphold the ethical standards of the public sector at all times, although they also make reference to 'in the course of employment'.[109]

We note that professional bodies such as Ahpra and the Teachers Registration Board, which regulate the conduct of health professionals and teachers respectively, have provisions in their legislation that allow them to consider the behaviour of these professionals outside a work setting. Ahpra can take immediate action against a registered health professional based on a 'public interest test' for conduct that may occur outside the practice of a health practitioner's profession (which could include child sexual abuse occurring outside the work environment).[110]

The Teachers Registration Board assesses a teacher's suitability against a good-character test and fitness-to-teach test. The Board can immediately suspend a teacher's registration if it reasonably believes they may pose a risk of harm to students for any reason.[111] The decisions of the Board affect a person's employment, and we consider they could be used as examples for the basis of a similar test in the State Service Code of Conduct.

In relation to police, there are provisions in Western Australia and Tasmania relating to 'loss of confidence'.[112] This enables a Head of Agency to terminate an employee's employment where they have lost confidence in the suitability of an employee to continue in their position having regard to competence, integrity, performance, conduct, or loss of community confidence.[113]

Recommendation 20.1

1. The Tasmanian Government should, by introducing legislation or through other means, ensure that the State Service Code of Conduct includes the following binding obligations:

    a. if a state servant's conduct creates an unacceptable risk to the safety and wellbeing of children or young people accessing government and government funded services, the State Service disciplinary framework should apply, and termination, suspension or sanction should be available (including being able to terminate employment based on a loss of confidence)

    b. in relation to child sexual abuse and related conduct, the requirement that state servants must comply with all applicable Australian law is determined on the basis of a balance of probabilities test and does not require a breach of the law to be determined by a court

    c. where a state servant has contact with a child or young person through their work, and an allegation is made of child sexual abuse or related conduct in relation to that child, this contact is sufficient to establish the conduct occurred 'in the course of employment' or, in the case of section 9(14), has a nexus to employment regardless of whether the conduct complained of occurred outside the workplace or outside working hours.

2. The Tasmanian Government should develop policy documents or guidance on the interpretation of the State Service Code of Conduct explaining (among other things):

    a. how the required connection between a state servant's employment and a child and young person should be interpreted in matters that involve child sexual abuse or related conduct

    b. explain that all provisions of the Code of Conduct should be interpreted to prioritise the protection of children.

5.4 Professional conduct policies

The broad application of the State Service Code of Conduct means it does not contain specific provisions about child sexual abuse. This has led some to call for a separate code of conduct for state servants working in organisational contexts that serve children, particularly in education.[114]

For example, in their evidence to our Inquiry, Professors Stephen Smallbone and Tim McCormack, authors of the *Independent Inquiry into the Tasmanian Department of Education's Responses to Child Sexual Abuse*, told us the State Service Code

of Conduct was 'generic' and inadequate for the specific context of schools.[115] As we note in Chapter 4, in their report, Professors Smallbone and McCormack recommended a separate code of conduct for schools.[116]

While we agree with the problem identified by Professors Smallbone and McCormack, we are reluctant to recommend a specific code of conduct for each institutional area that serves children. In his evidence, Secretary Bullard was also hesitant to endorse the idea of an education-specific code of conduct due to the current drafting of the State Service Act:

> … if I could reflect on the professors' report, they came back with a recommendation that we should have an education-specific code of conduct, they called it. Our advice is that that would be difficult under the current drafting of the Act because you're going to end up with duelling codes, but the closer that we can get to describing behaviours that are or aren't acceptable in a context, the better.[117]

We are also conscious that developing an institution-specific code of conduct would not be in line with the approach in most Australian jurisdictions, which have one code of conduct applying across the public sector.[118]

To meet the intent of Professors Smallbone and McCormack's proposal, we recommend professional conduct policies be instituted in all child-serving government institutions.

These departmental policies should address child sexual abuse, including related conduct such as boundary breaches, grooming and other inappropriate behaviours of a sexual nature, for example, voyeurism, and inappropriate speech and other forms of communication, including electronic communication.[119]

To ensure disciplinary action can be taken for conduct that breaches these professional conduct policies, the State Service Code of Conduct should be amended to include a provision that stipulates that when a breach of a specified departmental policy occurs, this breach may amount to a breach of the State Service Code of Conduct. This would avoid the situation that currently exists; for example, in education, where a breach of a departmental policy must be shown to amount to a direct breach of one or another of the provisions of the State Service Code of Conduct, such as a failure to act with due care or diligence in section 9(2) or the requirement that employees must behave in a way that does not adversely affect the integrity and good reputation of the State Service in section 9(14).[120]

We understand that, at the time our hearings concluded in September 2022, the State Service was exploring changes to its Code of Conduct and to disciplinary processes.[121] One such potential change was the use of standing orders made under the State Service Act to link specific prohibited behaviours to breaches of the State Service Code of Conduct. Section 34(2) of the Act provides that a Head of Agency can make standing orders for administration and operation of the agency. It is a requirement of the State Service Code of Conduct that an 'employee must comply with any standing orders *and* with any lawful and reasonable direction given by a person having authority to give the

direction' [emphasis added] (section 9(6)). However, it appears that, in practice, in the event of a failure to follow a lawful and reasonable direction there does not need to also be a standing order to establish a breach of the State Service Code of Conduct.[122]

Secretary Gale told us she had asked the State Service Management Office, which is in the Department of Premier and Cabinet and advises Secretary Gale on State Service employment matters, to:

> ... investigate the use of standing orders for departments which may then make clear the link between certain behaviours that must or must not occur through a standing order that then would make the link between that behaviour and the Code of Conduct quite explicit.[123]

The standing orders could allow specific behaviours to be proscribed in the particular settings in which they are likely to occur, for example, health, education, out of home care or youth justice. They could allow for specific behaviours to be described and prohibited.

However, we note this approach to regulating misconduct in the State Service was previously attempted in the Department of Education. Documents provided to us show that the Department's policy document, *Professional Standards for Staff,* was initially intended to be in the form of a standing order. It was drafted and internally approved as such in 2013 after comprehensive consultation. Before the document could receive final approval from the Premier, the Solicitor-General advised the Department that standing orders could not be used for this purpose.[124] We are unclear why this was the case. The consequence of that advice was that *Professional Standards for Staff* (and its associated guidelines) became a policy document.[125]

Even if standing orders can now be used for this purpose, we do not consider there should also have to be a lawful and reasonable direction, in addition to the requirements set out in a professional conduct policy, before there can be a breach of the State Service Code of Conduct. We understand this may reflect current practice.[126]

To improve how State Service disciplinary processes operate in respect of child sexual abuse allegations and related conduct, we recommend the State Service Code of Conduct be amended to include a provision that a breach of a specified departmental professional conduct policy may be taken to be a breach of the Code, without needing to assess whether a separate provision of the State Service Code of Conduct has been breached.

5.4.1 Content of professional conduct policies

The relevant departmental professional conduct policy should specify what behaviours are, or are not, acceptable regarding the behaviour of their employees towards children and young people. Following the National Royal Commission's advice on codes

of conduct and observations we have made throughout our report (refer especially to Chapters 6, 9, and 12), these departmental professional conduct policies should:

- explain what behaviours are unacceptable, including concerning conduct, misconduct or criminal conduct
- define and prohibit child sexual abuse, grooming and boundary violations. These definitions should be consistent across departments and should align with the Tasmanian Government's Child and Youth Safe Organisations Framework established by the *Child and Youth Safe Organisations Act 2023* ('Child and Youth Safe Organisations Act') and avoid vague terms such as 'appropriate' and 'inappropriate', unless they are further defined and examples provided
- acknowledge the challenge of maintaining professional boundaries in small communities and provide clear identification of, instructions about and examples of how to manage conflicts of interest and professional boundaries in small communities
- provide guidance on identifying behaviours that are indicative of child sexual abuse, grooming and boundary violations relevant to the particular context of the organisation
- outline the types of behaviours that must be reported to authorities, including what behaviours should be reported to police, child protection authorities, the Registrar of the Registration to Work with Vulnerable People Scheme and the Independent Regulator of the Reportable Conduct Scheme or other relevant agencies
- outline the protections available to individuals who make complaints or reports in good faith
- provide and clearly outline response mechanisms for alleged breaches of the policy
- specify the penalties for breach, including that a breach of the policy may be taken to be a breach of the State Service Code of Conduct, without needing to assess whether a separate provision of the Code has been breached, and may result in disciplinary action
- include a statement that the failure to report a breach or suspected breach of the policy may be taken to be a breach of the policy
- cross-reference any other policies, procedures and guidelines that support, inform or otherwise relate to the professional conduct policy, for example, complaints-handling or child protection policies or other codes of conduct relevant to particular professions.

The professional conduct policies should be:

- easily accessible to everyone in the department and communicated by a range of mechanisms
- explained to, acknowledged and signed by all employees
- accompanied by a mandatory initial training session and regular refresher training, including as part of professional development training
- communicated to children and young people and their families through a range of mechanisms, including publication on the department's public facing website.[127]

We consider that professional conduct policies should also outline that sexual relationships between State Service employees and young people are prohibited for a period of two years in certain situations. We note the Teachers Registration Board's *Professional Boundaries: Guidelines for Tasmanian Teachers* cautions that a sexual relationship between a teacher and a recent student that occurs within two years of the student turning 18 or finishing compulsory education (whichever is later) will likely result in an investigation by the Board that could result in disciplinary action, regardless of whether the teacher taught that student.[128] In assessing the appropriateness of the teacher's conduct in such cases, the Teachers Registration Board will consider a range of other factors in addition to the time that has passed since the former student ceased to be a student or turned 18. These include:

- the age difference between the teacher and the recent student
- the emotional and social maturity of the recent student
- the vulnerability of the recent student
- evidence regarding the nature of the past teacher-student relationship, including the closeness, dependence, significance, and length of the relationship in the educational setting
- any other conduct that may impact on the teacher's good character and/or fitness to teach during the professional relationship with the student.[129]

Similar imbalances of power and authority may also exist in other contexts where an adult is in a position of authority, care or protection of a child or young person because of the adult's employment or work. For example, child protection workers, doctors and nurses can have relationships with children and young people that are characterised by authority, care and protection. To guard against the possibility that a relationship between an employee and a young person has developed as a result of a breach of professional boundaries (including through grooming behaviours), we recommend that departmental professional conduct policies include a prohibition on romantic or sexual relationships between an employee and a young person where the employee is in

a position of authority, care and protection of the young person for two years after the employee's position of authority, care or protection has ended or the young person turns 18, whichever is later. This requirement does not displace any other professional and ethical obligations.

In Chapter 16, we discuss the recent introduction of a criminal offence of penetrative sexual abuse of a child or young person by a person in a position of authority. We also consider it important to include provisions regarding the position of authority in the professional conduct policies.

We also consider that a professional conduct policy should make it clear that repeatedly not following reasonable directions is a breach of professional standards (refer to Chapter 14, Case study 3 for an example of Mr Griffin repeatedly failing to follow direction).

Further to these considerations, useful guidance to help protect children and young people in government institutions may be provided by professional conduct policies in other Australian jurisdictions. Tasmanian Government departments should draw on relevant codes of conduct (and any related guidance) in other Australian jurisdictions in drafting professional conduct policies.

Departments should also ensure the professional conduct policy spells out expected standards of behaviour for volunteers, contractors, sub-contractors and other adults where relevant to the specific organisation, and use appropriate mechanisms to ensure volunteers, contractors and sub-contractors comply with the policy.

5.4.2 Professional conduct policies and the State Service Code of Conduct

The approach we recommend—that a breach of a specified departmental professional conduct policy may be taken to be a breach of the State Service Code of Conduct—will allow child and young people-facing government departments to have specific policies tailored to the requirements of their areas of responsibility that can directly ground a breach of the State Service Code of Conduct. In our volumes and chapters on education, health, youth justice and out of home care, we recommend that specific 'professional conduct policies' be developed that will ground a breach of the State Service Code of Conduct.

This approach avoids the need to align a breach of a departmental policy with one of the general provisions of the State Service Code of Conduct. If an employee is found, after an investigation conducted in line with disciplinary processes, to have breached the relevant departmental professional conduct policy, then this may be taken to be a breach of the State Service Code of Conduct.

We have heard suggestions that the responsiveness of the State Service Code of Conduct to child sexual abuse matters could be improved by including a specific reference to child sexual abuse or a provision relating to serious misconduct in the Code itself. For example, Secretary Morgan-Wicks wrote that:

> In my respectful view the Code of Conduct could be strengthened to include a specific subsection to prohibit violence or abuse against a vulnerable person, grooming behaviours or other behaviours leading to an investigation or charge for the commission of an indictable offence. Suspension with pay could automatically apply and any investigation would depend on the outcome of a police investigation or court proceeding.[130]

While there is merit in this, and in similar suggestions to amend the State Service Code of Conduct, we consider our recommended approach would provide more flexibility in that it would allow government departments to tailor their professional conduct policies to their institutional contexts but still ground a breach of the State Service Code of Conduct to suit their specific needs and circumstances. And, if required, the departmental policy in question could be amended relatively quickly to account for unanticipated behaviours or consequences, for example, in response to changes in technology-facilitated abuse.

Recommendation 20.2

1. All Heads of Agencies whose agencies provide services to children should develop a professional conduct policy for the agency's employees that:
    a. explains what behaviours are unacceptable, including concerning conduct, misconduct or criminal conduct
    b. defines and prohibits child sexual abuse, grooming and boundary violations, in language consistent with the *Child and Youth Safe Organisations Act 2023.*
2. The professional conduct policy should:
    a. acknowledge the challenge of maintaining professional boundaries in small communities and provide clear identification of, instructions about and examples of how to manage conflicts of interest and professional boundaries in small communities
    b. provide guidance on identifying behaviours indicative of child sexual abuse, grooming and boundary violations relevant to the particular organisation
    c. outline behaviours that must be reported to authorities, including what behaviours should be reported to Tasmania Police, Child Safety Services, the Registrar of the Registration to Work with Vulnerable People Scheme and the Independent Regulator under the *Child and Youth Safe Organisations Act 2023*, or other relevant agencies
    d. provide that not following reasonable directions is a breach of professional standards

e. provide that a failure to report a breach or suspected breach of the policy may be taken to be a breach of the policy

f. outline the protections available to individuals who make complaints or reports in good faith

g. provide and clearly outline response mechanisms for alleged breaches of the policy

h. specify the penalties for a breach, including that a breach of the policy may be taken to be a breach of the State Service Code of Conduct without needing to assess whether a separate provision of the Code has been breached, and may result in disciplinary action

i. cross-reference any other policies, procedures and guidelines that support, inform or otherwise relate to the professional conduct policy, for example, complaints handling or child protection policies or other codes of conduct relevant to particular professions.

3. The professional conduct policies should be:

   a. easily accessible to everyone in the agency and communicated by a range of mechanisms

   b. explained to and acknowledged and signed by all employees

   c. accompanied by a mandatory initial training session and regular refresher training, including as part of professional development training

   d. communicated to children and young people and their families through a range of mechanisms, including publication on the agency's public-facing website.

4. The professional conduct policies should include a specific prohibition on romantic or sexual relationships between an employee and a young person where that employee has been in a position of authority, care or protection with the young person for two years after the young person turns 18 or the employee's position of authority, care or protection has ended, whichever is later. This requirement should operate in addition to any other professional and ethical obligations.

5. Heads of Agencies should ensure the professional conduct policy spells out expected standards of behaviour for volunteers, contractors and sub-contractors, and other adults where relevant to the specific organisation and use appropriate mechanisms to ensure their compliance with the policy.

6. The Tasmanian Government should introduce legislation, or other binding mechanisms, to ensure:

   a. a breach of a departmental professional conduct policy may be taken to be a breach of the State Service Code of Conduct, without needing to assess whether a separate provision of the Code has been breached

   b. such a breach does not have to be accompanied by a lawful and reasonable direction for there to be a breach of the Code of Conduct.

5.5 Intersection with the Reportable Conduct Scheme

The Child and Youth Safe Organisations Act came into effect on 1 July 2023. As discussed in Chapter 18, the Act introduces the Government's Child and Youth Safe Organisations Framework, which comprises the Child and Youth Safe Standards and a Reportable Conduct Scheme. In section 7 of the Act, 'reportable conduct' is defined broadly, as including:

- a relevant offence (these offences are defined in the Act and relate to child sexual offences in the *Criminal Code Act 1924*)
- sexual misconduct, which includes inappropriate behaviour, physical contact, voyeurism and speech or other communication including electronic communication when performed in a sexual manner or with a sexual intention
- grooming of a child
- conduct that causes or is likely to cause emotional or psychological harm to a child.[131]

Under the Reportable Conduct Scheme, it is the responsibility of government departments to investigate whether an employee has committed reportable conduct.[132] It should be clear that where an employee is found to have committed reportable conduct, this is a breach of the State Service Act. To achieve this, there should be a mechanism to ensure that reportable conduct, as defined in the Child and Youth Safe Organisations Act, is a breach of the State Service Code of Conduct in section 9 of the State Service Act.

Recommendation 20.3

The Tasmanian Government should introduce legislation to ensure that where a finding is made that a State Service employee has committed reportable conduct under the Reportable Conduct Scheme, this also constitutes a breach of the State Service Code of Conduct under section 9 of the *State Service Act 2000*.

5.6 Contractors, volunteers and temporary staff

The State Service Act applies to 'employees', who are defined as permanent employees or fixed-term employees.[133] This means certain people who perform duties for the State Service, for example, foster care volunteers for the Department for Education, Children and Young People, are not subject to the State Service Code of Conduct.

There are specific policies with which contractors, volunteers and temporary staff must comply. For example, relief teachers were previously expected to comply with the Department's Conduct and Behaviour Standards, and a failure to do so resulted in removing them or flagging them on the Fixed Term and Relief Employment Register.[134] However, this also meant the Department was not obligated to conduct a thorough review of any conduct-related matter. As discussed in Case study 'Brad' in Chapter 5, the Department's response to the matter involving a relief teacher was conducted outside the State Service's disciplinary processes through a 'duty of care lens' and further investigation depended on the relief teacher's response.[135] The inability to treat breaches of departmental policies as breaches of the State Service Code of Conduct because of the employment classification of the person who has committed the breach may not be in the interests of child safety. We have been told by the State that relief teachers are now included in the category of employee covered by the State Service Act.[136]

Under the proposed Reportable Conduct Scheme, a reportable allegation against a 'worker' must be investigated.[137] A 'worker' is defined in the Act as including someone who is 'engaged by the entity to provide services, including as a volunteer, contractor … whether or not the person is engaged in connection with any work or activity of the entity that relates to children'.[138] To align the Reportable Conduct Scheme with any disciplinary processes, and to protect children, we encourage the State Service to ensure the obligations and provisions of the State Service Code of Conduct apply to contractors, sub-contractors, volunteers and temporary staff. However, the process for terminating employment or applying other sanctions to contractors, sub-contractors volunteers and temporary staff should remain simpler than for terminating the employment of permanent employees.

Recommendation 20.4

The Tasmanian Government should introduce legislation to ensure the provisions in the professional conduct policies apply to contractors, sub-contractors, volunteers and other adults who have contact with children.

6 Employment Directions

To take disciplinary action against an employee, including for child sexual abuse or related conduct, the Head of Agency must comply with Employment Directions issued by the Premier.[139] Relevant to our Commission of Inquiry, Employment Directions provide instruction on how the State Service must manage matters concerning employee misconduct, including suspensions, investigations of alleged breaches of the State Service Code of Conduct, and considerations relevant to whether an employee no longer has the ability to perform their role. The relevant Employment Directions to our Inquiry are:

- Employment Direction No. 4—Procedures for the suspension of State Service employees with or without pay (Employment Direction No. 4—Suspension)
- Employment Direction No. 5—Procedures for the investigation and determination of whether an employee has breached the Code of Conduct (Employment Direction No. 5—Breach of Code of Conduct)
- Employment Direction No. 6—Procedures for the investigation and determination of whether an employee is able to efficiently and effectively perform their duties (Employment Direction No. 6—Inability). This direction may apply when a person no longer has the capacity to perform their role or does not satisfy the minimum requirements for employment, such as registration to work with vulnerable people or professional registration.

These Employment Directions are dated 4 February 2013, and were to be reviewed one year later, but remain current.[140] These disciplinary processes must be undertaken at the direction of the Head of Agency, who is the ultimate decision maker. Before any disciplinary process for misconduct under Employment Direction No. 5—Breach of Code of Conduct takes place, there is often what is called a preliminary assessment. As we noted, preliminary assessments are sometimes carried out before the Head of Agency is aware of the allegation.[141] Once the preliminary assessment is complete, the information is transmitted to the Head of Agency, who then decides whether the matter should be investigated.

While investigations are initiated and disciplinary measures applied by Heads of Agencies, the Head of the State Service and the State Service Management Office also have a role in the administration of employment-related matters. The Head of the State Service manages employment-related matters in the State Service on behalf of the Minister administering the State Service Act and is responsible for the employment framework and overarching guidelines.[142] The Head of the State Service is supported in this role by the State Service Management Office.[143]

We note that neither the State Service Act nor Employment Direction No. 5—Breach of Code of Conduct mentions 'misconduct'. Rather, they refer to breaches of the State Service Code of Conduct. However, it is standard practice to refer to a breach of the State Service Code of Conduct as misconduct and we have adopted that approach.[144]

Many people who engaged with our Inquiry were critical of the Employment Directions and how they functioned in relation to matters that involve protecting children. We discuss these issues in more detail in this section.

There have been several recommendations to amend aspects of the Employment Directions, particularly Employment Direction No. 5—Breach of Code of Conduct, over the years.[145] Documents provided to us show that amendments to the current Employment Directions were drafted in 2016.[146] However, these amendments were not implemented. It is unclear why the amendments did not result.

In 2021, the final report of the *Independent Review of the Tasmanian State Service* recommended that the Government rewrite all Employment Directions.[147] In relation to disciplinary processes, the Independent Review concluded that the 'overly prescriptive' nature of these processes affected how they were managed, such that 'the risk associated with taking action is often so high that managers elect not to proceed'.[148] Further, the review noted that the 'top heavy' nature of misconduct procedures, requiring the involvement of the Head of Agency in many of the steps, led to delays.[149]

The Government has accepted all the Independent Review's 77 recommendations and set a five-year implementation period. At the time of writing, it was implementing the first stage of those recommendations, which includes several amendments to Employment Directions.[150]

The Independent Review's recommendations about Employment Directions include that:

- all unnecessary Employment Directions be revoked and, where required, converted to practice guides or other suitable instruments
- the remaining Employment Directions be rewritten as 'standards-based directions, with increased flexibility for agency decision making and process design'
- Employment Direction No. 5—Breach of Code of Conduct be rewritten to be standards-based, and to allow for Heads of Agencies to adapt investigations based on the circumstances of the alleged breach
- Employment Direction No. 5—Breach of Code of Conduct be rewritten to allow for 'a simple, local process to be used where the facts are clear and not disputed and the agency seeks to impose a low-level sanction'.[151]

While these recommendations are not specifically aimed at issues associated with child safeguarding, they will undoubtedly help to increase the responsiveness of the State Service misconduct and disciplinary processes by ensuring serious matters take precedence for investigation. We also consider there should be further reforms to improve the State's disciplinary response to allegations of child sexual abuse. The State Service Employment Directions are not well suited to protecting children because they place disproportionate weight on the rights of employees. Under these directions, it is difficult for Heads of Agencies to take action that prioritises the safety of children. To address these concerns, we make several recommendations, including:

- formalising the preliminary assessment process
- improving Employment Direction No. 5—Breach of Code of Conduct, including increasing the rights of complainants and children, increasing the speed of investigations, ensuring investigations are informed about the nature of child sexual abuse and are child/victim centred, and clarifying that all matters relevant to children should be considered potential serious misconduct
- providing for immediate termination of employment in specific situations
- allowing for the immediate suspension of staff when there is a risk to child safety
- simplifying the process for ending the employment of staff who do not hold requisite registration, such as a working with vulnerable people registration.

We also call for the Head of the State Service to play a more active role in leading the State Service in the conduct of disciplinary processes through providing guidance and advice and undertaking active monitoring and reporting.

6.1 Preliminary assessments

Preliminary assessments are not currently part of Employment Directions. However, when misconduct by a state servant is alleged, it is common practice for staff to undertake a preliminary assessment to determine whether to recommend to the decision maker (usually the Head of Agency) to appoint a person to formally investigate the matter under Employment Direction No. 5—Breach of Code of Conduct. Preliminary assessments are used to assess whether the decision maker would be able to form a reasonable belief that there may have been a breach of the State Service Code of Conduct. It is also used to determine the most appropriate way to respond to the conduct in question. A threshold consideration in conducting a preliminary assessment is whether the alleged conduct occurred in the course of the employee's State Service employment.

The government agencies we examined use preliminary assessments. From the period January 2000 to February 2023, the numbers were:

- 24 preliminary assessments by the then Department of Communities
- 48 preliminary assessments by the then Department of Education
- 9 preliminary assessments by the Department of Health.[152]

6.1.1 Problems with preliminary assessments

Preliminary assessments seem to have developed to determine whether the threshold for engaging with the formal investigative processes required by Employment Direction No. 5—Breach of Code of Conduct has been reached. While gathering some information is necessary to confirm basic facts about the alleged misconduct or incident, there is a danger that a preliminary assessment can assume the role of a de facto investigation but without independence, appropriate considerations or safeguards for victims and witnesses, and procedural fairness for alleged perpetrators.[153] Further, because preliminary assessments are generally not subject to formal rules or policy frameworks, they are usually not subject to specific timeframes.

For example, under clause 7.3 of Employment Direction No. 5—Breach of Code of Conduct, where it is likely that an investigation will require interviewing a child or young person, the relevant Head of Agency must ensure the process is 'sensitive and appropriate' to the age, maturity and personal circumstances of the child or young person. Further, before such an interview is conducted, consideration should be given to obtaining appropriate permissions and whether the child or young person should be accompanied by a parent, guardian or other support person.[154] None of these requirements apply to preliminary assessments because they are not part of the Employment Directions.

6.1.2 Guidance (and policies) on preliminary assessments

Most of the government agencies we engaged with did not have a specific policy on preliminary assessments, except for the recent introduction of such a policy in the Department of Health (which we discuss next). However, the Integrity Commission provides guidance on conducting preliminary assessments as part of its *Guide to Managing Misconduct in the Tasmanian Public Sector*.[155]

Integrity Commission guidance

As part of its 2017 own motion investigation into the management of how misconduct is managed in the public sector, the Integrity Commission produced a model preliminary assessment process and guidance on managing misconduct, including on conducting preliminary assessments.[156] It outlines the type of information that might be sought in a preliminary assessment, including time sheets or rosters, emails and personnel files, applicable policies and position descriptions, record access logs, and following up detail with the source of the complaint.[157] The guidance stresses it is important that

preliminary assessments do not turn into 'investigations' and they should be completed quickly: within three working days.[158] The Integrity Commission's guidance also cautions that interviews with anyone other than the source of the complaint should be avoided at the preliminary assessment stage.[159]

In our view, most of the Integrity Commission's guidance provides helpful and clear instruction on conducting preliminary assessments. However, it does not account for specific issues that may be raised in matters involving allegations of inappropriate conduct towards children or young people. Our recommendations in this section build on the Integrity Commission's guidance to ensure that preliminary assessments are conducted in a way that enhances child safety.

We understand the Integrity Commission is currently reviewing the Guide and the associated training module to consider changes in administrative law and good practice, including the need to consider trauma-informed practices and any relevant outcomes of our Inquiry.[160]

Department of Health

A 2019 audit of the Department of Health's conduct and investigation and management processes revealed preliminary assessments were taking the form of investigations. As a result, these preliminary assessments may not have been objective or have involved procedural fairness. This makes the process open to challenge and criticism.[161] Whether in response to the audit or otherwise, the Department developed Guidance Notes for conducting preliminary assessments.[162]

The Guidance Notes emphasise that preliminary assessments are not investigations—their purpose is not to uncover the facts of the matter. Nor should they 'make findings or arrive at conclusions regarding the alleged conduct'.[163] The Guidance Notes specify that preliminary assessments should be completed within three to seven business days. They note that where it is not possible to meet this timeframe, the reasons for the delay may need to be recorded and communicated to the parties.[164] The Guidance Notes also provide brief instruction on collecting information. This includes that, most times, witnesses should not be contacted, but further information may be required from the complainant. They also set out the possible courses of action that can be taken when the preliminary assessment concludes, including recommending the delegate of the Head of Agency initiate an investigation.[165]

While the Guidance Notes do not mention specific considerations relating to children or young people, an attached preliminary assessment form (for the assessor to complete) has a section relating to allegations of inappropriate conduct towards children. This section instructs that where an allegation involving children or young people is made, the assessor should refer to the Department's Internal Checklist—Child Related Allegations. Significantly, it instructs that the assessor should consider relevant

provisions in Employment Direction No. 5—Breach of Code of Conduct, which, as discussed earlier, require contact with a child to be 'sensitive and appropriate'. We have been told that the separate notation relating to children is to reflect 'the Department's position that an investigation will proceed, the employee be stood down and that such requires immediate action through Human Resources'.[166]

The form also sets out that a threshold consideration in conducting a preliminary assessment is whether the alleged conduct occurred in the course of State Service employment. This contrasts with the Integrity Commission's guidance. Their guidance highlights that the State Service Code of Conduct requires conduct 'in connection with' employment 'at all times' and 'in the course of' employment depending on the requirement, including that at all times the employee must act in a way that does not adversely affect the integrity and good reputation of the State Service.[167]

Department for Education, Children and Young People

The Department for Education, Children and Young People did not appear to have a specific policy about preliminary assessments. Relevantly, the Department's flowchart, *Advice for School Staff—Responding to Incidents, Disclosures or Suspicions of Child Sexual Abuse*, advises that, in supporting a child or young person who has suffered sexual abuse, staff should not question or interview the child or young person. The flowchart further states that Workplace Relations can provide advice about recording information and that a 'Concern Notice template' has been developed to help with this process (refer to Chapter 6).[168]

The former Department of Communities also did not appear to have a specific policy on conducting preliminary assessments. However, Michael Pervan, then Secretary of the Department of Communities, told us the Department had adopted the Integrity Commission's *Guide to Managing Misconduct in the Public Sector* when conducting preliminary assessments 'with a focus on the risk of safety to children and young people'.[169] We discuss in more detail in Chapter 11 on Ashley Youth Detention Centre, problems with the preliminary assessment processes in the then Department of Communities. The Department took considerable time to conduct preliminary assessments regarding several employees alleged to have engaged in incidents of child sexual abuse. In some cases, quasi-investigations were conducted, contrary to the Integrity Commission's guidance.[170] In relation to preliminary assessments, in Chapter 11, Case studies 5 and 7, we discuss problems in how the Department approached preliminary assessments, which contributed to delays in responding to serious allegations against staff at Ashley Youth Detention Centre.

6.1.3 Improvements to preliminary assessments

We consider that several improvements should be made to the preliminary assessment process to provide stronger safeguards for children and young people in government

institutions. The process of conducting preliminary assessments should be formalised across the State Service in Employment Direction No. 5—Breach of Code of Conduct (refer to Section 6.3). It should be stipulated that preliminary assessments are to be conducted as quickly as possible: within three to five business days. If more time is required, the reasons for the delay should be documented, a new timeframe set, and the reasons for the delay and the new timeframe communicated to the relevant parties. Preliminary assessments should be confined to a basic assessment of the matter and should not require evidence of wrongdoing. Such evidence should be considered and assessed at the investigative stage. Accordingly, interviews should not be conducted during a preliminary assessment. However, if an interview involving a child or young person is necessary at the preliminary assessment stage, then the interview should be subject to the same considerations as those in clause 7.3 of Employment Direction No. 5—Breach of Code of Conduct, including the matters discussed in Section 6.3 and in Recommendation 20.8.

Child-facing departments should develop policies for conducting preliminary assessments that suit their operating environments. These policies should be developed based on our recommendations and in line with the Integrity Commission guidance, where appropriate. Due to the nature of the preliminary assessment process, any such policies should not require procedural fairness to be accorded to the employee. If the outcome of the preliminary assessment recommends an investigation occurs under an employment direction, then procedural fairness will be accorded to the employee during that investigative process. We recommend the Child-Related Incident Management Directorate conducts preliminary assessments in matters involving child sexual abuse and related conduct.

We also consider that the question of whether the alleged conduct occurred in the course of the employee's State Service employment can involve complex considerations that will not lend themselves to a fast preliminary assessment process. The question of whether conduct occurred in the course of employment is better addressed at the investigative stage in all but the most obvious of cases.[171] We also note that our proposed changes to the State Service Code of Conduct will render the focus on a nexus to employment less central.

Recommendation 20.5

1. The State Service should develop guidance material for conducting preliminary assessments to ensure:

    a. they are conducted quickly (within three to five business days after an allegation is received)

b. the reasons for any delay are documented, a new timeframe set, and the reasons for the delay and the new timeframe are communicated to the parties if applicable in the circumstances

c. they are confined to a basic gathering of information and do not require evidence of wrongdoing

d. they do not assess whether the alleged conduct occurred in the course of the employee's State Service employment.

2. Victim-survivors and child witnesses should not normally be interviewed at the preliminary assessment stage to avoid them being interviewed more than once or being interviewed by a person without special skills. If it is necessary to interview a child or young person at this stage, then this should be done in line with clause 7.3 of Employment Direction No. 5—Breach of Code of Conduct. Any such interview should be conducted by individuals who have been trained in child development, child sexual abuse (including taking a Whole Story approach), and trauma-related behaviours.
3. Any engagement with a child or young person during the preliminary assessment stage should be child-centred and trauma-informed.
4. The Child-Related Incident Management Directorate should conduct preliminary assessments in child sexual abuse or related conduct matters.

6.2 Employment Direction No. 4—Suspension

One way to protect children from potential harm is to suspend staff who may pose a risk to children until a further assessment of risk is determined.

Employment Direction No. 4—Suspension allows a Head of Agency, who believes on reasonable grounds that it is in the public interest to do so, to suspend an employee with full pay if the Head of Agency believes that the employee:

- has, or may have, breached the State Service Code of Conduct in such a manner that the employee should not continue to perform his or her duties; or
- has been charged in or outside Tasmania with an offence punishable by imprisonment for a term exceeding six months; or
- is, or may be, unable to 'efficiently and effectively' perform their duties.[172]

Staff who do not have appropriate professional registration or a working with children registration would satisfy clause (c).

The Head of the State Service may, after considering submissions, suspend an employee without pay.[173] Decisions to suspend employees (either with or without pay) must be made on a case-by-case basis. Decisions should consider several factors, including whether:

- the breach of the State Service Code of Conduct is 'of such a serious nature that it is inappropriate for the employee to continue'; or
- it is in the 'best interests of the public, the Agency, other employees and the employee being investigated'.[174]

In terms of child safety in government institutions, we note two key issues with Employment Direction No. 4:

- There are questions about whether the suspension of an employee under Employment Direction No. 4 may occur *immediately* when misconduct is alleged or suspected; that is, the basis for an employee's immediate removal is uncertain.
- The requirement that the Head of Agency have reasonable grounds to believe that it is in the public interest to suspend an employee is an unnecessary barrier in matters involving child sexual abuse.

These points are discussed next.

6.2.1 Immediate suspension

The immediate removal of an employee from the workplace when there has been an allegation or incident of child sexual abuse is critical. However, there seems to be some uncertainty about the timing of employee suspensions in the State Service and the basis on which an employee is otherwise removed from the workplace.

Employment Direction No. 4 notes that:

> [A s]uspension is not a sanction, it is only to be used where an investigation of an employee is underway and proper investigation requires the employee to be absent or where because of the nature of the alleged offence it is not appropriate that the employee remain in the workplace.[175]

This provision has caused confusion because it appears to suggest that a suspension can only occur once a misconduct investigation has started. For example, it took the former Department of Health and Human Services (which was responsible for child protection and out of home care at the time) 166 days to suspend a rostered carer who was alleged to have sexually abused a 16-year-old girl in care (refer to Chapter 8).[176] This may have been partly due to the presumed requirement to conduct an Employment Direction No. 5 investigation before suspending a person for misconduct.

Secretary Gale told us that once a Head of Agency has formed a reasonable belief

there may have been a breach of the State Service Code of Conduct, they may suspend the employee on full pay. According to Secretary Gale, this allows Heads of Agencies to:

> adopt a zero-tolerance approach to allegations of child sexual abuse and remove employees against whom an allegation has been made from the workplace *immediately*, to avoid risk to the safety of children and young people [emphasis added].[177]

However, as discussed, whether a Head of Agency could form a reasonable belief that the State Service Code of Conduct has been breached is subject to a preliminary assessment process that can take several days at best and, as described in our case studies, several months at worst.

Departmental secretaries have (at least, recently) adopted different justifications for immediately removing employees from the workplace. These practices are welcome if they protect children. For example, Secretary Bullard told us that, as Secretary of the Department of Education, he had a 'duty of care' to children and young people who were under the care of the Department, indicating this justified an employee's immediate removal from a site when there had been an allegation or incident of child sexual abuse. He told us it was the Department's practice that:

> in every case where allegations of child sexual abuse are made against a current employee, the employee is requested, as soon as possible, to leave the workplace prior to service of formal documentation. If after initial examination of the circumstances it is concluded that employees may have breached the State Service Code of Conduct, they are then formally suspended in accordance with Employment Direction No. 4 at the same time as an investigation is commenced pursuant to Employment Direction No. 5.[178]

Regarding the former Department of Communities, then Secretary Pervan and Jacqueline Allen, then Acting Executive Director, People and Culture, told us that Employment Direction No. 4 did not allow them to suspend an employee from duty immediately after an allegation or incident of child sexual abuse was reported or became known.[179] Nor, in their understanding, did it allow for suspension to occur while a preliminary assessment was being conducted.[180]

Secretary Pervan told us that to minimise the risk to children and young people while Employment Directions No. 4 and No. 5 processes are commenced, the employee subject to the allegation was directed to 'remain away from the workplace'.[181] Secretary Pervan told us he had:

> an overriding legislative responsibility to manage and eliminate and/or minimise the health and safety risks to children and young people so far as reasonably practicable in accordance with the *Work Health and Safety Act 2012*.[182]

So, in then Secretary Pervan's view, removing an employee from the workplace in the former Department of Communities was justified based on workplace health and safety laws.[183]

The Department of Health's approach to the timing of suspension under Employment Direction No. 4 is unclear. The State has advised us that suspensions occur immediately.[184] Secretary Morgan-Wicks told us it 'is Department of Health practice that the respondent is formally advised of suspension pursuant to Employment Direction No. 4 pending further notification of actions to be taken'.[185] Secretary Morgan-Wicks further said:

> Where an allegation of child sexual abuse is made it is current practice that the Department Official is stood down, giving consideration to duty of care and the risk of the employee continuing in the workplace. This is considered in line with the considerations in section 6.4 of Employment Direction No. 4.
>
> The Department of Health does not currently have protocols or guidelines which cover the period between standing the Department Official down and the formal notification of suspension in accordance with Employment Direction No. 4.[186]

What is important for the safety of children and young people is that where there has been an allegation or incident of child sexual abuse, the subject employee is immediately removed from the workplace pending the start (or not, as the case may be) of disciplinary processes. We consider the basis on which this can occur should be clear.

We recommend that Employment Direction No. 4 provides for the immediate removal of an employee from the workplace when there is an allegation or incident of child sexual abuse. Suspension should not be contingent on the commencement of disciplinary processes. It should precede them. This will help to keep children safer in government institutions by providing a clear basis for removing employees who are subject to allegations of child sexual abuse from the workplace, while the necessary inquiries are made.

6.2.2 Belief that suspension is in the public interest

As discussed in this chapter, the Head of Agency must have reasonable grounds to believe it is in the public interest to suspend an employee under Employment Direction No. 4.[187] In our view, this requirement is superfluous when the allegation or incident involves child sexual abuse as immediate suspension will almost always be in the public interest. We consider child safety warrants, in matters involving allegations or incidents of child sexual abuse or related conduct, there not being the requirement that the Head of Agency have reasonable grounds to believe it is in the public interest to suspend an employee.

We also note that there are several factors the Head of Agency must consider on a case-by-case basis when deciding to suspend an employee.[188] These include the nature of the 'offence', the attitude of the public towards the breach and the employee, and the repercussions for the State Service.[189] However, there is no requirement to consider the safety of children or young people (or of other employees, for that matter). We consider that child safety should be included as a consideration in making such a decision.

Recommendation 20.6

The Tasmanian Government should amend Employment Direction No. 4—Suspension to:

a. specify that in matters involving complaints or concerns about child sexual abuse or related conduct of an employee, they may be suspended immediately

b. clarify, to avoid any doubt, that suspension can occur before the start of any disciplinary processes, including preliminary assessments

c. exclude, in matters involving complaints or concerns of child sexual abuse or related conduct, the requirement that the Head of Agency must have a reasonable belief that it is in the public interest to suspend the employee

d. include the safety of children and young people among the matters a Head of Agency must take into account when deciding whether to suspend an employee.

6.3 Employment Direction No. 5—Breach of Code of Conduct

Employers must be able to terminate the employment of, or take other disciplinary action against, staff who have harmed or pose a risk to children. Breaches of the State Service Code of Conduct are determined through the investigative processes set out in Employment Direction No. 5—Breach of Code of Conduct, which 'establishes … the procedures for the investigation and determination of whether an employee, senior executive, equivalent specialist or [an employee] has breached the State Service Code of Conduct'.[190]

Employment Direction No. 5 stipulates that the powers and functions it grants must not be delegated, except for the Head of Agency for the Department of Health and the Department for Education, Children and Young People.[191] It also stipulates that the procedures within it 'are to be applied with procedural fairness, natural justice and in a timely manner', noting that 'timely' means 'within a reasonable timeframe and free from unreasonable delay'.[192]

Where a Head of Agency has reasonable grounds to believe there may have been a breach of the State Service Code of Conduct, Employment Direction No. 5 requires them to appoint an investigator to investigate the alleged breach. Employment Direction No. 5 sets out several requirements for the ensuing investigation, including that:

- investigators must be impartial and report to the Head of Agency about the outcome of the investigation
- if the Head of Agency becomes aware that an employee has committed certain crimes, they may determine that the State Service Code of Conduct has been

breached without first conducting an investigation (the employee must be afforded procedural fairness and natural justice)

- if the investigation requires interviewing a child or young person:

> the head of agency must ensure that the processes involving the child are sensitive and appropriate, bearing in mind the age, maturity and personal circumstances of the particular child. Before interviewing a child, consideration must be given to such issues as the permission of the parent or guardian, the child being accompanied by a parent, guardian or support person and, where appropriate, keeping the child informed of the progress of the investigation.[193]

6.3.1 Procedural fairness and the rights of children

Employment Direction No. 5 also sets out other procedural fairness requirements for investigations, such as communicating suspected breaches to employees and informing them of the investigation, their rights regarding the investigation and the possible implications of the investigation.[194] There is no mention of the interests of a complainant in the conduct of an investigation. In the case of alleged child sexual abuse or related conduct, this may mean a child or parent does not have an automatic right of reply once the employee's version of events is presented, although the Head of Agency can request further investigations if new information comes to light.[195]

Employment Directions are focused on providing employees their right to know the allegations made about them and to answer them (often referred to as procedural fairness or natural justice). This focus stems from an 'employment relationship', where the employee is considered to be in the weaker position in relation to the employer: the State. However, this framework poses problems for protecting children in government institutions, who are in a weaker position than an employee within an institution. As explained by Secretary Gale, Employment Direction No. 5:

> exists to provide procedural fairness and natural justice to employees …
>
> It does not directly reference rights of the complainant, for example, to be kept informed of any investigation's progress or outcome.
>
> [Employment Direction No. 5] is not constructed with the primary goal of facilitating a trauma-informed or child-centred investigation process …[196]

Further, as then Secretary Pervan said, '[t]here is a real tension between child protection and natural justice being given to employees and the [Employment Direction] process favours the protection of employees'.[197]

The tension identified by then Secretary Pervan has not been helped by the fact that Employment Direction No. 5 has not substantially changed over the past 20 years, despite increased awareness of the role of behaviours such as boundary breaches and grooming in child sexual abuse. Despite this, the focus of Employment Direction

No. 5 continues to be on providing procedural fairness to employees. In practice, this has been at the expense of protecting children or providing fairness to complainants.

Affording procedural fairness to employees being investigated under State Service disciplinary processes is necessary and a fundamental principle of our legal system. However, it should not come at the expense of pursuing investigations or considerations of child safety, nor should the pursuit of procedural fairness unduly affect complainants or witnesses.

An employee who is the subject of a misconduct determination also has a right of review. Employment Direction No. 5 provides that if an employee wants to dispute a finding that they have breached the State Service Code of Conduct, and the sanction imposed is termination of employment, 'the dispute will be dealt with by the appropriate industrial tribunal', which in this case is the Tasmanian Industrial Commission.[198] If the sanction imposed was other than termination of employment, the employee will have a right of review under the State Service Act, which is also heard by the Tasmanian Industrial Commission but under different procedural requirements.[199] A complainant or other relevant party does not have a right of review, even when they have been directly adversely affected by the conduct. In our view, this is unfairly biased towards the rights of the employee. The correct forum for a right of review for such a complainant is a complex legal question we have not attempted to solve here, focusing instead on the need for the right of review.

Our recommendations that investigations into employee misconduct be conducted by the Child-Related Incident Management Directorate will help to ensure that the 'tension' between procedural fairness and the needs and concerns of complainants and witnesses is appropriately addressed, particularly in matters involving child sexual abuse (refer to Recommendations 6.6, 15.17 and 20.8). This is because we recommend the Directorate conducts investigations that consider child safety as well as disciplinary measures. We have also recommended expanding the State Service Code of Conduct so that if a state servant's conduct creates an unacceptable risk to the safety and wellbeing of children or young people, the State Service disciplinary framework should apply. Termination, suspension or sanction should be available. The disciplinary framework should ensure that departmental professional conduct policies address behaviour that may pose a risk to children.

We have been advised the State is currently reviewing and rewriting Employment Direction No. 5.[200] We consider that the Employment Directions should be amended to protect the rights of children and complainants, particularly to afford children and complainants a right of reply and review.

We also note the importance of conducting investigations, even if an employee has resigned prior to the initiation of an investigation, to ensure the safety of children and young people is prioritised. For example, we heard evidence from Alana Girvin,

the former Director, Incident Management Directorate, Department for Education, South Australia, that in South Australia, if a person resigns, the investigation continues. A determination of their suitability is made on the evidence before the Directorate. A prompt is included on their system, and notifications made to the Catholic or independent systems, public sector, Commissioner of Public Sector and other jurisdictions.[201]

6.3.2 Anonymous complaints

People affected and other employees may be discouraged from making a complaint about an employee's conduct because they are concerned they will be identifiable to that employee. We heard from people who believed they were targeted by an employee because the person making the complaint was revealed to the employee.[202] At our stakeholder consultations in Launceston, we were told one of the problems with Launceston General Hospital's approach to complaints included allowing the identity of the person making a complaint to become known.[203] The State has since advised that the State-wide Complaints Management Overview unit has been established and the identity of complainants is kept strictly confidential.[204]

We do not consider that the complainant's identity must be revealed, although it appears to have been the practice.[205]

It is unclear why this practice has emerged. Employment Direction No. 5 requires a Head of Agency to write to an employee who is the subject of a complaint to inform them of the substance of the complaint. 'Substance', in this context, means 'the essential elements that have given rise to the allegation of the breach of the Code and the specific parts of the Code allegedly breached'.[206] The Employment Direction does not specify that the respondent be informed of the identity of the person making the complaint (or witness). The Integrity Commission's guidance on managing misconduct states that people (complainants) should be told that while confidentiality cannot be guaranteed, it should be maintained as far as possible. In a small jurisdiction such as Tasmania, where 'everyone knows everyone else', maintaining confidentiality, while difficult, can ensure people are not discouraged from coming forward to make a complaint.[207]

It is not intended that all witness statements produced for an investigation must be provided to the respondent in full to ensure procedural fairness. The Integrity Commission's guidance cautions that 'decisions about what to give or show the respondent needs to be balanced against other considerations', including 'confidentiality, privacy, security risks, and legal professional privilege'.[208] Departmental advice about Employment Direction No. 5 to principals and managers in the Department for Education, Children and Young People states that '[c]onfidentiality is critical to maintain the integrity of the process, provide privacy and protect all those involved'.[209]

In this chapter, we recommend that, in any investigation of alleged misconduct, government agencies should ensure they have appropriate measures to protect, where possible, people, including witnesses, who come forward with complaints or concerns. These measures should include the ability to make anonymous complaints in cases of child sexual abuse and related conduct, and clear guidance about maintaining confidentiality. We recognise there may be limitations with progressing an anonymous complaint, for example, where there is insufficient information or details outlined in the complaint to conduct an investigation. We also acknowledge the challenges the State faces where allegations are contained in information not specifically designed for conducting a disciplinary process. However, these difficulties should not prevent the State from pursuing an investigation of the allegations to the extent it is possible to do so.

6.3.3 Timely investigations

Disciplinary processes in relation to child sexual abuse and related conduct matters often take too long to resolve, leaving children or young people exposed to potential risks.[210] We heard of significant delays in starting investigations or where, once started, investigations took too long to complete. For example:

- There have been delays in the initiation of Employment Direction No. 5 investigations of employees at Ashley Youth Detention Centre.
- The original investigation into victim-survivor Rachel's matter by the Department of Education took more than two years to complete. Rachel told us the length of the investigation had a devastating effect on her.[211]

Not only do long investigations leave children other than the particular child affected exposed to risks, but they can be distressing and retraumatising for the person affected and witnesses. Delays can also be distressing for those under investigation.

In our hearings on education, Secretary Bullard told us that timeframes were not placed on Employment Direction No. 5 investigations when independent investigators were appointed.[212] However, Secretary Bullard later advised us that the Department had changed this practice to require the investigator to provide an expected timeframe to be met. Further, the Department now provided guidance on seeking extensions, and required investigators to provide monthly updates.[213]

We commend these changes and consider that the requirement to set timeframes for conducting investigations should be included in Employment Direction No. 5—Breach of Code of Conduct. Instructions for seeking an extension for the investigation should also be incorporated into Employment Direction No. 5. All relevant parties should be kept informed of the progress of the investigation and, in the event of any delays, informed about revised timeframes for its completion. Heads of Agencies should report

to the Head of the State Service on compliance with these timeframes, and the Head of the State Service should monitor and publicly report on this compliance.

6.3.4 Prioritising serious misconduct

Another problem with the State Service disciplinary processes is that Employment Direction No. 5—Breach of Code of Conduct is used for all misconduct matters, regardless of their seriousness. As noted, there is a 'one-size-fits-all' approach to investigations in the State Service. This means that the investigation of minor misconduct matters can use up vital resources and lead to delays in investigations. Secretary Webster told us:

> I think, if some of the lower-level Code of Conduct issues were able to be dealt with more easily, then it would free up time and expertise to be able to focus on the more serious level of Code of Conduct issues that do require trauma-informed practice ...[214]

At the time of writing, the Government was in the process of implementing the recommendations of the *Independent Review of the Tasmanian State Service*. Relevantly, the Independent Review has recommended that Employment Direction No. 5 be rewritten 'to allow for a simple, local process to be used where the facts are clear and not disputed and the agency seeks to impose a low-level sanction (that is, reprimand or that the employee engages in counselling for their behaviour)'.[215] We support this restructuring of Employment Direction No. 5 in this way, as long as there is robust record keeping in any such 'local process', as discussed in the following section.

There is a risk in this approach that grooming and boundary breach behaviour may not be treated as serious. We discuss, in our institution-specific chapters, examples of cases where such behaviours were not taken seriously enough in institutions (such as James Griffin's case study in Chapter 14 and Brad's case study in Chapter 5). To avoid this risk, we recommend that all concerns about a staff member's interactions with a child or young person that could constitute grooming, a boundary breach or other related conduct be treated as potential serious misconduct.

6.3.5 Record keeping and monitoring

A key way to improve responses to child sexual abuse in government institutions is to ensure that accurate and comprehensive records are kept in relation to employee misconduct. In the context of employee misconduct (whether the misconduct be alleged, suspected, substantiated or unsubstantiated), a lack of appropriate record keeping can lead to a failure to identify and, therefore, respond to risks to the safety of children in government institutions, including when there is a pattern of behaviour.[216]

As noted, the Integrity Commission conducted an own motion investigation into misconduct in the State Service.[217] The investigation report recommended that public authorities:

> maintain an appropriately confidential register of all alleged and suspected misconduct committed by public officers.
>
> This is to include all misconduct matters, including those that do not proceed to investigation and those that are not substantiated.[218]

As the Integrity Commission recognised, such a register would help to identify multiple allegations made against an employee over time.[219] Importantly, maintaining a record of all allegations, whether substantiated or not, would also help to identify patterns of behaviour associated with child sexual abuse.

In materials provided to us, it appeared the Government supported this recommendation in principle.[220] However, it noted that a central register would only be supported for concluded investigations—it was suggested that unsubstantiated allegations 'be addressed at an agency level'.[221] Although the status of the document containing this information is unclear, it stated that the revision of Employment Direction No. 5—Breach of Code of Conduct would reference 'maintenance of a central register for defined and proven breaches'. In 2022, the Government introduced a register for breaches of the Code of Conduct. However, the register only includes matters where an investigation under Employment Direction No. 5 has resulted in termination of employment.[222]

We support this development. However, considering state servants move across departments, we consider there should be a cross-government register of misconduct investigations for serious and non-serious misconduct, not just for matters that result in termination of employment, or would have resulted in termination of employment had the employee not resigned. We understand the State Service Management Office considered such a register in response to the Integrity Commission's 2017 own motion investigation report.[223] We consider that this important initiative should be implemented. Any such register should include a record of unsubstantiated matters, including those that did not proceed to any sort of investigation. The Heads of Agency should report quarterly to the Head of the State Service about these matters. The Head of the State Service should report on misconduct across the State Service in their annual report.

6.3.6 Using evidence of past concerns or allegations—substantiated or not

As discussed, keeping a record of all misconduct-related matters is important to help identify patterns of behaviours. When an allegation is made, evidence of allegations of prior misconduct, whether substantiated or not, may lend weight to the assessment of whether misconduct has occurred. However, during our Inquiry, we understood there was concern (and confusion) in some government departments about the ability to use evidence of alleged prior misconduct in any investigation into a new allegation of employee misconduct. The State has since advised us that any relevant prior conduct will either be part of an allegation or be considered when determining the sanction.[224]

Whether evidence of prior concerns or allegations can be used in other misconduct matters does not appear to be well understood in the State Service. Evidence provided to us showed that government departments, and sometimes staff in the same department, took different approaches to this issue (and, consequently, different justifications for the use or non-use of prior conduct).

For example, in relation to Walter (a pseudonym)—a former employee at Ashley Youth Detention Centre who was the subject of at least 19 allegations before his resignation, and subject to disciplinary action on multiple occasions—then Secretary Pervan conceded that the inability to use information about prior disciplinary processes as well as information held by the Department as a result of allegations raised through redress claims was a 'system failure'.[225] He also told us that the wording of Employment Direction No. 5 itself provided the basis for the restriction on using prior allegations:

> it appears that the focus [of Employment Direction No. 5] is on allegations and those particulars, so if we're talking about bringing in other matters, the only way you could bring them in would be to add them as separate allegations, and have the whole lot investigated.[226]

In Chapter 14, we note the views of two former human resources staff members at Launceston General Hospital were that they were unable to consider unsubstantiated complaints or concerns cumulatively in disciplinary proceedings. Mathew Harvey, former Human Resources Consultant with the Department of Health, told us he was unable to use the content of previous unsubstantiated allegations as evidence in misconduct proceedings. He told us that this position had been confirmed by the Tasmanian Industrial Commission in a matter he had attended.[227] On the other hand, James Bellinger, former Human Resource Manager at the Department of Health told us in his statement that previous allegations of misconduct were considered in new matters to establish whether there is a pattern of behaviour.[228] However, Mr Bellinger did not specify whether this included unsubstantiated allegations.

Secretary Morgan-Wicks advised us she was establishing a complaints management oversight unit ('Statewide Complaints Oversight Unit') in the Office of the Secretary.[229] She said the unit will be responsible for recording and tracking the progress of complaints in a document management system, assessing complaints against previous complaints, and allocating the complaint to an appropriate business unit for action after identifying any potential conflicts of interest.[230]

The Solicitor-General's office has advised that, during investigations, procedural fairness to the employee under investigation requires that:

> [c]are must be taken to ensure the investigator does not have reference to any previous complaints with respect to the employee. That information would be irrelevant to the determination of the current investigation and could arguably adversely affect the employee's right to procedural fairness and natural justice.[231]

An approach excluding previous allegations appears to be influenced by the principles relating to the admission of tendency evidence in criminal trials. This approach is ill-suited to disciplinary proceedings and may result in risks of child sexual abuse not being sufficiently addressed. There is, at the least, confusion about whether prior concerns, complaints or allegations about an employee, whether substantiated or unsubstantiated, can be used in future misconduct proceedings. Variation in approaches to investigations is undesirable in and of itself. But it is more concerning that a valuable way to identify patterns of behaviour that may point to child sexual abuse is not being used, or at least is not being uniformly used, in relation to State Service disciplinary matters. We consider the safety of children in government institutions demands more. It requires a consistent approach—one that allows patterns of behaviour to be identified and used, where necessary, as evidence of that behaviour in future disciplinary proceedings.

In our view, where there are allegations of child sexual abuse and related behaviours, it is critical that prior substantiated and unsubstantiated complaints, allegations and disciplinary action, as well as suspected misconduct, can be considered both by the investigator and the Head of Agency. Any weight given to previous unsubstantiated concerns should consider that they have not been substantiated.

The Integrity Commission told us that prior allegations (including unsubstantiated allegations) should be considered at various stages of the disciplinary process, including:

- in determining the process to be used to deal with new allegations
- at the finding stage in determining, on the balance of probabilities, whether the conduct occurred—previous substantiated allegations should have more weight than unsubstantiated allegations
- in determining if misconduct has occurred
- the sanction to apply.[232]

We agree with this approach.

We understand there may be procedural fairness concerns about using prior matters in this way. However, these concerns would be addressed by amending clause 7.4 of Employment Direction No. 5—Breach of Code of Conduct to include a requirement that the Head of Agency notify the employee that any prior complaints, allegations and disciplinary action will be provided to the investigator and by putting the substance of these former complaints to the employee. Further, amending clause 7.9 of Employment Direction No. 5 to require that the investigator's report to the Head of Agency detail any reliance on prior complaints, allegations and disciplinary action would also help to address procedural fairness concerns. In this respect, we note that the investigator's report must be provided to the employee, and the employee is to be afforded an opportunity to respond to the report (refer to clause 7.10 of Employment Direction No. 5).

6.3.7 Summary dismissal

To protect children, it may be appropriate to summarily dismiss an employee for misconduct in some circumstances.

Currently, Employment Direction No. 5—Breach of Code of Conduct allows an employee to be dismissed without investigation where they have been convicted of a crime that is 'punishable by imprisonment for a term of 6 months or more'.[233] Clause 9(d) of the Tasmanian State Service Award enables the summary dismissal of an employee for serious misconduct or serious neglect of duty. The Independent Review of the State Service has recommended that the State Service adopt the Fair Work approach to serious misconduct. Under Fair Work regulations, misconduct is defined as 'wilful or deliberate behaviour by an employee that is inconsistent with the continuation of the contract of employment'.[234] It is also defined as conduct that causes a serious and imminent risk to the health or safety of a person.[235]

According to the Independent Review, the test for termination of employment based on serious misconduct under the Fair Work framework is:

> whether the reason for the termination was 'sound, defensible or well founded'. The employer must be satisfied on the balance of probabilities that serious misconduct has occurred (a standard lower than criminal charges) and that summary dismissal is not a disproportionate response.[236]

We support this recommendation in principle because it may help to streamline the disciplinary process in uncontested cases of serious misconduct, and free up time and other resources. However, we note that in matters involving child sexual abuse, investigations can uncover important matters that may not otherwise be discovered, including that other children have been harmed or that systemic reform is needed. Even if an employee is summarily dismissed, the Child-Related Incident Management Directorate should still investigate to determine if other children were exposed to risks and if system changes are required.

6.3.8 Interviewing children

As noted, Employment Direction No. 5—Breach of Code of Conduct sets out matters that must be considered when interviewing a child or young person. Chapter 16 sets out the best practice approach to interviewing children and young people in the context of police investigations. In Chapter 6, we discuss how these principles should be extended to the interviewing of children by the Child-Related Incident Management Directorate we recommend. In summary, these principles include that interviewers should have appropriate qualifications and training in dealing with matters involving child sexual abuse and should:

- take a 'whole story' approach to interviewing victim-survivors or witnesses, to allow for a pattern of behaviour to be apparent

- ensure the environment of the interview is comfortable for the child or young person
- minimise multiple interviews through techniques such as video recordings.

These principles should also apply to investigations conducted in the employment disciplinary context for investigating child sexual abuse or related conduct. In addition to the considerations already required by Employment Direction No. 5 clause 7.3, we recommend it be amended to include these principles.

Recommendation 20.7

The Tasmanian Government should ensure investigations into misconduct in relation to child sexual abuse or related conduct by State Service employees of the Department for Education, Children and Young People and the Department of Health under Employment Direction No. 5—Breach of Code of Conduct are conducted by the Child-Related Incident Management Directorate.

Recommendation 20.8

The Tasmanian Government should amend Employment Direction No. 5—Breach of Code of Conduct, as it relates to child sexual abuse or related conduct, to:

a. ensure people making a complaint and children or young people who have been abused have the right to
    i. reply to any factual matters put forward by the alleged abuser
    ii. know the outcome of an investigation
    iii. seek a review of decisions in an appropriate forum
b. clarify timeframes for carrying out investigations, set out the process for seeking an extension of time for an investigation and the considerations involved, and require the granting of, and reasons for, an extension of time be communicated to the parties affected
c. provide that all matters of concern relevant to an employee's conduct with a child or young person pertaining to child sexual abuse or related conduct be treated as potential serious misconduct

d. note the importance, in circumstances where it is appropriate to summarily dismiss an employee for misconduct, of conducting an investigation to identify children who have been harmed and any systemic problems that need to be addressed

e. ensure investigations are conducted by people who have been trained in child development, child sexual abuse (including taking a Whole Story approach) and trauma-related behaviours.

Recommendation 20.9

The Tasmanian Government should maintain a central cross-government register of misconduct concerning complaints and concerns about child sexual abuse and related conduct. This register should contain records of substantiated and unsubstantiated matters, including those that did not proceed to investigation.

Recommendation 20.10

1. The Tasmanian Government should take measures to ensure that misconduct investigations under Employment Direction No. 5—Breach of Code of Conduct in relation to complaints and concerns of child sexual abuse are able to take into account prior substantiated, untested and unsubstantiated complaints, allegations and disciplinary action, in addition to the immediately alleged misconduct.
2. The Tasmanian Government should take measures to ensure that prior allegations (including unsubstantiated allegations) should be considered at various stages of the disciplinary process, including in determining:
    a. the process to be used to deal with new allegations
    b. whether the conduct occurred on the balance of probabilities, with previous substantiated allegations being given more weight than unsubstantiated allegations
    c. if misconduct has occurred
    d. the sanction to be applied.

Recommendation 20.11

1. The Head of the State Service should monitor and publicly report annually on the management of misconduct matters related to child sexual abuse or related conduct.
2. Heads of Agencies should report quarterly to the Head of the State Service on all misconduct matters related to child sexual abuse or related conduct, substantiated and unsubstantiated.

6.4 Employment Direction No. 6—Inability

Another way to help protect children in institutions is to require staff to have a working with vulnerable people registration. In addition, some staff such as teachers and health practitioners are required to have professional registration, which contains suitability requirements related to protecting the public. When staff no longer hold these registrations, employers need to be able to act.

Employment Direction No. 6—Inability allows for investigation of whether an employee can perform their duties, where the Head of Agency has reasonable grounds to believe that an employee may not be able to do so. Government departments can rely on Employment Direction No. 6 where an essential requirement of the employee's role has been suspended or revoked, for example, where their registration to work with vulnerable people or professional registration has been revoked.

Under Employment Direction No. 6—Inability, when the Head of Agency forms the requisite belief, an investigator must be appointed to investigate the alleged inability.[237] If the investigation finds the employee is unable to perform their duties, the employer can take one or more of the following actions:

- direct appropriate counselling
- direct appropriate retraining
- reduce salary within the range of salary applicable to the employee
- reassign duties
- reduce classification
- terminate employment.[238]

Ms Allen, former Acting Executive Director, People and Culture, Department of Communities, explained the Employment Direction No. 6—Inability, as follows:

> For allegations of professional boundary breaches, grooming behaviours or child sexual abuse, an investigation pursuant to [Employment Direction

> No. 6] is usually only appropriate in certain circumstances. For example, if an employee no longer holds one of the Essential Requirements to perform their duties, such as Registration to Work with Vulnerable People. By not holding a legislative requirement, the head of agency could form reason to believe that the … official could not efficiently or effectively perform their duties and therefore commences an investigation.[239]

We understand that, in addition to the former Department of Communities, the Department of Education and the Department of Health have relied on this Employment Direction in matters related to allegations of child sexual abuse or related conduct where an essential requirement of the employee's role has been suspended or revoked.[240]

In our view, appointing an investigator who must then adhere to strict processes is unnecessary if their role is simply to establish that an employee no longer has a certification required for their continued employment. As the Independent Review of the State Service noted, the investigative processes required by Employment Direction No. 6 are more suited to alleged inability due to reasons other than a loss of accreditation, for example, inability due to some form of physical or mental impairment.[241]

We agree with the Independent Review of the State Service that a separate, simplified, process should apply to the loss of an essential employment requirement under Employment Direction No. 6. If the requirement is needed so that the employee can work with children or young people, once it is established that the employee no longer satisfies the requirement (other than for administrative reasons, for example, a failure to pay a fee), then the Head of Agency should be able to terminate the employee.

Recommendation 20.12

The Tasmanian Government should introduce legislation to amend Employment Direction No. 6—Inability to provide for:

a. a simplified process that applies to matters where the employee no longer has an essential employment requirement (for example, no registration under the *Registration to Work with Vulnerable People Act 2013*)

b. powers to immediately terminate a person's employment if the employee no longer meets an employment requirement for working with children or young people

c. any interview with a child or young person in line with Employment Direction No. 6—Inability to be subject to the same considerations as should apply under clause 7.3 of Employment Direction No. 5—Breach of Code of Conduct (Recommendation 20.8).

6.5 Advice and guidance

As is clear, there is confusion about the meaning of some provisions in the Employment Directions. Some people who engaged with our Inquiry suggested a guideline and procedures document should be developed to supplement the Employment Directions with 'overarching principles and specific guidance on approaches, responses and action'.[242]

We consider our recommendation that misconduct matters be investigated by the Child-Related Incident Management Directorate will help to resolve many uncertainties or confusion regarding the application of Employment Directions. However, we also consider that general guidance on the relevant considerations, applications and principles involved in State Service disciplinary processes will help to strengthen the safety of children and young people in government institutions. They will help by providing clear and consistent messages across the State Service about what is expected when misconduct issues arise, particularly for those involving child sexual abuse.

Earlier, we briefly noted the role that the Head of the State Service plays in public sector employment matters. Secretary Gale, Head of the State Service, described her role as being responsible for the employment framework and overarching guidelines with the State Service.[243] We also note that Heads of Agencies can seek advice from the State Service Management Office 'on matters relating to the approach of Employment Direction No. 5, and in relation to previous cases'.[244] Given this, we consider the Head of the State Service and the State Service Management Office are well placed to develop and implement guidelines and advice in relation to State Service disciplinary processes.

As noted, the Integrity Commission's *Guide to Managing Misconduct* provides helpful instruction on conducting preliminary assessments. It also provides useful and instructive information about managing the whole disciplinary process in the State Service. However, we consider the Head of the State Service and State Service Management Office are best placed to know what issues, including those we have identified in our report, require further explanation and guidance.[245]

Therefore, we recommend that guidance is developed on State Service disciplinary processes, containing key principles and procedures to be followed regarding Employment Directions. This guidance should be in line with any relevant child safety considerations, the relevant recommendations in our report and the guidance the Integrity Commission developed.

General principles relevant to handling complaints in government agencies, particularly in relation to complaints involving child sexual abuse and related conduct, could be included in the guidance.

Recommendation 20.13

1. The Head of the State Service should issue guidance on State Service disciplinary processes that contains key principles and procedures to be followed. This guidance should include information on:
    a. the steps involved in the process of dealing with disciplinary matters
    b. maintaining confidentiality
    c. setting timeframes for investigations and communicating timeframes to the parties
    d. preliminary assessments
    e. employee suspensions, in particular where matters are alleged to involve child sexual abuse
    f. considerations when interviewing children
    g. an employee's inability to perform a role due to the loss of employment requirements
    h. the rights of an employee and any complainant.
2. This guidance should be developed in line with relevant child safety considerations, relevant recommendations of this Commission of Inquiry and the Integrity Commission's *Guide to Managing Misconduct in the Tasmanian Public Sector*.

7 Cultural change

We heard evidence from the Head of the State Service Secretary, Jenny Gale, that, particularly regarding Employment Direction No.5—Breach of Code of Conduct, behaviour had largely been driven by custom and practice. She said:

> [I]t's one thing to enable through processes, legislation, and so on, but it is another to change the way in which people behave.[246]

Secretary Gale indicated her belief there was 'a lot more flexibility within it [Employment Direction No. 5] currently than people are using'.[247] She highlighted the importance of cultural and education initiatives in disciplinary process reform to ensure that risks to children were at the centre of State Service thinking.[248] Secretary Gale suggested the need for improvement in areas such as:

- modelling of agency values by senior leaders
- ensuring employees felt supported and encouraged when reporting improper conduct
- having confidence there would be no repercussions for making any reports.[249]

We agree that, besides legislative and policy framework reforms, it is critical to ensure a cultural shift in the State Service's interpretation and application of disciplinary processes. Anyone reporting improper conduct must feel supported, safe and encouraged and should not face repercussions. It is vital for staff to not only understand the disciplinary process and proposed reforms but actively and willingly foster a culture that promotes the safety and protection of children. We recommend funding for cultural change and educational initiatives to promote disciplinary practices that prioritise the safety and wellbeing of children and young people.

Recommendation 20.14

The Tasmanian Government should allocate funding for initiatives aimed at cultural change and awareness raising to promote a shared understanding and application of disciplinary processes across the State Service in a manner that ensures the safety and wellbeing of children at risk of child sexual abuse or related conduct.

8 Role of unions

Unions can have an important and influential effect on child safety matters in government workplaces, through advocacy on behalf of members who are subject to State Service disciplinary processes and by fostering a culture in the union that prioritises the safety of children and young people. In our hearings, Professor Richard Eccleston, University of Tasmania, noted that:

> … in terms of the important work that unions do in protecting and defending employee rights, that they too must be, and I'm sure are willing to be, part of the solution in terms of dealing with some of these issues around conduct and criminal abuse.[250]

To make the proposed changes we recommend to disciplinary processes, the Government will need the support of unions.

Throughout our Inquiry, we received evidence from several unions with membership in the Tasmanian State Service. These unions, and the officials that provided statements and evidence on their behalf, include the:

- Australian Education Union (Tasmanian branch)—Steven Smith, Senior Industrial Advocate
- Australian Nursing and Midwifery Federation (Tasmanian branch)—Emily Shepherd, Branch Secretary
- Health and Community Services Union (Tasmanian branch)—Lucas Digney, Assistant State Secretary
- Community and Public Sector Union (State Public Service Federation Tasmania) Inc—Thirza White, General Secretary.

Their evidence covered union approaches to child sexual abuse generally as well as how matters involving individual members who were subject to allegations were handled (particularly in health). The focus of this section is on how the unions with which we engaged generally approach child sexual abuse matters. Our case study chapters discuss union involvement in individual matters. Nothing in this discussion is intended to undermine the fundamental role of unions in protecting individual and collective employee rights.

8.1 Union policies and approaches to child sexual abuse matters

The materials we received in relation to unions revealed the variability in how they approached matters involving members who were subject to allegations of child sexual abuse. There appeared also to be considerable variance in the general approaches of unions to child sexual abuse. Some were proactive and developed policies and publicly available position statements about child sexual abuse, while others did not provide evidence of any materials that addressed this issue and were primarily focused on advocating in their members' interest, rather than considering issues raised by child sexual abuse matters.

8.1.1 Australian Education Union

Steven Smith, Senior Industrial Advocate with the Australian Education Union (Tasmanian branch) told us that the branch's perception was that child sexual abuse allegations against teachers in Tasmania are a significant issue.[251] Mr Smith told us the branch supported 'roughly one or two members a year' who have been the subject of a Department of Education investigation into allegations relating to child sexual abuse.[252] We were told the support provided in this context was primarily to ensure the members' rights were respected throughout any investigative processes.[253] Mr Smith told us that while providing support to a member would be similar for all matters, where there are allegations of child sexual abuse, the union's 'focus is heightened'.[254] Mr Smith said that this heightened focus was because:

> Firstly, … the potential consequences for the member include termination, loss of career, and criminal prosecution. Secondly, … because we are concerned to ensure that, as we support our member, we do not act in a way that could add to the child or children's trauma. Thirdly, the nature of these matters is that there is a natural desire to not risk letting an abuser to stay at work; this is appropriately part of the pressure on the decision maker.[255]

Mr Smith told us that the branch takes a neutral position in supporting members where allegations of child sexual abuse have been made against its members. He said the support provided is limited to helping the member navigate investigative processes. The focus of the support is on the member's welfare. Mr Smith said that if a member were to admit wrongdoing regarding the allegations, then the branch would cease to support the member.[256] He also told us that, in terms of supporting members, the union had so far never refused to support a member, even where child sexual abuse was alleged.[257]

Counsel Assisting our Commission of Inquiry asked Mr Smith whether he would characterise the union's support for its members in this context as falling short of advocacy, to which Mr Smith replied:

> Most of the time, yes. There are some occasions where we might step into a more advocacy role, but generally speaking we're trying to get them to advocate for themselves.[258]

When asked whether it would be appropriate to assume an advocacy role where there were allegations of child sexual abuse against a member, Mr Smith told us that, in those circumstances, the union's role would be in relation to advocating about deficiencies in the investigative process.[259]

The branch told us that it had developed a set of guidelines in 1999 that broadly outline notification responsibilities in relation to suspected child abuse. The guidelines were updated in 2004 to account for changes to mandatory reporting. This guidance document was not provided to us.

Mr Smith indicated the union is willing to 'be part of the solution' to issues concerning misconduct and child sexual abuse.[260]

8.1.2 Australian Nursing and Midwifery Federation (Tasmanian branch)

Emily Shepherd, Branch Secretary, Australian Nursing and Midwifery Federation (Tasmanian branch), told us the role of the Federation is to protect and promote the interests of its members and to 'provide professional, industrial and political leadership for the nursing and midwifery industries and the health sector'.[261]

In 2007, the Federation developed a National Position Statement on Child Abuse and Neglect that sets out what it considers best practice in protecting children who have

been subject to abuse.[262] This position statement was last reviewed and re-endorsed in 2019.[263] It includes:

- recognition of the harm that is caused by child abuse
- requiring that nurses and midwives are able to assess, identify, report and implement intervention strategies where child abuse is suspected
- recognising the duty of care that nurses and midwives have to children and young people and that they have statutory notification obligations
- requiring employers to have in place policies, protocols and reporting guidelines 'that support a culture of reporting when children, adolescents and young adults are at risk of abuse or neglect'
- advocating that community education be provided to raise awareness about child abuse and that sufficient funding for investigations into alleged abuse be provided by governments.[264]

In our hearings, Counsel Assisting our Inquiry explored the role of the Australian Nursing and Midwifery Federation in the events that had occurred at Launceston General Hospital, where James Griffin, who was a nurse on Ward 4K (the former Paediatric Inpatient Unit) and a Federation workplace delegate, was accused of child sexual abuse perpetrated over a long period (refer to Chapter 14). In response to revelations about the allegations of child sexual abuse against Mr Griffin after his death, Ms Shepherd told us:

> … at that time we were shocked and horrified and certainly felt it was appropriate to undertake [an] immediate review to understand if there was any indication that [Australian Nursing and Midwifery Federation] had any knowledge of these allegations so that we could obviously examine our own systems and processes to make sure that we did address those allegations appropriately.[265]

Ms Shepherd told us that, in response to the revelations about Mr Griffin, the Federation implemented changes to its workplace delegate processes, including to inform members that if they have concerns about a delegate (or a nominee for appointment as a delegate), they should raise those concerns with the Australian Nursing and Midwifery Federation.[266] However, Ms Shepherd conceded that encouraging members to raise concerns about nominees or incumbent delegates may not be enough to ensure that the Federation is made aware of any issues. To that end, she told us the Federation had developed and implemented a mandatory training policy for its staff in 2022. Ms Shepherd said:

> We have implemented a mandatory training policy internally to encourage our staff to raise concerns if any are made in relation to abuse of children, child sexual assault, et cetera …

> [W]e have reflected on the events of James Griffin and our support of members on Ward 4K, and we felt that it was important that we needed to be looking at our systems and our processes and understanding that, although we didn't have any knowledge of reports of inappropriate conduct or anything untoward, any disciplinary matters involving James Griffin, we felt that we needed to reflect and look at our systems to make sure that our systems and our policies were absolutely in line with best practice to support our staff in supporting members in these situations.[267]

We are encouraged by the broad, practical approach to child safety matters adopted by the Federation. We discuss the role that the Federation played in Mr Griffin's case in more detail in Chapter 14.

8.1.3 Health and Community Services Union

The Health and Community Services Union seems to have maintained a more traditional, industrial relations advocacy approach to its members who have been accused of child sexual abuse and related conduct.

Lucas Digney, Assistant State Secretary of the Health and Community Services Union, told us that 52 workers (all operational staff) at Ashley Youth Detention Centre were members of the union, making it the primary union representing employees at the Centre.

Mr Digney told us the union's role was to advocate on behalf of its members in industrial matters. He told us the union tried to 'ensure that procedural fairness and natural justice are upheld in the disciplinary process and that any outcome is proportionate to the alleged or proven misconduct'.[268] According to Mr Digney, this approach did not change if the disciplinary processes in question involved allegations of child sexual abuse.[269]

In his evidence at our hearings, Mr Digney told us that when disciplinary processes were initiated against union members, at times, the union would dispute whether the Head of Agency had 'the relevant information in front of them that would enable them to form a requisite belief'.[270] Mr Digney then said:

> That's not to say that allegations haven't been made, but that's to say that perhaps an allegation that there's been a breach of the Code of Conduct has been made prematurely before other enquiries are made.[271]

Mandy Clarke, former Deputy Secretary of the Children, Youth and Families division of the Department of Communities, told us that while the safety of young people in detention was a paramount concern for the Department, this concern had to be balanced with the need for a preliminary assessment that supported 'a plausible allegation when/if subjected to industrial scrutiny'.[272] More pointedly, Ms Allen, former Acting Executive Director, People and Culture, Department of Communities, told us that in relation to initial allegations against employees, the Department was:

> [o]perating against a background of unions who would lodge applications to review actions in the Tasmanian Industrial Commission, including about whether

the Secretary could form reason to believe that a breach of the *State Service Act 2000* Code of Conduct.[273]

This may partly explain why preliminary assessments have become long, drawn-out processes.

In terms of the safety of children in government institutions, the approach of the Health and Community Services Union to preliminary assessments of the conduct of workers that potentially threatens the safety of children in government institutions could be better directed. We consider that the relevant information needed to form a reasonable belief that there may have been a breach of the State Service Code of Conduct should be confined to a basic assessment of the alleged facts. As discussed, there is a danger that a preliminary assessment can become a de facto investigation. Further, undue delays in the investigative process should be avoided. As discussed, given procedural fairness and a right of reply is permissible at the investigation stage, we do not view it as necessary for such rights to be accorded at the preliminary assessment stage.

The Health and Community Services Union has shown concern about issues involving child safety; for example, we note its support for therapeutic approaches to residential care for young people in the youth justice system and its willingness to work with the government on reforms to disciplinary processes, so these processes are more trauma-informed.[274] The Health and Community Services Union states that its approach to advocacy is to simply enforce basic and fundamental rights regarding the proper conduct of disciplinary processes.[275]

8.1.4 Community and Public Sector Union

Thirza White, the General Secretary of the Community and Public Sector Union, told us the union provides general advice to its members who are subject to State Service disciplinary procedures about what will occur during process.[276] As with other unions, Ms White told us the Community and Public Sector Union was concerned to ensure the employer complied with the requirements of disciplinary processes, including that any sanctions imposed be 'reasonable and proportionate to any breaches found'.[277] As with other unions, Ms White said that where a member requested assistance with State Service disciplinary processes, the Community and Public Sector Union's approach to the 'industrial services provided' did not change based on the nature of the allegations, including allegations of child sexual abuse, against the member.[278] Ms White noted that '[i]nformation, advice, and representation is provided in respect of the Employer's compliance with the procedure that the Head of Agency has commenced'.[279]

Ms White's statement reveals a level of concern for matters that involve the safety of children. For example, she acknowledges that '[i]n workplaces where services are provided to vulnerable people, additional measures should be taken by the Employer

to ensure safe staffing levels and to foster a workplace culture of complaint raising and reporting of incidents'.[280]

The Community and Public Sector Union informed us of the actions it has undertaken regarding how the union handles matters involving child sexual abuse. These include:

- a review of internal processes leading to introducing an employment policy on 'Disclosure of Child Safety Matters' (the Community and Public Sector Union did not include the policy in their response, but offered to supply it on request)
- new protocols in relation to the election of delegates that are similar to those outlined above in relation to the Australian Nursing and Midwifery Federation
- raising concerns formally and through the Independent State Service Review 'around the functionality of [Employment Direction No. 5] and the grievance procedure to adequately deal with inappropriate, and at times, illegal behaviour, as well as support a culture that encourages bystander action through reporting of inappropriate conduct'
- establishing, in 2021, 'a dedicated reporting webpage for employees who had witnessed or experienced sexual and gendered violence in the workplace to allow employees to submit a report and receive a call from the [Community and Public Sector Union] Member Advice & Support Team about their options and next steps'.[281]

8.2 Union support for child safety reform

We understand the difficulties that can arise for unions (and other industrial advocates) when a member is subject to disciplinary proceedings involving child sexual abuse and related matters. On the one hand, unions are concerned with ensuring disciplinary processes are followed and procedural fairness is accorded to the member. On the other hand, unions recognise the importance of the safety of children in the workplaces where their members are employed.

These difficulties aside, there are actions that unions can take to help improve the safety of children and young people. For example, unions can:

- provide resources to members on recognising and reporting child sexual abuse and related matters
- provide clear public statements about the union's position on child sexual abuse and how the union approaches matters involving child sexual abuse
- develop policies that direct how these matters are to be addressed in the union.

Together, initiatives such as these can help to improve the safety of children and young people in the workplaces where their members are employed by fostering a culture in the union and its membership that prioritises child safety.

To this end, we are heartened by the proactive stance that some unions have taken regarding matters concerning the safety of children and young people, for example, the developments in the Australian Nursing and Midwifery Federation. We also note that, generally, all unions we engaged with appear to recognise the importance of these issues and support changes to disciplinary processes that will help to keep children and young people safe in government institutions.

To help improve the safety of children and young people in government institutions where their members work, we invite unions to:

- develop a position statement on allegations of child sexual abuse and professional boundary breaches consistent with grooming. The statement should be publicly available and easily accessible
- develop and make available to their membership policies that address how the union handles matters involving child sexual abuse and professional boundary breaches consistent with grooming
- make training available to their members that covers topics including recognising, reporting and responding to child sexual abuse and related conduct. The training should include information about child trauma-related behaviours for union delegates or workplace representatives who represent members facing allegations of child sexual abuse.[282]

We also invite unions to support the changes we are recommending to State Service disciplinary processes in the interests of ensuring the safety of children and young people in government institutions. This could be done by issuing a statement of support.

9 Role of the Tasmanian Industrial Commission

Workplace actions taken by the State against an employee are subject to review by the Tasmanian Industrial Commission.[283] The Industrial Commission may not have direct responsibility for the safety of children in government institutions. However, its review of actions taken regarding government employees can influence how these matters are approached in government agencies.

In our hearings on health, the prospect of appeals to the Tasmanian Industrial Commission figured prominently with those in the Department of Health who were responsible for such matters. For example, Mathew Harvey, former Human Resources Consultant with the Department of Health, told us that regarding unsubstantiated allegations, the Tasmanian Industrial Commission had said such allegations could not be used in any 'claim in any forum going forward'.[284]

When asked whether the focus should be on the protection and safety of children and young people as opposed to industrial relations issues in these matters, Mr Harvey's view was:

> I mean, it's the same thing: if we were to find him [James Griffin] guilty and then he took it to, for instance, appealed it through the Industrial Commission, which is the way appeals can [progress], through our system, then [they] would have said, you've relied on unsubstantiated claims to make a finding and you can't do that, and it's a decision that would have most likely been overturned.[285]

As discussed, the ability to use past matters to establish patterns of behaviour that may indicate child sexual abuse is vitally important. We also noted above Ms Allen's suggestion that appeals to the Industrial Commission can shape the way a preliminary assessment or disciplinary process is conducted.

Similar to issues involving allegations of past misconduct, we heard that the question of whether inappropriate conduct could be considered to have occurred in the course of an employee's employment (for the purpose of the State Service Code of Conduct) presented challenges for the Department of Health. The Department of Health told us that it did not consider appeals a deterrent for taking action.[286] However, the Department said that where there were allegations or incidents were not subject to criminal charges and the relevant conduct was alleged to have occurred outside the course of employment, this could mean that 'actions have greater exposure to appeals' to the Tasmanian Industrial Commission.[287]

Affording procedural fairness to employees, including through appeal processes is, of course, essential. However, we are concerned the Tasmanian Industrial Commission's approach to matters that involve child sexual abuse and related behaviours is through a strict and technical industrial relations focus, rather than one that fully considers the issues raised by such matters. This strict focus may be due to the highly prescriptive nature of State Service disciplinary processes, which can lead Tasmanian Industrial Commission reviews to focus on technical details and procedural aspects. As stated previously, the 2021 report *Critical Analysis Report on Termination in the State Service* for the Department of Premier and Cabinet said:

> This focus, internally, on form over substance then unduly narrows the focus of the [Tasmanian Industrial Commission]. The [Tasmanian Industrial Commission] is reviewing strict procedures which already burden the [Tasmanian State Service] system and is not empowered, through legislation, to take a more practical or discretionary view of matters.[288]

Because the Tasmanian Industrial Commission is required to determine employment matters regarding child sexual abuse and related conduct, we consider it should regard the need to protect children and the impacts of child sexual abuse. We consider that training in the issues raised by child sexual abuse and related conduct will help to foster a more responsive approach to these issues when they arise in reviews of government

actions by the Tasmanian Industrial Commission. This training will also help when the Government adopts our recommendation for increased rights for a complainant in cases of allegations of child sexual abuse (refer to Recommendation 20.8). We recommend in Chapter 16 that the Tasmanian Government funds the provision and/or development of training for judges on the dynamics of child sexual abuse and trauma-informed practice or funds judges to attend interstate programs such as those offered by the Judicial College of Victoria (refer to Recommendation 16.25).

Such training should be designed to raise awareness about the nature and impact of trauma and child sexual abuse, its prevalence and how to apply trauma-informed principles in judicial decision making. We recommend that Tasmanian Industrial Commission members also receive such training, either locally or by attending any relevant interstate program or training, such as the programs offered by the Judicial College of Victoria.

Recommendation 20.15

The Government should fund the Tasmanian Industrial Commission to enable its members to attend training on child sexual abuse either locally or through any relevant interstate program or training, such as the programs offered by the Judicial College of Victoria.

10 Conclusion

In this chapter, we have outlined many problems with the State's disciplinary framework in relation to responding to allegations of child sexual abuse and related conduct, including the State Service Code of Conduct and employment directions. We have proposed many reforms relating to the application and implementation of the Code itself and to the employment directions related to suspensions, breach of code of conduct investigations and inability to perform duties. Fundamentally, we are calling for a shift in the focus of this disciplinary framework to allow for a prioritisation of the safety of children. It will take significant commitment and culture change to achieve this outcome. But it should be done.

Notes

1 The State Service Code of Conduct is in section 9 of the *State Service Act 2000*. Relevant employment directions are: Tasmanian Government, *Employment Direction No. 4 – Procedure for the Suspension of State Service Employees With or Without Pay* (4 February 2013); Tasmanian Government, *Employment Direction No. 5 – Procedures for the Investigation and Determination of Whether an Employee Has Breached the Code of Conduct* (4 February 2013); and Tasmanian Government, *Employment Direction No. 6 – Procedures for the Investigation and Determination of Whether an Employee Is Able to Efficiently and Effectively Perform Their Duties* (4 February 2013). Also relevant are the State Service Principles, which are in section 7 of the *State Service Act 2000*. The Principles are a statement about the way employment in the State Service is to be managed, and the standards expected of State Service employees.

2 *Royal Commission into Institutional Responses to Child Sexual Abuse* (Final Report, December 2017) vol 7, 33.

3 Refer to Statement of Timothy Bullard, 10 May 2022, 50 [298]; Statement of Michael Pervan (Provisional), 26 October 2022, 61 [331]; Statement of Kathrine Morgan-Wicks, 24 May 2022, 39 [332]. In relation to Ashley Youth Detention Centre employees, refer to Department of Communities, 'Preliminary Assessments', undated, produced by the Tasmanian Government in response to a Commission notice to produce.

4 Tasmanian Government, *Employment Direction No. 5 – Procedures for the Investigation and Determination of Whether an Employee Has Breached the Code of Conduct*, 4 February 2013, cl 7.1.

5 *State Service Act 2000* ss 10(1)(a)–(b), (e), (g).

6 Department of Communities, 'ED tracker' (Excel spreadsheet), January 2023, produced by the Tasmanian Government in response to a Commission notice to produce; Department of Education, 'ED tracker' (Excel spreadsheet), 22 February 2023, produced by the Tasmanian Government in response to a Commission notice to produce; Department of Health, 'ED tracker' (Excel spreadsheet), February 2023, produced by the Tasmanian Government in response to a Commission notice to produce. Refer to Appendix H for the methodology used to calculate these numbers. We note there were also four suspensions in the Department of Police, Fire and Emergency Management, refer to Department of Police, Fire and Emergency Management, Spreadsheet: 'ED tracker', undated, produced by the Tasmanian Government in response to a Commission notice to produce.

7 Department of Communities, 'ED tracker' (Excel spreadsheet), January 2023, produced by the Tasmanian Government in response to a Commission notice to produce; Department of Education, 'ED tracker' (Excel spreadsheet), 22 February 2023, produced by the Tasmanian Government in response to a Commission notice to produce; Department of Health, 'ED tracker' (Excel spreadsheet), February 2023, produced by the Tasmanian Government in response to a Commission notice to produce.

8 Department of Communities, 'ED tracker' (Excel spreadsheet), January 2023, produced by the Tasmanian Government in response to a Commission notice to produce

9 Department of Communities, 'ED tracker' (Excel spreadsheet), January 2023, produced by the Tasmanian Government in response to a Commission notice to produce

10 Department of Communities, 'ED tracker' (Excel spreadsheet), January 2023, produced by the Tasmanian Government in response to a Commission notice to produce.

11 Statement of Michael Pervan, 4 August 2022, 2 [7]; Transcript of Clare Lovell, 14 June 2022, 1184 [46]–1185 [5]; Transcript of Michael Pervan, 17 June 2022, 1587 [14–41], 1594 [36–45], 1633 [47]–1634 [6]; Statement of Michael Pervan, 27 July 2022, 73 [249].

12 Department of Education, 'ED tracker' (Excel spreadsheet), 22 February 2023, produced by the Tasmanian Government in response to a Commission notice to produce.

13 Department of Health, 'ED tracker' (Excel spreadsheet), February 2023, produced by the Tasmanian Government in response to a Commission notice to produce.

14 Department of Health, 'ED tracker' (Excel spreadsheet), February 2023, produced by the Tasmanian Government in response to a Commission notice to produce.

15 Refer to Chapter 6.

16 Refer to Chapter 6.

17 Refer to Chapter 6.
18 Refer to Chapter 6.
19 Refer to Chapter 6.
20 Refer to Chapter 6.
21 Refer to Chapter 6.
22 Refer to Chapter 7.
23 Refer to Chapter 11, Case study 7.
24 Refer to Chapter 11, Case studies 5 and 7.
25 Refer to Chapter 11, Case study 7.
26 Refer to Chapter 11, Case study 7.
27 Refer to Chapter 11, Case study 7.
28 Refer to Chapter 11, Case studies 5, 6 and 7.
29 Refer to Chapter 11, Case study 7.
30 Statement of Jacqueline Allen, 15 August 2022, 38 [203(c)].
31 Refer to Chapter 11, Case studies 6 and 7.
32 Refer to Chapter 11, Case study 7.
33 Refer to Chapter 11, Case study 7.
34 Refer to Chapter 11, Case study 7.
35 Refer to Chapter 14, Case study 1.
36 Refer to Chapter 14, Case study 3.
37 Refer to Chapter 14, Case study 2.
38 Refer to Chapter 14, Case study 3.
39 Refer to Chapter 14, Case study 3.
40 Refer to Chapter 14, Case study 3.
41 Refer to Chapter 14, Case study 3.
42 Ian Watt, *Independent Review of the Tasmanian State Service* (Interim Report, 2020) 54.
43 Ian Watt, *Independent Review of the Tasmanian State Service* (Final Report, 2021) 202.
44 Ian Watt, *Independent Review of the Tasmanian State Service* (Final Report, 2021) 202.
45 Ian Watt, *Independent Review of the Tasmanian State Service* (Final Report, 2021) 201. The Review found that, in Tasmania, most terminations were for inability (65 per cent in 2019) whereas terminations for underperformance or State Service Code of Conduct breaches were only 24 per cent of the total in 2019. In the Australian Government, terminations for underperformance or misconduct were 40 per cent of all terminations.
46 Edge Legal, *Critical Analysis Report on Termination in the State Service* (Report, 2021) 8–9.
47 Edge Legal, *Critical Analysis Report on Termination in the State Service* (Report, 2021) 9.
48 Ian Watt, *Independent Review of the Tasmanian State Service* (Interim Report, 2020) 54.
49 Ian Watt, *Independent Review of the Tasmanian State Service* (Interim Report, 2020) 54.
50 Submission 084 Integrity Commission of Tasmania, 4.
51 Submission 084 Integrity Commission of Tasmania, 4.
52 Transcript of Eric Daniels, 30 June 2022, 2106 [23–28].
53 Transcript of Eric Daniels, 30 June 2022, 2106 [41–44].
54 Transcript of Eric Daniels, 30 June 2022, 2107 [16–17].
55 Statement of Richard Eccleston, 2 May 2022, 9 [34].
56 Statement of Richard Eccleston, 2 May 2022, 12 [49].
57 *State Service Act 2000* s 9.

58 *State Service Act 2000* s 10.

59 *State Service Act 2000* ss 44, 45. Other potentially relevant provisions of the *State Service Act 2000* are: the inability to perform duties (s 48); review of actions (ss 50–51); and performance management, including underperformance (Part 7A).

60 Refer to, for example, *Public Sector Management Act 1994* (ACT) s 9; *Public Sector Employment and Management Act 1993* (NT) s 49; *Government Sector Employment Act 2013* (NSW) s 69 and *Government Sector Employment (General) Rules 2014* (NSW) pt 8 (refer also to *Public Service Commissioner Direction No 2 of 2022* (NSW) which incorporates *the Code of Ethics and Conduct for NSW Government Sector Employees*); *Public Service Act 2008* (Qld) s 187, *Public Sector Ethics Act 1994* (Qld) pt 4 and Code of Conduct for the Queensland Public Service; *Public Sector Act 2009* (SA) s 6 and *Code of Ethics for the South Australian Public Sector*; *Public Administration Act 2004* (Vic) s 61 and *Code of Conduct for Victorian Public Sector Employees*; *Public Sector Management Act 1994* (WA) s 9; *Public Service Act* (Cth) s 13.

61 *State Service Act 2000* s 9(1).

62 *State Service Act 2000* s 9(2).

63 *State Service Act 2000* s 9(3).

64 *State Service Act 2000* s 9(4).

65 *State Service Act 2000* s 9(13).

66 *State Service Act 2000* s 7(1)(a).

67 *State Service Act 2000* s 9(14).

68 *State Service Act 2000* s 9(6).

69 *State Service Act 2000* s 10.

70 Statement of Timothy Bullard, 4 April 2022, 10 [49].

71 Statement of Kathrine Morgan-Wicks, 24 May 2022, 42 [353]. Refer also to Isabel Bird, 'Stronger Code for Abuses', *The Examiner* (Launceston, 1 December 2022) 3.

72 Statement of Michael Pervan, 23 August 2022, 6 [15], 12 [42].

73 Statement of Stephen Smallbone, 28 April 2022, 8 [32]; Statement of Tim McCormack, 22 April 2022, 3 [15].

74 Refer to Transcript of Jenny Gale, 13 September 2022, 4019 [8–43]; Transcript of Ginna Webster, 12 September 2022, 3959 [10–13].

75 *State Service Act 2000* s 9(4).

76 Tasmanian Government, *Employment Direction 5 – Procedures for the Investigation and Determination of Whether an Employee Has Breached the Code of Conduct*, 4 February 2013, cl 6.5.

77 Statement of James Bellinger, 10 June 2022, 27.

78 Statement of Kathrine Morgan-Wicks, 24 May 2022, 42 [351].

79 This was repeated in several of Secretary Bullard's statements. Refer to, for example, Statement of Timothy Bullard, 'Wayne' 4 April 2022, [48–49]; Statement of Timothy Bullard, 'Jeremy' 4 April 2022, 10–11 [48–49].

80 Tasmania, *Parliamentary Debates*, House of Assembly, 21 November 2000, 84 (Denise Swan). The Australian Public Service Code of Conduct is found in section 13 of the *Public Service Act 1999* (Cth).

81 Australian Public Service Commission, *Handling Misconduct – A Human Resource Manager's Guide* (2021) 135 [2.29] <https://www.apsc.gov.au/circulars-guidance-and-advice/handling-misconduct-human-resource-managers-guide>.

82 Letter from Michael O'Farrell to Timothy Bullard, 11 June 2021, 5 [25], produced by the Tasmanian Government in response to a Commission notice to produce. The view of Mr Michael O'Farrell, the previous Solicitor-General, was based on the decision of the High Court in *Comcare v Banerji* (2019) 267 CLR 373, which dealt with a similar integrity provision in the *Commonwealth Public Service Act 1999* (Cth). The issue in *Banerji* was whether the relevant provision in the Public Service Act fettered the implied freedom of political communication, in a case where a public servant had posted tweets criticising the government. The High Court did not clearly indicate that the obligations of Australian public servants could not extend beyond the workplace, so that the case does not necessarily confine the acts to which s 9(14) could apply.

83 Queensland Government, *Code of Conduct for the Queensland Public Service* (1 January 2021) cl 1.5(d).

84 *Public Service Act 1999* (Cth) s 13(11)(b).

85 Australian Public Service Commission, *Handling Misconduct – A Human Resource Manager's Guide* (2021) 21 [2.28].

86 Australian Public Service Commission, *Handling Misconduct – A Human Resource Manager's Guide* (2021) Appendix 2, 135 [2.56].

87 Australian Public Service Commission, *Handling Misconduct – A Human Resource Manager's Guide* (2021) Appendix 2, 135 [2.56].

88 Refer to *State Service Act 2000* ss 9(1)–(4), (13).

89 Statement of Timothy Bullard, 'Wayne', 4 April 2022, 11 [50].

90 Statement of Ginna Webster, 10 June 2022, 38 [234].

91 Email from Senior Workplace Relations Consultant to Industrial Relations Consultant, 9 February 2022, 1, produced by the Tasmanian Government in response to a Commission notice to produce.

92 Email from Senior Workplace Relations Consultant to Industrial Relations Consultant, 9 February 2022, 1–2, produced by the Tasmanian Government in response to a Commission notice to produce.

93 Letter from Solicitor General of Tasmania to Senior Advisor, Legal Services Unit, 22 December 2005, produced by the Tasmanian Government in response to a Commission notice to produce. We note that in terms of the vicarious liability of schools for the conduct of teachers, Gleeson CJ has said: 'where the teacher–student relationship is invested with a high degree of power and intimacy, the use of that power and intimacy to commit sexual abuse may provide a sufficient connection between the sexual assault and the employment to make it just to treat such contact as occurring in the course of employment. The degree of power and intimacy in a teacher–student relationship must be assessed by reference to factors such as the age of students, their particular vulnerability if any, the tasks allocated to teachers, and the number of adults concurrently responsible for the care of students. Furthermore, the nature and circumstances of the sexual misconduct will usually be a material consideration': *New South Wales v Lepore; Samin v Queensland; Rich v Queensland* (2003) 195 ALR 412, 434 (Gleeson CJ). On this topic, refer also to *Prince Alfred College Inc v ADC* (2016) 335 ALR 1, 17 (French CJ, Kiefel, Bell, Keane and Nettle JJ).

94 As explained in Chapter 17 Redress, Civil Litigation and Support, the State may now be held liable for child sexual abuse committed by employees in circumstances where vicarious liability might not apply.

95 Refer to Transcript of Timothy Bullard, 12 May 2022, 929 [8–15]. Refer also to Statement of Timothy Bullard, 'Wayne', 4 April 2022, 29 [120–121]; Briefing Note from Lyn Metcalfe to John Smyth, 1 August 2007, 3–4, produced by the Tasmanian Government in response to a Commission notice to produce.

96 Statement of Timothy Bullard, 'Wayne', 4 April 2022, 20 [91].

97 Statement of Timothy Bullard, 'Wayne', 4 April 2022, 20 [91].

98 Transcript of Sarah Kay, 8 July 2022, 2657 [16–23].

99 Statement of Timothy Bullard, 'Wayne', 4 April 2022, 22 [95–96].

100 Transcript of Timothy Bullard, 12 May 2022, 930 [34–37].

101 Statement of Timothy Bullard, 'Wayne', 4 April 2022, 22 [98].

102 Transcript of Sarah Kay, 8 July 2022, 2658 [13–26].

103 Transcript of Kathrine Morgan-Wicks, 9 September 2022, 3858 [6–9].

104 Statement of Kathrine Morgan-Wicks, 20 May 2022, 41 [338].

105 Transcript of Kathrine Morgan-Wicks, 9 September 2022, 3858 [17–18].

106 *Public Sector Employment and Management Act 1993* (NT) s 49(f).

107 *Public Sector Management Act 1994* (ACT) s 9(1)(c).

108 ACT Public Sector Standards Commissioner, *Guidelines to the Misconduct Process* (October 2019) 23.

109 Refer to, for example, *Public Service Act 1999* (Cth) s 13. Refer also to Australian Public Service Commission, *Handling Misconduct – A Human Resource Manager's Guide* (2021) Appendix 2, 20 [2.24]; NSW Public Service Commission, *Public Service Commissioner Direction No 2 of 2022*, 4, which incorporates the *Code of Ethics and Conduct for NSW Government Sector Employees*; *Public Sector Act 2009* (SA) s 15(1)(b); Victorian Public Sector Commission, *Code of Conduct for Victorian Public Sector Employees* (1 June 2015) 3.9.

110 Transcript of Matthew Hardy, 4 July 2022, 2216 [23–29]. Refer also to *Health Practitioner Regulation National Law Act 2009* (Qld) s 156.

111 *Teachers Registration Act 2000* ss 17J–17L, s 24B.

112 Refer to, for example, *Police Act 1892* (WA), s33L; *Police Service Act 2003,* s30.

113 Refer to, for example, *Police Act 1892* (WA), s33L; *Police Service Act 2003,* s30.

114 Statement of Stephen Smallbone, 28 April 2022, 9 [34–35]; Transcript of Tim McCormack, 9 May 2022, 663 [45]–664 [23].

115 Transcript of Tim McCormack and Stephen Smallbone, 9 May 2022, 664 [1–3]. Refer also to Stephen Smallbone and Tim McCormack, *Independent Inquiry into the Tasmanian Department of Education's Responses to Child Sexual Abuse* (Report, 2021) 10.

116 Stephen Smallbone and Tim McCormack, *Independent Inquiry into the Tasmanian Department of Education's Responses to Child Sexual Abuse* (Report, 7 June 2021) 79, Recommendation 12.

117 Transcript of Timothy Bullard, 12 September 2022, 3938 [23–30].

118 Western Australia has a system that requires public agencies to implement agency-specific codes of conduct.

119 *Royal Commission into Institutional Responses to Child Sexual Abuse* (Final Report, December 2017) vol 7, 36.

120 Refer to, for example, Transcript of Timothy Bullard, 12 May 2022, 931 [3–32], in which he describes linking departmental policies to particular provisions of the State Service Code of Conduct to establish a breach of the code.

121 Transcript of Jenny Gale, 13 September 2022, 4019 [11–14].

122 Refer to Letter from Michael Pervan to 'Stan', 12 February 2021, 3, produced by the Tasmanian Government in response to a Commission notice to produce.

123 Transcript of Jenny Gale, 13 September 2022, 4019 [38–43].

124 While we were not provided the Solicitor-General's advice in relation to this issue, we understand that the advice was given in relation to a different request and was of the nature that standing orders could only be made for 'purposes of the administration and operation of the relevant Agency': Frank Ogle, Email, 5 February 2014, 1, produced by the Tasmanian Government in response to a Commission notice to produce.

125 Refer to Department of Education, 'DoE Executive Group Meeting, Professional Standards for Staff', 17 March 2014, 2, produced by the Tasmanian Government in response to a Commission notice to produce.

126 Refer to Letter from Michael Pervan to 'Stan', 12 February 2021, 3, produced by the Tasmanian Government in response to a Commission notice to produce.

127 Refer to *Royal Commission into Institutional Responses to Child Sexual Abuse* (Final Report, December 2017) vol 7, 186.

128 Teachers Registration Board, *Professional Boundaries: Guidelines for Tasmanian Teachers* (2021) 8. We note that similar cautionary advice or restrictions exist in most states and territories. For example, refer to Victorian Institute of Teaching, *The Victorian Teaching Profession's Code of Conduct* (2021) 6 Principle 1.5; Queensland College of Teachers, *Professional Boundaries* (August 2019) 6; Department of Education and Child Development, *Protective Practices for Staff in Their Interactions with Children and Young People: Guidelines for Staff Working and Volunteering in Education and Care Settings* (2nd rev ed, Government of South Australia, 2019) 10; Northern Territory Teachers Registration Board, *Managing Professional Boundaries: Guidelines for Teachers* (2015) 4, 9.

129 Teachers Registration Board, *Professional Boundaries: Guidelines for Tasmanian Teachers* (2021) 9.

130 Statement of Kathrine Morgan-Wicks, 24 May 2022, 42 [353]. Refer also to Statement of Jacqueline Allen, 15 August 2022, 54 [326(c)] (in the context of 'in the course of employment'); Isabel Bird, 'Stronger Code for Abuses', *The Examiner* (Launceston, 1 December 2022) 3.

131 *Child and Youth Safe Organisations Act 2023* s 7(1).

132 *Child and Youth Safe Organisations Act 2023* s 35.

133 *State Service Act 2000* s 3(1) (definition of 'employee').

134 Refer to discussion in Chapter 5.

135 Statement of Timothy Bullard, 10 May 2022, 34 [194(b)], 36 [217].

136 Solicitor-General of Tasmania, *Procedural Fairness Response*, 27 June 2023, 30.

137 *Child and Youth Safe Organisations Act 2023* s 35(1)(a).

138 *Child and Youth Safe Organisations Act 2023* s 8(b).

139 *State Service Act 2000* s 17. Under section 17 of the *State Service Act*, the Employer may issue Employment Directions. Section 14 of the *State Service Act* provides that the Minster administering the *State Service Act* is the 'Employer'.

140 We note that Employment Direction No.5—Breach of Code of Conduct was recently updated in April 2023, after we had completed our inquiry phase. Due to the timing of the update, we discuss the previous iteration of Employment Direction No.5—Breach of Code of Conduct in this chapter.

141 Refer to Statement of Timothy Bullard, 10 May 2022, 50 [298]; Statement of Michael Pervan (Provisional), 26 October 2022, 61 [331]; Statement of Kathrine Morgan-Wicks, 24 May 2022, 39 [332]. In relation to Ashley Youth Detention Centre employees, refer to Department of Communities, 'Preliminary Assessments', undated, produced by the Tasmanian Government in response to a Commission notice to produce.

142 *State Service Act 2000* ss 15, 16, 20, although the Head of the State Service cannot issue Employment Directions: s 20(2).

143 Under sections 3 and 14 of the *State Service Act 2000*, the 'Employer' is the Minister administering the *State Service Act 2000*. By virtue of the Administrative Arrangements for Tasmanian Enactments, the relevant Minister is the Premier. Part of the role of the State Service Management Office is to support 'the Minister administering the *State Service Act 2000* and the Head of the State Service to undertake the employer functions and powers'. Refer to Department of Premier and Cabinet, *State Service Management Office* (Web Page) <https://www.dpac.tas.gov.au/divisions/ssmo>.

144 Refer to, for example, Integrity Commission Tasmania, *An Own-Motion Investigation into the Management of Misconduct in the Tasmanian Public Sector* (Report No. 3, December 2017).

145 Refer to, for example, William Cox, *Independent Review of the Integrity Commission Act 2009 – Report of the Independent Reviewer* (Report, May 2016); Integrity Commission Tasmania, *An Own-Motion Investigation into the Management of Misconduct in the Tasmanian Public Sector* (Report No. 3, December 2017).

146 Department of Premier and Cabinet, 'Draft Employment Direction No 4', 'Draft Employment Direction No 5' and 'Draft Employment Direction No 6', produced by the Tasmanian Government in response to a Commission notice to produce. Refer also to State Service Management Office, 'Examination of Employment Framework – Update Report – April 2018', 2018, produced by the Tasmanian Government in response to a Commission notice to produce.

147 Refer generally to Department of Premier and Cabinet, *Government Response to the Independent Review of the Tasmanian State Service* (Report, 2021).

148 Ian Watt, *Independent Review of the Tasmanian State Service* (Final Report, 2021) 202.

149 Ian Watt, *Independent Review of the Tasmanian State Service* (Final Report, 2021) 202.

150 Department of Premier and Cabinet, *Government Response to the Independent Review of the Tasmanian State Service* (Report, 2021).

151 Refer generally to Department of Premier and Cabinet, *Government Response to the Independent Review of the Tasmanian State Service* (Report, 2021), Recommendations 37, 55, 56.

152 Department of Communities, 'ED tracker' (Excel spreadsheet), January 2023, produced by the Tasmanian Government in response to a Commission notice to produce; Department of Education, 'ED tracker' (Excel spreadsheet), 22 February 2023, produced by the Tasmanian Government in response to a Commission notice to produce; Department of Health, 'ED tracker' (Excel spreadsheet), February 2023, produced by the Tasmanian Government in response to a Commission notice to produce. Refer to Appendix H for the methodology used to calculate these numbers.

153 We note that in evidence provided to us, the term 'preliminary assessment' is used interchangeably with 'preliminary investigation'. We have chosen to use 'preliminary assessment' as this aligns with the Integrity Commission's guidance on preliminary assessments and emphasises that these are not investigations.

154 Tasmanian Government, *Employment Direction No. 5: Procedures for the Investigation and Determination of Whether an Employee Has Breached the Code of Conduct*, 4 February 2013, cl 7.3.

155 Integrity Commission Tasmania, *Guide to Managing Misconduct in the Tasmanian Public Sector* (March 2021).

156 Integrity Commission Tasmania, *An Own-Motion Investigation into the Management of Misconduct in the Tasmanian Public Sector* (Report No. 3, December 2017) 68–74. The original guide to managing misconduct in the own-motion report was updated in 2021. See Integrity Commission, *Guide to Managing Misconduct in the Tasmanian Public Sector* (March 2021).

157 Integrity Commission Tasmania, *Guide to Managing Misconduct in the Tasmanian Public Sector* (March 2021) 9–10.

158 Integrity Commission Tasmania, *Guide to Managing Misconduct in the Tasmanian Public Sector* (March 2021) 10.

159 Integrity Commission Tasmania, *Guide to Managing Misconduct in the Tasmanian Public Sector* (March 2021) 10.

160 Michael Easton, *Integrity Commission Procedural Fairness Response*, 8 March 2023, 2.

161 Department of Health, 'Code of Conduct Investigations – Internal Audit', August 2019, 6, produced by the Tasmanian Government in response to a Commission notice to produce.

162 Department of Health, 'Guidance Notes – Employment Direction No. 5 Preliminary Assessment', undated, produced by the Tasmanian Government in response to a Commission notice to produce.

163 Department of Health, 'Guidance Notes – Employment Direction No. 5 Preliminary Assessment', undated, produced by the Tasmanian Government in response to a Commission notice to produce.

164 Department of Health, 'Guidance Notes – Employment Direction No. 5 Preliminary Assessment', undated, produced by the Tasmanian Government in response to a Commission notice to produce.

165 Department of Health, 'Guidance Notes – Employment Direction No. 5 Preliminary Assessment', undated, produced by the Tasmanian Government in response to a Commission notice to produce.

166 Solicitor-General of Tasmania, *Procedural Fairness Response*, 27 June 2023, 33–34.

167 Integrity Commission Tasmania, *Guide to Managing Misconduct in the Tasmanian Public Sector* (March 2021) 11.

168 Department for Education, Children and Young People, *Advice for School Staff—Responding to Incidents, Disclosures or Suspicions of Child Sexual Abuse* (2022) 2.

169 Statement of Michael Pervan, 14 June 2022, 43 [229]; refer also to Statement of Jacqueline Allen, 15 August 2022, 32 [181].

170 Refer to, for example, case examples of Lester, Ira and Stan in Chapter 11. The names 'Lester', 'Ira' and 'Stan are pseudonyms; Order of the Commission of Inquiry, restricted publication order, 18 August 2022.

171 Refer to Statement of Timothy Bullard, 10 May 2022, 10 [60(c)].

172 Tasmanian Government, *Employment Direction No. 4 – Procedure for Suspension of State Service Employees With or Without Pay*, 4 February 2013, cl 6.1.

173 Tasmanian Government, *Employment Direction No. 4 – Procedure for Suspension of State Service Employees With or Without Pay*, 4 February 2013, cl 6.2.

174 Tasmanian Government, *Employment Direction No. 4 – Procedure for Suspension of State Service Employees With or Without Pay*, 4 February 2013, cl 6.4.

175 Tasmanian Government, *Employment Direction No. 4 – Procedure for Suspension of State Service Employees With or Without Pay*, 4 February 2013, cl 6.4.

176 Department of Communities, 'Official Stand Downs' (Excel spreadsheet), August 2021, 4, produced by the Tasmanian Government in response to a Commission notice to produce.

177 Statement of Jenny Gale, 10 June 2022, 35 [37].

178 Statement of Timothy Bullard, 4 April 2022, 9 [40].

179 Statement of Jacqueline Allen, 15 August 2022, 54 [326]; Statement of Michael Pervan, 14 June 2022, 65 [357].

180 Statement of Jacqueline Allen, 15 August 2022, 54 [326]; Statement of Michael Pervan, 26 October 2022, 65 [357].

181 Statement of Michael Pervan, 14 June 2022, 68 [373].

182 Statement of Michael Pervan, 14 June 2022, 68 [373].

183 Statement of Michael Pervan, 14 June 2022, 68 [373].

184 Solicitor-General of Tasmania, *Procedural Fairness Response*, 27 June 2023, 38.

185 Statement of Kathrine Morgan-Wicks, 24 May 2022, 41 [344].

186 Statement of Kathrine Morgan-Wicks, 24 May 2022, 43 [365–366].

187 Tasmanian Government, *Employment Direction No. 4 – Procedure for Suspension of State Service Employees With or Without Pay,* 4 February 2013, cl 6.1.

188 Tasmanian Government, *Employment Direction No. 4 – Procedure for Suspension of State Service employees With or Without Pay*, 4 February 2013, cl 6.4.

189 Tasmanian Government, *Employment Direction No. 4 – Procedure for Suspension of State Service Employees With or Without Pay*, 4 February 2013, cls 6.4a–i.

190 Tasmanian Government, *Employment Direction 5 – Procedures for the Investigation and Determination of Whether an Employee Has Breached the Code of Conduct*, 4 February 2013, cl 1.1.

191 Tasmanian Government, *Employment Direction 5 – Procedures for the Investigation and Determination of Whether an Employee Has Breached the Code of Conduct*, 4 February 2013, cl 6.3; Solicitor-General of Tasmania, Procedural Fairness Response, 27 June 2023, 38.

192 Tasmanian Government, *Employment Direction 5 – Procedures for the Investigation and Determination of Whether an Employee Has Breached the Code of Conduct*, 4 February 2013, cl 6.6.

193 Tasmanian Government, *Employment Direction 5 – Procedures for the Investigation and Determination of Whether an Employee Has breached the Code of Conduct*, 4 February 2013, cl 7.3.

194 Tasmanian Government, *Employment Direction 5 – Procedures for the Investigation and Determination of Whether an Employee Has Breached the Code of Conduct*, 4 February 2013, cl 7.4.

195 Tasmanian Government, *Employment Direction 5 – Procedures for the Investigation and Determination of Whether an Employee Has Breached the Code of Conduct*, 4 February 2013, cl 7.7.

196 Statement of Jenny Gale, 29 April 2022, 3–4 [29].

197 Statement of Michael Pervan, 24 August 2022, 36 [138].

198 Tasmanian Government, *Employment Direction 5 – Procedures for the Investigation and Determination of Whether an Employee Has Breached the Code of Conduct*, 4 February 2013, cl 11.1 a.

199 *State Service Act 2000* s 50(1)(b).

200 Department of Premier and Cabinet, *Tasmanian Government's Interim Response to the Commission of Inquiry* (Report, 30 June 2023) 3 (Action 8).

201 Transcript of Alana Susan Girvin, 11 May 2022, 875 [40–46].

202 Transcript of Will Gordon, 27 June 2022, 1754 [45]–1755 [7].

203 Launceston consultation, 19 August 2021.

204 Solicitor-General of Tasmania, *Procedural Fairness Response*, 27 June 2023, 41.

205 Statement of James Bellinger, 10 June 2022, 27.

206 Tasmanian Government, *Employment Direction 5 – Procedures for the Investigation and Determination of Whether an Employee Has Breached the Code of Conduct*, 4 February 2013, cl 7.4 footnote 3.

207 Integrity Commission Tasmania, *Guide to Managing Misconduct in the Tasmanian Public Sector* (March 2021) 13. Difficulties with maintaining confidentiality in a small jurisdiction such as Tasmania (where 'everyone knows everyone else'), were noted in submissions we received and by participants in both our targeted and stakeholder consultations. Refer to, for example, Submission 056 Engender Equality, 8; Hobart consultation, 13 August 2021; Launceston consultation, 19 August 2021; Targeted consultation, anonymous, 2021.

208 Integrity Commission Tasmania, *Guide to Managing Misconduct in the Tasmanian Public Sector* (March 2021) 48.

209 Department of Education, 'Employment Direction No.5 Fact Sheet – Principal/Manager Guide', undated, 5, produced by the Tasmanian Government in response to a Commission notice to produce.

210 Transcript of Ginna Webster, 12 September 2022, 3958 [29–33].

211 Transcript of 'Rachel', 11 May 2022, 813 [15–19]. The name 'Rachel' is a pseudonym; Order of the Commission of Inquiry, restricted publication order, 11 May 2022.

212 Transcript of Timothy Bullard, 11 May 2022, 902 [22–26].

213 Statement of Timothy Bullard, 6 June 2022, 3 [16].

214 Transcript of Ginna Webster, 12 September 2022, 3958 [35–39].

215 Ian Watt, *Independent Review of the Tasmanian State Service* (Final Report, 2021) 203, Recommendation 56.

216 *Royal Commission into Institutional Responses to Child Sexual Abuse* (Final Report, December 2017) vol 8, 30.

217 Integrity Commission Tasmania, *An Own-Motion Investigation into the Management of Misconduct in the Tasmanian Public Sector* (Report No 3, 2017).

218 Integrity Commission Tasmania, *An Own-Motion Investigation into the Management of Misconduct in the Tasmanian Public Sector* (Report No 3, 2017) 51, Recommendation 3. The Integrity Commission recommended that the records be kept for two years.

219 Integrity Commission Tasmania, *An Own-Motion Investigation into the Management of Misconduct in the Tasmanian Public Sector* (Report No 3, 2017) 49 [267].

220 State Service Management Office, 'Notes for Head of Agency Group Meeting', 24 January 2018, 10, produced by the Tasmanian Government in response to a Commission notice to produce.

221 State Service Management Office, 'Notes for Head of Agency Group Meeting', 24 January 2018, 10, produced by the Tasmanian Government in response to a Commission notice to produce.

222 Department of Premier and Cabinet, *Tasmanian Government's Interim Response to the Commission of Inquiry* (Report, 30 June 2023) 6 (Action 22).

223 State Service Management Office, 'Notes for Head of Agency Group Meeting', 24 January 2018 1, 10, produced by the Tasmanian Government in response to a Commission notice to produce.

224 Solicitor-General of Tasmania, *Procedural Fairness Response*, 27 June 2023, 44–45.

225 Transcript of Michael Pervan, 26 August 2022, 3510 [12–38].

226 Transcript of Michael Pervan, 26 August 2022, 3512 [38–42].

227 Statement of Mathew Harvey, 17 June 2022, 9 [35].

228 Statement of James Bellinger, 10 June 2022, 21.

229 Statement of Kathrine Morgan-Wicks, 22 June 2022, 16 [96].

230 Statement of Kathrine Morgan-Wicks, 22 June 2022, 16 [97].

231 Solicitor-General of Tasmania, 'Employment Direction No. 5 – Investigation by Different Agency – *Personal Information Protection Act 2004* – sharing information between Agencies – *Youth Justice Act 1997*', 16 March 2022, 6 [32], produced by the Tasmanian Government in response to a Commission notice to produce.

232 Integrity Commission, 'Comment on Draft Chapter, "Disciplinary responses"', 8 March 2023, 3.

233 Tasmanian Government, *Employment Direction No. 5 – Procedures for the Investigation and Determination of Whether an Employee Has Breached the Code of Conduct*, 4 February 2013, cl 7.2.

234 *Fair Work Regulations 2009* (Cth) reg 1.07 (2)(a).

235 *Fair Work Regulations 2009* (Cth) reg 1.07 (2)(b)(i).

236 Ian Watt, *Independent Review of the Tasmanian State Service* (Final Report, July 2021) 204.

237 Tasmanian Government, *Employment Direction No. 6 – Procedures for the Investigation and Determination of Whether an Employee Is Able to Efficiently and Effectively Perform Their Duties*, 4 February 2013, cl 7.

238 State Service Act 2000 ss 48(1)(a)–(f).

239 Statement of Jacqueline Allen, 15 August 2022, 46 [271].

240 For example, in Kerri's case 'John' was eventually subject to an Employment Direction No. 6 investigation as he had lost his Registration to Work with Vulnerable People. Refer to Chapter 5 and Chapter 14, Case study 3. In relation to the former Department of Communities, refer also to Department of Justice, 'Item 4: Policies and Procedures Tasmanian Government's Current Service System', undated, 31, produced by the Tasmanian Government in response to a Commission notice to produce. The name 'John' is a pseudonym; Order of the Commission of Inquiry, restricted publication order, 11 May 2022.

241 Ian Watt, *Independent Review of the Tasmanian State Service* (Final Report, 2021) 206.

242 Statement of Jacqueline Allen, 15 August 2022, 54 [326].

243 Transcript of Jenny Gale, 6 May 2022, 542 [28–29].

244 Statement of Jenny Gale, 10 June 2022, 34 [27].

245 We note that in some other jurisdictions, comprehensive guidance is provided on conducting investigations and the management of misconduct in the public sector. For example, refer to Queensland's Public Service Commission, *Managing Workplace Investigations – A Practical Guide for the Queensland Public Sector* (September 2018); Australian Public Service Commission, *Handling Misconduct – A Human Resource Manager's Guide* (2021).

246 Transcript of Jenny Gale, 13 September 2022, 4021 [44–47].

247 Transcript of Jenny Gale, 13 September 2022, 4022 [8–9].

248 Transcript of Jenny Gale, 13 September 2022, 4022 [9–13].

249 Statement of Jenny Gale, 10 June 2022, 41–42 [44].

250 Transcript of Richard Eccleston, 5 May 2022, 356 [12–16].

251 Statement of Steven Smith, 22 April 2022, 2 [9].

252 Statement of Steven Smith, 22 April 2022, 2 [10].

253 Statement of Steven Smith, 22 April 2022, 3 [17].

254 Statement of Steven Smith, 22 April 2022, 3 [18].

255 Statement of Steven Smith, 22 April 2022, 3 [18].

256 Statement of Steven Smith, 22 April 2022, 3–4 [21].

257 Transcript of Steven Smith, 11 May 2022, 850 [38–44].

258 Transcript of Steven Smith, 11 May 2022, 846 [1–4].

259 Transcript of Steven Smith, 11 May 2022, 846 [9–11].

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261 Statement of Emily Shepherd, 23 June 2022, 1 [6].

262 Statement of Emily Shepherd, 23 June 2022, 2 [10]. The Position Statement was last reviewed and re-endorsed in 2019.

263 Australian Nursing and Midwifery Federation, *ANMF Position Statement – Child Abuse and Neglect* (2007, reviewed and re-endorsed November 2019).

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265 Transcript of Emily Shepherd, 29 June 2022, 1928 [42]–1929 [1].

266 Transcript of Emily Shepherd, 29 June 2022, 1932 [4–14].

267 Transcript of Emily Shepherd, 29 June 2022, 1934 [35–38], 1935 [15–24].

268 Statement of Lucas Digney, 9 August 2022, 3.

269 Statement of Lucas Digney, 9 August 2022, 4.

270 Transcript of Lucas Digney, 24 August 2022, 3268 [26–28].

271 Transcript of Lucas Digney, 24 August 2022, 3268 [2–32].

272 Statement of Mandy Clarke, 19 August 2022, 5–6 [6].

273 Statement of Jacqueline Allen, 19 December 2022, 8 [59].

274 Statement of Lucas Digney, 9 August 2022, 11; Transcript of Lucas Digney, 24 August 2022, 3263 [26–28].

275 Health and Community Services Union, comments in relation to the draft Disciplinary Responses Chapter, 17 March 2023, 2.

276 Statement of Thirza White, 8 August 2022, 5 [20].

277 Statement of Thirza White, 8 August 2022, 5 [21].

278 Statement of Thirza White, 8 August 2022, 5 [23].

279 Statement of Thirza White, 8 August 2022, 5 [24].

280 Statement of Thirza White, 8 August 2022, 5 [40].

281 Community and Public Sector Union, Comments in relation to the draft Disciplinary Responses Chapter, 15 March 2023, 1–2.

282 In the case of education, we acknowledge this training is recommended to be provided by the Department for Education, Children and Young People in accordance with Recommendation 6.5 in the Education Chapter.

283 *State Service Act 2000* s 50. Refer also to *Industrial Relations Act 1984* s 19AA, which states the Industrial Commission is to review matters under section 50 of the *State Service Act 2000*.

284 Transcript of Mathew Harvey, 28 June 2022, 1848 [14–18].

285 Transcript of Mathew Harvey, 28 June 2022, 1848 [22–28].

286 Department of Health, 'NTP-TAS-002 Item 14', undated, 7, document produced by the Tasmanian Government in response to a Commission Notice to Produce.

287 Department of Health, 'NTP-TAS-002 Item 14', undated, 7, document produced by the Tasmanian Government in response to a Commission Notice to Produce.

288 Edge Legal, *Critical Analysis Report on Termination in the State Service* (Report, 2021) 9.

21 Therapeutic services

1 Introduction

In this chapter, we consider the therapeutic service system in Tasmania, which has the potential to support victim-survivors of institutional child sexual abuse and children who have engaged in harmful sexual behaviours.

Without the right support and intervention, victim-survivors can be left to cope with their trauma in ways that are harmful to themselves and others—such as using alcohol and other drugs, engaging in violent or criminal behaviour, or self-harming. It can have an impact on their life opportunities, including their ability to engage in education and employment. They can also become vulnerable to more victimisation.[1]

We heard that the first contacts a victim-survivor has with a therapeutic service can affect their trajectory towards recovery. If they feel supported and validated, they are more likely to engage in therapeutic treatment and to seek justice. However, if they feel dismissed or minimised, they may be less likely to pursue recovery or justice for themselves.[2] Therefore, when a victim-survivor reaches out for help, referral pathways need to facilitate timely access to appropriate services. This service system needs to be informed by its users—adult and child victim-survivors.

While our terms of reference require us to inquire into the needs of victim-survivors of child sexual abuse in institutional settings, we consider our recommendations in this chapter will benefit all victim-survivors of child sexual abuse who have similar and complex therapeutic needs.

Victim-survivors may disclose their abuse at any time after it occurs and sometimes do so very late in their lives. Impacts of child sexual abuse can also manifest differently at various stages in a person's life—for example, when they enter adolescence or when they have their own children. Recognising these diverse needs across the lifespan, this chapter considers the different support needs of child and adult victim-survivors. We also consider victim-survivors who have extra needs or often experience barriers to receiving suitable support, such as those who have disability or are Aboriginal.

We discuss the needs of children who have engaged in harmful sexual behaviours separately in this chapter. These children need an added level of specialised help and intervention to address the harm that the behaviour does to their development, and to reduce the likelihood of them repeating the behaviour. Although children who have displayed harmful sexual behaviours may experience criminal justice issues as a result, and cause harm to victim-survivors, we consider it vital to recognise that these children need help. We also consider that children who have been harmed by the sexual behaviours of another child need equivalent therapeutic supports to victim-survivors of other forms of child sexual abuse.

We do not explore therapeutic interventions available to adult perpetrators of child sexual abuse in this chapter, although we consider it briefly in Chapter 16.

This chapter is divided into four main sections, in addition to the Introduction (Section 1) and Conclusion (Section 6).

In Section 2, we outline the National Royal Commission's recommendations for an accessible, well-coordinated therapeutic service system designed to meet the needs of victim-survivors.

In Section 3, we describe the services available to victim-survivors of child sexual abuse. We refer to these services as 'sexual assault services' in line with current practice, noting that they provide services for victim-survivors of child sexual abuse and of adult-on-adult sexual assault (and do not limit services to abuse that meets a criminal definition of assault).

As outlined in Section 3, we found it difficult to get a handle on the therapeutic service system and how the various components of the service system intersect.[3] We note that it may be even more difficult for people who need these forms of support to understand how the service system works and what is available to them.

In Section 4, we consider the extent to which the therapeutic service system meets the needs of victim-survivors of child sexual abuse and offers services that are accessible and appropriate. We identify several areas for improvement including:

- a need for government leadership to develop and fund a well-coordinated therapeutic service system for child sexual abuse

- a need for more sexual assault counselling services to enable adult and child victim-survivors of child sexual abuse to access them easily and in a timely way
- an urgent need for more culturally appropriate Aboriginal healing services and for sexual assault services that accommodate diversity and disability in a natural and welcoming way.

In Section 5, we focus on the therapeutic service system for children who have displayed harmful sexual behaviours. We conclude that children who have displayed harmful sexual behaviours need better access to therapeutic services, and that there needs to be a coordinated response across government agencies, which the Government should lead.

Overall, a well-functioning, trauma-informed, accessible, collaborative and appropriate therapeutic service system for child sexual abuse and harmful sexual behaviours requires the Tasmanian Government to assume a higher level of responsibility for overseeing, funding and monitoring such a system.

2 National Royal Commission

The Royal Commission into Institutional Responses to Child Sexual Abuse ('National Royal Commission') dedicated volume 9 of its final report to 'advocacy, support and therapeutic treatment services' for victim-survivors. Five of the recommendations in that volume are relevant to the Tasmanian Government's responsibility for the funding and characteristics of the Tasmanian service system for child sexual abuse, namely:

- ensuring there is a system of integrated advocacy, support and counselling for child and adult victim-survivors of child sexual abuse in institutional settings (Recommendation 9.1)
- increasing funding to sexual assault services to improve their capacity to support adult and child victim-survivors of child sexual abuse in institutional settings (Recommendation 9.6)
- funding Aboriginal and Torres Strait Islander-specific healing approaches (Recommendation 9.2)
- funding for support services for victim-survivors with disability (Recommendation 9.3)
- ensuring government human services agencies' policy frameworks and strategies recognise the needs of victim-survivors and the benefits of trauma-informed approaches in their work (Recommendation 9.8).[4]

Since 2018, Tasmanian Government has reported annually on its implementation of the National Royal Commission's recommendations, most recently in the *Fifth Annual Progress Report and Action Plan 2023*.[5] From its progress report in 2020 onwards, the Government began referring to its action plans for family violence as also including 'sexual violence' and fulfilling many of the National Royal Commission's recommendations.[6]

The Government's fifth report suggested that its *Survivors at the Centre: Tasmania's Third Family and Sexual Violence Action Plan 2022–2027* has fulfilled the above five National Royal Commission recommendations, but it provided little information to address each recommendation.[7]

Our reading of the Government's third action plan and its predecessor—*Safe Homes Families Communities: Tasmania's Action Plan for Family and Sexual Violence 2019–2022*—revealed that only six of the 38 actions contained in the plans could be considered relevant to the sexual assault service system (depending on how they are implemented); the others relate to family violence.[8] The relevant six actions cover improved forensic testing technology (Action 4), increased core funding to sexual assault counselling services with five-year funding contracts (Action 12), establishing a peak family and sexual violence body (Action 14), 'strengthening' the Victims of Crime Service (Action 19), continuing the Sexual Assault Support Service's recently funded Prevention, Assessment, Support and Treatment program for addressing harmful sexual behaviours (Action 28) and establishing two multidisciplinary centres (Action 1).[9]

We are concerned that the Government decided to incorporate the National Royal Commission's recommendations about child sexual abuse into the existing activities and frameworks for family and sexual violence. We recognise that child sexual abuse can co-occur with family violence, but this approach misses the intention of the National Royal Commission's recommendations; namely, that child sexual abuse, and particularly child sexual abuse *in institutions* requires a specific response. We consider this recognition requires the Government to lead, coordinate and fund therapeutic services specifically for child sexual abuse and harmful sexual behaviours. We discuss these concerns further in Chapter 19.

3 The current service system

Tasmania's therapeutic service system for child sexual abuse took us some time to comprehend despite our own research activities and our notices to produce to the Government (discussed in Section 4). We benefited greatly from the information provided by local sexual assault services: the Sexual Assault Support Service and Laurel House.

Broadly speaking, the Tasmanian therapeutic service system for child sexual abuse appears to have evolved over time, often in silos and in response to local issues.

We identified its main components to be:

- the Strong Families Safe Kids Advice and Referral Line ('Advice and Referral Line') for concerns or suspicions about the sexual abuse of a child
- local sexual assault counselling services, which provide a crisis response and short-, medium- or longer-term support
- counselling support available through the National Redress Scheme
- local counselling support for victims of crime
- local therapeutic services for children who have displayed harmful sexual behaviours
- national online or phone sexual assault support services
- forensic services to collect evidence that may be used to prosecute a sexual crime (explored in Chapter 16)
- multidisciplinary centres where sexual assault services are co-located with other services that victim-survivors may need, such as police, the Child Safety Service or family violence assistance
- mainstream counselling or mental health services that often need to respond to disclosures of sexual abuse or its impacts while delivering therapeutic support.

In a collaborative and responsive therapeutic service system, as advocated by the National Royal Commission, all aspects of the service system communicate well and refer to each other easily.[10] In the rest of this section, we explore each part of Tasmania's service system in turn before examining areas requiring improvement in Section 4.

3.1 Advice and Referral Line

For people who are concerned about the welfare of a child, the Advice and Referral Line is often their first port of call for advice about what to do and where to go. As well as its statutory role in the child protection system, the Advice and Referral Line refers families and children to services that could assist with problems they are experiencing, including referring a family to sexual assault services to receive support for child sexual abuse or harmful sexual behaviours.[11]

3.2 Local counselling services

3.2.1 MY SUPPORT helpline

In the first instance, Tasmanian victim-survivors can phone the State Government funded 24-hour 1800 MY SUPPORT helpline for support in relation to sexual assault or

sexual abuse.[12] The MY SUPPORT helpline number is directed to counsellors employed at the Sexual Assault Support Service or Laurel House (described in the next section), depending on the caller's location.[13] Phone counsellors provide immediate crisis support for victim-survivors, assist them if they want to make a report to police and/or want a forensic medical assessment, and refer them for in-person counselling and support, including through Laurel House and the Sexual Assault Support Service.[14]

3.2.2 Sexual assault counselling services

The two main sexual assault counselling services generally service distinct geographical regions in Tasmania—Laurel House provides services to northern Tasmania and the North West, and the Sexual Assault Support Service provides services in southern Tasmania.[15] The Tasmanian Government funds both services to offer counselling and support for a wide range of victim-survivors, including victim-survivors of institutional child sexual abuse and children who have experienced harmful sexual behaviours from another child.[16] Following the disbandment of the Department of Communities on 1 October 2022, the Department of Premier and Cabinet began funding sexual assault services.[17]

There is a third, much smaller service—Enterprising Aardvark—in northern Tasmania, but it is not government funded.

Broadly speaking, the Sexual Assault Support Service and Laurel House appear to offer roughly equivalent services in many respects. Both agencies support victim-survivors of child sexual abuse (including harmful sexual behaviours) of all ages and genders, as well as 'secondary victims such as parents, siblings, friends and supporters' by a variety of means: in person, phone, online and outreach.[18] We concluded that both agencies employ experienced therapists who have degree-level qualifications in counselling, psychology or social work, and provide their staff with professional development and supervision.[19]

Laurel House and the Sexual Assault Support Service accept referrals from many different sources.[20] When a victim-survivor contacts either service directly, they speak to an intake counsellor who triages the case for allocation to a counsellor.[21] While a person is awaiting allocation, both services provide crisis assistance (refer to discussion about waiting lists in Section 4.3.1).[22]

The Sexual Assault Support Service has the advantage of having greater capacity, perhaps due to the larger population in southern Tasmania. The Sexual Assault Support Service has also secured the entire government funding for providing therapy to children and young people up to the age of 18 who engage in harmful sexual behaviours (the Prevention, Assessment, Support and Treatment program described in Section 5.2.1) and receives Commonwealth funding to provide counselling for victim-survivors seeking redress through the National Redress Scheme (refer to Section 3.2.3 and, for more

detail, Chapter 17). It employs 48 staff, most of whom are part-time, and receives about 1,400 referrals a year.[23]

Laurel House provided counselling to just under 900 clients in the 2020–21 financial year.[24] The service did not provide staffing numbers, but its Chief Executive Officer, Kathryn Fordyce, advised us that the case load of a full-time counsellor at Laurel House was the same as for the Sexual Assault Support Service: about 30 clients at any one time.[25]

We learned of Enterprising Aardvark from a victim-survivor who had heard about the service from police.[26] According to its website, Enterprising Aardvark is a free counselling and support service in northern Tasmania for victim-survivors of child sexual abuse and their families.[27] Its website says it relies on donations because it receives no government funding, employs two part-time counsellors and has provided about 1,500 hours of counselling each year since it started in 2017.[28]

We were told that, in 2020, Enterprising Aardvark provided education sessions for Ward 4K staff at Launceston General Hospital about profiles of abusers, grooming tactics and strategies.[29] Otherwise, we have little information about this service and we presume it is not well-publicised outside informal networks. It did not make a submission to us.

3.2.3 Redress support services

We discuss the National Redress Scheme in Chapter 17, but consider here the supports provided to victim-survivors as part of that scheme. Many of those involved in accessing the National Redress Scheme, or supporting those who access the scheme, told us that the process can be traumatising, and that support is vital while victim-survivors retell their experiences of child sexual abuse and go through the distressing process of having those experiences quantified against a scale of seriousness.[30]

In Tasmania the Commonwealth Government funds the Sexual Assault Support Service, Relationships Australia and the South East Tasmanian Aboriginal Corporation to provide redress support services, which are counselling services for victim-survivors in the National Redress Scheme.[31] Laurel House said it does not provide redress support services but aims to do so in the future.[32]

Under the National Redress Scheme, victim-survivors can also choose counselling services from approved counsellors to be included in their redress offer.[33] The Department of Justice coordinates this part of the service system.[34]

Civil legal action can be protracted and very stressful for victim-survivors (refer to Chapter 17).[35] Although there is no specifically funded support service for victim-survivors who take civil action over their abuse, sexual assault counselling services will support victim-survivors who are engaging in civil action.[36]

3.2.4 Victims of Crime Service

Provided by the Department of Justice's Victims Support Services (refer to Chapter 17), the Victims of Crime Service has offices in Burnie, Launceston and Hobart.[37] The service 'provides a counselling, support and referral service to victims of serious interpersonal violence and sexual offences'.[38]

This free service is generally used by victim-survivors who have reported their abuse to police.[39] Basic information about the service is available on the Department of Justice's website.[40]

3.3 Online and phone sexual assault support services

Phone and online sexual assault support services for victim-survivors strengthen Tasmania's service system. Victim-survivors can contact the free national 24-hour 1800RESPECT helpline, which offers immediate support and counselling for sexual assault and family violence via phone and online. The helpline has a referral database for local services and provides self-help information and apps to help victim-survivors access supports in a safe way.[41] Organisations, such as the Sydney-based Survivors and Mates Support Network for male victim-survivors and the national organisation Blue Knot Foundation, provide some support, information and referral services to victim-survivors and their supporters.[42]

3.4 Forensic medical assessments

The Tasmanian Health Service can undertake forensic examinations for victim-survivors after a sexual assault. These examinations can be conducted at the Royal Hobart Hospital, the Launceston General Hospital and the North West Regional Hospital (Burnie).[43] The victim-survivor's chosen service will conduct the medical examination, record injuries and collect biological samples if relevant. A victim-survivor does not need to have made a police report to have a forensic medical examination.[44] Counsellors from Laurel House or the Sexual Assault Support Service can support the victim-survivor during the examination.[45]

Chapter 16 discusses forensic medical examinations including the roles of police, medical and nursing personnel and specialist sexual assault services.

3.5 Multidisciplinary centres

Survivors at the Centre: Tasmania's Third Family and Sexual Violence Action Plan 2022–2027 committed to piloting two multidisciplinary centres as a new action 'to provide survivor-centred, holistic and integrated responses to family and sexual violence'.[46] These centres, named Arch centres, should be up and running in 2023.[47] Tasmania Police has led development of these multidisciplinary centres to improve

specialisation for police and coordinate responses to sexual violence in general.[48] In Chapter 16, we call for Tasmania Police to prioritise police specialisation. Refer to Section 4.2 for more on the new Arch centres.

3.6 Mainstream services

Not everyone who was sexually abused as a child will access only specialist sexual assault services. Many victim-survivors will seek support for the problems arising from experiencing child sexual abuse, such as post-traumatic stress disorder, alcohol and other drug misuse, suicidal ideation, depression, anxiety and relationship issues.[49]

The key mainstream services that we consider would have contact with victim-survivors for treatment or referral are:

- medical practitioners such as psychiatrists and general practitioners who can provide Mental Health Treatment Plans under Medicare
- private psychologists and mental health practitioners who see clients referred by general practitioners, often subsidised for a set number of sessions by Medicare under a Mental Health Treatment Plan
- public mental health services offered by the Tasmanian Health Service such as Adult Mental Health Services, Child and Adolescent Mental Health Services, the Alcohol and Drug Service and adult inpatient mental health units
- Aboriginal health organisations (discussed more in Section 4.4.7).

We discuss the need for government mainstream services to become more trauma-informed in Chapter 19.

4 Improving the therapeutic service system

As a basis for its recommendations (refer to Section 2), the National Royal Commission identified the key characteristics of a responsive service system for adult and child victim-survivors of child sexual abuse and for children who have displayed harmful sexual behaviours:

- The system and its components need to be trauma-informed and knowledgeable about child sexual abuse.
- The system needs to work together to meet the range of potential needs of victim-survivors and the complexity of the service system.
- Enough services should be available for victim-survivors to access and be delivered for as long as necessary for each person.

- Services should be accessible for all victim-survivors regardless of their capacity to pay, geographical location, disability or cultural background.
- Services should be 'acceptable' to victim-survivors who have diverse needs; that is, they should be flexible enough to respond to victim-survivors from a variety of cultural and social contexts.
- The high quality of the services should be assured through ongoing evaluation of evidence-informed approaches.
- The service system should include Aboriginal healing approaches.[50]

The National Royal Commission's recommendations assigned responsibility to the state and territory governments to ensure the therapeutic service system has these characteristics.[51] We consider that the Tasmanian Government needs to do more to meet these requirements.

This section considers the extent to which the current therapeutic service system meets the needs of victim-survivors and provides services that are accessible and appropriate. We also identify several areas for improvement.

4.1 Developing a therapeutic service system for child sexual abuse

The Tasmanian therapeutic service system has evolved organically from the bottom up. Over time, separate non-government services have been established in communities to meet the needs of victim-survivors at that time. Gradually, services have sought and received government funding to expand into areas where they have identified gaps. Consequently, the service system is not particularly cohesive or equitable.

At the strategic level, we consider the Tasmanian Government has not taken responsibility for ensuring the therapeutic service system is adequately planned and funded. Instead, the task of service provision and leadership in the system has fallen to hard-working and dedicated non-government organisations. There has therefore been no coordination or overarching plan for developing the system that would ensure consistency in approach, coordination of services, appropriate coverage or equitable access.

We asked the Government to describe its service system in preventing, identifying, reporting and responding to allegations or incidents of child sexual abuse in institutional contexts, including for:

- advocacy, therapeutic and social supports for victim-survivors
- therapeutic and social supports for children who have displayed harmful sexual behaviours

- targeted supports for
    - Aboriginal children
    - children with a culturally and linguistically diverse background
    - children in youth detention
    - children in out of home care
    - children with disability
    - children who identify as LGBTQIA+
    - any other groups that receive targeted supports.[52]

The Government's response did not demonstrate to us that there is a well-structured therapeutic service system for adult and child victim-survivors of child sexual abuse and children who experience or display harmful sexual behaviours.[53] In the remainder of Section 4 and in Section 5, we outline gaps in the scope of sexual assault services for victim-survivors of child sexual abuse and harmful sexual behaviours, as well as in a consistently coordinated approach to service delivery.

Given the difficulties we experienced trying to understand the therapeutic service system for child sexual abuse, it follows that victim-survivors would also find it difficult to understand the service system and access the services they need when they need them.

The Tasmanian Government should lead, coordinate and fund development of a therapeutic service system that includes responses for adult and child victim-survivors of child sexual abuse and for children who have experienced or displayed harmful sexual behaviours. This therapeutic service system should ensure coordination of services, appropriate service coverage and equitable access to quality services.

The Government should ensure the therapeutic service system is easily understood by victim-survivors and those affected by child sexual abuse, as well as mainstream services that may need to make or receive warm referrals.

The Government also needs to know the therapeutic service system is working and meeting the needs of victim-survivors. The National Royal Commission stated that 'a high-quality service system is informed by evidence, well-trained and supported, outcome focused, accountable and subject to ongoing evaluation'.[54]

We only heard about two of the services in Tasmania's sexual assault service system that are being actively evaluated, mainly because they are both pilot programs—the Prevention, Assessment, Support and Treatment program for harmful sexual behaviours and the Arch centres.

The Sexual Assault Support Service expressed concern about a lack of quality assurance or standards required in government funding contracts.[55] We identified a similar concern in the context of non-government out of home care provider funding agreements (refer to Chapter 9). Commissioning arrangements appear to have been problematic in several areas in the former Department of Communities.

The Department of Premier and Cabinet, in its new role of funding sexual assault services, should provide leadership, fill service gaps and ensure funding agreements with non-government sexual assault counselling services have governance requirements, service evaluation and child safe accreditation built in. The child safe accreditation will empower children to contribute to how the services provided for them are shaped.

It is important that in leading development of this therapeutic service system, the Government collaborates with all those affected by the service system including children and adult victim-survivors, specialist counselling services, police, government agencies and the peak body for the sexual assault service system recommended in Recommendation 21.3.

Recommendation 21.1

1. The Department of Premier and Cabinet should lead, coordinate and fund a therapeutic service system for child and adult victim-survivors of child sexual abuse and children who have experienced or displayed harmful sexual behaviours.
2. The Department should ensure the therapeutic service system:
    a. addresses service gaps and provides coordination of services, appropriate coverage and equitable access to quality services
    b. is easily understood and accessible to the public, state servants and other mainstream service providers.
3. The Department, in leading this work, should consult with:
    a. any relevant government departments, including the Department for Education, Children and Young People, the Department of Health and Tasmania Police
    b. sexual assault and abuse counselling services
    c. the Premier's Youth Advisory Council and the adult victim-survivors of child sexual abuse advisory group (Recommendation 19.5)

d. the peak body for the sexual assault service system (Recommendation 21.3).

4. The Tasmanian Government should ensure funding agreements with non-government specialist services include appropriate governance requirements, sexual abuse service standards, service evaluation and child safe accreditation.

4.2 Creating a collaborative system

The National Royal Commission heard that services victim-survivors need 'span several sectors and can be difficult to navigate' and that those services '[do] not collaborate with one another, compounding the difficulties victims and survivors faced when navigating the complex policy and service environment'.[56]

Kylee's experience

One victim-survivor told us about her experience of having to tell nine people her story in order to report to police and receive therapeutic care.

> For someone who never wanted to tell anyone, the amount of people I then had to tell … One example is Victims of Crime, I was encouraged by the Detective to contact them, so I ring up to make an initial appointment, you're then speaking to a counsellor to do an extension of time application, that then goes to someone to be assessed. Then come in and see someone else to do an application … then I'm contacted by someone who says 'you need to see a counsellor' … They then organise me to see a phone link-up counsellor, she says, 'you do realise you're going to have to tell your GP?' … Then because the counsellor thought I had a diagnosis of moderate post-traumatic stress disorder, I had to then be referred on to a psychologist … Then I had an interview with a Commissioner [for Victims of Crime], and an assistant and they then determined whether I was eligible or not … nine people I had to share my experience with.[57]

The National Royal Commission recommended establishing:

> … dedicated community support services for victims and survivors in each jurisdiction, to provide an integrated model of advocacy and support and counselling to children and adults who experienced childhood sexual abuse in institutional contexts.[58]

The Blue Knot Foundation's *Organisational Guidelines for Trauma-Informed Service Delivery* also supports providing collaborative, integrated care:

> People living with the impacts of trauma often present to multiple services over a long period of time. The care they receive is frequently fragmented and not well coordinated between services. There are often inadequate referral and follow-up pathways. These failures in the system can mean that clients experience a 'merry go round' of unintegrated care. As a result, people are more likely to be retraumatised and their trauma is more likely to be compounded.[59]

We heard of local examples of close working relationships between services, such as in North West Tasmania. Community members there proudly reported that police, schools and the Child Safety Service in their area had developed a good working relationship to respond in a trauma-informed way to disclosures of child sexual abuse and, perhaps consequently, they reported an increase in disclosures.[60] Laurel House also noted the flow-on benefits for victim-survivors of developing positive working relationships with police and other services.[61]

The response to child sexual abuse in Tasmania includes some systems for collaboration, such as interagency case discussions and a memorandum of understanding to share information between police and the Child Safety Service. However, we were told that 'effective collaboration and therefore responses stem beyond this' and:

> ... the response to allegations and incidents of child sexual abuse in institutional contexts is complex and requires multi-agency collaboration, inclusive of co-located cross-agency teams, improved information sharing, appropriate specialised training and consultations between key agencies.[62]

Jillian Maxwell, Chief Executive Officer, Sexual Assault Support Service, noted that:

> Victim-survivors of all ages express feeling overwhelmed in respect of the number of agencies who they are meant to 'follow up with'. The onus is often placed on the individual, who has already experienced significant hardship and distress, to contact the Police, Child Safety Services and other State Government agencies ... [multidisciplinary centres] would be particularly beneficial given the way we work in Tasmania; a place which is built on relationships, trust and safety. Having a client, whether an adult or a child, attending at one place where they are supported by their counsellor in accessing the other services that are either co-located or coming onsite would also be much more trauma-informed than current 'siloed' approaches.[63]

For the past few years, the Sexual Assault Support Service and Laurel House have lobbied for the setting up multidisciplinary centres in Tasmania to better coordinate services and provide 'collaborative and integrated responses to victim-survivors in one location'.[64]

4.2.1 The Tasmanian model of multidisciplinary centres

As discussed above, the Government committed to piloting two multidisciplinary centres as part of its *Survivors at the Centre: Tasmania's Third Family and Sexual Violence Action Plan 2022–2027*.[65] On 2 December 2022 the Government announced that two

Arch centres, one in Hobart and one in Launceston, would be 'available in 2023'.[66] In conjunction with sexual assault services, Tasmania Police has led development of the centres as a means of improving specialisation for police and for coordinating responses to sexual violence more generally.[67] The Government has said that these multidisciplinary centres will enable victim-survivors to 'receive immediate and integrated support in a safe place'.[68] The intention is to facilitate a positive first contact with counselling and statutory services for victim-survivors.

We discuss the evidence for the effectiveness of multidisciplinary centres and the need for police specialisation in Chapter 16. This section focuses on the proposed Tasmanian model of multidisciplinary centres and how they might meet the therapeutic needs of victim-survivors.

Arch centres

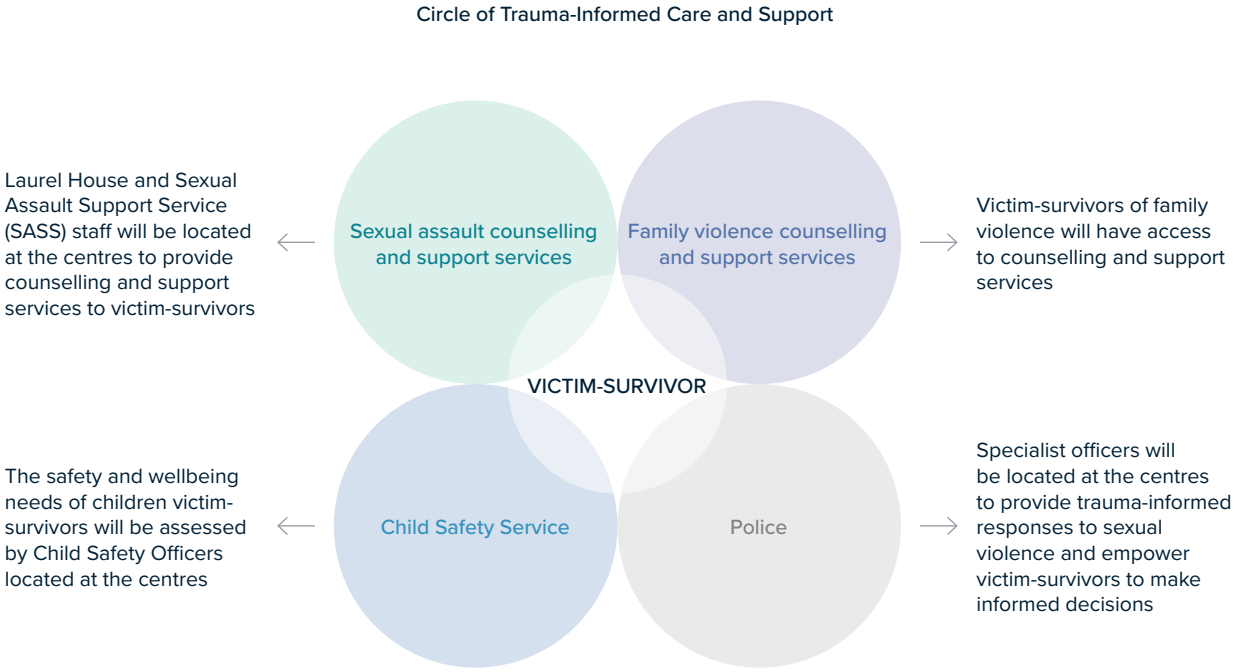
The Tasmanian Government has indicated that the pilot Arch centres aim to be a 'one-stop shop' for victim-survivors of sexual abuse to access all the services they need in one location.[69] On the basis of available information at the time of writing, it appears that services at the centres may include:

- sexual assault counselling services
- specialist sex crimes police investigators
- child safety support workers
- family violence counselling support services
- witness intermediaries (as requested)
- facilities for tailored service provision (as required)
- State Service employees in investigative support roles.[70]

Arch centres are being co-designed with victim-survivor advocates and existing services in the family and sexual violence sector to ensure 'service delivery meets the needs of victim-survivors'.[71] As part of the process of ensuring these are child safe organisations, we encourage the Government to work with children to inform their design. We also caution the Government to ensure the design process goes beyond co-locating services to the purposeful systems, processes and practices that will support multidisciplinary collaboration, preventing victim-survivors from having to retell their story to each service in the Arch centre with which they engage.

Key elements of the proposed model are set out in Figure 21.1.

Figure 21.1: Key elements of the Arch centre model[72]



Source: *Sexual and Family Violence Project Newsletter*, Issue 1 (July 2022).

The $15.1 million allocated to Arch centres for the two-year pilot includes funds for new full-time-equivalent positions:

- 15 specialist sex crimes investigators (10 in the south and five in the north)
- nine State Service employees in analytics and specialist roles (across the model)
- three Child Safety Officers (two in the south and one in the north)
- two family violence counselling support workers (one each in the south and north).[73]

It is unclear how many staff from sexual assault counselling services will be at the centres, but we note that, in addition to the above, $21 million has been allocated to the sexual violence sector and $51 million to the family violence sector 'to support the implementation of the *Third Sexual and Family Violence* action plan'.[74]

Key considerations

Although there are many potential benefits to the multidisciplinary centre model, its success depends on several factors. Professor Leah Bromfield, one of the Commissioners for our Inquiry, co-authored an article with James Herbert based on a national analysis of the multidisciplinary centre model. In the article, Commissioner Bromfield commented: 'There is often a difference between the stated models and

how models operate in practice'.[75] The Victorian Law Reform Commission also recently identified some common challenges with multidisciplinary centres including:

- power imbalances between agencies
- tensions in agencies' purposes and goals
- information sharing and privacy concerns
- being responsible and accessible to victim-survivors with diverse and complex needs
- not having enough resources.[76]

There is an absence of evidence directly comparing models of cross-agency responses to determine what contributes to positive outcomes, which makes it difficult to work out the essential components for an effective response.[77] However, a recent scoping review identified 11 factors that may support quality cross-agency responses and outcomes in cases of child sexual abuse.[78] These are listed in Table 21.1. Arch centres will need to consider such factors in their design, implementation and evaluation.

Table 21.1: Factors that may support quality cross-agency responses and outcomes[79]

Process factors (factors reflecting the delivery of a cross-agency model)	Protocols	Clear and comprehensive cross-agency protocols that have been developed and agreed to by agencies taking part in the response
	Case review meetings	Provide an opportunity for decision making across agencies and disciplines and for participants to understand each agency's role
	Cross-agency training	Similar training is provided to different professional disciplines
	Co-location	Staff are easily accessible and can develop rapport with those from other agencies and disciplines
Individual factors (factors enabling workers to effectively collaborate with one another)	Professional skills and knowledge	Staff have the skills and knowledge to undertake their own work and to collaborate with others
	Mandates, vision, roles and priorities	Staff can reconcile their own professional responsibilities with their role in a cross-agency team
Enabling factors (factors supporting processes and collaboration)	Feedback and evaluation	Data is received from victim-survivors and staff to enhance responses
	Leadership and governance	Emphasises the importance of cross-agency leadership, teamwork and dispute resolution
	Resources	A lack of resources to support cross-agency collaboration is a barrier to models
Improved cross-agency collaboration factors (factors reflecting good practice)	Trust and respect	Relationships between staff centre on mutual trust and respect
	Communication and information sharing	There is frequent communication and exchange of quality information across agencies

Source: Adapted from: James Herbert et al., 'Possible Factors Supporting Cross-Agency Collaboration in Child Abuse Cases'.

Genuine collaboration

Although Arch centre materials indicate that the centres will be physically designed to facilitate collaboration and coordination, Jenny Wing, Chair, Victorian Harmful Sexual Behaviour Network, told us that co-location or proximity does not guarantee collaboration:[80]

> … [collaboration] is a constant relationship that needs to be maintained. Being co-located in multidisciplinary centres provides greater opportunities to maintain these relationships … there still needs to be a combined effort to meet and engage regularly for the relationship to work effectively.[81]

The New South Wales experience was similar. Peter Yeomans, Detective Chief Inspector, New South Wales Police Force, who leads the Child Abuse and Sex Crimes Squad, said that 'effective and regular communication between agencies is critical', whether the service is co-located or not.[82] Tasmania Police acknowledged that the effectiveness of multidisciplinary centres was 'dependent upon relationships at a practice level, these relationships need to be established prior to systems and structures being imposed'.[83] Former Commissioner Darren Hine AO APM from Tasmania Police commented that:

> … it's not having those people in one area; it's having the right people in that area. And that's one of the things we've learned from other states: some centres work better than others, and it comes down to … leadership, and it comes down to the people actually involved and we need to learn from that.[84]

Given the importance of coordination and collaboration, it is essential for Arch centres to facilitate these relationships in an ongoing way through strong leadership and deliberate and purposeful collaboration mechanisms that put victim-survivor needs at the centre.

Police presence

A police presence in multidisciplinary centres is pivotal to their success. Tasmania's sexual assault counselling services recommended that the police presence must be unobtrusive and inconspicuous.[85] Indications are that the Arch centres will reflect this principle. Commissioner Hine said: 'it's not connected to a police station, will not look like a police station'.[86]

Laurel House noted that those victim-survivors who do not want to engage with police or direct government services should still be able to access the other services—choice is critical.[87] Indeed, choice is a principle of trauma-informed care that must be central to the multidisciplinary centre model.[88] Arch centre materials indicate that they have:

> … carefully considered the choices clients might make at the centres and what this will mean for their movement within them. If you choose to see one particular service provider only, the design will help to ensure that you do not bump into any others. For example, we respect that some clients may not want to, or may not be ready to, see a police officer. With this in mind, police officers who work in the centres will not be in uniform and will use an alternative door.[89]

Family violence

Following their examination of the Victorian multidisciplinary centre model, Tasmania Police reported their impression that Victoria Police 'considered the integration of sex crimes and family violence appropriate given there is extensive research regarding the correlation between the two'.[90]

Victoria Police told us:

> … given the high prevalence of sexual offending in family violence, Victoria Police is continually looking for opportunities to align its responses to these crime themes when they co-occur. Family violence and sexual offence units are specialist units but will operate collaboratively in some instances, such as, when the sexual violence is intrafamilial. Some multidisciplinary centres … include both specialist teams but the key function of [multidisciplinary centres] is to provide specialist sexual offence responses.[91]

We also heard from several people who have worked in the sexual assault field across different jurisdictions that family violence can become 'the dominant force' and that it is better to not 'dilute the expertise of dealing with child sexual assault matters'.[92]

Commissioner Hine told us that Arch centres will not incorporate Tasmania Police Family Violence Units, nor will the Safe at Home model change.[93] We understand the Safe at Home model to be a cross-government partnership to coordinate responses to family violence.[94] Tasmania Police told us that the intention is for extra resources to be allocated to the Safe Families Coordination Unit to expand its role to include sexual violence, enabling it to 'coordinate information to deliver the Government's vision of a collaborative, multi-agency response to sexual violence'.[95] Commissioner Hine stated that:

> This approach provides confidence that high-volume family violence matters will not impact the priority afforded to sexual assault and it is acknowledged that this will need to be subject to evaluation as part of the pilot program.[96]

Arch centre materials indicate that 'offences or information relating to family violence' that require a response will be sent to local police as is the current system, which we take to mean matters will continue to be referred to local Family Violence Units. The material also indicated that if the matter includes 'sexual violence', it will be sent to an Arch centre.[97]

We welcome the commitment to ensure family violence matters do not overwhelm a specialisation in child sexual abuse.

Resourcing

Adequate resourcing of Arch centres will be essential. Ms Maxwell, from the Sexual Assault Support Service, noted that the funding allocated may not be enough to create ideal multidisciplinary centres.[98]

It is not yet known how the extra funding to the sexual and family violence sectors will be allocated, and whether it will be enough to resource the Arch centres *and* existing services. However, Arch centre materials indicate that choice will be paramount in terms of services accessed within and outside of the centres. Materials suggest that Arch centres will be an extra rather than a replacement resource and that 'established counselling and support services already available in the community will not change when the centres commence'.[99]

Evaluation

The National Royal Commission noted that while multidisciplinary models can achieve goals such as reducing retraumatisation, assisting victim-survivors to navigate the system and promoting effective collaboration between services, 'co-location and other models of collaboration are only tools to achieve a better service offering, not goals in themselves'.[100] Given the complexities of providing effective therapeutic and statutory services to victim-survivors of child sexual abuse, evaluation of Arch centres must be independent, robust and ongoing.

Commissioner Hine told us that, as a pilot program, 'evaluation will be critical and commence from the program launch to ensure experience informs the future'.[101] This is supported by *Survivors at the Centre: Tasmania's Third Family and Sexual Violence Action Plan 2022–2027*, which indicates that 'learnings from the pilot will inform future considerations of the model'.[102] The evaluation should follow sound principles to provide an accurate picture of the impact of Arch centres.

We heard from stakeholders that multidisciplinary centres 'will not provide the solutions to all the issues and challenges that affect victim-survivors of child sexual assault in Tasmanian Government settings'.[103] Similarly, the Victorian Law Reform Commission recommended expanding multidisciplinary centres in Victoria, but acknowledged that they are only one feature of a much larger system.[104] We discuss other aspects of the service system, including sexual assault counselling services, in Section 4.3.

Recommendation 21.2

1. The Tasmanian Government should conduct an independent process and outcomes evaluation for the pilot multidisciplinary Arch centres and any future centres after three years of operation to inform the Government of any systems improvements that could be made to the centres and whether they have resulted in improvements in client outcomes. The evaluation should incorporate:

a. an evaluation and data outcomes framework established during the first year that includes required baseline and outcomes data for clients receiving services through the Arch centres, and considers how Arch centre outcomes can be compared with the outcomes of cases that have not received an Arch centre response

b. the collection of data in line with the data outcomes framework in the first year

c. the storing and retention of data in a format that can be provided to the independent evaluators.

2. The evaluation and data outcomes framework should include outcome measures for adult and child victim-survivors of child sexual abuse and children who have experienced or displayed harmful sexual behaviours.

3. The Tasmanian Government should ensure multidisciplinary centres are not the sole response to the therapeutic needs of adult and child victim-survivors of child sexual abuse.

4.2.2 Peak body

Despite the small size of its service system, Tasmania's specialist sexual assault service providers can be relatively isolated from one another, and from interstate services, due to the north–south Tasmanian divide and the lack of a coordinated service system. Other states have peak bodies representing sexual assault services to coordinate services and advocate for system improvements, but Tasmania does not have such an organisation.[105]

The closest approximation in Tasmania is Providers of Sexual Assault Care. The organisation's website lists its main members as Tasmania Police, Sexual Assault Forensic Examiners at Launceston General Hospital, the specialist sexual assault support services of Laurel House and the Sexual Assault Support Service, and Forensic Science Service Tasmania.[106] Although its membership reflects a strong forensic focus, Providers of Sexual Assault Care has a broader stated purpose: to bring together the services that respond in the event of a sexual assault to support those involved in the care of victim-survivors of sexual assault, share multidisciplinary knowledge, facilitate 'expert total care' to victim-survivors and raise awareness of the problem of sexual assault.[107] The Providers of Sexual Assault Care administrator advised us that the organisation is funded through membership fees. The Tasmanian Government did not refer to it in its 'Tasmanian Government's current service system' response to our notice to produce, discussed in Section 3.[108]

The Government has recognised the need for a peak body in Action 14 of *Survivors at the Centre: Tasmania's Third Family and Sexual Violence Action Plan 2022–2027*,

which committed the Government to funding the Tasmanian Council of Social Services to establish a peak family and sexual violence body.[109] The peak body would:

> ... streamline engagement between Government and the community sector, and support the sector in policy development, enabling it to focus on service delivery to the Tasmanian community.[110]

This is a promising move, but we remain concerned about the Government combining family violence with child sexual abuse. Such a peak body risks being dominated by a focus on family violence, given the sheer size of this important social problem.

The Tasmanian Government should establish a more active, supported peak body to improve the sexual assault service system in a more consistent and coordinated way and, in this, consider the existing Providers of Sexual Assault Care. The coordination function of a peak body would be important as the Government expands sexual assault services available to victim-survivors, as described in Recommendation 21.4. A peak body could also develop or adopt existing standards of practice to ensure consistent quality in sexual assault services, as the Victorian Harmful Sexual Behaviour Network has done in Victoria.[111]

Recommendation 21.3

1. The Tasmanian Government should establish a peak body for the sexual assault service system, including therapeutic interventions for children who have engaged in harmful sexual behaviours, to:
    a. ensure the needs of adult and child victim-survivors of child sexual abuse and children who have experienced or displayed harmful sexual behaviours are met by the sexual assault service system
    b. represent sexual assault service providers in a coordinated way
    c. share evidence and experience
    d. develop or identify practice standards for sexual assault services and interventions for child sexual abuse and harmful sexual behaviours
    e. coordinate service delivery for victim-survivors
    f. advocate for improvements in the sexual assault service system.
2. This peak body for the sexual assault service system should be distinct from, but work in cooperation with, a family violence peak body.

4.3 Building on sexual assault services

Our resounding impression is that there are not enough local sexual assault services available or accessible to Tasmanian victim-survivors of child sexual abuse or children who have displayed harmful sexual behaviours. This shortage applies to timely, local forensic medical examinations, sexual assault counselling services, therapeutic interventions for children who have engaged in harmful sexual behaviours and counselling services available through the Victims of Crime Service.

Also, victim-survivors in Ashley Youth Detention Centre and more remote parts of the State experience particular difficulty in accessing suitable supports. The Government needs to address this shortfall in specific ways, which we describe in this section.

In Section 4.4, we discuss the problems of accessing services that meet the needs of some victim-survivors including victim-survivors with disability, or those wanting to access an Aboriginal service.

In Section 5, we consider and make recommendations about services for children who have engaged in harmful sexual behaviours.

4.3.1 Sexual assault services

Sexual assault counselling services

Ms Maxwell told us that victim-survivors of child sexual abuse in institutional settings can be especially sensitive to a service's response because they have often experienced poor institutional responses.[112] Therefore, she said, quick access to services is important for those people because they can perceive delays as not being heard or supported.[113]

During sessions with a Commissioner and in consultations, we heard concerns about waiting lists for sexual assault counselling, which people attributed to lack of funding.[114] Victim-survivors told us how difficult it was to wait for sexual assault counselling once they had disclosed their abuse.[115]

In May 2022, the Sexual Assault Support Service told us that it had about 90 people on its waiting list and it expected some of those would need to wait six-to-eight weeks before they could start work with a counsellor.[116] At the same time, Laurel House said it had about 40 people on its waiting list and some were waiting up to 33 working days (more than six weeks) to see a counsellor.[117] This is too long to wait for services.

Laurel House and the Sexual Assault Support Service said they develop a plan with each person on the waiting list to ensure they have access to support while they wait to see a counsellor.[118] A child sexual abuse counsellor told us that there should not be a waiting time for a child victim-survivor and their family to access specialist support.[119] Both services said, where possible, they prioritise children on their waiting lists ahead of adults.[120]

It appears that a significant increase in referrals without a corresponding increase in funding has contributed to larger waiting lists.[121] Both services also told us that they can struggle at times to attract and retain qualified and experienced counselling staff, which has further increased waiting times.[122] Kathryn Fordyce, the Laurel House Chief Executive Officer, told us that one factor contributing to difficulties with staff attraction and retention is the short-term nature of government funding; staff can be anxious about continuing in a role if funding is not secure.[123]

In November 2022, the Tasmanian Government announced a 37 per cent increase in core funding to family and sexual violence services and has introduced five-year contracts to assist with funding certainty.[124] However, the Government did not specify how the funding will be allocated to services.[125] Because the funding increase covers family violence services as well as sexual assault services, it is not clear what proportion will be allocated to specialist services for victim-survivors of child sexual abuse.

Victims of Crime Service

For a variety of reasons, some victim-survivors may prefer not to engage with the sexual assault service in their area. Having access to other free or low-cost counselling services offers victim-survivors some choice, which is an important characteristic of a trauma-informed sexual assault service system. The Victims of Crime Service provides an alternative counselling service option for those victim-survivors who cannot or prefer not to engage with the Sexual Assault Support Service or Laurel House.

Victim-survivors told us that they thought the Victims of Crime Service was underfunded.[126] However, Catherine Edwards, Manager, Victims Support Services, told us that the average waiting time for a victim-survivor to see a Victims of Crime Service counsellor was one-to-two weeks, which seems reasonable.[127] The service has one full-time counsellor in southern Tasmania, one almost-full-time counsellor in northern Tasmania and a 0.4 full-time-equivalent counsellor in the North West.[128] Ms Edwards also said there was 'an urgent pressing need' to increase the Victims of Crime Service counsellor position in the North West to full-time and, ideally, she would like to see two counsellors in each region.[129] She said the scope of the Victims of Crime Service is confined by its budget, and more resourcing would allow the service to provide more for victim-survivors.[130] We expect that more promotion of the service would increase demand, so it would seem wise to expand the service to at least Ms Edwards' ideal staff complement.

We welcome the Tasmanian Government's commitment to 'Strengthen the Victims of Crime Service' in Action 19 of *Survivors at the Centre: Tasmania's Third Family and Sexual Violence Action Plan 2022–2027;* however, we note that the plan has no information about what this might involve.[131] We recommend that it increases the number of counsellors available to support victims of crime and promotes the service to victim-survivors (refer to Recommendation 21.5). While some victim-survivors of child sexual

abuse in institutional settings will choose not to seek support from a government service, others will welcome an alternative among the limited range of options.

4.3.2 Geographical isolation

As a very small jurisdiction with a widely distributed population, Tasmania has always posed a significant challenge to the fair and equitable distribution of services. This challenge is amplified when trying to ensure all Tasmanians have access to sexual assault services. Such services might only be required intermittently and are more expensive to provide and access than in larger jurisdictions, which can benefit from the economies of scale associated with larger population centres. While this problem is not unique to Tasmania—victim-survivors in rural and regional areas across Australia are disadvantaged when it comes to accessing sexual assault services—the Government should address the need for these services across the State.[132] The situation appears to be particularly challenging in Tasmania's West Coast and North West. For example, in Queenstown we heard that a lack of transport options and difficulty attracting skilled staff make it difficult for victim-survivors to access sexual assault services.[133] In a general discussion about the challenges of reduced services overall, Aboriginal community members in the North West spoke of difficulties accessing sexual assault counselling for children.[134] In January 2023, the *King Island Courier* reported an increase in the number of people disclosing sexual abuse on the island and islanders wanted 'to develop structures and systems' to enable victim-survivors to access reporting and forensic services.[135] The article reported that the local council had attempted to fill the service gap but had struggled to find the resources.[136]

The two main Tasmanian sexual assault counselling services offer outreach services to parts of regional Tasmania. Laurel House has offices in Burnie, Devonport and Launceston and provides outreach services to some regional areas in northern Tasmania and the North West, such as George Town, Ulverstone, Beaconsfield and Smithton. However, they have found it harder to offer regular outreach to more remote locations such as Circular Head, the East Coast and the Bass Strait islands.[137]

In the south, the Sexual Assault Support Service has offices in Hobart and Huonville and will travel to locations such as the Southern Midlands to provide counselling when a client cannot travel to an office.[138] The Sexual Assault Support Service will also subsidise clients' travel to an office if cost is a barrier.[139]

Both services can provide online or phone counselling for people in remote areas.[140] However, some clients do not have access to a computer or a private space at home where they can take part in a session, so they may prefer to travel or meet a counsellor somewhere locally.[141] Some community members said phone support services were not personal enough.[142]

Located in Launceston and Hobart, the two pilot Arch centres will leave large areas of the State without ready access to that service. Commissioner Hine noted that many areas of Tasmania will be too small to have an Arch centre but that consideration is being given to how those areas will have 'the same service or a similar service'.[143] This will need to be carefully considered to ensure victim-survivors can access effective support, regardless of their location.

One of the challenges of holding outreach clinics or visiting clients in remote locations is the cost to the service of the counsellor's travel time, which makes it more expensive per client to conduct a remote outreach clinic than to provide in-house counselling services.[144]

However, having access to sexual assault counselling from agencies outside the local community through outreach clinics can be helpful for victim-survivors in small communities. Ms Fordyce said that when specialist services are delivered and located in the local community, service users have encountered difficulties with knowing a service provider in a personal capacity, conflicts of interest and a lack of privacy.[145] Ms Maxwell agreed that being external to a local community is a strength in some cases:

> It means people can address issues arising in the community without having to approach a member of the community, who might be linked to the issue or person involved in some way.[146]

Azra's experience

Azra's experience illustrates some of the difficulties victim-survivors face in seeking help in a small community:

> 'Abe' (a pseudonym) recommended a psychologist who was a friend of his to help me.[147] Initially I spoke to this therapist about Abe using a nickname for him. When I eventually mentioned that I was talking about Abe, the therapy broke down.
>
> I felt so used and discarded by Abe. I was let down by him and by the therapist he recommended. I had invested over 12 months into the therapy and thanks to Abe it was a waste of my time. I had to start again with a new therapist. Abe made something that was already traumatic worse.[148]

When increasing funding to improve access to sexual assault services, the Tasmanian Government should pay particular attention to improving access for those in regional and remote areas, particularly the far North West, Bass Strait islands and the West Coast. Based on the principle of retaining choice for victim-survivors, this should ideally involve a combination of outreach by sexual assault services to provide in-person counselling, phone and online services; improving transport for victim-survivors to service locations; and increasing the capacity of local mainstream health services to provide trauma-informed care.[149]

4.3.3 Ashley Youth Detention Centre

As discussed in Chapter 10, children at Ashley Youth Detention Centre often enter the Centre having experienced child sexual abuse. They may then experience sexual abuse or experience or display harmful sexual behaviours while at the Centre. As a result, they have a high need for sexual assault counselling services.

The Department of Health provides mental health support to children while they are in Ashley Youth Detention Centre.[150] However, the Sexual Assault Support Service thought it was advantageous for an external specialist agency to offer outreach to the Centre because children can receive continuity of care in the community when they are discharged.[151] Tasmania Legal Aid agreed that this model would be better for their clients in Ashley Youth Detention Centre.[152] It also affords children some privacy and oversight of care from a provider external to the Centre, which has been lacking.

Laurel House said it has sometimes given therapeutic support to children at Ashley Youth Detention Centre. The Sexual Assault Support Service said it had not previously had referrals and that it found it difficult to deliver interventions for harmful sexual behaviours in that setting.[153] Some people provided examples of a lack of action by staff at Ashley Youth Detention Centre to facilitate therapeutic supports for children in the Centre.[154]

In contrast with Ashley Youth Detention Centre, the Sexual Assault Support Service said that it had been visiting Risdon Prison since the National Royal Commission to provide sexual assault counselling to inmates. It said that demand has grown to the point where it now has almost three full-time counsellors for that site.[155] It said that over time, the prison has become more open to referring inmates who can now also self-refer to the Sexual Assault Support Service.[156]

Former Secretary of the Department of Communities, Michael Pervan, stated that since our hearings in May 2022, 'the Sexual Assault Support Service is now available to support young people who were victims or witnesses' of harmful sexual behaviours in Ashley Youth Detention Centre, and that a private psychology practice provides three hours per week of psychology services to residents via a digital platform.[157] He told us that a child who has experienced harmful sexual behaviours at Ashley Youth Detention Centre would receive therapeutic support from the private psychology practice, the Centre's nurse and the visiting doctor.[158]

Although it took our Inquiry to trigger them, these changes sound like progress for children in Ashley Youth Detention Centre who need therapeutic support for sexual assault. However, we consider more should be done. The Tasmanian Government should ensure sexual assault services receive enough funding to offer outreach services to children in detention or remand now and into the future. We discuss the need for Ashley Youth Detention Centre to embrace therapeutic supports for young people in Chapter 12.

4.3.4 Peer support

Some Tasmanians access support from peer support organisations such as the Survivors and Mates Support Network and the Care Leavers Australasia Network. The latter supports care leavers and their families via services that include advocacy, counselling and casework; in Tasmania, it also operates peer support groups in Hobart and Launceston.[159] We heard from the Care Leavers Australasia Network that the Tasmanian Government does not fund its services and that it would like to better support victim-survivors.[160] We also heard from a victim-survivor who received support from local peer support organisation Beyond Abuse and found this helpful.[161] We note that the Survivors and Mates Support Network is the only sexual abuse support specifically for male victim-survivors of child sexual abuse in Tasmania. Men can face different challenges when disclosing child sexual abuse and engaging with support services than women (discussed in Section 4.4) and would benefit from having the choice to access male-specific services.

The National Royal Commission 'highlighted the importance of peer support in helping victims and survivors to overcome feelings of guilt and betrayal, and reduce isolation through sharing their experiences with one another', particularly for victim-survivors of child sexual abuse in residential institutions.[162] It recommended that dedicated community support services for victim-survivors of child sexual abuse be required and enabled to 'support and supervise peer-led support models' as part of their services.[163] It also suggested that services 'should provide practical assistance to peer-led support groups, including by providing professional supervision where required'.[164]

Given the potential of peer support groups to assist recovery and facilitate advocacy for victim-survivors, this area warrants more investigation and investment in Tasmania. Funding for specialist sexual assault services should include assistance for peer support groups.

Recommendation 21.4

1. The Tasmanian Government should increase the funding for free or low-cost sexual assault counselling services to:
    a. reduce waiting times to no longer than four weeks for victim-survivors, regardless of where they live in Tasmania
    b. enable fortnightly access to sexual assault counselling in Ashley Youth Detention Centre
    c. assist peer support groups.

2. The Department of Premier and Cabinet should adopt strategies to increase the number of professionals with skills to provide therapeutic responses to abuse-related trauma to address the challenge in attracting and retaining sufficient suitably qualified staff to fill vacancies and meet the need for therapeutic responses to child sexual abuse.

Recommendation 21.5

The Tasmanian Government should increase the capacity of the Victims of Crime Service by:

a. increasing the number of counsellors available in each of the Victims of Crime Service offices to at least three in southern Tasmania, two in northern Tasmania and two in the North West

b. promoting the availability of the Victims of Crime Service counselling service to victim-survivors of sexual assault.

4.4 Meeting the needs of specific groups of victim-survivors

We know from the National Royal Commission that children who are Aboriginal, have disabilities, are from culturally and linguistically diverse backgrounds or identify as LGBTQIA+ and who have experienced trauma or neglect are at higher risk of sexual abuse and are more likely to receive an inadequate response to sexual abuse than other children.[165]

The National Royal Commission described an 'acceptable' service system as one that:

> ... considers the diversity of individuals who have been affected by institutional child sexual abuse and is responsive to their lived, social and cultural contexts. Services should be culturally appropriate and aware of needs related to disability, gender and sexuality, particularly in regional areas where choice of services is limited.[166]

In this section, we consider the acceptability of the Tasmanian service system for sexual assault, and areas in which it might be improved for victim-survivors and children who have displayed harmful sexual behaviours in the following cohorts:

- children—they require a more family-based and developmentally appropriate approach than adult victim-survivors
- people with disability or a mental health issue
- people who identify as LGBTQIA+
- male victim-survivors

- people from culturally and linguistically diverse communities
- Aboriginal people.

We also consider how the Arch centres can be designed to ensure they are acceptable to a diverse range of victim-survivors.

There is significant scope for the service sector in Tasmania to improve care provided to victim-survivors who have specific needs. For mainstream services, this includes equipping and training the workforce and collaborating with sexual assault services. Also, the National Royal Commission noted that there is 'very little research' on effective treatment for some of these groups and that more is needed to inform practice.[167]

4.4.1 Children as a subspeciality

The Sexual Assault Support Service told us that about one-third of the referrals they receive are for child victim-survivors.[168] As indicated above, the Sexual Assault Support Service and Laurel House prioritise children on their waiting lists.[169]

The National Royal Commission established that, to be effective, sexual assault services for child victim-survivors need to slightly differ from those for adult victim-survivors, namely:

- they should be flexible and appropriate for the child's developmental stage
- practitioners working with children 'need to have specialist expertise and be appropriately qualified'
- therapy needs to involve non-offending carers and family
- it can be helpful to involve the child's school
- traumatised children can benefit from programs in non-clinical settings that help build their sense of confidence more generally.[170]

We heard evidence to suggest that Laurel House and the Sexual Assault Support Service attempt to involve schools and families in a child victim-survivor's treatment and, in the case of harmful sexual behaviours, Mission Australia assists with case management.[171]

Such a systemic approach with a child victim-survivor is more time-intensive than the direct therapy usually provided to an adult victim-survivor. Therefore, services will need more funding to provide a suitable child-appropriate service than for the same number of adult clients.

4.4.2 Victim-survivors with disability

The limited evidence available about the prevalence of the child sexual abuse of children with disability suggests that these children are three times more likely to experience

child sexual abuse than other children.[172] The rates are even higher for female children and children with intellectual and behaviour-related disabilities.[173]

A range of factors is thought to account for this increased risk:

- children with disability have more exposure to health, medical and other disability-related services, making them more susceptible to mistreatment from service staff
- children with disability are often socially isolated due to stigma and discrimination
- the increased risk arising from their disability is compounded by other risk factors common to many children with disability, such as gender, age, socioeconomic disadvantage and Aboriginality
- their disability may make it harder for them to communicate and disclose child sexual abuse
- families often depend on services and so are reluctant to complain
- the increased regular personal touch associated with physical therapies and personal care can cause a child to develop a 'broken touch radar' so they do not recognise inappropriate touch or realise that their bodies belong to them and they are entitled to privacy
- adults often expect children with disability to be more compliant than other children
- adults can misinterpret a child's attempts to communicate distress or attempts to disclose as disobedience or part of their disability.[174]

In response to the specific needs of victim-survivors with disability, the National Royal Commission recommended, as Recommendation 9.3, that:

> The Australian Government and state and territory governments should fund support services for people with disability who have experienced sexual abuse in childhood as an ongoing, integral part of advocacy and support and therapeutic treatment service system responses for victims and survivors of child sexual abuse.[175]

The Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability may make more recommendations on providing sexual assault services to people with disability. In the interim, the National Royal Commission's Recommendation 9.3 needs to be fully implemented.

The Tasmanian Government reported its progress towards implementing this recommendation in its *Survivors at the Centre: Tasmania's Third Family and Sexual Violence Action Plan 2022–2027*.[176] This plan commits to a 'new Disability Action Plan' for the State and, more relevantly, to:

> Deliver funding for community-based projects to support inclusion, access and equity to support diverse Tasmanians who experience barriers for accessing support for family and sexual violence … This includes … Tasmanians with a disability …[177]

While we welcome recognition of the needs of people with disability, we found it difficult to understand the nature and extent of the Government's commitment. Moreover, it was the only action in the plan that related to victim-survivors of sexual assault who have disability.

Children with disability are also more likely to engage in or be subjected to harmful sexual behaviours.[178] We heard in the out of home care stakeholder consultation that it is difficult to find therapists in Tasmania who can deliver specialised interventions to these children.[179] This issue is not unique to Tasmania—there is generally a lack of trauma-informed resources and specially trained therapists to deliver such interventions.[180]

The National Royal Commission observed that the disability service system can be siloed from other service systems.[181] Consequently, disability services remain largely non-trauma informed.[182] Conversely, trauma and mental health services struggle to know how to respond to their clients who have disability.[183]

There are some examples of attempts to cross this divide. For example, Laurel House has a Disability Workforce Support Project to raise awareness of, and the responses of carers and professionals to, the sexual assault and abuse of people with disability.[184] It is designed to improve the response of those directly supporting victim-survivors who live with disability. The toolkit and resources webpage provides extensive information about sexual violence and people with disability, including communication guides, trauma-informed approaches, how to respond to a disclosure, referral pathways and links to advocacy services and specialist disability supports for victim-survivors.[185]

In view of the silos that exist, we suspect that a multipronged solution will be required to improve the quality of therapeutic services for children with disability who have engaged in harmful sexual behaviours and sexual assault services for victim-survivors of child sexual abuse who have disability. This would likely include measures to increase the inclusiveness of sexual assault services, as well as to make disability services more trauma-informed and knowledgeable about child sexual abuse.

The Tasmanian Government should ensure victim-survivors with disability can access appropriate supports, including children with disability who need help with harmful sexual behaviours. On 13 September 2022, the Tasmanian Minister for Disability Services announced the appointment of 'the State's first Interim Disability Commissioner'.[186] We consider the new Interim Disability Commissioner should be closely consulted in achieving this outcome.

4.4.3 Victim-survivors who identify as LGBTQIA+

The National Royal Commission heard that there are:

> … particular barriers to disclosing child sexual abuse and seeking support faced by victims and survivors who identify as lesbian, gay, bisexual or transgender

> … marginalisation and a lack of understanding in the service system may act as a barrier to effective support.[187]

It also found that victim-survivors who identify as lesbian, gay, bisexual or transgender—due to experiencing significant levels of sexual violence, abuse, discrimination, shame, transphobia, homophobia, keeping a low profile and invisibility—may be less likely to access support services.[188]

We heard during hearings that children and young people who identify as LGBTQIA+ are more vulnerable to being groomed and sexually abused, as well as being less likely to report abuse, partly due to not feeling safe and accepted.[189] Also, in a school setting—where these children are at greater risk of experiencing harmful sexual behaviours—disclosures are often not responded to appropriately, further marginalising victim-survivors and dismissing their experiences.[190]

One transgender victim-survivor told us that the abuse she experienced, as well as the inadequate response she received when she disclosed to the institution and to police, were part of a broader context of her experiences of homophobic and transphobic bullying.[191] We also heard from a non-binary victim-survivor who experienced violence and sexual abuse by several abusers; this was partly linked to the vulnerabilities associated with not conforming to gender norms.[192] Over many years, they also experienced significant difficulties accessing effective services that accounted for gender identity and sexuality.[193]

In the absence of substantial research into effective treatment, at a minimum staff must have an awareness of the challenges faced by victim-survivors who identify as LGBTQIA+ and be adequately trained to meet their needs, either via their own services or effective collaboration. This is an area that warrants more attention from service providers in Tasmania.

4.4.4 Male victim-survivors

We heard from many male victim-survivors of institutional child sexual abuse in Tasmania, such as Robert, who bravely reached out for help.

Robert's experience

> … here I was, 6 foot 6, walk into [the Sexual Assault Support Service], and I was standing behind a lady with her daughter and they moved on, and the lady behind the counter looked up at me and she said, 'Oh, what do you want?', and, yeah, at that time I broke down because it was … and I said, 'I'm here, I've been sexually abused as a kid', and she went, 'Oh, oh', and ran off and grabbed someone, but it was that kind of reaction of, you know, obviously they don't get men or, you know, coming in all that often, let alone maybe sort of tall people that they would consider to be sort of strong enough to not go and get abused; yeah, everyone's a kid at some stage, yeah.[194]

Although overall, more females than males report child sexual abuse, there is still a substantial number of male victim-survivors who need to access the therapeutic service system.[195] Evidence suggests that historically more males than females experienced child sexual abuse in an institutional setting.[196]

The National Royal Commission observed that male and female victim-survivors of child sexual abuse often have different needs, and so sexual assault services must consider the needs of males who seek their services.[197] This could be particularly important for services set up to respond to gendered violence, where males are not immediately considered to be potential victim-survivors. The National Royal Commission heard that the greater number of female counsellors in sexual assault services can restrict males' access to a male counsellor, which some would prefer.[198]

Therefore, it is important that male victim-survivors are included in the adult victim-survivors of child sexual abuse advisory group (refer to Recommendation 19.5 in Chapter 19) and that sexual assault services ensure they are set up to meet the needs of men and boys who seek help. Also, the Government must increase the visibility of sexual assault services as catering to male victim-survivors.

4.4.5 Victim-survivors from culturally and linguistically diverse backgrounds

The National Royal Commission heard that people from culturally and linguistically diverse backgrounds face specific barriers to accessing appropriate services. These include:

- concerns around privacy, confidentiality and conflicts of interest in small communities
- inadequate cultural competence among practitioners, including lack of knowledge of culturally acceptable ways to discuss sex and sexuality
- racism and discrimination from service staff
- mainstream services offering individualised responses where community-based approaches may be more culturally appropriate
- multicultural organisations lacking training in child sexual abuse
- lack of appropriate referral pathways
- scarcity of interpreters able to work appropriately with victim-survivors who are independent of the victim-survivor's community
- failure to provide culturally appropriate information about child sexual abuse and available services in different languages.[199]

We received limited information about victim-survivors from culturally and linguistically diverse backgrounds overall. In Hobart and Launceston, we contacted agencies that

support culturally and linguistically diverse communities.[200] We invited them to speak with us but, unfortunately, none provided information or attended stakeholder consultations.

However, given the findings of the National Royal Commission and our awareness of the needs of culturally and linguistically diverse people in Tasmania, we consider there is room for improvement in creating specialist sexual assault services for victim-survivors that can accommodate people from a variety of backgrounds in a culturally appropriate way, including greater collaboration. The National Royal Commission found that collaboration 'is particularly important for meeting the needs of victims and survivors from culturally and linguistically diverse backgrounds'; this can mean integrating specialist culturally and linguistically diverse services into mainstream services or coordinating victim-survivors' care in different parts of the service system.[201]

4.4.6 Diversity and inclusion at Arch centres

All victim-survivors should have choices and be able to access the specialist knowledge that Arch centres are designed to provide. Therefore, it is essential that Arch centres respect diversity and inclusion.[202] Laurel House Chief Executive Officer, Kathryn Fordyce, said that centres 'should be welcoming and engaging for children and adults regardless of gender, sexuality, disability, cultural background and experience'.[203] Tasmania Police Commissioner Hine indicated that:

> … there will be services engaged to provide specialised advice and support who are not co-located but are within close proximity to the facility. These will include services specific to the individual needs of people with a disability, culturally diverse and indigenous cultural requirements.[204]

Given the centrality of collaboration to successful therapeutic care, it will be important for Arch centres to carefully consider how services directed at particular groups will work alongside those at the centres. It is not enough to engage specialist services; mainstream services must 'have the skills and capability to respond effectively to diverse needs or collaborate with other agencies to meet those needs'.[205]

Recommendation 21.6

1. The Tasmanian Government should ensure that the needs of particular groups of victim-survivors are met by the therapeutic service system and related contracting of services, including the needs of:
   a. children who are victim-survivors or have displayed harmful sexual behaviours (Recommendation 21.8)
   b. victim-survivors with disability or mental illness

c. victim-survivors who identify as LGBTQIA+

d. male victim-survivors

e. victim-survivors who are from culturally and linguistically diverse backgrounds.

2. The Tasmanian Government should consult on the therapeutic service system with relevant stakeholder groups, including the Interim Disability Commissioner, community groups and representative bodies.

4.4.7 Aboriginal healing centres

The National Royal Commission recommended that federal, state and territory governments fund Aboriginal and Torres Strait Islander healing approaches as part of therapeutic services for victim-survivors of child sexual abuse.[206] Despite this, in Tasmania there are no specific Aboriginal healing services for victim-survivors of child sexual abuse. The Tasmanian Aboriginal Centre provides some therapeutic services via programs such as its health services, family services and children's services.[207] While victim-survivors are generally supported to access mainstream sexual assault counselling services, the Tasmanian Aboriginal Centre also employs some practitioners 'with specialist experience in sexual assault treatment'.[208] Other Tasmanian Aboriginal organisations also support community members in various ways, including with healing from child sexual abuse, but do not have targeted programs.[209]

Heather Sculthorpe, Chief Executive Officer, Tasmanian Aboriginal Centre, told us that some of the barriers to providing Aboriginal healing services include inconsistent government funding as well as 'narrowly targeted funding' that does not 'recognise the importance of ongoing relationships in the Aboriginal community'.[210]

Adding to this, our research found no evidence to suggest that existing sexual assault services have sought to specifically develop culturally appropriate approaches. This may create a barrier for Aboriginal people to access sexual assault services because they appear intrinsically 'white', and limit the effectiveness of counselling provided to those Aboriginal victim-survivors who do engage. Participants in one consultation told us that the 'white' way of counselling not only differs from but it also 'undermines the First Nations approach'.[211] One Aboriginal victim-survivor told us that support services consistently failed to take into account cultural identity, which compounded their trauma.[212] We also heard that existing services do not necessarily have capacity: 'when abuse happens, you need timely support—there is a waitlist for everything'.[213]

When we conducted consultations with Aboriginal communities, we frequently heard about the lack of culturally appropriate therapeutic services in Tasmania. We heard about the following service needs:

- Aboriginal-led therapeutic services across the State that encompass an understanding of intergenerational trauma and are genuinely designed and led by Aboriginal people:

  > It has to be authentic co-design, not Aboriginal people being asked afterwards … You need to listen to our ideas because our communities worked for thousands of years. The government is always trying to come up with these innovative things, but the knowledge is already sitting there in Aboriginal communities … Let us mend and fix our community.[214]

- Aboriginal-run cultural healing centres on Country across the State where children and families can visit or stay to receive support (this is also discussed in Chapter 9): 'We need our kids to have a space where they can be with community members and still looked after'.[215]

- Training and development opportunities to support Aboriginal people to gain therapeutic skills to benefit their communities:

  > We need training for our mob.[216]

  > Our kids want to talk to someone from their community, work with someone from their community.[217]

- Consistent funding for therapeutic programs, including those that are already working well. Organisations 'have to have reliable funding, otherwise you are playing with people's lives'.[218]

Given the over-representation of Aboriginal children in out of home care and in youth detention, and that harmful sexual behaviours often occur in those settings, these therapeutic programs also need to be equipped to address harmful sexual behaviours.

We heard that part of embedding culture is having programs that are Aboriginal-led and -controlled. Ms Sculthorpe stated that successful programs require 'Aboriginal decision-making in the context of Aboriginal community control'.[219] This approach is supported by the Healing Foundation, which, in response to the National Royal Commission, found that:

> … a culturally based approach to understanding trauma and to resourcing healing and recovery is required by Aboriginal and Torres Strait Islander people who have been, or may in the future be, sexually abused in public and private institutions, and that healing is most effective when designed, developed and delivered by Aboriginal and Torres Strait Islander people with and for their own communities.[220]

In Chapter 9 on out of home care, we recommend establishing recognised Aboriginal organisations (Recommendation 9.15). We also recommend implementing all elements of the Aboriginal and Torres Strait Islander Child Placement Principle (Recommendation 9.15).[221] This recommendation includes investing in Aboriginal-led targeted early intervention and prevention services, transferring decision-making authority to

Aboriginal organisations and establishing therapeutic residential programs for Aboriginal children. There is also a need for Aboriginal-led healing programs to be established more widely.

We are pleased that the Tasmanian Government has recognised this service gap and has committed in *Survivors at the Centre: Tasmania's Third Family and Sexual Violence Action Plan 2022–2027* to Aboriginal-led 'deep collaboration' with Aboriginal organisations to 'agree actions and strategies to prevent and respond to family and sexual violence in the Aboriginal community'.[222]

Models for Aboriginal services can be found nationally and may be useful to inform programs in Tasmania. For example, alongside community members, the Healing Foundation has developed resources, such as a guide to establishing 'healing centres' and a training program for communities working with victim-survivors of child sexual abuse.[223] The central tenets of these resources—such as strengthening connections to community and culture and emphasising design and implementation by and for Aboriginal people—are reflected in the ideas shared with us by local Aboriginal communities.[224]

It became apparent during our community consultations that the healing of Aboriginal victim-survivors is inextricably linked to colonisation and intergenerational trauma, as well as to cultural and family needs: 'when something happens to someone in our mob, it affects all of us'.[225] While this broader landscape extends beyond our terms of reference, we consider that to be effective and culturally appropriate, Aboriginal healing services developed for victim-survivors of child sexual abuse must be broad in scope and enabled to take a holistic approach.

Similarly, we heard from Aboriginal communities about how taxing it can be to be frequently 'consulted' by government, especially when consultation does not result in desired changes. One participant spoke about contributing to numerous consultation processes but never seeing change: 'look where we are. I'm tired. I'm so tired'.[226] In consultation processes, Aboriginal communities nationwide are generally 'asked to do a lot of work, a lot of which is unpaid or un-resourced'.[227] Consequently, developing existing and new healing services must be carefully planned, well-funded and Aboriginal-led to avoid unfairly adding to this burden.

In addition to Aboriginal-led healing approaches, existing sexual assault services should improve their cultural appropriateness for Aboriginal victim-survivors. For a variety of reasons, some Aboriginal people will prefer to seek support from non-Aboriginal-led services, so sexual assault services need to become more comfortable and effective for Aboriginal victim-survivors of institutional child sexual abuse. One important way of achieving this is to ensure these agencies have representation from Aboriginal communities on their boards of management or in their executive structures. In that way, sexual assault services would have an internal source of assistance to improve the cultural appropriateness of their services.

Recommendation 21.7

The Tasmanian Government should improve healing services for Aboriginal victim-survivors and their families and communities by:

a. fully resourcing and supporting recognised Aboriginal organisations across the state to design, develop and deliver Aboriginal-led healing approaches targeted to victim-survivors of child sexual abuse

b. ensuring Aboriginal representation on the boards of management or in the executive structures of sexual assault services.

5 Strengthening services for children who have displayed harmful sexual behaviours

Terminology and definition

We have adopted the National Office of Child Safety National Clinical Reference Group's draft definition of harmful sexual behaviours, which was proposed in December 2022, for general use across Australian jurisdictions:

> Harmful sexual behaviours are sexual behaviours displayed by children and young people that fall outside what may be considered developmentally, socially, and culturally expected, may cause harm to themselves or others, and occur either face to face and/or via technology. When these behaviours involve another child or young person, they may include a lack of consent, reciprocity, mutuality, and involve the use of coercion, force, or a misuse of power.[228]

We note that the National Office for Child Safety is continuing to work with the National Harmful Sexual Behaviours Clinical Reference Group, states and territories to finalise a nationally endorsed definition of harmful sexual behaviours. This definition, when finalised, should inform the definition in the whole of government harmful sexual behaviours framework (Recommendation 21.8) and related Tasmanian Government documents, policies and practice guidance.

For the following reasons provided by harmful sexual behaviours researcher Dr Gemma McKibbin, we have also taken care with the use of the terms 'victim', 'victim-survivor' and 'perpetrator' in this section, in keeping with the general view of the sector that children who engage in harmful sexual behaviours need help and assistance:

> The binary between victim and perpetrator in instances of harmful sexual behaviour is not always clear. For example, in situations of sibling sexual abuse that is, where two or more siblings engage in sexual behaviour with one another, the initiator of the behaviour can change, and one sibling can be the perpetrator in one instance and the victim in another. It is important to use person-centred language; this means that we talk about the problem behaviour and not the problem child. It is important that we do not use stigmatising language as this actually inhibits children from recovering from being sexually abusive. I always use the language 'child or young person displaying harmful sexual behaviour'.
>
> Perpetrator is not the right term to use in the context of children and young people who sexually harm because it is stigmatising and obfuscates the harm that children have often experienced themselves. I do tend to use the term 'victim-survivor' for children or young people who have been sexually harmed by other children or young people. However, in some cases of sibling sexual abuse, the victim may also be a child who sexually harms. Further, a child who sexually harms is likely to be a victim of abuse in their own right. In this way the victim/perpetrator binary does not hold in cases of harmful sexual behaviour and more sophisticated thinking is needed in this space that accounts for the complexity of victimisation experiences.[229]

For the purposes of highlighting the specific therapeutic needs of children who have engaged in harmful sexual behaviours, we have distinguished between children who have engaged in harmful sexual behaviours and those who have been subject to them. As mentioned, we have considered those children who have been subject to another's harmful sexual behaviours as 'victim-survivors' in terms of their therapeutic needs—that is, they will likely require sexual assault counselling in the same way as other victim-survivors of child sexual abuse. But the distinction is somewhat artificial because many children who have engaged in harmful sexual behaviours are themselves victim-survivors of sexual abuse. Such children will need a therapeutic approach that addresses both their harmful sexual behaviours and their sexual abuse experiences. Therefore, it is common in other jurisdictions, as in Tasmania, for the harmful sexual behaviours service system to exist within the broader child sexual abuse therapeutic service system.

The National Royal Commission recognised that harmful sexual behaviours can have similar negative effects on a child as sexual abuse by an adult.[230] Recognising the significance of the issue, the National Royal Commission dedicated an entire volume to the issue of harmful sexual behaviours.[231] It made seven recommendations about harmful sexual behaviours in general, which required the Australian and state/territory governments to fund primary and secondary prevention strategies or services, and tertiary therapeutic services. In relation to harmful sexual behaviours, in summary, the National Royal Commission recommended that:

- support services be accessible for all children and young people, regardless of age, incarceration, voluntary status, disability, cultural background, gender, sexual orientation, geographic location, setting or the nature of the sexual behaviour
- support be increased for generalist counselling services to improve their responsiveness to harmful sexual behaviours
- therapeutic services be safe, developmentally appropriate, trauma-informed, culturally informed, have clear referral pathways and provide a systemic intervention, with good staff training and supervision
- therapeutic services be evaluated to ensure effectiveness.[232]

We heard of significant problems with how institutions responded to harmful sexual behaviours in schools, out of home care and Ashley Youth Detention Centre (refer to Chapters 5, 6, 8, 9, 11 and 12). These institutions appear to be the most at risk of harmful sexual behaviours occurring.[233]

A mother's experience—the importance of timely intervention

A mother told us that her two primary-aged children were sexually abused by an older boy from school. They told her that he was coercive and violent. She described her children's traumatised responses of incontinence, emotional outbursts, self-harm and drawing sexual pictures.

Both children have disability, and the mother expressed fear for their mental health because they have told her they should kill themselves. She has experienced difficulty accessing timely and affordable services for them.

The older boy who displayed harmful sexual behaviours also has disability and has experienced violence in his home. The mother said she felt sorry for the boy, but she described the frustration of knowing that other parents had raised concerns about the older boy displaying harmful sexual behaviours before her, but the school took a long time to act, even after her complaint.

The mother said the school, because of privacy reasons, would not tell her if the boy was getting therapeutic help. She felt powerless to protect her children, so she changed schools, but she is worried for other students.[234]

5.1 Understanding harmful sexual behaviours

Understanding harmful sexual behaviours and how to address these behaviours effectively is a rapidly developing field. Most frameworks consider the behaviours as occurring along a continuum of increasing deviation from what is considered normal for a child's developmental age in terms of severity, duration and impact.[235] They also consider that children engage in harmful sexual behaviours for a combination of reasons; these reasons are often called 'pathways' to harmful sexual behaviours.[236]

Due to this variation in severity and motivation, not all children who have engaged in harmful sexual behaviours will benefit from the same form of therapeutic intervention, and responses to harmful sexual behaviours need to be 'both proportionate and appropriate'.[237] For example, for less severe incidents that are motivated by misguided curiosity about sex, setting boundaries and educating about consent and appropriate behaviours are likely to be sufficient interventions to prevent a child engaging in those behaviours again.[238] However, the more severe and persistent the behaviour, the more likely a child will need a more intensive specialised therapeutic response. Often criminal justice and child protection responses are also involved, depending on the circumstances of the behaviour.[239] If the behaviour has occurred in youth detention or in an out of home care or school environment, those settings also will need to be involved in the response.

While research has shown that most adult sex offenders started their offending as teenagers, experts in harmful sexual behaviour interventions generally agree that therapeutic intervention for most children who engage in harmful sexual behaviours is effective in stopping the behaviours.[240]

Therefore, early intervention to address harmful sexual behaviours is paramount to prevent recurrence and minimise harm.[241] Therapeutic intervention for harmful sexual behaviours requires specialist skills and training in addition to that required for counselling for child sexual abuse.[242]

In terms of the intensive specialised response required for children who have displayed behaviours further along the spectrum, recent literature reviews indicate that evidence for using any of the main approaches across a variety of settings is still being established.[243] The experts we heard from suggested that several approaches could be effective when responding to harmful sexual behaviours.[244] Rather than recommending a particular model, Dale Tolliday, a harmful sexual behaviours clinician, recommends that the Tasmanian Government adopts 'best practice principles for therapeutic intervention for children with harmful sexual behaviours, which are relevant to children of all ages', as identified by the National Royal Commission.[245] Mr Tolliday and researcher, Dr Gemma McKibbin, recommended that therapeutic interventions should have certain key characteristics, which we have consolidated and summarised. Interventions should:

- be accessible to all children with harmful sexual behaviours and delivered early
- be based on an individual assessment of each child, with tailored therapy that takes a contextual and systemic approach, recognising other problems in the child's life
- be safe, including through being non-punitive, trauma-informed and culturally safe
- assign accountability and responsibility for the harmful sexual behaviours
- focus on behavioural change and work towards broader outcomes than simply reducing harmful sexual behaviours
- use developmentally and cognitively appropriate interventions based on techniques that are specialised for treating harmful sexual behaviours
- be delivered by staff who have specialist training and supervision
- actively involve the parent or caregiver to support treatment.[246]

Mr Tolliday recommended that in developing its approach the Government considers these characteristics, as well as ensuring the model is suited to the way services are organised.[247]

In keeping with the National Royal Commission's findings, Mr Tolliday said specialist harmful sexual behaviours treatment should sit within a broader public health approach to improve knowledge about harmful sexual behaviours and how to respond to them:

> In particular, building service system capacity should include key general and focused prevention actions (primary and secondary prevention), building generalist service capacity to respond (such as schools, GPs, childcare services, child and youth counselling) as well as specialist services. Building only a specialist service limits [the] response to a limited number of children and families and the scale and scope of [problematic and harmful sexual behaviours] demands a larger and more comprehensive strategy.[248]

We agree.

5.2 The Tasmanian Government's response

The Department of Communities stated that the Government had responded to the National Royal Commission's recommendations by:

- contributing to and signing on to the *National Strategy to Prevent and Respond to Child Sexual Abuse 2021–2030* (released on 27 October 2021)

- funding the Sexual Assault Support Service for two years from 1 April 2021 to provide a statewide therapeutic program for children with harmful sexual behaviours (called Prevention, Assessment, Support and Treatment, discussed in Section 5.2.1), which the then Department of Communities said fulfils the principles in the National Royal Commission's Recommendation 10.5
- funding the Sexual Assault Support Service for two years from 1 April 2021 to provide primary and secondary prevention programs for children engaging in problematic sexual behaviours (under the Prevention, Assessment, Support and Treatment program)
- funding an independent evaluation of the Sexual Assault Support Service's Prevention, Assessment, Support and Treatment program for harmful sexual behaviours
- the Department of Justice representing Tasmania on the Inter-jurisdictional Working Group on Therapeutic Responses for Children with Problematic and Harmful Sexual Behaviours.[249]

Apart from contributing to the two national initiatives, the Tasmanian Government's primary response to the National Royal Commission's recommendations about harmful sexual behaviours is to fund a non-government organisation (the Sexual Assault Support Service) to deliver the Prevention, Assessment, Support and Treatment program.

While recognising the outstanding efforts of the Sexual Assault Support Service in identifying a service gap and attempting to fill it, we are concerned that this approach is not enough, which we discuss in Section 5.4.

5.2.1 Prevention, Assessment, Support and Treatment program

Before April 2021, as part of their normal service delivery, Laurel House and the Sexual Assault Support Service provided interventions for children up to age 11 or 12 who had displayed harmful sexual behaviours.[250]

In April 2021, the Sexual Assault Support Service received government funding to provide a free, statewide specialist harmful sexual behaviours prevention and therapeutic intervention program for children up to 17 years of age—the Prevention, Assessment, Support and Treatment program.[251] Laurel House also said it will still see children under 12 who have displayed harmful sexual behaviours in northern Tasmania and the North West, but it is not specifically funded for that work.[252] Victim-survivors of harmful sexual behaviours can access supports through the Sexual Assault Support Service's and Laurel House's usual sexual assault counselling services.

The prevention and early intervention element of the Prevention, Assessment, Support and Treatment program involves the Sexual Assault Support Service presenting training sessions for school staff, Child Safety Service staff and other community members about how to prevent harmful sexual behaviours and respond to them appropriately if they occur.[253] The service also presents sessions in primary and high schools about consent and respectful relationships that complement the sessions with school staff.[254]

We consider that the funding for this aspect of the Prevention, Assessment, Support and Treatment program is insufficient. The program is funded to provide the full set of harmful sexual behaviours awareness and response sessions to only four schools per year, although the Department for Education, Children and Young People funds another four.[255] Other schools can purchase the training from the Sexual Assault Support Service.[256] We calculate that, without schools purchasing the training themselves, it would take the Sexual Assault Support Service about 24 years to present government funded harmful sexual behaviours sessions to all 195 government schools in Tasmania.[257] In Chapter 6, we recommend mandatory child sexual abuse prevention education in all schools.

The therapeutic element of the Prevention, Assessment, Support and Treatment program is funded for one specialist harmful sexual behaviours counsellor to work three days a week in each region: southern Tasmania, northern Tasmania and the North West.[258] Mission Australia delivers case management for families alongside the Sexual Assault Support Service's therapeutic intervention to assist with other issues that are assessed as contributing to the behaviours—for example, assisting to gain access to National Disability Insurance Scheme supports for a child with disability whose needs are not being appropriately addressed.[259]

Initially the program was funded for two years as a pilot, but Action 28 of *Survivors at the Centre: Tasmania's Third Family and Sexual Violence Action Plan 2022–2027* states that the Government will 'continue to deliver' the program.[260] Although Action 28 lacks detail, we hope this means the program will be funded on an ongoing basis.[261]

In the year following the start of the program in April 2021, the Sexual Assault Support Service said it received 90 referrals for children who had displayed harmful sexual behaviours.[262] Many of the referrals were from schools, parents and the Child Safety Service.[263] As of 31 March 2022, the program had 29 active clients engaged with a therapist and an average waiting list of 10 children, who can wait from four-to-10 weeks for therapy.[264]

Despite the recent introduction of this therapeutic service for harmful sexual behaviours, we heard in submissions and at consultations that some people are still concerned about a lack of available therapeutic services in Tasmania for children exhibiting harmful sexual behaviours.[265] Renae Pepper from the Sexual Assault Support Service told us that they have not actively promoted the Prevention, Assessment, Support and Treatment

program due to limited funding and said there have been plenty of referrals since starting the program; promotion would only exacerbate waiting lists.[266]

We consider that although funding the Prevention, Assessment, Support and Treatment program is a welcome start, the Government needs to increase the capacity of the therapeutic component of the service system's response to harmful sexual behaviours. In addition, for all the reasons outlined above in relation to appropriate sexual assault services, these therapeutic services need to be designed to meet the needs of particular groups of children, including those with disability, who identify as LGBTQIA+, who are from a culturally or linguistically diverse background, or who are Aboriginal. It should be accessible to children statewide.

5.2.2 Government agency responses

School-based responses

The Department for Education, Children and Young People has initiated its own response to the issue of harmful sexual behaviours among students in Tasmanian schools, including a flowchart to guide principals' responses, a working group focused on the issue and appointing extra senior support staff.[267] Timothy Bullard, Secretary of the Department, told us that the Department had received extra funding in the 2021–22 State Budget to equip staff to identify and respond to harmful sexual behaviours in schools.[268]

The Department's approach appears to be based on the same model of understanding harmful sexual behaviours as the Sexual Assault Support Service has used for the Prevention, Assessment, Support and Treatment program: Hackett's continuum of harmful sexual behaviours.[269] We anticipate that by using the same model and linking its response to the Prevention, Assessment, Support and Treatment program, the Department can develop a common understanding of harmful sexual behaviours and the roles of schools and Prevention, Assessment, Support and Treatment therapists when coordinating a response.[270]

Unfortunately, the Department's response for schools is not replicated elsewhere in Tasmanian Government institutions, because other areas that are often involved with children who have engaged in harmful sexual behaviours have not taken similar steps to improve their understanding of, or response to, harmful sexual behaviours.

Child protection responses

Many professionals and government employees are mandatory reporters and will advise the Advice and Referral Line of concerns about a child who has displayed harmful sexual behaviours. Concerned parties will also contact the Advice and Referral Line for advice and referral for a child's sexualised behaviours.

The National Royal Commission considered that a child protection response to harmful sexual behaviours (in Tasmania this would involve the Advice and Referral Line referring the matter to the Child Safety Service) is generally only appropriate where other children are at risk and there is no parent who can act protectively.[271]

However, the need for protection is not always immediately clear. While the child's behaviour may imply a risk to other children, research indicates that children who have engaged in harmful sexual behaviours may themselves be at risk of harm and in need of care and protection.[272] Consequently, staff taking calls at the Advice and Referral Line need to have a nuanced understanding of, and ability to enquire into, the circumstances of an incident of harmful sexual behaviours.

Despite this, we heard evidence that suggested Advice and Referral Line staff were not always knowledgeable enough about responding to harmful sexual behaviours, particularly in institutional settings.

In Chapter 8 on out of home care, we report the results of our analysis of the files of 22 children in out of home care and note that Child Safety Officers did appear to refer children for specialist harmful sexual behaviour interventions. However, at our consultation with out of home care providers, they suggested that this is not consistently the case.[273] They also considered that the Child Safety Service relied too heavily on Tasmania Police to respond to instances of harmful sexual behaviours.[274] Given that out of home care is a high-risk institutional environment for children experiencing harmful sexual behaviours, we identify in Chapter 9 that the Child Safety Service and out of home care providers, carers and volunteers should be supported to build their knowledge and skills concerning harmful sexual behaviours.[275]

As established in Chapter 9, the Advice and Referral Line and the Child Safety Service receive little mandatory specialised training in child sexual abuse or harmful sexual behaviours, nor do they have a clear policy to guide staff when assessing and responding to harmful sexual behaviours.[276] The only real direction provided to the Advice and Referral Line staff by the Child Safety Service is the *Assessing and Responding to Sexual Abuse Procedure*.[277] The procedure instructs Advice and Referral Line staff to record a contact about a child's harmful sexual behaviours in the Child Advice and Referral Digital Interface and—if the child is 10 years of age or older—to record it as an 'incident' in the Child Protection Information System.[278] In some circumstances, the procedure suggests the Advice and Referral Line may refer a concern about a child who has engaged in harmful sexual behaviours to the Child Safety Service for assessment and/or to police, although the procedure is not clear about when this might occur.[279]

We are not confident that Advice and Referral Line staff have been supported with the skills and knowledge to ensure children who have engaged in harmful sexual behaviours or who are victim-survivors of harmful sexual behaviours are protected, as well as

referred for appropriate therapeutic supports. The Government should address this gap in developing a whole of government framework to address harmful sexual behaviours and in drafting detailed and specific out of home care policies, protocols and practice guidance to support best responses to harmful sexual behaviours displayed or experienced in out of home care (Recommendation 9.28). There should also be mandatory induction and ongoing professional development about child sexual abuse and harmful sexual behaviours, as well as policy guidance and access to the Harmful Sexual Behaviours Support Unit for assistance (refer to Recommendation 9.28).

Criminal justice responses

A criminal justice response will be relevant only for a minority of harmful sexual behaviours that meet the criteria for a potential criminal offence. These cases require that the child displaying the behaviours is old enough to be considered to have criminal responsibility for their actions under the law and for the behaviour itself to amount to the physical element of a criminal offence.[280] However, Tasmania Police will often need to be involved in a case of harmful sexual behaviours to determine if the behaviour meets the threshold for charges to be laid, and if there is enough evidence for a charge.

Police may receive a report about a child who has engaged in harmful sexual behaviours from the Advice and Referral Line, the Child Safety Service, a school or from a parent.[281] Our analysis of the 22 files of children in out of home care, set out in Chapter 8, confirmed that Tasmania Police and the Child Safety Service regularly refer incidents of harmful sexual behaviours to each other.

However, the Sexual Assault Support Service expressed concern about the coordination of referrals from Tasmania Police for therapeutic support services for victim-survivors of harmful sexual behaviours.[282] It said the service receives very few referrals for harmful sexual behaviours from police and that those they do receive may be inaccurate—for example, when a child is referred for harmful sexual behaviours, but upon inquiry the case is clearly one of child sexual exploitation.[283]

When deciding on a response, Tasmania Police indicated a preference for diversion in instances of harmful sexual behaviours.[284] We agree. But we acknowledge that there will be some children detained in youth justice due to engaging in sexual violence. In Chapter 16, we discuss the usefulness of a therapeutic component forming part of youth justice options for children who have been charged with or convicted of a sexual offence, using the court's diversionary powers.

The *Keeping Children Safe Handbook* outlines how Tasmania Police and the Child Safety Service will interact in response to child protection concerns.[285] Unfortunately, the handbook offers minimal direction to either agency in how to respond to harmful sexual behaviours, outside of referring one to the other in circumstances 'where a child is an alleged offender'.[286]

The use of terms such as 'alleged offender' or 'alleged perpetrator' are commonplace law enforcement terms. However, as discussed in 'Terminology and definition' above, such language stigmatises children who have displayed harmful sexual behaviours and can interfere with providing a trauma-informed response and therapeutic intervention.

To improve the effective response by Tasmania Police and the Child Safety Service to harmful sexual behaviours, the *Keeping Children Safe Handbook* should be updated to include clear directions that are trauma-informed and use language that reflects modern understandings of harmful sexual behaviours. Having shared definitions and understandings of harmful sexual behaviours will also help achieve a consistent response to this behaviour across government agencies.

5.3 Involuntary treatment

Jenny Wing, Chair of the peak body Victorian Harmful Sexual Behaviour Network, told us that most children who receive therapeutic interventions in the Victorian Sexually Abusive Behaviour Treatment Services do so voluntarily.[287] However, occasionally a family and/or their child will not consent to treatment, thus placing other children and the child themselves at more risk because the concerning behaviour goes unaddressed.[288]

If the Child Safety Service decides that a child does not need care and protection and the matter is not pursued by police, it can be difficult to impose interventions without parental agreement.[289] The National Royal Commission identified that 'in most states and territories, there is no express legal basis upon which child protection agencies can respond'.[290] The exception would be if it can be proven that the child is at risk of abuse or harm as required by the *Children, Young Persons and Their Families Act 1997*.[291]

Dale Tolliday, the harmful sexual behaviours treatment expert previously mentioned, told us that compulsory treatment for harmful sexual behaviours can be necessary, but should be a last resort:

> [Treatment] should be therapeutic rather than punitive. More coercive strategies may be required for more serious and/or repeat cases, or where engagement strategies fail, but effectively dealing with these behaviours early on is the best form of prevention.[292]

Where the child is not facing criminal charges for the harmful sexual behaviours, there is a need for a mechanism that would allow children with harmful sexual behaviours to be treated when parents or carers are unwilling to engage voluntarily.

The most logical way would be to amend the *Children, Young Persons and Their Families Act 1997* to provide an explicit legislative power to allow the Magistrates Court (Children's Division) to order a child to receive therapeutic intervention for harmful

sexual behaviours. This has been done successfully in Victoria with the introduction of therapeutic treatment orders and would empower the Child Safety Service to protect the child and other children in the complex context of harmful sexual behaviours.[293]

In Victoria, if a child appears before the Criminal Division of the Children's Court on a criminal charge and the court considers there are grounds to apply for a therapeutic treatment order in respect of the child, the Court can refer the matter to the Secretary of the Victorian Department of Families, Fairness and Housing for investigation.[294] In deciding whether to refer a matter to the Secretary, the Court must consider the seriousness of the child's sexually abusive behaviours, among other matters.[295]

If, on the application of the Secretary, the Family Division of the Children's Court makes a therapeutic treatment order in respect of the child, the Criminal Division must adjourn the criminal proceedings to enable the child to complete the therapeutic treatment order.[296] Once the child has completed the order, and the Criminal Division is satisfied that the child has attended and taken part in the therapeutic treatment program, the Court must discharge the child without any further hearing of the criminal proceedings.[297] We recommend that Tasmania adopts a similar mechanism (refer to Chapter 16).

The introduction of therapeutic treatment orders in Victoria has delivered secondary, and possibly more important, consequences for children with harmful sexual behaviours. Ms Wing observed better collaboration between statutory child protection, police, children's courts and the sexual abuse behaviour treatment services, as well as increased confidence in the effectiveness of harmful sexual behaviour interventions.[298]

5.4 A broader whole of government response

We are concerned that the Government's principal response to the issue of harmful sexual behaviours in Tasmania has been to fund a non-government organisation to provide a limited range of prevention and intervention services that does not meet demand. Apart from the Department for Education, Children and Young People's decision to improve its response to harmful sexual behaviours to align with the Prevention, Assessment, Support and Treatment program, the Government does not have a consistent response across agencies. This is far from sufficient to address the National Royal Commission's recommendations or, more importantly, to meet the needs of children who have displayed harmful sexual behaviours.

Other jurisdictions are working to standardise responses to harmful sexual behaviours, such as New South Wales' *Children First 2022–2031* shared whole of government framework for preventing and responding to problematic and harmful sexual behaviours by children and young people, which provides a sector-wide, multiagency public health approach.[299]

Other examples include Western Australia's *Understanding and Guiding Responses to Harmful Sexual Behaviours in Children and Young People* and South Australia's work towards an 'interagency response framework', which is underway with the University of South Australia (projects in which Commissioner Bromfield is involved).[300]

The Victorian Government has also developed a framework to respond to harmful sexual behaviours that includes prevention, early intervention and therapeutic intervention.[301] The Victorian Government has funded sexual abuse behaviour treatment services across the State since the early 2000s, which it 'attached' to its existing network of government funded non-government organisations that deliver specialist sexual trauma services across Victoria.[302] Ms Wing told us that the Victorian model of assigning harmful sexual behaviours services to geographical regions creates a more cooperative and better quality service system because it avoids the 'hostile environment' that can develop between agencies when funding is competitive.[303]

Ms Wing identified several advantages to harmful sexual behaviour interventions being delivered as part of the sexual assault service system, including harnessing existing expertise in child sexual abuse and the ability to adapt to local contexts.[304]

In addition to increasing the availability and accessibility of therapeutic services for children who have engaged in harmful sexual behaviours, the Tasmanian Government must also lead a whole of government response to harmful sexual behaviours. Undertaking this task will assist government agencies that have the greatest involvement with children who have displayed harmful sexual behaviours to be equipped to prevent and respond to the issue. The response must be coordinated across departments, which requires a common understanding of the issue and an agreed approach between departments and the therapeutic service system for harmful sexual behaviours.

The Tasmanian Government should develop a statewide framework for preventing, identifying and responding to harmful sexual behaviours. The framework should provide a common understanding of harmful sexual behaviours, high-level guidance on how to respond, and clear roles and responsibilities of different government provided and funded agencies in the response. The definition adopted in the framework should be informed by the work of the National Office for Child Safety in developing a revised national definition for harmful sexual behaviours.

In developing the framework, the Tasmanian Government should carefully consider when and for what purpose incidents of harmful sexual behaviours in government institutions should be reported to Tasmania Police and the Advice and Referral Line. This should consider the role of these agencies in responding to harmful sexual behaviours, different responses for children under and over the age of criminal responsibility, and the intention for harmful sexual behaviours to be responded to with diversionary and therapeutic responses in the first instance.

The Government should develop the framework in consultation with stakeholders and include the role of government funded services that form part of the State's harmful sexual behaviour response, such as the Prevention, Assessment, Support and Treatment program.

Services for children displaying harmful sexual behaviours should be considered in the Arch centres. We heard that such services are often co-located in multidisciplinary centres in Victoria, which facilitates collaboration and provides an advantage when dealing with in-family harmful sexual behaviours, because both the child who has experienced harmful sexual behaviours and the child who has displayed harmful sexual behaviours are seen in one location.[305] This means families do not need to 'tell their story multiple times' and staff develop 'a more sophisticated understanding of the dynamics of sexual violence'.[306] This practice would be possible at Arch centres.

The framework should be translated into action through detailed context-specific policies, protocols and guidance, including those we have recommended for education, out of home care and youth justice (refer to Recommendations 6.9, 9.28 and 12.30). We have identified several existing statewide frameworks developed for other jurisdictions above. While we do not recommend a particular framework, we note that the authors of these approaches appear to be open to making their work available and have made materials publicly available.[307] The Department would likely find it cost-effective to adapt material from existing approaches to the Tasmanian context.

Recommendation 21.8

1. The Tasmanian Government, in collaboration with key stakeholders, should develop a statewide framework and plan for preventing, identifying and responding to harmful sexual behaviours. The framework should:
    a. agree on a common definition and understanding of harmful sexual behaviours, including adopting a recognised, contemporary continuum of sexual behaviours from 'developmentally expected' to 'harmful'
    b. use an evidence-informed framework for understanding, preventing, identifying and responding to harmful sexual behaviours
    c. clarify the roles and responsibilities of the various agencies and departments involved in preventing and responding to the full continuum of harmful sexual behaviours, including programs delivered by non-government providers
    d. meet the needs of particular groups of children (Recommendation 21.6)

e. include structures to support ongoing engagement with emerging evidence regarding harmful sexual behaviours

f. include an evaluation framework.

2. The Tasmanian Government should ensure the therapeutic service system for children who have displayed harmful sexual behaviours:

   a. provides sufficient therapeutic services that can be accessed in a timely manner

   b. ensures timely access to therapeutic services for all children who need them, regardless of their age, identity or location in the state (including in youth detention)

   c. ensures specialist interventions for children with disability

   d. ensures all providers of therapeutic interventions for harmful sexual behaviours have Aboriginal representation in their governance structure.

3. The Tasmanian Government should provide ongoing and increased funding for specialist therapeutic interventions for harmful sexual behaviours that:

   a. ensures children who have displayed abusive or violent harmful sexual behaviours and their families need not wait more than two weeks for support when therapeutic treatment is required

   b. provides an advisory service for child-facing organisations, such as independent schools, childcare, disability and at-risk youth services and Tasmania Police (this service is not intended for the Department for Education, Children and Young People, which will have access to an internal Harmful Sexual Behaviours Support Unit (Recommendation 9.28))

   c. contributes to the statewide plan for preventing harmful sexual behaviours and its agencies' responses to children who have displayed such behaviours.

Recommendation 21.9

The Tasmanian Government should introduce legislation to amend the *Children, Young Persons and Their Families Act 1997* and the *Youth Justice Act 1997* to:

a. give the Magistrates Court explicit power to order that a child who has displayed harmful sexual behaviours (and their family) engage in a therapeutic intervention for harmful sexual behaviours

b. ensure the Magistrates Court has the power to divert from the criminal justice system a child who has been charged with a criminal offence and who has engaged in harmful sexual behaviours, by adjourning the criminal proceeding to enable the child to engage in a therapeutic intervention, and discharging the child where the intervention has been completed successfully.

Recommendation 21.10

Tasmania Police and the Department for Education, Children and Young People should update the *Keeping Children Safe Handbook* to reflect the Tasmanian Government's statewide framework and plan for addressing harmful sexual behaviours, including by:

a. modifying the language used when discussing children who have displayed harmful sexual behaviours to align with the definitions developed through the National Office of Child Safety

b. clarifying the roles and responsibilities of the two agencies in responding to incidents involving harmful sexual behaviours, including the conditions under which each agency will lead the response

c. clarifying the involvement of specialist therapeutic services in responses to incidents.

6 Conclusion

Our Inquiry into Tasmania's therapeutic service system for victim-survivors of institutional child sexual abuse and children who have displayed harmful sexual behaviours has revealed scope for improvement.

Specialist services for victim-survivors are few and staffed by hard-working, dedicated professionals who have advocated for increased services and better coordination for many years. Even after the National Royal Commission made many recommendations to create a responsive service system for victim-survivors, the Tasmanian Government has continued to adopt a passive position of responding with piecemeal funding offerings instead of assuming leadership for providing a robust service system.

It is vital that the Tasmanian Government leads the development and funding of a responsive service system. The Government must ensure services reach those who are missing out, such as children in Ashley Youth Detention Centre, victim-survivors with

disability, victim-survivors who identify as LGBTQIA+, victim-survivors from culturally and linguistically diverse backgrounds, male victim-survivors and those in isolated communities or Aboriginal victim-survivors.

For children who have displayed harmful sexual behaviours, the Tasmanian Government has only recently responded to the National Royal Commission's recommendations by funding a single service to provide services across the State. This is not enough, and it lacks the government leadership required to provide a collaborative, effective therapeutic service system for children who have these difficulties. The Tasmanian Government should develop a cross-agency framework to prevent and respond to harmful sexual behaviours.

Notes

1 Statement of Michael Salter, 7 April 2022, 31 [120]–32 [121].

2 Transcript of Jillian Maxwell and Kathryn Fordyce, 3 May 2022, 143 [22]–144 [9].

3 We use the term 'sexual assault' in this section in preference to other common terms such as 'sexual violence' or the specific term 'child sexual abuse', because it is the term most commonly used by specialist sexual assault services to describe adult and child sexual assault.

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6 Tasmanian Government, *Second Annual Progress Report and Action Plan 2020* (Report, December 2019) 15–17.

7 Tasmanian Government, *Survivors at the Centre: Tasmania's Third Family and Sexual Violence Action Plan 2022–2027* (November 2022); Department of Justice, *Fifth Annual Progress Report and Action Plan 2023* (Report, December 2022) 17.

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12 Transcript of Jillian Maxwell and Kathryn Fordyce, 3 May 2022, 142 [32–33].

13 Transcript of Jillian Maxwell and Kathryn Fordyce, 3 May 2022, 135 [1–12].

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21 Transcript of Jillian Maxwell and Kathryn Fordyce, 3 May 2022, 135 [19–29], 142 [20–33].

22 Transcript of Jillian Maxwell and Kathryn Fordyce, 3 May 2022, 137 [35–39], 142 [27–33].

23 Statement of Jillian Maxwell, 26 April 2022, 2 [11].

24 Laurel House, *Annual Report 2021* (Report, 2021) 14–16.

25 Email from Kathryn Fordyce to Commission, 13 July 2022, 1; Transcript of Jillian Maxwell and Kathryn Fordyce, 3 May 2022, 136 [31–38].

26 Session with Keelie McMahon, 13 March 2022.

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30 Statement of Kathryn Fordyce, 3 May 2022, 11 [31–32]; Session with Kylee Pearn, 5 October 2021; refer also to Submission 086 Angela Sdrinis, 75; Submission 099 Anonymous, 1; Session with Anonymous, 30 November 2021; Stakeholder consultation, 23 November 2021.

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22 Monitoring reforms

1 Introduction

Our Commission of Inquiry shares the hopes we heard in evidence from victim-survivors, and their families, carers and supporters, that our Inquiry will result in meaningful change that benefits Tasmania and its children and young people. The Tasmanian Government has said it will implement our recommendations, and we expect this to occur. It would be a tragedy if our report were treated as the product of 'just another inquiry', to file and forget. The cost to taxpayers, the trust of the community and the toll on victim-survivors and whistleblowers that comes from telling their stories require a forceful and immediate response.

This chapter discusses ways to ensure our recommendations lead to positive change. We hope to see sustainable systemic improvements that will help prevent child sexual abuse in institutions and improve institutional responses to such abuse. We want better outcomes for children and young people who have been abused.

This chapter lists our recommendations and includes suggested timeframes for implementing them. It focuses on the monitoring and reporting needed to effectively implement these recommendations. We recommend the Tasmanian Government establishes the role of the Child Sexual Abuse Reform Implementation Monitor to oversee and report on the Government's progress in implementing our recommendations and the recommendations of previous inquiries and reviews.

2 Our recommendations

Our Commission of Inquiry had three main functions.

The first was to provide a safe place where victim-survivors and their families and carers could share their accounts of child sexual abuse in Tasmanian Government institutions. These accounts informed our understanding of measures to prevent, identify and respond to child sexual abuse in Tasmanian Government institutions.

The second was to investigate the adequacy or otherwise of past and present responses to allegations and incidents of child sexual abuse in Tasmanian Government institutions, and to identify systemic issues. Institutions investigated include schools, out of home care, health services and Ashley Youth Detention Centre.

The third was to recommend concrete and practical reforms to address any inadequacies identified, so children can be better protected against child sexual abuse in Tasmanian government institutions.

Our terms of reference directed us to make any recommendations arising from our Commission of Inquiry we consider appropriate. These include recommendations about any policy, legislative, administrative or structural reforms, and to focus our recommendations on systemic issues.

Our report represents the end of our Commission of Inquiry. We make 191 recommendations. During more than two years of operation, we examined more than 95,000 documents, held more than 120 sessions with a Commissioner, conducted hearings over nine weeks and engaged widely with the Tasmanian community. This enabled us to understand the systemic failings in the Tasmanian Government's response to child sexual abuse in institutional settings and to identify opportunities for lasting reform. Our recommendations represent an extensive reform agenda for Tasmania—the way to achieve a future where children and young people feel safe in government institutions, as they and their families have a right to expect.

Some of our recommendations focus on creating new structures to support a government-wide system where children are kept safe from child sexual abuse and where the Tasmanian Government is held to account for its responses to abuse. Other recommendations concentrate on ensuring the right care and support are available and accessible to children and young people and their families and carers, and to adult and child victim-survivors of child sexual abuse. Others focus on improving processes and procedures regarding child sexual abuse. However, at the core of all our recommendations is the view that the Tasmanian Government and State Service must be accountable for the safety and wellbeing of children and young people in government institutions.

We have articulated a six-year reform agenda that prioritises our recommendations into three waves of reform:

- short-term—by 1 July 2024
- medium-term—by 1 July 2026
- long-term—by 1 July 2029.

We consider this approach balances the need for urgent reforms but also acknowledges that implementing other reforms should and will take careful planning and require long-term investment and support. Our recommendations are listed at the end of this chapter, along with our suggested reform timeframes and role holders or agencies responsible, as a guide for the Tasmanian Government (refer to Table 21.1).

With this report representing the end of our Commission of Inquiry, it is now time for the Tasmanian Government to do the work necessary to implement our recommendations. We acknowledge this will take considerable effort and commitment. In the next section, we recommend establishing the Child Sexual Abuse Reform Implementation Monitor to hold the Tasmanian Government to this task.

3 Monitoring and reporting

The impact of our Commission of Inquiry will depend primarily on the Tasmanian Government implementing the recommendations in our report. Monitoring and publicly reporting on implementation is vital for:

- making real progress in preventing child sexual abuse in government and government funded institutions by learning from experience
- improving institutional responses to child sexual abuse
- improving outcomes for children and young people who have been abused.

This section discusses how implementing our recommendations, and those of other inquiries and reviews, should be monitored and reported against so the public can hold the Tasmanian Government and its institutions to account.

We are mindful the Tasmanian Government has held multiple inquiries and reviews on matters relevant to institutional child sexual abuse. It also has a history of:

- accepting and then not implementing recommendations
- not implementing recommendations in line with the intent of the inquiries or reviews
- failing to implement recommendations in a timely way.

For example, in Volumes 4, 5 and 6 of our report, we discuss how problems identified in previous reviews and inquiries into out of home care, the health system and Ashley Youth Detention Centre have not been addressed over many years. We are also conscious that key recommendations of the National Royal Commission have not been implemented, and it has been more than five years since those recommendations were made. Although the Tasmanian Government has made progress on reforms by introducing the Child and Youth Safe Organisations Bill 2022, which was passed by the Tasmanian Parliament and commenced as the *Child and Youth Safe Organisations Act 2023* in July 2023, the Child and Youth Safe Standards and Reportable Conduct Scheme are still in the implementation stages.[1]

Ongoing monitoring is essential if our recommendations for reform are to be successfully implemented. Monitoring plays an important role in:

- maintaining momentum for reform
- embedding accountability for change
- ensuring progress is transparent
- mitigating and avoiding unintended consequences of reforms
- continuously improving and adapting reform efforts.

Jenny Gale, Secretary, Department of Premier and Cabinet and Head of the State Service, noted the need for independent oversight to ensure change occurs: 'I do think independent oversight is a very important factor in accountability and also in raising public awareness about what is happening and what needs to be improved'.[2]

Ginna Webster, Secretary, Department of Justice, who is responsible for the Child Abuse Royal Commission Response Unit, acknowledged the role public monitoring and reporting can play in building trust in government action:

> I think one of the barriers that I touched on at the beginning was the need to rebuild the trust and the confidence of the community, so I think that work will have to be done as well as we progress, and I think that's through regular reporting and monitoring.[3]

In this section, we discuss our recommended Child Sexual Abuse Reform Implementation Monitor, which would be the key mechanism to hold the Tasmanian Government to account for implementing our recommendations. We also discuss our expectation that the Government reports on its implementation of our and other inquiries' recommendations. Such reports should examine the implementation of particular recommendations, the broader outcomes of new policies, procedures and laws and the interaction between them.

3.1 An implementation monitor

In the final two days of hearings, we invited experts to advise us about the way forward, including how to ensure the Tasmanian Government effectively implements our recommendations for reform. Dr Samantha Crompvoets, Director of the Australian Human Rights Commission, told us it is important to monitor the implementation of recommendations to ensure they result in change:

> I think that it's important for people who are giving recommendations to build in a monitoring and evaluation part of it … Otherwise, what happens is in, say, two to three years after those recommendations come out and issues start to bubble up again and there's another review, and more recommendations, and no one really understands what happened to the initial ones.[4]

Tim Cartwright APM and Jan Shuard PSM shared their observations and experiences as former Family Violence Reform Implementation Monitors in Victoria, a role responsible for monitoring the implementation of the Victorian Royal Commission into Family Violence recommendations. Mr Cartwright was the inaugural Family Violence Reform Implementation Monitor from August 2016 until August 2019 and Ms Shuard held the role from August 2019 until May 2023. The Family Violence Reform Implementation Monitor concluded its monitoring work on 31 May 2023.[5]

The Family Violence Reform Implementation Monitor was an independent statutory body. It was established in 2016 in response to the Victorian Royal Commission into Family Violence recommendation that an independent family violence agency be established to hold the Victorian Government to account.[6] As Mr Cartwright outlined in his statement to our Commission of Inquiry:

> Recommendation 199 concerned the establishment of an independent function to (among other things) monitor and report on implementation of the Commission's recommendations. That function was created through the establishment of the Family Violence Reform Implementation Monitor (Implementation Monitor) *under the Family Violence Reform Implementation Monitor Act 2016* (Vic).[7]

Mr Cartwright and Ms Shuard observed that a key aspect of the Family Violence Reform Implementation Monitor's role is to look at how recommendations have been implemented relative to the intended outcomes of the Victorian Royal Commission into Family Violence.[8] We note that a flexible approach is sometimes needed when assessing whether a recommendation has been effectively implemented. Mr Cartwright said that he sometimes needed to 'go behind' the intent of the Victorian Royal Commission into Family Violence recommendations to work out a better process: 'So that critical question I always asked was what would make this better for victim-survivors … is this working to produce the outcomes that the Royal Commission in that case wanted?'[9]

Importantly, Mr Cartwright and Ms Shuard highlighted to us how the Family Violence Reform Implementation Monitor role allowed them to continue advocating for change on behalf of victim-survivors, beyond the life of the Victorian Royal Commission into Family Violence. Mr Cartwright said:

> The other important part of the role which surprised me a little was eventually becoming, in some ways, not an advocate for victim-survivors, but certainly the middle person between those implementing and those who were affected or advocating for change.[10]

Mr Cartwright's and Ms Shuard's evidence showed that the role of the Family Violence Reform Implementation Monitor was effective in holding the Victorian Government to account and ensuring transparency in government actions.[11] We are of the view that Tasmania needs to establish a similar role to ensure the reform work our Commission of Inquiry and previous inquiries and reviews have begun continues.

We recommend below that a Child Sexual Abuse Reform Implementation Monitor be established. The Implementation Monitor should:

- be independent
- report publicly, through Parliament
- consult and work closely across the child sexual abuse sector, including with government, peak bodies and victim-survivors.

3.1.1 Independence

Mr Cartwright told us that the independence of Victoria's Family Violence Reform Implementation Monitor was essential to the role's success: 'It is critical that the legislation establishing the role of Implementation Monitor gives the Implementation Monitor independence, and the ability to report free from interference'.[12]

When asked to expand on this at our hearings, Mr Cartwright said:

> The legislation removes any doubt that the voice of a critical Monitor or a critical person will be made public regardless of whether the bureaucracy or the government of the day agrees or disagrees with it, so that was very important to me … I still think that some protection of the Monitor's independence and right to speak publicly is very important as a foundational aspect.[13]

The Family Violence Reform Implementation Monitor is a statutory role that reports directly to Parliament.[14] Mr Cartwright explained in his statement that the Implementation Monitor's independence was achieved by:

- the statutory nature of the role and the requirement to report directly to Parliament
- the establishing legislation, which gives the Implementation Monitor independence and the ability to report free from interference from the minister or others

- security of tenure of the role, with appointment by the Governor in Council and limited grounds on which the Implementation Monitor may be suspended or removed.[15]

Ms Shuard agreed about the importance of the Implementation Monitor's independence, while maintaining productive relationships.[16] She said that in order for independence to be maintained it is essential the Implementation Monitor's monitoring and reporting functions be separate from implementation functions: 'I think, if you're in charge of implementation, you can't possibly monitor, or if you're in charge of the framework for implementation and all the elements of it you can't possibly be an independent Monitor'.[17]

3.1.2 Public reporting

Ms Shuard explained the public reporting requirements of the Victorian Family Violence Reform Implementation Monitor role in her statement:

> For the first four years after the Royal Commission [into Family Violence], the legislation required the Implementation Monitor to deliver an annual report to Parliament. The first three reports (tabled in Parliament in May 2018, March 2019 and February 2020) specifically looked at achievements from the previous year but the fourth report, being the last planned report (tabled in May 2021), looked back across all four years. I envisaged that, after delivery of the fourth annual report, the function would cease, as that was all the government had required. However, the Victorian Government has extended the reporting obligation for a further 18 months, although the requirement to table the report in Parliament has been removed and the resources of the office of the Implementation Monitor have been slightly reduced.[18]

We consider this public reporting requirement is essential to the effectiveness of the recommended Child Sexual Abuse Reform Implementation Monitor's role in holding the Tasmanian Government to account.

3.1.3 Consulting and working across government

We consider that the Child Sexual Abuse Reform Implementation Monitor should consult broadly when determining whether the Tasmanian Government has effectively implemented our recommendations and those of other inquiries and reviews. In the family violence context in Victoria, Ms Shuard said it was important for the Family Violence Reform Implementation Monitor to establish strong relationships across the family violence sector and be transparent with all parties. Ms Shuard said:

> I think for me one of the absolute critical roles of the Implementation Monitor is the relationships that you can build with the government agencies, the service providers and the victim-survivors.... The Monitor is a small office relatively to the task, and you couldn't do your work justice without the absolute cooperation, transparency of the agencies that you're working with.[19]

The role of the Family Violence Reform Implementation Monitor was to listen to and reflect all voices in the family violence sector when assessing the effectiveness of the implementation of recommendations, including government agencies, service providers and victim-survivors. Ms Shuard said:

> … I guess it was really important to me … to hear the voices of everybody involved. You know, I say you have the designers and the funders of the system, you have the service providers who deliver the services, and you have the victim-survivors who are most important in terms of experiencing the changes in the system but, more than that, influencing the design of the system so that it meets their needs and I think that's absolutely critical.
>
> I think a view that our job was … to add value to the outcomes for the family violence systems, so therefore to provide an independent view by listening to all of the voices that were involved in the system, and sometimes there's a difference, I guess, of view about how it's going, what's working, whether it's being effective in its implementation, and to be able to represent all of those voices so that the designers of the system and the users of the system and those delivering the services get a shared understanding of our independent view.[20]

Ms Shuard explained how she worked with the Victorian Government in practice:

> … when you form your independent view and you do a report, the process of providing that report to the government agencies that are affected, allowing those government agencies to have input into that report insofar as, not just factual errors, but if they think you've been unduly harsh perhaps or haven't captured a point correctly, then it should be—it's open for them to provide that advice back to the Implementation Monitor.[21]

Mr Cartwright and Ms Shuard emphasised the importance of a formal mechanism to ensure victim-survivors' views on the impacts of reform were heard and acted upon during implementation.[22] In Victoria, this was achieved through the Statewide Family Violence Advisory Committee, which was set up after the Victorian Royal Commission into Family Violence to advise the Government on family violence policy and service provision.[23]

In Chapter 19, we recommend the Tasmanian Government ensures children and young people and adult victim-survivors of child sexual abuse can contribute to policy and reform work through the Premier's Youth Advisory Group and through the establishment of an adult victim-survivors of child sexual abuse advisory group (refer to Recommendation 19.5). We also recommend a peak body for the sexual assault service system in Chapter 21 (refer to recommendation 21.3).
The Child Sexual Abuse Reform Implementation Monitor should consult regularly with these entities about the effectiveness of the implementation of our recommendations and the recommendations of other reviews and inquiries.

3.2 Future reporting

The National Royal Commission recommended that each state and territory government reports on its implementation of the National Royal Commission's recommendations through five consecutive annual reports tabled in their respective parliaments.

Adhering to this recommendation, the Tasmanian Government issued its fifth and final annual report and action plan in December 2022.[24] The report indicated that, while the Government was committed to ongoing annual reporting on implementing reforms for the safety and wellbeing of children, it was considering changing the form of this reporting.[25] The report stated that, given the 'several inquiries and commissions' that have examined child sexual abuse in the Tasmanian institutional context in recent years, it proposed annual reporting shifts from a focus on completing the recommendations to outcomes-based reporting.[26]

While we support a focus on intended outcomes rather than superficial acquittal of recommendations, we are concerned this may result in reducing accountability for implementing individual recommendations, particularly considering evidence we heard from Mr Cartwright and Ms Shuard about the importance of accountability, transparency and reporting at all levels. Any focus on outcomes needs to identify how the intent behind the implementation of individual recommendations has been met.

We consider that implementing recommendations from our Commission of Inquiry and those of other reviews and inquiries across the child sexual abuse sector would benefit from being monitored and reported against by an implementation monitor model similar to the Family Violence Reform Implementation Monitor that was established in Victoria.

Recommendation 22.1

1. The Tasmanian Government should introduce legislation to establish and fund an independent Child Sexual Abuse Reform Implementation Monitor to:
    a. monitor and report to Parliament annually on the implementation of
        i. the recommendations of this Commission of Inquiry
        ii. any recommendations of the Royal Commission into Institutional Responses to Child Sexual Abuse that were accepted by the Tasmanian Government and have not been implemented
        iii. the recommendations of the Independent Inquiry into the Tasmanian Department of Education's Responses to Child Sexual Abuse
    b. undertake independent evaluations of the effectiveness of the measures and actions taken in response to the recommendations identified above, especially the impact on the safety and wellbeing of children in government

and government funded institutions and victim-survivors of child sexual abuse in institutional contexts.

2. Independent evaluations should enable assessment of change over time and involve:
    a. identifying an evaluation framework and baseline data requirements within the first year of the appointment of the Implementation Monitor
    b. commencing collection of data identified in the evaluation framework as soon as possible after the evaluation framework has been developed
    c. assessing the change against the evaluation framework at five- and ten-year intervals following the tabling of this report
    d. making independent evaluations publicly available.
3. The Tasmanian Government should protect the independence of the Implementation Monitor by:
    a. appointing the Implementation Monitor for a fixed term that cannot be prematurely terminated except in extraordinary circumstances
    b. maintaining the role of the Implementation Monitor until implementation of the recommendations identified above is substantively complete
    c. separately and directly funding the Implementation Monitor, rather than through a line agency.
4. The Tasmanian Government, through the Secretaries Board, should be required to report to:
    a. the Implementation Monitor as requested and in the form required by the Implementation Monitor
    b. the public on its implementation and reform activity through the Department of Premier and Cabinet's annual report.
5. The Implementation Monitor should consult as required with:
    a. the Premier's Youth Advisory Council
    b. the adult victim-survivors of child sexual abuse advisory group (Recommendation 19.5)
    c. the peak body for the sexual assault service system (Recommendation 21.3)
    d. the institution-specific advisory groups established within Tasmanian government agencies (Recommendations 9.6, 12.8 and 15.7).

4 Hope for the future

Despite reforms having been made in response to the National Royal Commission, there is much more work to do. These reforms will not be easy. As noted in Chapter 19, the Tasmanian Government has committed to an extensive reform agenda regarding institutional child sexual abuse. The multiple systems involved in responding to institutional child sexual abuse are complex and so, too, are the causes of institutional child sexual abuse. Strong and committed leadership is required across government and institutions for change to occur. We saw this commitment during our Commission of Inquiry—the Premier, along with all major parties, made a public apology in Parliament. The Premier said:

> We have failed you; we are all accountable, and we are sorry.
>
> Our institutions have a responsibility to ensure the safety and wellbeing of children, and our institutions have clearly failed in that responsibility … [27]

In the same apology, the Premier committed to implementing our reforms:

> Over the past eight months—throughout this Inquiry—we have heard about a very dark chapter in Tasmania's history.
>
> It's a chapter no-one should ever, ever forget. And today we give a solemn undertaking to all Tasmanians, to never, ever allow a repeat of this abuse, secrecy and suppression.
>
> To never, ever allow a repeat of the failures that allowed such abuse to occur.
>
> Our Government is acutely aware of the enormous responsibility to act swiftly and decisively to implement the Commission's recommendations …
>
> This Parliament will be defined by the actions we take now to ensure that the injustices perpetrated by Tasmanian Government institutions can never ever happen again …
>
> We know there is still much more work to do, and we are committed to making the changes required to ensure Tasmania is a safer place for all children and young people.[28]

We are pleased the Premier has committed to implementing our recommendations and emphasise that the work is in ensuring that appropriate structures are set up to enable our recommendations and those of other inquiries and reviews to be not only accepted but effectively implemented.

Secretary Gale also committed to achieving change:

> It was difficult to listen to but very important and I sincerely thank all of the brave people who have spoken out as part of the Commission's proceedings, including our state servants, as hearing their stories, their sadness, their frustration, their anger and their feelings of powerlessness has highlighted that there are significant improvements that must be made across the service.

> The traumas that systemic failures has caused children, young people and their families has been palpable, and I commit to doing whatever I can to effect change.[29]

Although our Commission of Inquiry has focused on child sexual abuse in institutions, we also see the potential for our recommendations to have benefits beyond the scope of our Inquiry. These benefits include:

- enhancing responses to all victim-survivors of institutional child sexual abuse
- improving the safety of institutions in relation to all forms of harm that may be experienced by vulnerable people and the responses of institutions when this harm occurs
- providing increased transparency and accountability to change the culture of silence and fear that was so dominant in people who spoke to us.

Throughout our report we have raised the challenges facing a small island state in preventing and responding to institutional child sexual abuse. But these challenges can also be strengths. Having strong, local connections can enable change to be achieved quickly. As Sam Leishman, a victim-survivor, told us (and as we have quoted before):

> … we talk about Tasmania as being a small jurisdiction and a small island, and it's isolating and … we don't have the resources and how difficult all of that is …. I sometimes think, well, why do we look at it like that, why can't we look at Tasmania as being a small, isolated state and that's actually our advantage? We are small, we can set the standards and we can be the one that says, this is the benchmark that everyone else has to meet, and we can do that because we're small and because we're isolated. There's no reason why we can't do things better here than the rest of the country.[30]

We agree. There is much cause for hope that effective and lasting reform can and will be achieved.

Table 22.1: List of recommendations with suggested reform timeframes and implementation leads[31]

Recommendation No.	Suggested reform timeframe (short, medium or long-term)	By when	Suggested implementation lead
Recommendation 6.1	Medium term	By 1 July 2026	Department for Education, Children and Young People
Recommendation 6.2	Short term	By 1 July 2024	Office of Safeguarding
Recommendation 6.3	Short term	By 1 July 2024	Department for Education, Children and Young People
Recommendation 6.4	Short term	By 1 July 2024	Department for Education, Children and Young People
Recommendation 6.5	Medium term	By 1 July 2026	Department for Education, Children and Young People
Recommendation 6.6	Medium term	By 1 July 2026	Tasmanian Government

Recommendation No.	Suggested reform timeframe (short, medium or long-term)	By when	Suggested implementation lead
Recommendation 6.7	Medium term	By 1 July 2026	Department for Education, Children and Young People
Recommendation 6.8	Medium term	By 1 July 2026	Department for Education, Children and Young People
Recommendation 6.9	Medium term	By 1 July 2026	Department for Education, Children and Young People (Harmful Sexual Behaviours Support Unit)
Recommendation 6.10	Medium term	By 1 July 2026	Tasmanian Government
Recommendation 6.11	Medium term	By 1 July 2026	Tasmanian Government
Recommendation 6.12	Medium term	By 1 July 2026	Tasmanian Government
Recommendation 6.13	Short term	By 1 July 2024	Tasmanian Government
Recommendation 6.14	Short term	By 1 July 2024	Tasmanian Government
Recommendation 6.15	Medium term	By 1 July 2026	Tasmanian Government; Teachers Registration Board
Recommendation 6.16	Short-medium term	By 1 July 2026	Tasmanian Government
Recommendation 9.1	Short term	By 1 July 2024	Tasmanian Government
Recommendation 9.2	Medium term	By 1 July 2026	Department for Education, Children and Young People
Recommendation 9.3	Medium term	By 1 July 2026	Department for Education, Children and Young People; Tasmanian Government
Recommendation 9.4	Short term	By 1 July 2024	Tasmanian Government
Recommendation 9.5	Short-medium term	By 1 July 2026	Department for Education, Children and Young People
Recommendation 9.6	Medium term	By 1 July 2026	Department for Education, Children and Young People
Recommendation 9.7	Medium term	By 1 July 2026	Department for Education, Children and Young People
Recommendation 9.8	Medium-long term	By 1 July 2029	Department for Education, Children and Young People
Recommendation 9.9	Short-medium term	By 1 July 2026	Department for Education, Children and Young People
Recommendation 9.10	Medium-long term	By 1 July 2029	Department for Education, Children and Young People
Recommendation 9.11	Medium term	By 1 July 2026	Department for Education, Children and Young People
Recommendation 9.12	Medium term	By 1 July 2026	Department for Education, Children and Young People
Recommendation 9.13	Long term	By 1 July 2029	Department for Education, Children and Young People
Recommendation 9.14	Long term	By 1 July 2029	Tasmanian Government
Recommendation 9.15	Long term	By 1 July 2029	Tasmanian Government; Department for Education, Children and Young People

Recommendation No.	Suggested reform timeframe (short, medium or long-term)	By when	Suggested implementation lead
Recommendation 9.16	Medium term	By 1 July 2026	Department for Education, Children and Young People
Recommendation 9.17	Medium-long term	By 1 July 2029	Department for Education, Children and Young People; Office of the Chief Practitioner
Recommendation 9.18	Medium term	By 1 July 2026	Department for Education, Children and Young People
Recommendation 9.19	Medium term	By 1 July 2026	Department for Education, Children and Young People
Recommendation 9.20	Medium-long term	By 1 July 2029	Department for Education, Children and Young People
Recommendation 9.21	Medium-long term	By 1 July 2029	Department for Education, Children and Young People
Recommendation 9.22	Medium term	By 1 July 2026	Department for Education, Children and Young People
Recommendation 9.23	Long term	By 1 July 2029	Tasmanian Government; Department for Education, Children and Young People
Recommendation 9.24	Medium term	By 1 July 2026	Tasmanian Government
Recommendation 9.25	Medium term	By 1 July 2026	Department for Education, Children and Young People
Recommendation 9.26	Short-medium term	By 1 July 2026	Department for Education, Children and Young People
Recommendation 9.27	Short-medium term	By 1 July 2026	Department for Education, Children and Young People
Recommendation 9.28	Medium-long term	By 1 July 2029	Department for Education, Children and Young People; Tasmanian Government
Recommendation 9.29	Medium-long term	By 1 July 2029	Department for Education, Children and Young People; Tasmania Police; Office of the Chief Practitioner
Recommendation 9.30	Short term	By 1 July 2024	Tasmania Police
Recommendation 9.31	Short-medium term	By 1 July 2026	Department for Education, Children and Young People; Office of the Chief Practitioner
Recommendation 9.32	Medium term	By 1 July 2026	Department for Education, Children and Young People; Child-Related Incident Management Directorate; Office of the Chief Practitioner
Recommendation 9.33	Medium term	By 1 July 2026	Tasmanian Government
Recommendation 9.34	Long term	By 1 July 2029	Tasmanian Government
Recommendation 9.35	Long term	By 1 July 2029	Tasmanian Government
Recommendation 9.36	Long term	By 1 July 2029	Tasmanian Government
Recommendation 9.37	Short-medium term	By 1 July 2026	Department for Education, Children and Young People; Tasmanian Government

Recommendation No.	Suggested reform timeframe (short, medium or long-term)	By when	Suggested implementation lead
Recommendation 9.38	Long term	By 1 July 2029	Tasmanian Government
Recommendation 12.1	Medium term	By 1 July 2026	Tasmanian Government
Recommendation 12.2	Medium term	By 1 July 2026	Tasmanian Government
Recommendation 12.3	Medium term	By 1 July 2026	Tasmanian Government
Recommendation 12.4	Short term	By 1 July 2024	Department for Education, Children and Young People; Office of the State Archivist
Recommendation 12.5	Short-medium term	By 1 July 2026	Tasmanian Government
Recommendation 12.6	Medium term	By 1 July 2026	Department for Education, Children and Young People
Recommendation 12.7	Medium term	By 1 July 2026	Tasmanian Government
Recommendation 12.8	Medium term	By 1 July 2026	Department for Education, Children and Young People
Recommendation 12.9	Medium-long term	By 1 July 2029	Department for Education, Children and Young People
Recommendation 12.10	Short term	By 1 July 2024	Department for Education, Children and Young People
Recommendation 12.11	Medium-long term	By 1 July 2029	Tasmanian Government
Recommendation 12.12	Medium term	By 1 July 2026	Tasmanian Government
Recommendation 12.13	Medium-long term	By 1 July 2029	Tasmanian Government
Recommendation 12.14	Long term	By 1 July 2029	Tasmanian Government
Recommendation 12.15	Medium-long term	By 1 July 2029	Tasmanian Government
Recommendation 12.16	Long term	By 1 July 2029	Tasmanian Government
Recommendation 12.17	Medium term	By 1 July 2026	Tasmanian Government; Commission for Children and Young People
Recommendation 12.18	Medium term	By 1 July 2026	Tasmanian Government; Custodial Inspector
Recommendation 12.19	Medium term	By 1 July 2026	Tasmanian Government
Recommendation 12.20	Medium term	By 1 July 2026	Tasmanian Government
Recommendation 12.21	Short term	By 1 July 2024	Tasmanian Government
Recommendation 12.22	Medium term	By 1 July 2026	Department for Education, Children and Young People
Recommendation 12.23	Short term	By 1 July 2024	Department for Education, Children and Young People
Recommendation 12.24	Long term	By 1 July 2029	Tasmanian Government
Recommendation 12.25	Medium term	By 1 July 2026	Tasmanian Government
Recommendation 12.26	Short term	By 1 July 2024	Tasmanian Auditor-General
Recommendation 12.27	Medium term	By 1 July 2026	Tasmanian Government
Recommendation 12.28	Medium term	By 1 July 2026	Tasmanian Government
Recommendation 12.29	Medium term	By 1 July 2026	Tasmanian Government; Department for Education, Children and Young People

Recommendation No.	Suggested reform timeframe (short, medium or long-term)	By when	Suggested implementation lead
Recommendation 12.30	Medium term	By 1 July 2026	Department for Education, Children and Young People (Harmful Sexual Behaviours Support Unit); Tasmanian Government
Recommendation 12.31	Medium term	By 1 July 2026	Tasmanian Government; Department for Education, Children and Young People
Recommendation 12.32	Medium term	By 1 July 2026	Tasmanian Government; Department for Education, Children and Young People
Recommendation 12.33	Medium term	By 1 July 2026	Tasmanian Government; Department for Education, Children and Young People
Recommendation 12.34	Medium term	By 1 July 2026	Department for Education, Children and Young People; Tasmania Police
Recommendation 12.35	Medium term	By 1 July 2026	Department for Education, Children and Young People
Recommendation 12.36	Medium term	By 1 July 2026	Tasmanian Government
Recommendation 12.37	Short term	By 1 July 2024	Ombudsman Tasmania
Recommendation 12.38	Medium term	By 1 July 2026	Tasmanian Government
Recommendation 12.39	Medium term	By 1 July 2026	Tasmanian Government
Recommendation 15.1	Short term	By 1 July 2024	Department of Health
Recommendation 15.2	Medium term	By 1 July 2026	Tasmanian Government; Department of Health
Recommendation 15.3	Short term	By 1 July 2024	Department of Health
Recommendation 15.4	Medium term	By 1 July 2026	Department of Health
Recommendation 15.5	Short term	By 1 July 2024	Department of Health
Recommendation 15.6	Medium term	By 1 July 2026	Department of Health
Recommendation 15.7	Short term	By 1 July 2024	Department of Health
Recommendation 15.8	Short term	By 1 July 2024	Department of Health
Recommendation 15.9	Long term	By 1 July 2029	Department of Health
Recommendation 15.10	Medium term	By 1 July 2026	Department of Health
Recommendation 15.11	Short term	By 1 July 2024	Department of Health
Recommendation 15.12	Short term	By 1 July 2024	Department of Health
Recommendation 15.13	Short term	By 1 July 2024	Department of Health
Recommendation 15.14	Short term	By 1 July 2024	Department of Health
Recommendation 15.15	Medium term	By 1 July 2026	Department of Health
Recommendation 15.16	Short term	By 1 July 2024	Department of Health
Recommendation 15.17	Medium term	By 1 July 2026	Department of Health
Recommendation 15.18	Short term	By 1 July 2024	Department of Health
Recommendation 15.19	Medium term	By 1 July 2026	Department of Health

Recommendation No.	Suggested reform timeframe (short, medium or long-term)	By when	Suggested implementation lead
Recommendation 15.20	Short term	By 1 July 2024	Department of Health; Launceston General Hospital; Tasmania Police
Recommendation 15.21	Long term	By 1 July 2029	Tasmanian Government
Recommendation 16.1	Medium term	By 1 July 2026	Tasmanian Government; Tasmania Police
Recommendation 16.2	Medium term	By 1 July 2026	Tasmania Police; Department of Justice; Department for Education, Children and Young People
Recommendation 16.3	Medium term	By 1 July 2026	Tasmania Police
Recommendation 16.4	Medium term	By 1 July 2026	Tasmania Police
Recommendation 16.5	Medium term	By 1 July 2026	Tasmania Police
Recommendation 16.6	Medium term	By 1 July 2026	Department of Health
Recommendation 16.7	Medium term	By 1 July 2026	Tasmania Police
Recommendation 16.8	Medium term	By 1 July 2026	Office of the Director of Public Prosecutions
Recommendation 16.9	Short term	By 1 July 2024	Tasmanian Government
Recommendation 16.10	Medium term	By 1 July 2026	Tasmanian Government
Recommendation 16.11	Short term	By 1 July 2024	Tasmanian Government
Recommendation 16.12	Medium term	By 1 July 2026	Tasmanian Government
Recommendation 16.13	Medium term	By 1 July 2026	Tasmanian Government
Recommendation 16.14	Medium term	By 1 July 2026	Tasmanian Government
Recommendation 16.15	Medium term	By 1 July 2026	Tasmanian Government
Recommendation 16.16	Medium term	By 1 July 2026	Tasmanian Government
Recommendation 16.17	Medium term	By 1 July 2026	Tasmanian Government
Recommendation 16.18	Short term	By 1 July 2024	Tasmanian Government; Director of Public Prosecutions
Recommendation 16.19	Short term	By 1 July 2024	
Recommendation 16.20	Medium term	By 1 July 2026	Department of Justice; Sentencing Advisory Council
Recommendation 17.1	Long term	By 1 July 2029	Tasmanian Government
Recommendation 17.2	Short-medium term	By 1 July 2026	Tasmanian Government; Tasmanian Solicitor-General (or the State Litigation Office)
Recommendation 17.3	Short term	By 1 July 2024	Tasmanian Attorney-General; Tasmanian Government
Recommendation 17.4	Short term	By 1 July 2024	Tasmanian Government
Recommendation 17.5	Short term	By 1 July 2024	Tasmanian Government
Recommendation 17.6	Medium term	By 1 July 2026	Department of Justice
Recommendation 17.7	Medium term	By 1 July 2026	Tasmanian Government
Recommendation 17.8	Medium term	By 1 July 2026	Tasmanian Government

Recommendation No.	Suggested reform timeframe (short, medium or long-term)	By when	Suggested implementation lead
Recommendation 18.1	Long term	By 1 July 2029	Tasmanian Government
Recommendation 18.2	Short term	By 1 July 2024	
Recommendation 18.3	Short term	By 1 July 2024	Tasmanian Government
Recommendation 18.4	Short term	By 1 July 2024	Tasmanian Government
Recommendation 18.5	Long term	By 1 July 2029	Tasmanian Government
Recommendation 18.6	Short term	By 1 July 2024	Tasmanian Government; Commission for Children and Young People
Recommendation 18.7	Short term	By 1 July 2024	Tasmanian Government
Recommendation 18.8	Medium term	By 1 July 2026	Tasmanian Government
Recommendation 18.9	Medium term	By 1 July 2026	Tasmanian Government
Recommendation 18.10	Short term	By 1 July 2024	Integrity Commission; Ombudsman Tasmania
Recommendation 18.11	Medium term	By 1 July 2026	Tasmanian Government
Recommendation 18.12	Short term	By 1 July 2024	Tasmanian Government
Recommendation 18.13	Short term	By 1 July 2024	Tasmanian Government
Recommendation 18.14	Short term	By 1 July 2024	Commission for Children and Young People; Registrar of the Registration to Work with Vulnerable People Scheme; Integrity Commission; Ombudsman Tasmania
Recommendation 18.15	Medium term	By 1 July 2026	Commission for Children and Young People; Integrity Commission; Ombudsman Tasmania; Registrar of the Registration to Work with Vulnerable People Scheme
Recommendation 19.1	Short term	By 1 July 2024	Tasmanian Government
Recommendation 19.2	Short term	By 1 July 2024	Tasmanian Government
Recommendation 19.3	Short term	By 1 July 2024	Department of Premier and Cabinet
Recommendation 19.4	Short term	By 1 July 2024	Premier of Tasmania; Department of Premier and Cabinet; Heads of Agencies
Recommendation 19.5	Medium term	By 1 July 2026	Tasmanian Government; Department of Premier and Cabinet
Recommendation 19.6	Medium term	By 1 July 2026	Tasmanian Government
Recommendation 19.7	Medium-long term	By 1 July 2029	Tasmanian Government
Recommendation 19.8	Medium term	By 1 July 2026	Department of Premier and Cabinet; Tasmanian Government
Recommendation 20.1	Long term	By 1 July 2029	Tasmanian Government

Recommendation No.	Suggested reform timeframe (short, medium or long-term)	By when	Suggested implementation lead
Recommendation 20.2	Short term	By 1 July 2024	Heads of Agencies; Tasmanian Government
Recommendation 20.3	Short term	By 1 July 2024	Tasmanian Government
Recommendation 20.4	Short term	By 1 July 2024	Tasmanian Government
Recommendation 20.5	Medium term	By 1 July 2026	Department of Premier and Cabinet; Child-Related Incident Management Directorate
Recommendation 20.6	Medium term	By 1 July 2026	Tasmanian Government
Recommendation 20.7	Medium term	By 1 July 2026	Tasmanian Government
Recommendation 20.8	Medium term	By 1 July 2026	Tasmanian Government
Recommendation 20.9	Medium term	By 1 July 2026	Tasmanian Government
Recommendation 20.10	Medium term	By 1 July 2026	Tasmanian Government
Recommendation 20.11	Medium term	By 1 July 2026	Head of the State Service; Heads of Agencies
Recommendation 20.12	Medium term	By 1 July 2026	Tasmanian Government
Recommendation 20.13	Medium term	By 1 July 2026	Head of the State Service
Recommendation 20.14	Short term	By 1 July 2024	Tasmanian Government
Recommendation 20.15	Medium term	By 1 July 2026	Tasmanian Government
Recommendation 21.1	Medium-long term	By 1 July 2029	Department of Premier and Cabinet; Tasmanian Government
Recommendation 21.2	Medium term	By 1 July 2026	Tasmanian Government
Recommendation 21.3	Short-medium term	By 1 July 2026	Tasmanian Government
Recommendation 21.4	Short-medium term	By 1 July 2026	Tasmanian Government; Department of Premier and Cabinet
Recommendation 21.5	Short-medium term	By 1 July 2026	Tasmanian Government
Recommendation 21.6	Medium term	By 1 July 2026	Tasmanian Government
Recommendation 21.7	Medium-long term	By 1 July 2029	Tasmanian Government
Recommendation 21.8	Medium-long term	By 1 July 2029	Tasmanian Government
Recommendation 21.9	Medium term	By 1 July 2026	Tasmanian Government
Recommendation 21.10	Short term	By 1 July 2024	Tasmania Police; Department for Education, Children and Young People
Recommendation 22.1	Short term	By 1 July 2024	Tasmanian Government; Child Sexual Abuse Reform Implementation Monitor

Notes

1 Department of Premier and Cabinet, 'Keeping Children Safer Implementation Status Report', *Keeping Children Safer* (Policy Document, 31 May 2023) Action 10 <https://www.dpac.tas.gov.au/keepingchildrensafer>.

2 Transcript of Jenny Gale, 13 September 2022, 4024 [21–24].

3 Transcript of Ginna Webster, 12 September 2022, 3967 [42–46].

4 Transcript of Samantha Crompvoets, 13 September 2022, 4035 [7–9], [22–26].

5 Family Violence Reform Implementation Monitor, *The Family Violence Reform Implementation Monitor*, (Web Page, 30 May 2023) <https://www.fvrim.vic.gov.au/family-violence-reform-implementation-monitor>.

6 *Family Violence Reform Implementation Monitor Act 2016* (Vic) s 1.

7 Statement of Tim Cartwright, 22 August 2022, 3 [13].

8 Statement of Jan Shuard, 4 September 2022, 3 [18]; Transcript of Tim Cartwright and Jan Shuard, 13 September 2022, 3995 [31–38].

9 Transcript of Tim Cartwright, 13 September 2022, 3995 [40–45].

10 Transcript of Tim Cartwright, 13 September 2022, 3994 [30–34].

11 Transcript of Tim Cartwright and Jan Shuard, 13 September 2022.

12 Statement of Tim Cartwright, 22 August 2022, 3 [16].

13 Transcript of Tim Cartwright, 13 September 2022, 4000 [41]–4001 [3].

14 *Family Violence Reform Implementation Monitor Act 2016* (Vic) ss 23–24.

15 Statement of Tim Cartwright, 22 August 2022, 3 [15]–[17].

16 Transcript of Jan Shuard, 13 September 2022, 3999 [3–5], [12–24].

17 Transcript of Jan Shuard, 13 September 2022, 4011 [29–33].

18 Statement of Jan Shuard, 13 September 2022, 4 [20].

19 Transcript of Jan Shuard, 13 September 2022, 3999 [3–10].

20 Transcript of Jan Shuard, 13 September 2022, 3995 [5–24].

21 Transcript of Jan Shuard, 13 September 2022, 3999 [17–24].

22 Statement of Jan Shuard, 13 September 2022, 6 [30]; Transcript of Tim Cartwright and Jan Shuard, 13 September 2022, 3994 [30–34], 3995 [5–13], 3995 [40–45], 3999 [3–10].

23 State of Victoria, *Royal Commission into Family Violence: Summary and recommendation* (Parliamentary Paper No 132, 2016) 100.

24 Tasmanian Government, *Fifth Annual Progress Report and Action Plan 2023: Implementing the Recommendations of the Royal Commission into Institutional Responses to Child Sexual Abuse* (Report, December 2022).

25 Tasmanian Government, *Fifth Annual Progress Report and Action Plan 2023: Implementing the Recommendations of the Royal Commission into Institutional Responses to Child Sexual Abuse* (Report, December 2022) 11.

26 Tasmanian Government, Fifth Annual Progress Report and Action Plan 2023: *Implementing the Recommendations of the Royal Commission into Institutional Responses to Child Sexual Abuse* (Report, December 2022) 11.

27 Ministerial Statement, Jeremy Rockliff, Premier of Tasmania, 8 November 2022.

28 Ministerial Statement, Jeremy Rockliff, Premier of Tasmania, 8 November 2022.

29 Transcript of Jenny Gale, 13 September 2022, 4016 [37]–4017 [1].

30 Transcript of Sam Leishman, 13 May 2022, 1064 [16–30].

31 This table is intended as a guide, noting the Government and Implementation Monitor may agree to alter the timeframes and leads as reforms progress.

23 Afterword

1 Introduction

This Commission of Inquiry was established to provide the Tasmanian Government with an opportunity to understand how to respond more effectively to allegations and incidents of child sexual abuse in institutional contexts.

In this chapter, we consider how the work of our Commission of Inquiry was shaped by the legislative context within which it operated. This legislative context is relevant to the outcomes of our Inquiry (namely this report and its findings and recommendations) and how we went about our work. We consider we should reflect on how to conduct such inquiries more effectively.

As with all human endeavours, there are aspects to the conduct of our Commission of Inquiry that we could no doubt have done better. Ultimately, this is for the judgment of others.

The *Commissions of Inquiry Act 1995* ('Commissions of Inquiry Act') governed the way our Inquiry was established and conducted, although other legislation was also relevant. Given the experience of conducting our Inquiry, we consider it is appropriate and useful to reflect on the ways in which the Commissions of Inquiry Act (and other legislation) could be improved for the benefit of future inquiries and the entire Tasmanian community.

2 Background

Our Commission of Inquiry is the first since the Commission of Inquiry into the Death of Joseph Gilewicz ('Gilewicz Commission of Inquiry') reported in 2000.[1] During its inquiry, the Gilewicz Commission of Inquiry identified difficulties with the Commissions of Inquiry Act.[2] As a result, the *Commissions of Inquiry Amendment Act 2000* was introduced. The Gilewicz Commission of Inquiry went on to note other practical problems with the amended Commissions of Inquiry Act in its final report.[3]

In March 2002, the then Attorney-General requested the Tasmania Law Reform Institute ('Law Reform Institute') examine and report on the operation of the Commissions of Inquiry Act, including considering the experience of the Gilewicz Commission of Inquiry. In August 2003, the Law Reform Institute published its final report, recommending further amendments to the Commissions of Inquiry Act.[4]

In 2013, the Commissions of Inquiry Act was again amended to facilitate the work of the Royal Commission into Institutional Responses to Child Sexual Abuse.[5]

In anticipation of establishing our Commission of Inquiry, the Tasmanian Government had preliminary conversations with the Honourable Marcia Neave AO about the Commissions of Inquiry Act. A range of possible amendments to the Act—including because of the Gilewicz Commission of Inquiry's report, the Law Reform Institute's report and the experience of inquiries in other jurisdictions—were discussed ahead of our Inquiry. Ultimately, it was a matter for the Tasmanian Government and Parliament to decide the amendments that should be made to the Commissions of Inquiry Act.

On 1 March 2021, the *Justice Miscellaneous (Commissions of Inquiry) Act 2021* came into force ('Justice Miscellaneous (Commissions of Inquiry) Act'). This Act amended the Commissions of Inquiry Act, including in response to the Law Reform Institute's report and in anticipation of establishing our Commission of Inquiry.[6] Among other changes, the amended Commissions of Inquiry Act enabled regulations to be made that disapplied other Acts (or certain provisions of those Acts) to any information collected or used by or on behalf of a commission of inquiry.[7]

On 15 March 2021, the Governor of Tasmania established the Commission of Inquiry into the Tasmanian Government's Responses to Child Sexual Abuse in Institutional Settings, appointing us as Commissioners and enabling our Inquiry to begin.[8]

In early May 2021, our Commission of Inquiry proactively engaged with the Tasmanian Government regarding provisions we recommended should be disapplied (that is, those that would not operate) to enable our Inquiry to do its work and to make it easier for people, including State Service employees, to share information with us.

On 14 July 2021, the *Commissions of Inquiry Regulations 2021*, which disapplied certain Acts in relation to our Commission of Inquiry, commenced.

The amended Commissions of Inquiry Act and the regulations made up the legal framework within which our Inquiry operated.

The Law Reform Institute's report commented that the fact the Gilewicz Commission of Inquiry identified aspects of the Commissions of Inquiry Act as being problematic was 'a familiar chain of events'.[9] Other royal commissions and inquiries have routinely identified in their reports challenges with the legislation under which they operated and opportunities for reform, with the goal of improving the conduct of future inquiries.[10] Indeed, given the limited time available to royal commissions and inquiries to undertake their work and, therefore, the need for them to focus on the subject matter of their inquiry, it is impractical for them to pursue legislative reforms during their term. In this context, we consider it is appropriate for us, at the end of our Inquiry, to also reflect on opportunities for reform.

3 A commission's conduct of its own inquiry

A commission of inquiry should be empowered to decide how it conducts its inquiry subject to the legislation and orders under which it is established, other relevant legislation and common law rules such as procedural fairness. In recognising the need for the Commissions of Inquiry Act to offer greater flexibility, the Justice Miscellaneous (Commissions of Inquiry) Act introduced provisions that gave a commission of inquiry the power to conduct its inquiry and obtain information in 'any manner that it considers appropriate' and to 'determine its own procedure in conducting its inquiry'.[11]

Importantly, the July 2021 regulations also provided that certain confidentiality provisions and other restrictions on sharing information in other Acts did not apply to information collected or used by or on behalf of our Commission of Inquiry.[12] As indicated, this removed barriers to State Service employees sharing information with us.

We recognise there is a delicate balance to be achieved between the important purposes of other Acts and whether such Acts should be disapplied in relation to a commission of inquiry to improve the conduct of its inquiry. This is a decision for the Tasmanian Government rather than any individual commission of inquiry, although the views of a commission of inquiry should be sought and carefully considered. The new regulations materially assisted our Inquiry, but we reflect below in Section 3.2 on the challenges presented by one particular provision that was not disapplied.

3.1 Adverse findings and misconduct findings

In Chapter 1, Section 2.3.4, we discuss the requirements imposed by the Commissions of Inquiry Act for a commission of inquiry to make findings of misconduct (section 18) and adverse findings (section 19), despite a commission of inquiry also being required by the Commissions of Inquiry Act and the common law to comply with the rules of procedural fairness. In a practical sense, these specific requirements make it more difficult to make such findings, where these requirements may be unnecessary, and indeed counterproductive, to appropriately protecting the rights and interests of those who might be affected by such findings. We do not repeat that discussion here.

In summary, we consider a commission of inquiry should be able to make any findings it wishes, subject to complying with the rules of procedural fairness. We do not consider that the legislation needs to set out any specific procedural requirements. It is not clear to us why the Commissions of Inquiry Act needs to have a specific regime for findings of misconduct, particularly when the equivalent legislation in other Australian jurisdictions does not have any such regime. This approach is inconsistent with contemporary inquiry practices. Ultimately, we are concerned that the Commissions of Inquiry Act creates legal complexities that prevent inquiries from being as effective and efficient as they might otherwise be.

We consider it appropriate and necessary for the Commissions of Inquiry Act to expressly provide that the rules of procedural fairness apply to a commission of inquiry.[13] However, one of the practical challenges of the specific procedural requirements for findings of misconduct in the Commissions of Inquiry Act is that it limited the ability of our Inquiry to determine how we conducted ourselves, as explained further below.

Under the current Act, a commission of inquiry must give a person notice of any allegation of misconduct (section 18(1)) and allow that person an opportunity to respond (section 18(3)). We consider giving a person notice about potential findings concerning them and an opportunity to respond is appropriate, but note that this would be required by the rules of procedural fairness anyway. The practical challenge is that the rights in relation to responding under section 18(3) could allow that person to effectively control the commission of inquiry's processes. Under section 18(3), the person may choose to make oral or written submissions, give evidence to a commission of inquiry, cross-examine the person who made the allegation or call witnesses. As a result, a person may compel a commission of inquiry to:

- conduct more hearings, even where the commission of inquiry's planned hearings have concluded
- call or re-call witnesses for cross-examination, even in circumstances where there may be other important reasons why this is not appropriate (for example, this could be retraumatising for some witnesses and the nature of the cross-examination may be inconsistent with trauma-informed practice).

The scheduling of hearings is complicated, requiring a wide variety of factors to be considered—among them, the availability of a venue, Commissioners, witnesses, parties, lawyers for all relevant parties, technical operators and other relevant supports (such as counselling). Hearings are resource-intensive, expensive and time-consuming. Therefore, it is better that commissions of inquiry control the calling of any hearings. Also, given that most inquiries continue to discover information throughout their term that may be relevant to findings they wish to make, the risk is that inquiries would need to hold repeated section 18 hearings to make findings that might constitute findings of misconduct, or otherwise artificially and prematurely conclude their information-gathering phases to allow enough time if any hearings related to section 18 may be required. It is also possible information that emerges from one section 18 hearing gives rise to new potential findings of misconduct that might require more section 18 hearings, meaning there is the potential for endless hearings unless the inquiry determines not to pursue findings based on information that is already before it. In addition, under the current Commissions of Inquiry Act, there is the risk that an individual might seek to 'run the clock' and delay providing information until after the commission's planned hearings conclude, and to then require a further hearing if the commission were to propose making a misconduct finding based on the information they subsequently provide.

While a commission of inquiry should certainly be required to consider a response from a person in relation to potential adverse content or findings about them, this could be achieved through written submissions and written evidence without requiring the substantial expense, delay and potential trauma of further public hearings. A person affected by a potential finding will usually only be motivated to consider their own position and possibly the position of any employer or organisation they represent. In contrast, a commission of inquiry must consider a raft of factors, including how to advance its inquiry for the benefit of the public, how to appropriately manage the public cost of its inquiry, how to sequence its work to meet its reporting deadline, how to weigh the information and position of each party and, of course, how to comply with the rules of procedural fairness. It is for these reasons that it is appropriate for a commission of inquiry to be able to control its own proceedings.

In this context, we consider section 18 does not achieve an appropriate balance between facilitating a commission of inquiry controlling its own proceedings (while complying with the rules of procedural fairness) and protecting the rights of a person subject to an allegation or potential finding of misconduct. We consider that further amendments to section 18, or the definition of 'misconduct', will not redress this imbalance. The Tasmanian Government should consider simply repealing section 18 and that definition.

Similarly, a commission of inquiry must give a person a notice of any adverse finding and allow the person at least 10 business days to respond (section 19).[14] While less prescriptive and, therefore, less problematic than the specific procedural requirements

for findings of misconduct, we do not consider it is necessary for this procedure to be specified in the legislation. Our Commission of Inquiry complied with these requirements in relation to all people subject to an adverse finding. Indeed, we provided the State with the opportunity to comment on content even where it was not an adverse finding. We also routinely provided the State and other people and entities with much more than 10 business days in which to respond, recognising that a longer period was sometimes fair and reasonable in the circumstances. Therefore, these are matters that a commission of inquiry should determine as part of its compliance with the rules of procedural fairness.

As stated above, we consider it appropriate and necessary for the Commissions of Inquiry Act to expressly provide that the rules of procedural fairness apply to a commission of inquiry.[15] We do not, however, consider the relevant legislation should set out any specific procedural requirements for making findings or complying with such rules of procedural fairness. We consider section 18, in particular, imposes requirements that are unnecessary, counterproductive, onerous and not in the public interest.

3.2 Legislative restrictions on certain information

Given the subject matter of our Commission of Inquiry, there was a range of other legislation that applied to the sensitive information (including about child sexual abuse) that we considered. Some of this legislation appropriately imposes restrictions on dealing with such information in the interests of achieving important purposes, while other provisions limited our Inquiry's effectiveness.

The *National Redress Scheme for Institutional Child Sexual Abuse Act 2018 (Cth)* ('National Redress Scheme Act') limits the use and disclosure of protected information in relation to the National Redress Scheme but allows it to be used and disclosed in certain circumstances.[16] As the National Redress Scheme Act is a Commonwealth Act, the Commissions of Inquiry Act and any regulations under it cannot override or disapply the National Redress Scheme Act. Our Commission of Inquiry complied with these limitations and relevant exceptions to them where appropriate.

The *Evidence Act 2001* also imposes relevant restrictions. Originally, section 194K created an offence for a person, in relation to any proceeding in any court, to publish identifying information about a person in respect of whom specific crimes involving a sexual offence were alleged to be committed (that is, a victim-survivor) and any witness or intended witness in those proceedings, without a court order. In 2020, a new section 194K was introduced making it an offence for a person, in relation to any proceeding in any court, to publish identifying information in respect of certain specified crimes involving a sexual offence.[17] The offence applies regardless of whether the criminal proceedings have been finally determined.[18] It is a defence to this offence

if the information is about a person against whom the crime is alleged to have been committed (that is, a victim-survivor) and that person consents to the disclosure (and the information does not identify any other victim-survivor unless that person has also consented). The change flowed from a campaign led by victim-survivors who wanted to speak about their own experiences of child sexual abuse. The legislation still does not, however, allow any witness or intended witness in those proceedings (other than the defendant) to be identified without a court order (that is, even if the victim-survivor and the witness both consent to being identified).

In conducting our Commission of Inquiry, our approach was to appropriately empower and protect victim-survivors; this included respecting their preferences for how their information would be shared and used. As part of our engagement with victim-survivors, if we proposed to identify them in our hearings or our report, and section 194K might apply, we asked for their consent.

Similar provisions to section 194K apply in other Australian jurisdictions and aim to achieve the important purpose of providing victim-survivors with the ability to share their experiences and control whether they are identified. As our Commission of Inquiry worked through applying section 194K, we identified a range of challenges. These included limitations on our ability to conduct hearings and include content in this report in circumstances where such limitations were not necessary to achieve the purpose of the provision (including empowering victim-survivors with the choice to be identified and how they can share their experiences).

First, a range of terms used in section 194K are not defined and are, therefore, uncertain. Section 194K does not spell out what constitutes 'proceedings in any court' and continues to apply regardless of whether the proceedings have been discontinued, finally determined or otherwise disposed of. Section 194K applies to any witness or intended witness in the proceedings. These terms are also not defined. It is not always readily apparent who is, or was, a witness or intended witness in any proceeding, and there can be practical difficulties in identifying all people for whom section 194K might apply. For example, James Griffin was charged with sexual offences against young people, but following his death by suicide, these proceedings were never finally determined. Relevantly, however, section 194K continues to apply in relation to those proceedings and anyone who was an intended witness in them.

Second, there is no way for a witness or intended witness to be identified (without a court order), even in circumstances where the relevant victim-survivor has consented to being identified in line with section 194K and might wish for the relevant witness to also be identified. This could lead to the strange outcome that a victim-survivor could be identified but an immediate family member who gave (or might have given) evidence in the proceedings (and who might also wish to be identified) or a professional witness, such as a police officer, could not be identified. It would also seem possible

to identify professional witnesses without necessarily identifying a victim-survivor or other witnesses, so would not be inconsistent with the purpose of the provision, but this would also not be permitted without a court order.

Third, section 194K specifies that only a victim-survivor aged 18 years or older can provide consent. Unlike other Australian jurisdictions, there is no way younger victim-survivors with appropriate capacity can give consent.[19]

Finally, although an application can be made to the Supreme Court for an order to allow identifying information to be published, this process risks being expensive, time-consuming and potentially traumatic for multiple parties. In circumstances where the relevant inquiry is directly engaging with the victim-survivor and any relevant witnesses, and the purposes of the provision are being facilitated, it appears to us that it would be better to avoid applying for such an order.

Two solutions to these practical challenges could be considered. First, section 194K could be redrafted to address the issues we have identified above, taking into account the more precise drafting in other Australian jurisdictions. Second, section 194K should be disapplied by regulations relating to any relevant commission of inquiry.

Our Commission of Inquiry complied with section 194K. We adopted a cautious approach and did not identify anyone if there was a risk that section 194K might apply and it was not possible to seek their consent to identification under section 194K.

We liaised with the Director of Public Prosecutions to consider any issues with section 194K applying to our work, as well as to try to avoid, in keeping with the order establishing our Commission of Inquiry, prejudicing any current or future criminal proceedings. We are grateful to the Director and his office for their assistance with these matters.

4 Flexibility with powers and privileges

In October 2009, the Australian Law Reform Commission ('ALRC') conducted a review of the *Royal Commissions Act 1902 (Cth)* and presented its findings in its *Making Inquiries: A New Statutory Framework report.*[20] Although the ALRC's review focused on the Commonwealth Act, it led to legislative reform in other Australian jurisdictions.[21] The review is relevant to reforms to the Commissions of Inquiry Act, including because the Justice Miscellaneous (Commissions of Inquiry) Act was said to implement the work undertaken by the Law Reform Institute and the ALRC.[22] Relevantly, the Justice Miscellaneous (Commissions of Inquiry) Act did not implement all the recommendations of either.

One important recommendation of the ALRC was to establish two tiers of public inquiry—namely, royal commissions and official inquiries—within a single statute.[23]

It was suggested this would 'enhance clarity, transparency and accountability, and preserve, as far as possible, the rights of individuals'.[24]

As the ALRC noted in its report, a royal commission is the highest form of inquiry, established to look into matters of substantial public importance, whereas an official inquiry looks into other matters of public importance.[25]

The ALRC noted key differences between these two tiers:

- A royal commission has a wide range of coercive powers of entry and search and seizure, whereas an official inquiry has fewer powers.
- A royal commission overrides legal professional privilege and the privilege against self-incrimination, but these continue to apply in an official inquiry.[26]

We agree that the purpose and nature of each inquiry is different and the powers and privileges that apply to each inquiry might also need to differ, so each inquiry can appropriately conduct its work while also appropriately balancing the rights of those involved with, or potentially affected by, its processes.[27]

In New South Wales, Victoria and the Australian Capital Territory, relevant legislation provides for these different tiers of inquiry.[28] For example, the *Inquiries Act 2014* (Vic) provides for establishing a royal commission, a board of inquiry or a formal review, with each having different powers. A royal commission overrides legal professional privilege and the privilege against self-incrimination, but a board of inquiry does not.[29] A royal commission and a board of inquiry also generally override statutory secrecy provisions in other legislation.[30] A formal review preserves legal professional privilege, the privilege against self-incrimination and statutory secrecy provisions. Other Australian jurisdictions also expressly override legal professional privilege and the privilege against self-incrimination in relevant inquiries.[31]

In Tasmania, commissions of inquiry have been far less frequent than in other Australian jurisdictions. Possibly because of this, the Commissions of Inquiry Act does not reflect the ALRC report approach of having different tiers of inquiry with flexibility in the powers and privileges that might apply to those different tiers.

While the Justice Miscellaneous (Commissions of Inquiry) Act amended the Commissions of Inquiry Act to empower a commission of inquiry to decide if a claim of privilege is valid, it does not expressly override legal professional privilege (although it does override the privilege against self-incrimination).[32]

Our Commission of Inquiry worked with the Tasmanian Government to manage State claims of privilege and was grateful for the approach adopted by the Tasmanian Government of seeking to confidentially share such material with us and, in some cases, waive privilege where it was possible to do so. Otherwise, we respected the State's claims for privilege. Nonetheless, it would be appropriate to consider whether

the Commissions of Inquiry Act should be amended to create greater flexibility in the powers and privileges that apply to future inquiries, including abolishing legal professional privilege in relevant inquiries.

5 Other opportunities for reform

As noted, the Commissions of Inquiry Act was amended in 2021 to empower a commission of inquiry to conduct its work and obtain information in any way it considers appropriate.[33] As reflected in this report, our Commission of Inquiry informed itself in several ways, including through public hearings.

The Commissions of Inquiry Act was originally enacted when public hearings were a—possibly *the*—primary vehicle by which evidence was obtained. Part 3 [Conduct of Inquiries], Division 1 [General powers and procedures] reflects this historical focus on public hearings. While amendments to the Commission of Inquiry Act make it clear that commissions of inquiry can get information in other ways, the Act still has various terms including 'information', 'evidence', 'documents' and 'thing'. None of these terms are defined.

In conducting our Inquiry and considering the relevant protections and offences that apply under the Commissions of Inquiry Act, we approached these terms broadly to ensure all who provided information, gave evidence or produced a document or thing—whether at a public hearing, during a session with a Commissioner, in a submission or as part of a consultation—were afforded these protections and rights.

More generally, however, the Act using different terms raises the question of whether any legal difference between them is intended. This requires careful consideration of each use of the different terms and creates the possibility of different interpretations and, therefore, greater legal complexity. Given a commission of inquiry can obtain information in any way it considers appropriate, we do not consider using different terms is necessary. The legislation could be simplified by using the same terminology consistently.

A commission of inquiry also has powers to control its proceedings, determine whether its hearings are open to the public, and prohibit or restrict the public reporting of a hearing or the publishing of any evidence it takes or receives.[34] A few comments might be made about these provisions. First, by their language, they reflect the historical focus of the Commissions of Inquiries Act on hearings, as opposed to empowering a commission of inquiry to make orders (including prohibitions or restrictions) relating to any information that it might receive. Second, before a commission of inquiry decides to close its hearings, or to make a prohibition or restricted publication order, it must announce that intention or make such an order at a hearing that is open to the public.[35]

While our Commission of Inquiry was able to close hearings and to make orders to prohibit or restrict the publication of evidence as part of our main hearings, such processes could be disruptive and inefficient. In the context of contemporary inquiry practices, we consider there may be more efficient ways of making such decisions and orders public without needing to do so during public hearings. For example, it might be possible to require such notices to be published at any relevant commission of inquiry office or hearing venue, or on the commission of inquiry's website, a reasonable period before they take effect.[36]

6 Conclusion

Our experience in conducting our Commission of Inquiry highlighted several ways in which the Commissions of Inquiry Act should be improved to enable future inquiries to achieve their objectives effectively, efficiently and in a way that is fit for purpose. We see opportunities for holistic reform of the Commissions of Inquiry Act rather than piecemeal amendments or amendments that react to circumstances surrounding establishing any given commission of inquiry. We hope our experiences and reflections might usefully inform any such reform for the benefit of future inquiries.

We encourage the Tasmanian Government to actively pursue the following potential framework for legislative reform:

1. Amend the *Commissions of Inquiry Act 1995* to:
    a. establish greater flexibility in the powers and privileges applying to different inquiries, including expressly abrogating legal professional privilege in relevant inquiries
    b. repeal the definitions of 'adverse finding' and 'misconduct' (section 3) and sections 18, 19(2A) and (2B)
    c. use consistent terminology and achieve drafting coherence across the various ways in which a commission of inquiry might obtain, manage and protect those who provide information
    d. provide for more practical ways in which to make decisions about closing hearings and making prohibition or restricted publication orders.
2. Amend section 194K of the *Evidence Act 2001*, considering equivalent provisions in other Australian jurisdictions and the practical challenges identified in this report.

Notes

1 *Commission of Inquiry into the Death of Joseph Gilewicz* (Report, 2000).

2 Tasmania Law Reform Institute, *Report on the Commissions of Inquiry Act 1995* (Final Report No. 3, August 2003) 7.

3 *Commission of Inquiry into the Death of Joseph Gilewicz* (Report, 2000) vol 3, Annexure 17, 3–7.

4 Tasmania Law Reform Institute, Report on the *Commissions of Inquiry Act 1995* (Final Report No. 3, August 2003).

5 *Commissions of Inquiry Amendment Act 2013*.

6 Tasmania, *Parliamentary Debates*, House of Assembly, 18 March 2021, 48 (Elise Archer, Minister for Justice).

7 *Commissions of Inquiry Act 1995* s 7A(2).

8 Order of the Governor of Tasmania made under the *Commissions of Inquiry Act 1995*, 15 March 2021 (Refer to Appendix A).

9 Tasmania Law Reform Institute, *Report on the Commissions of Inquiry Act 1995* (Final Report No. 3, August 2003) 7.

10 Refer to, for example, *Royal Commission into the Management of Police Informants* (Final Report, November 2020) vol 4, ch 16.

11 *Commissions of Inquiry Act 1995* s 5(3)(a).

12 *Commissions of Inquiry Act 1995* s 7A(2).

13 *Commissions of Inquiry Act 1995* s 5(3)(b)(i), noting this is also repeated in s 19(2B). Refer also to *Royal Commissions Act 1991* (ACT) s 23(a); *Inquiries Act 2014* (Vic) s 12(a).

14 *Commissions of Inquiry Act 1995* s 19(2A).

15 *Commissions of Inquiry Act 1995* s 5(3)(b)(i), noting this is also repeated in s 19(2B). Refer also to *Royal Commissions Act 1991* (ACT) s 23(a); *Inquiries Act 2014 (Vic)* s 12(a).

16 *National Redress Scheme for Institutional Child Sexual Abuse Act 2018* (Cth) pt 4.3.

17 *Evidence Amendment Act 2020; Evidence Act 2001* s 194K(1).

18 *Evidence Act 2001* s 194K(2).

19 Refer to *Evidence (Miscellaneous Provisions) Act 1991* (ACT) s 74(2); *Crimes Act 1900* (NSW) s 578A(4)(b); *Children (Criminal Proceedings) Act 1987* (NSW) s 15D(b); *Criminal Law (Sexual Offences) Act 1978* (Qld) s 10(2); *Evidence Act 1929* (SA) s 71A(4); *Judicial Proceedings Reports Act 1958* (Vic) s 4(1BB); *Evidence Act 1906* (WA) s 36C(6). In the Northern Territory, there is an exception provided there are no pending court proceedings: *Sexual Offences (Evidence and Procedure) Act 1983* (NT) s 6(2)(b).

20 Australian Law Reform Commission, *Making Inquiries: A New Statutory Framework* (Report No 111, October 2009).

21 Refer to, for example, *Inquiries Act 2014* (Vic).

22 Tasmania, *Parliamentary Debates*, House of Assembly, 18 March 2021, 48 (Elise Archer, Minister for Justice).

23 Australian Law Reform Commission, *Making Inquiries: A New Statutory Framework* (Report No 111, October 2009) 108 (Recommendation 5-1).

24 Australian Law Reform Commission, *Making Inquiries: A New Statutory Framework* (Report No 111, October 2009) 34–35.

25 Australian Law Reform Commission, *Making Inquiries: A New Statutory Framework* (Report No. 111, October 2009) 31.

26 Refer to, for example, *Inquiries Act 2014* (Vic) div 6, ss 32, 33.

27 Australian Law Reform Commission, *Making Inquiries: A New Statutory Framework* (Report No. 111, October 2009) 31.

28 *Royal Commissions Act 1991* (ACT); *Inquiries Act 1991* (ACT); *Royal Commissions Act 1923* (NSW); *Special Commissions of Inquiry Act 1983* (NSW); *Inquiries Act 2014* (Vic).

29 *Inquiries Act 2014* (Vic) ss 32–33.

30 *Inquiries Act 2014* (Vic) ss 34, 74.

31 *Royal Commissions Act 1902* (Cth) ss 6A, 6AA; *Royal Commissions Act 1991* (ACT) s 24; *Inquiries Act 1991* (ACT) s 19; *Royal Commissions Act 1923* (NSW) s 17(1); *Special Commissions of Inquiry Act 1983* (NSW) s 23(1); *Commissions of Inquiry Act 1950* (Qld) s 14(1A); *Inquiries Act 2014* (Vic) ss 32(1), 33(1).

32 *Commissions of Inquiry Act 1995* s 23A and s 26.

33 *Commissions of Inquiry Act 1995* ss 5(3)(a)(i), (ii).

34 *Commissions of Inquiry Act 1995* ss 12–14.

35 *Commissions of Inquiry Act 1995* ss 13(3), 14(2).

36 Refer to, for example, *Inquiries Act 2014* (Vic) s 24(2).

Appendices

Appendix A: Order establishing the Commission of Inquiry

Order Under the

Commissions of Inquiry Act 1995

WHEREAS all children deserve a safe and happy childhood.

AND Tasmania recognises that Australia has undertaken international obligations to take all appropriate legislative, administrative, social and educational measures to protect children from sexual abuse and other forms of abuse, including measures for the prevention, identification, reporting, referral, investigation, treatment and follow up of incidents of child abuse.

AND all forms of child sexual abuse are a gross violation of a child's rights to this protection and a crime under Tasmanian law and may be accompanied by other unlawful or improper treatment of children, including physical assault, exploitation, deprivation and neglect.

AND child sexual abuse and other related unlawful or improper treatment of children have a long-term cost to individuals, the economy and society.

AND government institutions, including child-care, educational, and other non-government institutions, provide important services and support for children and their families that are beneficial to children's development.

AND it is important that claims of systemic failures or responses by government and non-government institutions in relation to allegations and incidents of child sexual abuse are explored, and that best practice is identified so that it may be followed in the future both to protect against the occurrence of child sexual abuse and to respond appropriately when any allegations and incidents of child sexual abuse occur, including holding perpetrators to account and providing justice to victims.

AND it is important that those affected by child sexual abuse can share their experiences to assist with healing and to inform the development of strategies and reforms in relation to systemic failures by government institutions in relation to child sexual abuse and related matters.

AND noting that the Royal Commission into Institutional Responses to Child Sexual Abuse did not specifically examine, make findings or recommendations about Tasmanian Government institutions.

AND noting that the findings and recommendations of the Royal Commission into Institutional Responses to Child Sexual Abuse substantially addressed issues relating to matters outside government institutional contexts.

AND as the Tasmanian Government expected from the findings and recommendations made by the Royal Commission into Institutional Responses to Child Sexual Abuse the Tasmanian Government continues to receive reports of child sexual abuse in government institutions.

AND noting that, it is also important to continuously improve the response to all forms of child sexual abuse in all contexts.

AND the Tasmanian Government has expressed its support for, and undertaken to cooperate with, an inquiry into its responses to child sexual abuse and related matters.

I, the Governor in and over the State of Tasmania and its Dependencies in the Commonwealth of Australia, acting with the Advice of the Executive Council, being satisfied that it is in the public interest and expedient to do so, by this my order made under Section 4 of the *Commissions of Inquiry Act 1995* –

(a) Direct that an Inquiry be made into the Tasmanian Government's Responses to Child Sexual Abuse in Institutional Settings.

(b) Establish a Commission to conduct and report, with such recommendations as it may consider appropriate, on Inquiry.

(c) Appoint

The Honourable Marcia Neave AO

Professor Leah Bromfield

The Honourable Robert Benjamin AM

as members of the Commission.

(d) Appoint the Honourable Marcia Neave AO as President of the Commission.

AND I require and authorise you, to inquire into the Tasmanian Government's responses to allegations and incidents of child sexual abuse in institutional contexts, and in particular, without limiting the scope of your inquiry, the following matters:

(i) what the Tasmanian Government should do to better protect children against child sexual abuse in institutional contexts in the future;

(ii) what the Tasmanian Government should do to achieve best practice in the reporting of, and responding to reports or information about, allegations, incidents or risks of child sexual abuse in institutional contexts;

(iii) what the Tasmanian Government should do to eliminate or reduce impediments that currently exist for responding appropriately to child sexual abuse in institutional contexts, including addressing failures in, and impediments to, reporting, investigation and responding to allegations and incidents of abuse;

(iv) what the Tasmanian Government should do to address, or alleviate the impact of, past and future child sexual abuse in institutional contexts, including, in particular, in ensuring justice for victims through, processes for referral for investigation and prosecution and support services.

AND I direct you to make any recommendations arising out of your inquiry that you consider appropriate, including recommendations about any policy, legislative, administrative or structural reforms.

AND I direct you, for the purposes of your inquiry and recommendations, to have regard to the following matters:

(i) the experience of people directly or indirectly affected by child sexual abuse in institutional contexts, and the provision of opportunities for them to share their experiences in appropriate ways while recognising that many of them will be severely traumatised or will have special support needs;

(ii) the adequacy and appropriateness of the responses by the Tasmanian Government, and its officials, to reports and information about allegations, incidents or risks of child sexual abuse in institutional contexts, including, without limiting the generality of your inquiry:

i. the adequacy and appropriateness of the responses by the Department of Education to allegations of child sexual abuse in Tasmanian Government Schools;

ii. the adequacy and appropriateness of the responses of the Tasmanian Health Service and the Department of Health to allegations of child sexual abuse, particularly in the matter of James Geoffrey Griffin (deceased 18 October 2019);

iii. the adequacy and appropriateness of the responses of the Department of Communities Tasmania to allegations of child sexual abuse at Ashley Youth Detention Centre;

(iii) the need to focus your inquiry and recommendations on systemic issues, recognising nevertheless that you may be informed by individual cases and may need to make referrals to appropriate authorities in individual cases;

(iv) changes to laws, policies, practices and systems that have improved over time the ability of government institutions to better protect against and respond to child sexual abuse in institutional contexts.

AND I further declare that you are not required by this Order to inquire, or to continue to inquire, into a particular matter to the extent that the matter has been sufficiently and appropriately dealt with by the Royal Commission into Institutional Responses to Child Sexual Abuse or another inquiry or investigation or criminal or civil proceeding.

AND, without limiting the scope of your inquiry or the scope of any recommendations arising out of your inquiry that you consider appropriate, I direct you, for the purposes of your inquiry and recommendations, to consider the following matters, and I authorise you to take (or refrain from taking) any action that you consider appropriate arising out of your consideration:

(i) the need to establish mechanisms to facilitate the timely communication of information, or the furnishing of evidence, documents or things, in accordance with section 34A of the *Commissions of Inquiry Act 1995* or any other relevant law, including, for example, for the purpose of enabling the timely investigation and prosecution of offences;

(ii) the need to establish investigation units to support your inquiry;

(iii) the need to ensure that evidence that may be received by you that identifies particular individuals as having been involved in child sexual abuse is dealt with in a way that does not prejudice current or future criminal or civil proceedings or other contemporaneous inquiries;

(iv) the need to establish appropriate arrangements in relation to current and previous inquiries, in Australia and elsewhere, for evidence and information to be shared with you in ways consistent with relevant obligations so that the work of those inquiries, including, with any necessary consents, the testimony of witnesses, can be taken into account by you in a way that avoids unnecessary trauma to witnesses;

(v) the need to ensure that government and non-government institutions and other parties are given a sufficient opportunity to respond to requests and requirements for information, documents and things, including, for example, having regard to any need to obtain archival material.

AND I declare that in this Order:

child means a child within the meaning of the *Convention on the Rights of the Child* of 20 November 1989.

child sexual abuse means

i. any act which exposes a child to, or involves a child in, sexual processes beyond their understanding or contrary to accepted community standards. Sexual abusive behaviours can include the fondling of genitals, masturbation, oral sex, vaginal or anal penetration by a penis, finger or any other object, fondling of breasts, voyeurism, and exhibitionism and exposing a child to or involving the child in pornography. It includes child grooming, which refers to actions deliberately undertaken with the aim of befriending and establishing an emotional connection with a child, to lower the child's inhibitions in preparation for sexual activity with the child; and

ii. any related matters.

Department of Communities Tasmania means the Government department referred to in Part 1 of Schedule 1 of the *State Service Act 2000* as the Department of Communities Tasmania, including its predecessors.

Department of Education means the Government department referred to in Part 1 of Schedule 1 of the *State Service Act 2000* as the Department of Education, including its predecessors.

Department of Health means the Government department referred to in Part 1 of Schedule 1 of the *State Service Act 2000* as the Department of Health including its predecessors, and includes Ambulance Tasmania within the meaning of the *Ambulance Service Act 1982* and all other publicly funded health services other than health services provided by the Tasmanian Health Service under the authority of the *Tasmanian Health Service Act 2018*.

government institution means any agency or statutory authority of the Crown in right of Tasmania, or local government entity.

non-government institution means any non-government institution that undertakes, or has undertaken, activities on behalf of the Tasmanian Government or is funded by the Tasmanian Government to provide services for children.

institutional context: child sexual abuse happens in an institutional context if, for example:

(i) it happens on premises of a government or non-government institution, where activities of the institution take place, or in connection with the activities of the an institution; or

(ii) it is engaged in by an official of a government or non-government institution in circumstances (including circumstances involving settings not directly controlled by the institution) where you consider that the institution has, or its activities have, created, facilitated, increased, concealed or in any way contributed to, (whether by act or omission) the risk of child sexual abuse or the circumstances or conditions giving rise to that risk; or

(iii) it happens in any other circumstances where you consider that a government or non-government institution is, or should be treated as being, responsible for adults having contact with children.

law means a law of the Commonwealth or of a State or Territory.

official means:

(i) any member, officer, employee, associate, contractor or volunteer (however described) of a government or non-government institution; and

(ii) any other person who you consider is, or should be treated as if the person were, an official of a government or non-government institution.

related matters means

(i) any unlawful or improper treatment of children that is, either generally or in any particular instance, connected or associated with child sexual abuse;

(ii) assisting a person to avoid detection for child sexual abuse or any other unlawful or improper treatment within the meaning of paragraph (i) of this definition.

statutory authority means a body or authority, whether incorporated or not, which is established or constituted by or under an Act or under the royal prerogative, being a body or authority which, or of which the governing authority, wholly or partly comprises a person or persons appointed by the Governor, a Minister or another statutory authority and includes the governing authority of a statutory authority.

Tasmanian Government means the executive government of Tasmania, and includes its agencies and statutory authorities.

Tasmanian Health Service means:

(a) the Tasmanian Health Service within the meaning of the *Tasmanian Health Service Act 2018*, and includes any subsidiary of the Tasmanian Health Service and all its predecessors;

(b) a Health Organisation under the *Tasmanian Health Organisations Act 2011*.

AND I:

(a) require you to begin your inquiry as soon as practicable; and

(b) require you to make your inquiry as expeditiously as possible; and

(c) require you to report to appropriate authorities where you have identified a risk or potential risk to the welfare of a child or children generally; and

(d) require you to submit to me:

(i) as soon as possible, and in any event not later than 31 August 2022, your final report of the results of your inquiry and your recommendations; and

(ii) authorise you to submit to me any recommendations or interim reports that you consider appropriate.

Dated 15 MAR 2021

Governor

By Her Excellency's Command

Elise Archer MP

Attorney-General

ENCLOSURE REFFERRED TO IN EXECUTIVE COUNCIL
MINUTE NO. 6 DATED 07 FEB 2022
CLERK EXECUTIVE COUNCIL

Order Under the

Commissions of Inquiry Act 1995

TO

The Honourable Marcia Neave AO
Professor Leah Bromfield
The Honourable Robert Benjamin AM

GREETING

WHEREAS I, the Governor in and over the State of Tasmania and its Dependencies in the Commonwealth of Australia, acting with the advice of the Executive Council by order made 15 March 2021 ("the order") established a Commission of Inquiry under the Section 4 of the *Commissions of Inquiry Act 1995* and appointed you as a Commission of Inquiry.

AND it is desired to amend the order

NOW THEREFORE I, acting with the advice of the Executive Council, by this further order made under Section 4 of the *Commissions of the Inquiry Act 1995* and Section 22 of the *Acts Interpretation Act 1931*.

AMEND the order

(a) by omitting from paragraph (d)(i) "31 August 2022" and substituting "1 May 2023".

Dated 07 FEB 2022

Governor

By Her Excellency's Command

Hon Elise Archer MP
Attorney-General

Order Under the

Commissions of Inquiry Act 1995

TO

The Honourable Marcia Neave AO
Professor Leah Bromfield
The Honourable Robert Benjamin AM

GREETING

WHEREAS, the Governor in and over the State of Tasmania and its Dependencies in the Commonwealth of Australia, acting with the advice of the Executive Council by order made 15 March 2021 ("the order") established a Commission of Inquiry under the Section 4 of the *Commissions of Inquiry Act 1995* and appointed you as a Commission of Inquiry.

AND it is desired to amend the order

NOW THEREFORE I, acting with the advice of the Executive Council, by this further order made under Section 4 of the *Commissions of the Inquiry Act 1995* and Section 22 of the *Acts Interpretation Act 1931.*

AMEND the order

(a) by omitting from paragraph (d)(i) "1 May 2023" and substituting "31 August 2023".

Dated 26 APR 2023

Governor

By Her Excellency's Command

Hon Elise Archer MP
Attorney-General

Appendix B: Terms of reference

TERMS OF REFERENCE

The Commission is to inquire into the Tasmanian Government's responses to allegations and incidents of child sexual abuse in institutional contexts, and in particular, without limiting the scope of its inquiry, what the Tasmanian Government should do to:

I. better protect children against child sexual abuse in institutional contexts in the future
II. achieve best practice in the reporting of, and responding to reports or information about, allegations, incidents or risks of child sexual abuse in institutional contexts
III. eliminate or reduce impediments that currently exist for responding appropriately to child sexual abuse in institutional contexts, including addressing failures in, and impediments to, reporting, investigation and responding to allegations and incidents of abuse, and
IV. address, or alleviate the impact of, past and future child sexual abuse in institutional contexts, including, in particular, in ensuring justice for victims through, processes for referral for investigation and prosecution and support services.

For the purposes of its inquiry and recommendations, the Commission is to have regard to:

I. the experience of people directly or indirectly affected by child sexual abuse in institutional contexts, and the provision of opportunities for them to share their experiences in appropriate ways while recognising that many of them will be severely traumatised or will have special support needs
II. the adequacy and appropriateness of the responses by the Tasmanian Government, and its officials, to reports and information about allegations, incidents or risks of child sexual abuse in institutional contexts, including, without limiting the generality of its inquiry, the adequacy and appropriateness of:
    i. the responses by the Department of Education to allegations of child sexual abuse in Tasmanian Government schools
    ii. the responses of the Tasmanian Health Service and the Department of Health to allegations of child sexual abuse, particularly in the matter of James Geoffrey Griffin (deceased 18 October 2019)
    iii. the responses of the Department of Communities Tasmania to allegations of child sexual abuse at Ashley Youth Detention Centre
III. the need to focus its inquiry and recommendations on systemic issues, recognising nevertheless that it may be informed by individual cases and may need to make referrals to appropriate authorities in individual cases, and
IV. changes to laws, policies, practices and systems that have improved over time the ability of government institutions to better protect against and respond to child sexual abuse in institutional contexts.

The Commission is directed to make any recommendations arising out of its inquiry that it considers appropriate, including recommendations about any policy, legislative, administrative or structural reforms.

The Commission is required to submit its report by no later than 1 May 2023.

Appendix C: Commission of Inquiry staff list

Commissioners

The Honourable Marcia Neave AO

Professor Leah Bromfield

The Honourable Robert Benjamin AM SC

Commission of Inquiry staff

Sarah Burne

Peta Carlyon

Sarah Darcey

Janet Dawson

Allan de Weys

Rachael Garrett

Anita George

Stephanie Glade-Wright

Dr Zoë Gill

Sarah Henderson

Tilda Hum

Anna Kay

Claire Leyden-Duval

Jill Murphy

Bruce Newey

Dana Rechtman

Cameron Rodger

Joanna Rolfe

Clair Shepherd

Andrew Smart

Bradley Wagg

Counsel Assisting

Elizabeth Bennett SC

Rachel Ellyard

Maree Norton

Alexandra Darcey

Georgina Rhodes

Legal Team

Suchira Chauhan

Betty Choi

Natalie Cooper

James D'Alessandro

Michelle Dean

Laura Deschamps Ferrari

Meagan Dujela

Amanda Dunn

Caitlyn Georgeson

Jared Heath

Bronte Howlett

Jesse Jin

Jessica Kiff

Harry Kim

Marin Kraljevic

Nicholas Laurie

Jarrod Mitchell

Philippa Munton

Mairead O'Connor

Emanuela Radulescu

Heidi Roberts

Fiona Ryan

Emily Steiner

Elena Stojcevski

Elly Sturgeon

Sophie Uhlhorn

Deborah White

Shana Webster

Ying Wong

Contractors, individuals and organisations providing assistance to our Commission of Inquiry

Donna Abela

Bruce Alston

Travis Atkins

Rowena Austin

Kathryn Bloom

Sarah Campbell

David Cocker

Matt Davies

Dr Simone Deegan

Rebecca Grant

Sam Horsfield

Fiona Hughes

Andrew Macrae

Tracey Matters

Emeritus Professor Morag McArthur

Associate Professor Timothy Moore

Sandra Muller

Keren Murray

Rebecca Nguyen

Renata Pasieczny

Mary Polis

Natalie Price

Professor Jeremy Prichard

Matthew Sidebotham

Caroline Spotswood

Catherine Tobin

Kate Turner

Olivia Wells

Katya Zissermann

Australian Centre for Child Protection

Converge International

Department of Justice

icourts

MSS Security

Riawunna Centre for Aboriginal Education

Sexual Assault Support Service

Tasmanian Civil and Administrative Tribunal

Tasmania Legal Aid

Tasmania Prison Service

WOO Agency

Appendix D: Tasmanian Government's *Keeping Children Safer* Interim Response to the Commission of Inquiry (actions)

1. Announce and implement Keeping Children Safer Premier's Priority.
2. Improve the Right to Information process, including providing training across the State Service to ensure more consistent responses.
3. Explore options to expand the scope of regulated activities under the Registration to Work with Vulnerable People legislation to ensure Tasmania's worker screening scheme for people who work or volunteer with vulnerable people.
4. Make arrangements in Heads of Agency Performance Agreements to clarify expectations and improve accountability, making sure child safety and wellbeing is embedded in organisational leadership, governance and culture.
5. Investigate rolling out trauma-informed training across the State Service starting with those in leadership positions including Heads of Agency.
6. Encourage and support staff to raise child safety concerns.
7. Review the structure and processes across civil litigation to ensure our approach is trauma informed and that all our legal practitioners recognise evidence-based understandings of the nature and impact of child sexual abuse.
8. Review and rewrite Employment Direction 5.
9. Fast track response to the remaining recommendations of the Royal Commission into Institutional Responses to Child Sexual Abuse.
10. Develop a Child and Youth Safe Organisations Framework including comprehensive legislated standards and the establishment of a Reportable Conduct Scheme.
11. Appoint a Safeguarding Officer in every Government school.
12. Require mandatory professional development for all Department for Education, Children and Young People (DECYP) staff.
13. Employ an additional four full time equivalent senior support staff (two psychologists and two social workers) to increase support for children and young people affected by harmful sexual behaviours or child sexual abuse.
14. Employ additional professional support staff, including eight full time equivalent psychologists and eight full time equivalent social workers to further support student wellbeing and safety.
15. Establish an Out of Home Care Accreditation Framework and an independent statutory body for accrediting and monitoring Out of Home Care Services, and develop a Carers' Register.

16. Draft legislation to create a new crime of 'failing to protect a child or young person' for people in authority within an organisation who fail to safeguard a child from substantial risk of sexual abuse by an adult associated with that organisation.
17. Amend the Criminal Code to introduce a new crime of 'penetrative sexual abuse of a child [or young person] by a person in authority', including a presumption that children under the age of 18 cannot consent to sexual intercourse when a person is in a position of authority over them.
18. Consider legislative solutions and other initiatives that will make it easier to share information about risks to children, including looking at whether issues of custom, practice and culture are creating unnecessary barriers.
19. Develop clear information regarding the circumstances where Agencies can and should share information about the status of investigations and/or investigative material.
20. Make trauma informed practice professional learning mandatory for investigators and other state servants involved in ED5 investigation processes.
21. Create a shared capability for the investigation of serious Code of Conduct breaches. Ensure the pool has a gender balance.
22. Establish a central register of employees who have been terminated as a result of an ED5 investigation.
23. Draft a formal apology on behalf of the parliament.
24. Provide information to all state servants on special two-day Commission of Inquiry leave.
25. Establish a Whole-of-Government Commission of Inquiry Response Unit.
26. Undertake a Child Safe Governance Review of the Launceston General Hospital and its Human Resources department informed by an advisory panel consisting of independent experts in child trauma, governance and hospital administration and human resources.
27. Establish a central complaints office to handle all future complaints about misconduct—including claims of child sexual abuse.
28. Establish two pilot multidisciplinary centres, one in the north and one in the south. Youth Justice Reform.
29. Develop a website to publicly report progress on implementation of the interim response actions and expected delivery dates.

Reproduced from: Department of Premier and Cabinet, Tasmanian Government's Interim Response to the Commission of Inquiry (Report, 31 July 2023) <https://www.dpac.tas.gov.au/__data/assets/pdf_file/0022/310576/Commission-of-Inquiry-Interim-Response-Report-as-at-31-July-2023.pdf>.

Appendix E: South Australian Guideline (May 2023)

Managing allegations of sexual misconduct in SA education and care settings guideline

This is a mandated policy under the operational policy framework. Any edits to this policy must follow the process outlined on the creating, updating and deleting operational policies page.

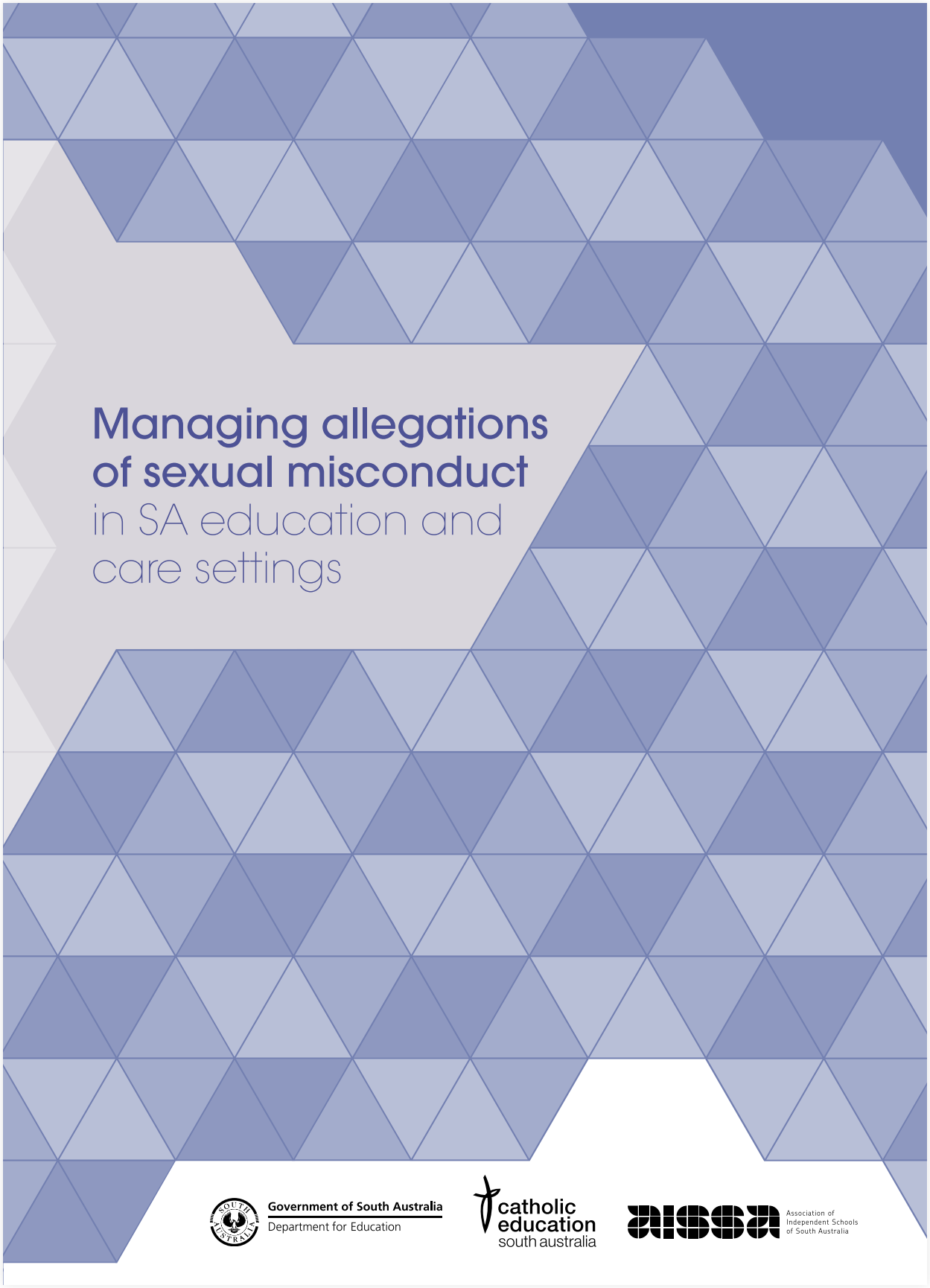
The reference to Section 26 of the Education Act 1972 in section 3.3.7 of this guideline is replaced by Section 114 of the Education and Children's Services Act 2019, as of 1 July 2020.

https://www.legislation.sa.gov.au/LZ/C/A/Education%20and%20Childrens%20Services%20Act%202019.aspx

The Education Regulations 2012 or Children's Services Regulations 2008 become the Education and Children's Services Regulations 2020 as of 1 July 2020.

https://www.legislation.sa.gov.au/LZ/C/R/EDUCATION%20AND%20CHILDRENS%20SERVICES%20REGULATIONS%202020.aspx

Government of South Australia
Department for Education


Managing allegations of sexual misconduct
in SA education and care settings
Government of South Australia
Department for Education
catholic education south australia
aisSA
Association of Independent Schools of South Australia

Acknowledgments

This document is very closely adapted from Chapter 15 of the *Royal Commission 2012–2013 Report of Independent Education Inquiry*. The adaptations give effect to recommendation 39 of the Report that the guideline be applicable to government, Catholic and independent education sectors. Grateful acknowledgment is made of the advice provided by the Hon Bruce Debelle AO QC in his drafting of Chapter 15, specifically his setting out of the application of various laws to the considerations to be made by education and care sites when responding to allegations of sexual misconduct by adults against children or young people.

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FOREWORD

The South Australian government and non-government education sectors have jointly developed all policies of a child protection nature since an agreement established in 2004. The policies and practices developed under that agreement help ensure that staff, children and parents can expect the same standards of child protection practice no matter which sector they access. This document joins that collection of guidelines and affirms that learning about child safety in education and care settings will continue to be shared across the government and non-government sectors.

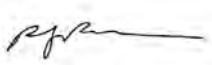
This document is very closely adapted from Chapter 15 of the *Royal Commission 2012–2013 Report of Independent Education Inquiry*. The adaptations give effect to recommendation 39 of the Report that the guideline be applicable to government, Catholic and independent education sectors. Grateful acknowledgment is made of the advice provided by the Hon Bruce Debelle AO QC in his drafting of Chapter 15, specifically his setting out of the application of various laws to the considerations to be made by education and care sites when responding to allegations of sexual misconduct by adults against children or young people.

An important feature of these incidents is that they involve the concerted and coordinated efforts of a number of professionals from different agencies. For this reason, it is unlikely that a site leader will undertake responses to an incident of this kind in isolation from other professionals. Site leaders can expect a high level of support and advice from their relevant sector office.

Education and care settings are meant to be safe environments for everyone who attends them. A range of processes and systems are utilised by the education sectors to prevent unsuitable individuals from working or volunteering in those settings. As leaders of the education sectors, we strongly support the ongoing development of legislative schemes to enable the most thorough assessments of an individual's suitability to work or volunteer with children and young people.

However, the best screening schemes are unlikely to remove all possibility of an adult exploiting his or her role in order to offend against children or young people. Education and care communities can help in limiting this risk by recognising and reporting *all* inappropriate adult behaviour towards children and young people. The introduction that follows strongly reinforces this responsibility and outlines the place of this guideline alongside other child protection responsibilities.

Finally, allegations against adults of sexual misconduct towards children and young people are complex matters. This guideline cannot be assumed to provide the appropriate directions for every case. It does not cover the full range of circumstances that an education or care site will encounter when assessing whether an individual is suitable to work or volunteer with children and young people. Therefore, in any situation of this kind, it may be necessary to seek legal advice. Nevertheless, it is hoped that this guideline will provide general assistance by removing confusion about the matters to be considered and actions that may need to be taken at different stages when allegations of sexual misconduct are made. In doing so, it is hoped that the guidance will help reduce any additional trauma for the affected children, young people, families and staff.



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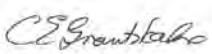

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SECTION 1: Introduction

1.1 A note for site leaders

Managing an allegation of adult sexual misconduct is a highly complex task for a site leader to face. This guideline document is designed to provide site leaders, their parent community and their respective sector offices with improved clarity about the actions to be taken and matters that require considerations at each stage. It is important to remember that the obligation to report and respond to allegations of sexual misconduct applies irrespective of whether the accused person is still working, volunteering or undertaking a role in connection to an individual site. The person may have moved, resigned, taken leave, or may be deceased. The obligation to report and respond remains.

In managing situations of this kind, site leaders can assume that sector office decisions impacting their school or care community will be made consultatively and that their local knowledge and professional judgment will contribute to those decisions. They can also assume that they will be kept informed of new information as it becomes available and of relevant actions undertaken by others. No two cases will be identical so matters such as whether and when to send a letter to parent communities, who signs letters, the content of letters or the facilitation of a parent meeting may differ in every circumstance and will always require consultation. Site leaders of independent schools should expect the same kind of collaboration with those from whom they seek support.

The information in Section 3 and the checklists provided as Appendices 1 and 2 give site leaders the scope and general sequence of actions they and their sector office will need to undertake. At the time parents of a victim are informed that a matter of this kind is being managed, they should also be informed that this guideline will be followed. If and when other parents are informed of the matter, they should also be advised that the guideline is being followed.

1.1.1 Associated responsibilities

This guideline is closely linked with two other intersectoral child protection policies summarised below. The role of these two policy documents in helping prevent inappropriate adult conduct and in contributing to safe environments **cannot be over-emphasised**. Both documents are incorporated in the mandatory staff training used by the three sectors. However, it is assumed that site leaders routinely refer to these documents as part of their site-based professional development programs. Copies of both documents should be held in all education and care sites and can be downloaded from each sector's website.

Protective practices for staff in their interactions with children and young people

The Protective Practices document outlines the professional boundaries within which all staff members are expected to operate in their relationships with children and young people. Meeting the requirements outlined in Protective Practices is critical to helping prevent the circumstances of adult sexual misconduct. The Protective Practices policy requires all staff to act if they observe or are told about adult behaviour that represents a breach of a professional boundary. This point cannot be overstated: 'It is not acceptable to minimise, ignore or delay responding to such information. For the wellbeing of all members of the education or care community, the site leader must be informed as a matter of urgency …' (p 14).

Immediate actions in response to inappropriate behaviour may enable more serious underlying behaviour to be identified, and may prevent sexual misconduct. The more vigilant and transparent an education or care community is in complying with the Protective Practices document the more likely it will be that sexual misconduct can be prevented—through early identification, intervention, and deterrence.

Responding to problem sexual behaviour involving children and young people

This guideline is to be followed in all circumstances where a child or young person is alleged to have engaged in problem sexual behaviour. The responsibilities staff members have in these circumstances are significantly different from those involving allegations of sexual misconduct by adults. They reflect the different rights and needs of children and young people and the different legislation within which staff must operate. The guideline applies to and is available in all sectors.

1.1.2 Differences between the sectors

One significant difference between the three sectors' implementation of this guideline is in the seeking of **legal advice**. In the government and Catholic sectors, seeking legal advice will occur through the respective sector office. An independent school can seek legal advice on its own behalf. Generally, the different responsibility that is carried by the site leader and governing authority of an independent school is identified, wherever appropriate, throughout the guideline and in the definition of 'sector office' in Section 1.3.

1.2 Purpose

This guideline document:

- Informs leaders in education and care settings of the procedures for managing and reporting allegations of sexual misconduct at an education or care site.
- Ensures that parents are informed at the appropriate time of allegations of sexual misconduct by an adult against a child or young person enrolled or previously enrolled, where relevant, at an education or care site.
- Assists parents to understand the process that is followed in managing allegations of sexual misconduct by an adult against a child or young person enrolled or previously enrolled, where relevant, at an education or care site.
- States the respective duties of site leaders and sector offices in managing allegations of sexual misconduct at a site.
- Provides a transparent policy that enables early intervention, effective management and provision of the support required in these complex and serious matters.

1.3 Definitions

'accused person' means a current or past employee of an education or care site or any other adult who has a connection to a site against whom allegations of sexual misconduct have been made

'an adult who has a connection to a site' means and includes current and past employees of the education or care site; current and past volunteers, contractors, professional service providers, other paid education and care participants, governing authority members, and tertiary students and supervisors; and any adult who has engaged with children and young people enrolled at the site

'CARL' means Child Abuse Report Line

'child or young person' means persons up to the age of 18 years and includes young adults with developmental disabilities attending education settings

'governing authority' means a site or service's Governing Council or School Board

'parent' means and includes natural parents, step parents, foster parents, guardians, grandparents and any other relative or other person caring for a child

'relevant date' means the relevant date as defined in section 71A(5) of the *Evidence Act 1929*, provided in Section 2.3.1 below

'sector office' in this document means the policy, legal, case management support and/or direction provided through the:

- central office of the South Australian Department for Education
- central office of Catholic Education South Australia
- Office of the Association of Independent Schools of South Australia

Note: The relationship between sites and their sector offices differs. It may be one of direct governance and accountability or a partnership in which the individual site retains ultimate responsibility with its governing authority.

'site' means a school; preschool; children's centre; a junior primary, primary, secondary or senior secondary school; an Out of School Hours Care service; and the home of a Family Day Care provider

'site leader' means the principal or director and any other person who has ultimate responsibility for the welfare of children and young people on that site

'staff' means all adults who have a duty of care to children and young people at the site and includes volunteers

'victim' means the child or young person against whom an act of sexual misconduct by an adult who has a connection to a site has been alleged

1.4 Scope

The procedures in this guideline apply to allegations of sexual misconduct made against any adult who has a connection with the site where the allegations affect the suitability of that adult to work or volunteer with children and young people.

These procedures apply to allegations of sexual misconduct where any of the following situations exist:

- the allegation is disclosed at or off the site
- the incident is alleged to have occurred at or off the site
- at the time of the alleged incident, the victim was or was not in the direct care of the site.

This guideline applies only to allegations of sexual misconduct by an adult against a child or young person. For incidents involving sexual harm between children and young people, please refer to the document *Responding to problem sexual behaviour in children and young people*, available at each site and located on each sector's website.

1.5 Sexual misconduct

Sexual misconduct may take many forms. It includes, but is not limited to, sexual assaults of all kinds and other forms of unlawful sexual behaviour including such offences as being in possession of child pornography and acts of gross indecency. A sexual assault ranges from indecent assault through a number of offences to rape.

In some cases, a particular behaviour may become unlawful only by virtue of repeated instances.

*Note: This definition is provided for general information. It is not necessary for staff to determine whether an alleged behaviour is sexually motivated. It is simply necessary that staff report **all** inappropriate behaviour as per the Protective Practices guidelines. Those guidelines identify any behaviour of a potentially sexual nature between an adult and a child or young person as a breach of professional conduct. In meeting that reporting obligation, it is then the site leader's task to consult with his or her sector office regarding all allegations so that the appropriate response is made at all times.*

SECTION 2: Legislative framework

2.1 Underlying principles

Teachers and site leaders owe to the children and young people in their care a duty to take reasonable care to protect them from a reasonably foreseeable risk of injury. That duty is not necessarily confined to events on the site or during site hours. In addition to observing sector policy, staff must comply with a number of statutory duties or obligations.

Note: Appendix 8 provides links to relevant legislation.

2.2 Mandatory notification

Section 31 Children and Young People (Safety) Act 2017 (SA) imposes a duty on employees and volunteers in education and care settings to notify CARL if, in the course of their work, they suspect on reasonable grounds that a child or young person is, or may be, at risk. The child or young person will be taken to be at risk if the child or young person has suffered harm or there is likelihood that the child or young person will suffer harm (being harm of a kind against which a child or young person is ordinarily protected). In practical terms, the duty to notify the Department for Child Protection is a duty to notify the Child Abuse Report Line (CARL) on 131 478.

If an allegation is made to staff, or the staff member has a suspicion on reasonable grounds that a child has been or is being abused or neglected, he or she must notify CARL as soon as practicable after he or she forms that suspicion or learns of the allegation. It is an offence to fail to do so.

All staff members in government, Catholic and independent schools are required to undertake training in their child protection responsibilities, both when they are first employed and every three years thereafter. This training is jointly developed by the three education sectors and describes this responsibility in detail.

An outline of the process for documenting mandatory notifications in education and care settings is provided at <https://www.education.sa.gov.au/child-protection>.

2.3 Prohibitions on disclosure of identity

2.3.1 Restrictions on publication of identity

When a person has been, or is about to be, charged with a sexual offence, it is necessary to comply with the legal obligations imposed by section 71A of the *Evidence Act 1929*. Section 71A restricts publication of the identity of the alleged victim and of the alleged offender who, in this guideline document, will be called 'the accused person'.

Where the alleged victim is a child or young person under the age of 18, the name of the alleged victim or anything that might identify the victim can never be published. Therefore, care must be taken to ensure that nothing is said or published that might identify the alleged victim.

The name of the accused person can be published but only after certain events have occurred and if there are no suppression orders in force (see section 2.3.2 "suppression orders"). Those events are identified in section 71A(5) of the Evidence Act. They are called 'the relevant date'. The definition of 'relevant date' in the Evidence Act is as follows:

relevant date means

(a) in relation to a charge of a major indictable offence or a charge of a minor indictable offence for which the accused person has elected to be tried by a superior court—the date on which the accused person is committed for trial or sentence; or

(b) in relation to a charge of any other minor indictable offence or a charge of a summary offence—the date on which a plea of guilty is entered by the accused person or the date on which the accused person is found guilty following trial; or

(c) in any case—the date on which the charge is dismissed or the proceedings lapse by reason of the death of the accused person, for want of prosecution, or for any other reason.

The relevant dates are listed below according to the kind of offence with which the accused person has been charged.

The relevant sector office will be informed by SA Police of the kind of offence with which the accused person has been charged, that is, whether it is a major indictable offence or other kind of offence. This information should be provided to the site leader.

It is lawful to publish the name of the accused person after any of the following relevant dates.

- Major indictable offences
  1. The date on which the accused person is committed for trial or to be sentenced.
  2. The date on which the charge is dismissed or that proceedings lapse by reason of the death of the accused person or for want of prosecution or for any other reason.

  These dates are also applicable to minor indictable offences for which the accused person has elected to be tried in the District Court.

- Minor indictable offences and summary offences
  1. The date on which the accused person pleads guilty.
  2. The date on which the accused person is found guilty following a trial.

3. The date on which the charge is dismissed or that proceedings lapse by reason of the death of the accused person or for want of prosecution or for any other reason.

Appendix 7 to this document gives a brief outline of the steps in a criminal prosecution. That outline will assist in understanding the relevant dates.

2.3.2 Suppression orders

Suppression orders are made by a court pursuant to section 69A of the Evidence Act. A suppression order is an order forbidding publication of whatever is the subject matter of the order. The order will state that it forbids publication of the subject matter of the order. For example, the order might read:

> *The name or anything tending to identify the accused be suppressed from publication in the interests of justice until further order.*

A suppression order is not a statement made by a judge or magistrate that he or she does not intend to name a person or a school in order to protect the victim.

Before sending a letter to parents, the relevant sector office should inquire of the Registrar of the relevant court whether a suppression order exists. If an order exists, the sector office should examine the terms of the order and consider whether the order forbids the kind of letter under consideration. If there is any uncertainty about what is prohibited, legal advice should be sought.

It is still possible to give some information to staff, the governing authority and parents while complying with these restrictions. Section 3 of this guideline provides advice as to how and when that information is to be provided.

2.3.3 Avoiding defamation

When allegations of sexual misconduct have been made, care must be taken to avoid stating anything that might defame the person against whom the allegations have been made. If a site wishes to send a letter before a person has been arrested and charged with an offence, it is desirable to obtain legal advice as to the terms of the letter to ensure that nothing is said that defames that person. If that person has been arrested and charged, it is lawful to state that fact but nothing should be said that would suggest the person is in fact guilty of the alleged misconduct.

SECTION 3: Managing allegations of sexual misconduct

Allegations might be made against a member of the teaching staff, administration or other support staff, employees of a governing authority, or against volunteers at a site. In most cases, the steps to be taken by the site leader will essentially be the same.

It must be emphasised that these are guidelines only. The manner in which a site will learn of allegations will vary. Different circumstances may require a variation of the sequence of these actions. It is not possible to draft guidelines that will address every possible variation of fact. The fundamental steps that should always be observed are to notify immediately:

- SA Police
- Child Abuse Report Line
- parents of the victim, unless a parent is the accused person, and with due regard for the victim's wishes
- the relevant sector office.

3.1 Importance of note taking

Memories fade and recollections of events will be difficult at a later date when site leaders or members of staff are asked to recall events or conversations.

It is essential that site leaders and all other members of staff involved keep a written record of all conversations relating to the allegations. The notes should, if possible, be made in the course of the conversation or immediately after. In addition, site leaders and other members of staff should complete the 'Record of allegation' and 'Record of meeting' forms contained in Appendices 3 and 4. They can be downloaded from the sector's website. These forms should be completed in addition to the site leader's own notes of conversations.

Staff and volunteers should be aware that they may be called to give evidence in court proceedings. Contemporaneous notes will then be very helpful in assisting the recollection of events and conversations. It is also important to be aware that notes may be subpoenaed for court proceedings and, therefore, should be completed in a legible and professional manner.

The notes and forms should be placed in a file marked 'Confidential' and held in a secure cabinet. The only person with access to the cabinet should be the site leader or the site leader's delegate. At a relevant time, the site leader will provide this documentation to the sector office, if required by that office.

3.2 Immediate action

Allegations of sexual misconduct might be made either to the sector office or directly to a member of staff at the site or to the site leader. The allegations may be made by a child or young person, a staff member, a parent, a volunteer or a member of the public. On other occasions, the first knowledge that either the sector office or anyone at the site has of the allegations is when police state that they have arrested a person and charged him or her with a sexual offence.

The following is a list of the steps that should be taken by the site leader when allegations of sexual misconduct have been made. Which step a site leader begins with will vary according to whether the site leader is responding to the allegation 'first hand' or acting on information and instructions from the police or the sector office. Nevertheless, all the steps are important and need to be attended to immediately. The site leader has responsibility to undertake or, if tasks are undertaken by others, to oversee and confirm the execution of all the steps. Some steps can be taken simultaneously and most will be undertaken through consultation with, or by direction from, police and the sector office.

3.2.1 Actions of site leader

Reminder: The steps outlined are not necessarily sequential (see above).

Step 1: Obtain medical assistance for child or young person if required

The site leader should attend immediately to any medical treatment that the victim might require and attend to the victim's emotional needs in all ways appropriate until he or she is in the care of parents.

Step 2: Receive report of allegation

If an allegation of sexual misconduct is made to a member of staff or a volunteer at the site, it should be reported to the site leader immediately. The member of staff or the volunteer to whom the allegation is reported should record the allegations on the form in Appendix 3.

If the allegation involves the site leader, the report should be made to the relevant sector office or, in the case of an independent school, the chairperson of the governing authority.

Step 3: Report to SA Police

Once the site is aware of an allegation of sexual misconduct, the site leader must immediately report the allegations to police on 131 444. If the site leader is the person against whom the allegation is made, it is the sector office (or governing authority of an independent school) that has responsibility to make this report to police.

During this report, the site leader should seek and note SA Police's immediate advice on:

- restricting the staff member's access to children and young people (very important to executing step 7)
- preservation of evidence
- contact with parents of the victim
- police contact number to provide to parents of victim.

This will help inform the strategy discussions that the sector office, the site and police will undertake. Site leaders should expect that police will not normally interview children or young people at a site except as a matter of urgency or immediate necessity. In the ordinary course, children and young people should be interviewed at a place nominated by police that is off-site.

Step 4: Notify the Child Abuse Report Line

The site leader should, as soon as practicable, notify CARL on 131 478 and ensure the report is documented using the mandatory report form used by the relevant education sector and securely stored in the site leader's file.

Step 5: Preservation of evidence (if applicable)

The site leader should immediately take basic steps to secure the place where the alleged offending occurred, if that is on the site, until police arrive. An example is blocking access to the site's network if an allegation regarding child pornography is made, or locking the room in which an incident is alleged to have occurred. Electronic material of any kind **must not be deleted** but must be quarantined as far as practicable for handover to SA Police. The police will properly secure the crime scene on arrival. The site leader should seek advice from police on this issue when making the initial report.

Step 6: Inform the sector office and establish who will be assisting

The site leader should inform the relevant sector office and establish who will be assisting the site (eg a nominated case manager) in its management of the allegation and begin discussions immediately regarding the steps below.

Step 7: Preventing access to children and young people

When it is necessary to prevent the accused person from having any further contact with children or young people at the site, the site leader should take steps to prevent the accused person from attending the site, on directions **from SA Police and the sector office**. The responsibility of SA Police and the relevant education sector to work together in managing this circumstance is outlined in Appendix C of the *Interagency Code of Practice—Investigation of suspected child abuse or neglect*.

In some circumstances, the sector office or SA Police may ask the site leader not to indicate to the accused person that an allegation has been made until SA Police are able to complete their own preparations. The site leader will discuss with the sector office the most appropriate plan to either re-direct the individual from their teaching or care duties or to allocate another adult to the teaching or care situation in order to provide supervision until the end of the day. Each situation will provide different options and challenges for site leaders and their sector office to consider in managing this situation.

Step 8: Inform parents of victim

Unless a parent is the accused person, the site leader should immediately seek the approval of SA Police to inform the parents of the victim of the allegations if the parents are not already aware. This should be done in a sensitive manner, taking into consideration the victim's wishes. Information about counselling services and support for the victim and family should be provided at this time.

When the victim is a child under the Guardianship of the Chief Executive Department for Child Protection, the Chief Executive and his or her delegates are responsible for case management and planning for the safety, care and wellbeing of that child or young person. The Department for Child Protection has the additional responsibility to advise the Guardian for Children and Young People about sexual abuse involving children under the Guardianship of the Chief Executive Department for Child Protection. For these reasons, it is essential that the social worker is immediately informed so the special circumstances of the child or young person can be properly considered and managed.

Step 9: Inform the accused person of his or her immediate work requirements

In consultation with the relevant sector office and SA Police, the site leader should determine which leave/employment/contract options are appropriate and available for the accused person. These will vary across the three sectors but the intent is that the accused person does not attend the site while an investigation proceeds.

Step 10: Complete sector specific reporting requirements

These reporting requirements vary across the three sectors:

- Department for Education: critical incident report through the Incident Response Management System
- Catholic Education SA: critical incident report through the relevant Principal Consultant
- independent schools: school-based procedure.

Step 11: Document all information/ discussions/observations

The template provided in Appendix 3 should be used to document all information, discussions and observations relating to the incident. They should be signed, dated and placed in a confidential, secure site leader's file and provided to the sector office as required.

3.2.2 Actions of sector office

Step 1: Liaise with SA Police

Under the Interagency Code of Practice, SA Police will provide the relevant sector office with the following information:

- the name, date of birth and address of the person who has been charged
- details of the charge and apprehension report
- the condition upon which the accused person has been bailed
- the court bailed to and the date of the first court appearance
- the education or care site involved whether there is a reasonable suspicion that there might be other victims
- whether there are any complicating factors that would affect disclosure to parents
- the contact details of the investigating officer
- whether the offence is a major or minor indictable offence or a summary offence.

Step 2: Create a central file and appoint a manager

The sector office, through its relevant divisions or personnel, will ensure that a central file is established and that a case manager is identified to support the site in its management of the allegation. In an independent school, this will be the responsibility of the school principal.

Step 3: Assist the site in establishing appropriate leave for the accused person

The sector office will assist the site leader to manage these arrangements. It will ensure that the accused person is directed not to attend the site but it will assist the accused person to have personal materials delivered to him or her that have been approved by SA Police as appropriate. In an independent school, this will be the responsibility of the school principal.

Step 4: Check that all immediate responsibilities have been met

The sector office needs to check that the immediate responsibilities of the site have been met; for example:

- contact with parents
- contact with a social worker if the alleged victim is under the Guardianship of the Chief Executive Department for Child Protection
- provision of counselling
- report to the Child Abuse Report Line
- documented notes and secure file established.

In an independent school, this will be the responsibility of the school principal.

Step 5: Alert others as required

This responsibility varies across the three sectors but will include, as appropriate:

- relevant Minister (confirmed in writing)
- relevant Chief Executive/Director
- chairperson of the governing authority
- other education sectors, as per the Intersectoral Information Sharing Protocol
- Education Standards Board in the case of early childhood and care settings
- any other agency/organisation where risks to children's or young people's safety are identified.

Step 6: Alert media unit

The sector office should alert its media unit or advisor as appropriate:

- Department for Education: 8226 7904
- Catholic Education SA: 8210 8147
- Association of Independent Schools of South Australia: 8179 1400.

Step 7: Collate notes

The sector office should ensure that the site leader and other staff have made notes of any relevant events and conversations, using the record templates provided as Appendices 3 and 4, and ensure copies are placed on the sector office's central file.

In an independent school, this will be the responsibility of the school principal.

3.3 Further action

As soon as the sector office has satisfied itself that the steps listed in Section 3.2 'Immediate action' have been carried out, liaison should occur with the site in considering the following:

- the future employment of the accused person
- providing counselling and support
- undertaking a risk assessment
- responsibly giving out appropriate information.

The previous section (Section 2 Legislative Framework) outlines actions that must be taken immediately. The tasks under this 'further action' section should be undertaken as promptly as possible without compromising the consultation, risk assessment and information gathering that is required for those tasks to be undertaken appropriately. It is understood that maintaining an unqualified focus on the protection of children and young people will mean varying lengths of time are taken to complete the required actions. However, the guiding principle for sites and sector offices is that all the steps outlined in Section 3.3 must be maintained as priority actions and shown to be so by the records kept.

3.3.1 Future employment of accused person

Where the accused person is a staff member, the site leader should consult the relevant sector office to ascertain whether the accused person can be suspended from duty pending the outcome of the investigations.

If the accused person is suspended, the site leader or sector office should send that person a formal letter of suspension.

If the accused person is a volunteer, the services of that person should be terminated immediately.

If the accused person is a contractor, legal advice should be obtained whether the contract can be terminated.

If the accused person is an employee of the governing authority, the site leader and the governing authority should seek advice from the sector office on suspending that person.

In the event of the charges being withdrawn or in the event of an acquittal, the sector office should inform the site leader about what is to occur in relation to the future employment of the accused person.

In an independent school, this will be the responsibility of the school principal.

3.3.2 Counselling and support

Appropriate support should be provided as required to:

- the victim and his or her parents
- other children or young people and parents of the school or care community
- staff members
- relatives of the accused person who are employees or enrolled students at the site or in the sector and who identify their needs.

Generally speaking, that support will be in the form of counselling.

Victim and victim's parents

The site leader should meet with the parents of the victim to discuss continuing support for him or her. Details of counselling services with contact numbers should be provided to the victim and his or her parents as part of this first meeting. After the meeting, the site leader should complete a written record and have it signed by the parents. A sample is provided as Appendix 4.

Over the following days, a support and safety plan should be finalised covering all aspects of the victim's and the family's ongoing needs and agreed actions (see Appendix 6). Copies of the plan, and all updated versions, should be provided to the victim and the family. A copy of the plan/s should also be provided to the sector office as required. The verbal offer of counselling to the victim and the family should be followed by a letter re-stating the offer and the specific service options. If these services have been taken up by the victim and the family and recorded as part of the support and safety plan, the letter should simply confirm those agreed arrangements and attach the support and safety plan. The site leader should consult with the sector office on drafting this letter.

The site and the sector office must continue to monitor the wellbeing of the victim and his or her family through regular reviews of the support and safety plan. Particular attention must be given to significant dates where court proceedings are likely to prompt further stress and emotional burden.

Other children or young people and parents of the school or care community

The nature of the support or counselling that may be appropriate for other children or young people and parents in the school or care community will vary depending on the circumstances of each incident. If the risk assessment indicates the appropriateness of informing a wider group of parents then, generally speaking, the same services as outlined above should be offered. This may happen via a letter, face-to-face meeting or small-group meeting, as appropriate. These actions will be undertaken in consultation with SA Police, the sector office and an appropriate provider of such counselling, for example Child and Adolescent Mental Health Services. Copies of letters and records of meetings must be stored with the site leader and provided to the sector office as required.

Staff members

Staff members may be profoundly impacted by sexual misconduct allegations. Consideration must continue to be given to the wellbeing of staff, particularly those who were in some way associated with the accused person (eg co-class teachers, friends, relatives), and to the site leader on whom the additional burden of ultimate responsibility for the safety of the site rests.

Particular care should be taken in explaining the restrictions that may be placed on the accused person to staff who are friends of the accused. Individual staff members may need specific help in knowing how to respond to requests for emotional or other support from the accused person without complicating their own obligations at the site or unwittingly complicating matters for the accused. It is reasonable and important that staff members are able to offer emotional support to others and that accused persons have access to the support of friends. However, staff will need clear guidance on how to respond to particular requests such as acting as a witness. Site leaders should seek sector office support in clarifying the advice they give in these circumstances.

As with any other kind of serious critical incident, the site or sector office may need to deploy additional personnel to the site to ensure that it can operate without placing staff wellbeing or the care of children and young people at risk. Staff members may not immediately appreciate the impact on their wellbeing so reminders about the availability of the relevant sector counselling service should be given to staff on a number of occasions in the weeks or months that follow. Important events such as the outcome of court proceedings can trigger new points of stress and need which the sector office must anticipate and monitor.

Relatives of the accused person who are employees or enrolled students at the site or in the sector

A sensitive plan of support may need to be developed with and for relatives of the accused person who make their needs known to the site leader or sector office. Each circumstance will differ but the site leader and sector office will need to consider the best ways to support relatives who identify their needs, including the provision of counselling and the option of alternative placements if requested.

In some instances, relevant information may need to be shared between the sector office and site leaders so that appropriate monitoring of an employee's or enrolled student's safety and wellbeing is maintained. The impact on relatives of media coverage or letters to the community should be anticipated and protected against wherever possible. The details of support plans for relatives should be provided to the sector office as required and filed by the site leader.

3.3.3 Risk assessment

A risk assessment will be made by the relevant sector office in consultation with the site leader and will draw on information provided by SA Police. In an independent school, this will be the responsibility of the school principal. The risk assessment will consider whether there is a reasonable suspicion that there might be other victims and the most appropriate way of addressing that risk through informing identified people. Where necessary, the relevant sector office or independent school principal should consult experts.

Note: It is likely that processes for identifying and assessing risk will change as the work is informed by further research and experience. Sectors will share learning and updated risk assessment resources to inform practice and maintain consistency.

The risk assessment should consider relevant factors, including:

- the nature of the offending
- the circumstances in which the offending occurred
- the place or places where the offending occurred
- the age and gender of the victim
- the age and gender of the accused person, whether the accused person had regular and frequent contact with other individual children or young people, or a group or groups of children or young people, and the nature and circumstances of that contact
- the opportunities that were available to the accused person on which to offend against other children or young people.

3.3.4 Informing responsibly

Although a suppression order and section 71A of the Evidence Act forbid publication of the name of the accused person generally to the public, it is proper for those with a legitimate interest in the matter to be informed of the alleged offending. Those who have a legitimate interest in the offending are the staff at the site, the members of the governing authority of the site and parents of children or young people who are likely to have been in contact with the accused person.

As considerable care must be taken when informing staff, the governing authority and parents of the incident, site leaders and sector offices should follow the advice below.

It is necessary to consider the question of providing information at three stages. They are:

1. when no more is known than what is contained in the allegations
2. after the accused person has been charged
3. after the committal or other appropriate relevant date.

Note: As with all other parent communications, site leaders should ensure that, wherever required, letters

are translated and interpreters are available at meetings. Written communications should be marked 'Confidential' and signed either by the site leader or a senior official of the relevant sector office. The decision about who signs letters will be taken consultatively and will respond to the unique circumstances of each case.

Stage 1: When allegations only are known

Informing staff

It might be necessary for the site leader to make arrangements to replace the accused person who has been placed, for example, on special leave, and to make other consequential administrative arrangements. The site leader is at liberty to inform the staff involved in the administrative arrangements of the allegations but should not inform other staff at that stage. Those staff members who are informed of the allegations should be asked to keep the information confidential and if contacted by the accused person they should not discuss the allegation. Other staff members should be told that the member of staff is on special leave, or another kind of leave using a neutral term applicable to processes utilised in the relevant sector.

Once the decision of the relevant sector has been taken to suspend the accused person, the site leader should call a staff meeting and inform all staff that the accused person has been suspended.

It might be necessary to state that the accused person has been suspended because his or her conduct is being investigated but nothing should be said that might indicate that allegations of sexual misconduct had been made against the accused person.

Staff should be informed that the accused person is not allowed on the site and if the accused person is seen at the site to report it to the site leader. See Section 3.3.2 regarding support for staff in managing this circumstance. Staff should be instructed to keep the information confidential and to refer any parents with questions to the site leader (see section on managing rumour, misinformation and curiosity below).

Staff members should be instructed that, if they have any information that will assist the police investigation, they should contact police and provide that information. If that information is relevant to the safe operation of the site, it should also be provided to the site leader. If the identity of the victim is known and consent is obtained from the victim or the victim's parents, specific staff members such as the victim's class teacher or school counsellor may be told who the victim is on a confidential basis in order to provide appropriate support for the victim.

Informing governing authority

The members of the governing authority should be informed by the site leader. They should be given the same information as staff, namely, that the accused person has been suspended until further notice and that the accused person has been directed not to attend the site. They should be asked to keep the information confidential and to refer any questions from parents to the site leader.

Informing parents

Generally speaking, while allegations are being investigated, it is not appropriate to inform parents of those allegations. The allegations might prove to be false, may not be substantiated, or there may be insufficient evidence to warrant criminal proceedings. A letter that named the accused person and reports what are no more than allegations has a real potential to be defamatory. As a general rule, the site should not, therefore, inform parents of allegations.

Generally speaking, if there is an occasion when it is necessary to send a letter to parents referring to allegations, for example as a means of managing serious and harmful misinformation, that letter should not name the person against whom the allegations have been made. Legal advice through the sector office should be obtained before sending such a letter. It will be necessary, also, to consult SA Police.

Managing rumour, misinformation and curiosity

In some cases, sites can anticipate that discussion will occur within their parent community once a member of staff has been suspended. It is appropriate that staff be provided with instructions for dealing with potential queries or comments. That instruction should be to refer all inquiries to the site leader.

If an inquirer asks the site leader why the suspended person is no longer at the site, the site leader should give the inquirer an answer that is as neutral as possible and one that does not disclose the nature of the alleged offending. One example of an appropriate answer is 'The person has been suspended. I am sorry I cannot give you any further information at this stage. As soon as I am in a position to do so, I will let you have more information'. If the inquirer persists, the site leader should do no more than state that the person has been suspended because his or her conduct is being investigated by police and more information will be given when the outcome of the police investigation is known.

Staff members should also be instructed to alert the site leader immediately if they become aware of accusations or threats by community members that pose risks to the safety or wellbeing of individuals or the broader site community. The site leader should consult with the sector office and SA Police about the best course of action. In some circumstances, this may prompt the need for a letter to the whole community. However, as stated above, this should occur only through consultation with the sector office and SA Police and legal advice must be sought.

The prompt actions of the site leader and sector office in facilitating all of the actions required in this guideline will help prevent rumour and misinformation in the community.

Stage 2: After accused person has been charged

Informing staff

Following the arrest of a member of staff, the site leader should convene a meeting of staff for the purpose of:

- informing them that a member of staff has been arrested and to name that person and the offence
- informing them of changes to staff required by the absence of the accused person
- informing them that the accused person is not permitted on the site
- asking staff to inform the site leader if the accused person is seen at or near site grounds so that the site leader may take appropriate action
- informing them that, if they have any information that will assist the police investigation, to report that information to police and to the site leader if relevant to the safe operation of the site.
- informing them that if they are contacted by the accused person they should not discuss the allegation.

Staff should also be instructed to keep the matter confidential in order to protect the confidentiality and identity of the victim and also instructed that it is an offence to publish any material identifying the accused person at this stage of the criminal proceedings.

See Section 3.3.2 regarding advice for staff members in managing their contact with or support of the accused person.

If new staff join the site, the site leader should give the same information to those new members of staff. Information should be given to a relieving teacher only if that teacher will be teaching the victim.

If the identity of the victim is known and consent is obtained from the victim or the victim's parents, specific staff members, such as the victim's class teacher or school counsellor, may be told on a confidential basis who the victim is in order to provide appropriate support for him or her.

Informing governing authority

The most suitable means by which to inform the governing authority is at an extraordinary general meeting called for that purpose. The site leader is at liberty to inform members of the governing authority of the same facts as revealed to staff members. Governing authority members should be given the same instructions regarding the requirement to maintain confidentiality and to inform SA Police and the site leader of any information relevant to the safety of the site.

The site leader should also advise the governing authority of parent communications (see below). Wherever practicable, this advice should be given ahead of the communications occurring.

Informing parents

The manner in which information is given to parents and the kind of information given to parents will depend on the result of the risk assessment (see Section 3.3.3).

Particular care must be taken when informing parents of the fact that a staff member has been arrested and charged with an offence. Parents will be advised either by letter, email or at a meeting, as described below.

Letters

As a general rule, the accused person should not be named in the letter to parents. The letter must be sent as soon as reasonably practicable.

There is no one letter that will be suitable for all occasions. With the assistance of the sector office, the site leader will have to prepare a letter suitable to the occasion in question.

Before finalising the contents of the letter with the site leader, the sector office must consult with police as to the timing and content of the letter.

The letter to be sent to parents should have regard for the following five factors:

- the presumption of innocence
- the fact that section 71A of the Evidence Act restricts publication of the name of the alleged offender until committal or 'relevant date' pursuant to section 71A of the Evidence Act. If, contrary to the recommendation in this guideline document, it is decided to name the accused person and, if the letter is to be sent to a large number of parents, advice should be taken as to whether the letter is permitted by section 71A
- the fact that a person who receives the letter might post it on Facebook or another internet site
- the fact that the name of the person alleged to have committed the offence can lawfully be published once that person has been committed for trial or sentence or after the 'relevant date'
- whether a suppression order has been made by a court.

The purpose of a letter is twofold: to inform parents of the fact that a person connected to the site has been charged with a sexual offence and to state whether there is any concern for the safety and welfare of children and young people other than the victim.

The letter should be sent by post or email as per the sector's or site's established process. It should not be sent home with the child or young person. It should not be posted on the site's noticeboard or published in a newsletter. It is strongly recommended against placing these communications on any social media or internet platform.

No other victims

If the result of the risk assessment is that there is no suspicion that there might be other victims, a letter should be sent to all parents at the site stating that fact. The letter should state that a person connected to the site has been arrested and charged with an offence, naming the offence but not naming that person. An example of this type of letter and a list of the topics the letter should contain are set out in Example 1 of Appendix 5.

When a group is identified

If the result of the risk assessment is that there is a group of children or young people who might include victims, two letters should be sent to parents. Neither letter should name the accused person.

The first of these two letters should be sent to the parents of those children or young people in the group in which it is suspected that there might be other victims. It will inform those parents of the fact that a person connected to the site has been arrested and charged with committing an offence, naming the offence but not naming that person. It would inform those parents if a meeting is being called to give information to parents, or if parents are being invited to meet personally with the site leader. At the same time, the letter should not suggest that the children or young people of those parents who received the letter are, in fact, victims.

An example of this type of letter and a list of the topics the letter should contain are set out in the first letter of Example 2 of Appendix 5.

The second letter to be sent should be addressed to all other parents at the site. It will contain essentially the same information as the first letter except that it will state that, while there is no evidence that any child or young person at the site apart from the victim is involved, a group meeting or individual meetings are occurring with parents whose children or young people have been in contact with the accused person. The letter may state that the site is holding such a group meeting and the recipient may attend the meeting if he or she wishes to do so.

An example of this type of letter and a list of the topics the letter should contain are set out in the second letter of Example 2 of Appendix 5.

When a particular group cannot be identified

In those cases where there is a reasonable suspicion of other victims but it is not possible to narrow down the group of children or young people because the accused person has had contact with most of the children or young people at the site, a communication process with all parents must be planned.

It will be necessary for only one letter to be sent to all parents. An example of this type of letter is Example 3 of Appendix 5.

Contact with parents

Where, as a result of the risk assessment, there is a reasonable suspicion that there might be other victims, contact should be made with the parents of those children or young people. Through that contact (eg telephone, individual meetings, group meetings), parents should be given information and instruction that cannot be given in a letter.

The information and instruction provided should deal with such matters as informing parents of the kind of behaviour that is indicative of a child having been the victim of abuse, the appropriate way to provide opportunities for the child or young person to talk about what has been a traumatic experience, and how to support the child or young person and manage the situation. The information and instruction should be directed to the type of offending that had been alleged. It should include a strong message that the parents should be available to their child but not to interrogate him or her.

The discussions should be planned with and attended by a qualified and experienced expert such as a psychologist with experience in assisting children who have been victims of child abuse and who would be able to answer any questions parents might have. The discussions should include giving parents appropriate advice on how to deal with any disclosures made by their child. Parents should be provided with the contact details for the relevant support services.

The site leader may name the accused person and answer any questions parents might have.

The site leader should ask parents to treat the information as confidential. They can be told that publication of the name of the accused person would be in breach of section 71A of the Evidence Act. It is recommended to encourage parents to treat that information as confidential by stating that it is in the interests of the victim and the parents of the victim to keep the matter confidential.

It should be stressed in the discussions that nothing should be said or done that might identify the victim.

Following the discussions, parents should be provided with an information sheet containing information about good parenting practice when dealing with a victim or possible victim of sexual abuse. That document should also include guidance as to how best to respond to a disclosure by a child or young person who has been abused.

The information sheet should also be made available to those parents who cannot or do not wish to attend the site.

Stage 3: After committal (or other relevant date)

After the accused person has been committed to stand trial or been sentenced, or after any other relevant date, there are no restrictions on informing either staff, members of the governing authority or parents of the fact that the accused person has been charged with a sexual offence. Any information given to people in those groups can name the accused person and state the offence with which the accused person has been charged. At this stage, there is no need for confidentiality about any of those facts.

However, if a suppression order has been made, legal advice should be obtained on the question as to whether it is possible to give information to staff, members of the governing authority or parents. It should also be noted that publication of any information that tends to identify a victim may still be prohibited under section 71(A) of the Evidence Act.

Informing parents of previous students

In consultation with the sector office and where appropriate based on the risk assessment undertaken earlier, a site leader should ascertain the names of children or young people who in previous years would have been in contact with the accused person. Having done so, the site leader should send a letter to the parents of those children or young people whose addresses are known or to the young people themselves if they are now adults.

This information should be given to those parents after committal or other relevant date, unless their child is identified during the risk assessment as being at risk of having been abused. They should then be informed in accordance with the procedure in the last part of Stage 2 above.

Informing other sites

Where the accused person has been employed at other education and care sites, the sector office will notify those other sites so that they can consider whether it is necessary to inform parents in the same way as described in Stage 2 above.

Informing other authorities

This responsibility to inform other authorities about changes to the situation and actions taken varies across the three sectors but will include, as appropriate:

- relevant Minister (confirmed in writing)
- relevant Chief Executive/Director
- chairperson of the governing authority
- other education sectors, as per the Intersectoral Information Sharing Protocol
- the Education Standards Board in the case of early childhood and care settings
- any other agency/organisation where risks to children's or young people's safety are identified.

3.3.5 Monitoring court proceedings

The sector office should monitor the court proceedings and inform the site leader of the stage the prosecution has reached. In an independent school, this will be the responsibility of the school principal.

Unless a suppression order has been made, the site leader should inform parents by letter of the fact that the prosecution has reached any of the following stages:

- when a plea of guilty has been made
- at the end of a trial, whether the accused person has been acquitted or convicted
- after the accused person has been sentenced
- after any appeal.

Any letters should be drafted in consultation with the sector office. Before sending any letters, it is necessary to check whether a suppression order has been made.

3.3.6 Responding to the media

All media inquiries should be referred to the relevant sector's media unit or advisor:

- Department for Education: 8226 7904
- Catholic Education SA: 8210 8147
- Association of Independent Schools of South Australia: 8179 1400.

3.3.7 Reporting the outcome

It is desirable to inform the staff, members of the governing authority and parents of the outcome of the criminal proceedings.

If the accused person is acquitted or if the charges against him or her are withdrawn or if the proceedings lapse for any reason, it is essential to inform staff, members of the governing authority and parents of the fact. The letter should be drafted by the sector office and signed by a very senior leader. In an independent school, this will be the responsibility of the school principal.

Should the accused person be acquitted or if the charges against him or her are withdrawn or if the proceedings lapse for any other reason, the sector office or the independent school principal will have to make a number of decisions in relation to the future employment of the accused person. They include:

- whether the accused person will be subject to any disciplinary proceedings under section 26 of the *Education Act 1972*, or any other sector specific policies or contractual arrangements
- whether the accused person will return to the site where he or she had been employed
- whether the accused person should be employed at another site.

APPENDIX 1: Checklist for site leaders

Note: These steps are not necessarily sequential. Different circumstances will dictate a variation in the sequence of actions. It is assumed site leaders will delegate responsibilities to ensure they are undertaken in a timely fashion. Many of the actions are undertaken under advice from SA Police or the sector office.

1. Attend to immediate welfare needs of victim. (Section 3.2.1) ❑
2. Receive report of allegation and make notes of complaint. (Appendix 3) ❑
3. Call SA Police on 131 444 to report allegations. Obtain appropriate police contact number for parents to use, and seek advice re steps 4, 5 and 6. ❑
4. If SA Police approves, take steps to preserve evidence. (Section 3.2.1) ❑
5. Following SA Police/sector office advice, prevent accused person from having access to children and young people. (Section 3.2.1) ❑
6. Following SA Police advice, contact parents of victim, taking into consideration victim's views. (Section 3.2.1) ❑
7. Notify CARL on 131 478. ❑
8. Inform victim and victim's parents of counselling and support options. Inform social worker if victim is under the Guardianship of the Chief Executive Department for Child Protection. Document allegations, meetings and support and safety plan. (Section 3.3.2 and Appendices 3, 4 and 6) ❑
9. Follow sector reporting procedures regarding critical incidents. (Section 3.2.1) ❑
10. Place accused person on sector specific leave as per sector office guidance. (Section 3.2.2) ❑
11. Consider the support needs of relatives of the accused person who work or are enrolled at the site and who identify their needs. (Section 3.3.2) ❑
12. Consider the support/advice needs of staff, in particular those closely associated with the accused person. (Section 3.3.2) ❑
13. Provide written offer of counselling support to victim and victim's family and formalise the support and safety plan for the victim. (Section 3.3.2 and Appendix 6) ❑
14. Inform staff and governing authority, in consultation with the sector office and in accordance with guideline (Section 3.3.4) ❑
15. Write letters to parents, in consultation with sector office and SA Police, and in accordance with the guideline. (Section 3.3.4 and Appendix 5) ❑
16. If appropriate, hold meeting of parents as outlined in the guideline. (Section 3.3.4) ❑
17. Inform site community, staff and governing authority of progress of the prosecution. This is especially important if there is an acquittal. (Section 3.3.4) ❑
18. Ensure all documentation is stored in a locked, confidential file and copies are provided to sector office as required. (Appendices 3, 4, 5 and 6) ❑

APPENDIX 2: Checklist for sector office

Note: These steps are not necessarily sequential. Different circumstances will dictate a variation in the sequence of actions. The involvement of Association of Independent Schools of South Australia in supporting its independent member schools will be at each individual school's request, however the Association of Independent Schools of South Australia recommends that its member schools adopt this checklist as best practice.

1. Receive the following information from SA Police, as per the Interagency Code of Practice:
   - (a) the name, date of birth and address of the person who has been charged ❑
   - (b) details of the charge and apprehension report ❑
   - (c) the condition upon which the accused person has been bailed ❑
   - (d) the court bailed to and the date of the first court appearance ❑
   - (e) the school or schools involved ❑
   - (f) whether there is a reasonable suspicion that there might be other victims ❑
   - (g) whether there are any complicating factors that would affect disclosure to parents ❑
   - (h) the contact details of the investigating officer ❑
   - (i) whether the offence is a major indictable offence, a minor indictable or a summary offence. ❑
2. Create file and appoint a person to supervise and manage the matter to its conclusion. ❑
3. Assist site leader to manage the immediate placement of the accused person including preventing him/her from having access to children/young people as necessary. ❑
4. Meet reporting obligations to other authorities and information sharing with other sectors/organisations in accordance with the guideline. ❑
5. Inform media unit. ❑
6. Conduct risk assessment drawing on SA Police information and decide whether letter should be sent to parents in accordance with guideline. ❑
7. Determine employment status of accused person. ❑
8. Ensure site leader has met all responsibilities, including notification to CARL and offer of counselling to victim and parents of victim. The offer should be made orally and be confirmed in writing. ❑
9. Assist site leader to support/advise relatives of the accused person, who identify their needs and staff who are friends of the accused person as appropriate. ❑
10. Check that relatives of the accused person who are employed or enrolled at different sites, and who identify their needs are supported as appropriate. ❑
11. Work with site and SA Police to draft letter/s to parents. ❑
12. Consider whether legal advice is needed on letter/s, especially if the matter is complex. ❑
13. Collate notes of site leader and other staff and place copies of these and victim's support and safety plan on central file. ❑
14. Assist site leader and other relevant child health professionals to facilitate a meeting with parents as relevant. ❑
15. Notify parents of children/young people of past years and other sites as relevant. ❑
16. Monitor court proceedings and the existence of suppression orders, and continue to consider the appropriateness of all actions as matters progress or new information comes to light. ❑
17. Inform site leader of the progress of the prosecution, and assist site leader in keeping staff, governing authority members and relevant parents similarly informed. ❑
18. Continue to meet reporting obligations to other authorities. ❑

APPENDIX 3: Record of allegation

Note: The staff member who first received information regarding the allegation must complete this record. It must be stored in a secure, confidential file in the site leader's office.

Record of allegation of sexual misconduct

Name of person making the allegation (complainant)

Date and time that allegation was reported

Age, gender and role of complainant

Name of accused person

Role of accused person

Name of victim (if not the complainant)

Age and gender of victim

Allegation details

Do not interrogate the victim. Complete in direct speech what was reported to you.

Name: (person who received the complaint)

Signature: Date:

APPENDIX 4: Record of meeting

Note: This record should be completed after all meetings or conversations relating to the management of allegations of sexual misconduct by adults and stored in a confidential file.

Date of meeting		
Location of meeting		
Attendees	Include full names and titles of attendees *Example: John Smith Principal, Ms Jones mother of Marcus*	
Purpose of meeting	*Example: Discuss allegation of sexual misconduct towards Ms Jones' son Marcus by staff member/volunteer* *Discuss as much of support and safety plan as possible* *Discuss options for changed enrolment, if considered appropriate by any party*	
Actions taken to date	*Example: Police contacted, referral to CAMHS*	
Contact names and contact details	Include all relevant contact details *Example: Contact number for Principal, contact number of SA Police investigating officer*	
Future actions	List future actions to be taken and person responsible Set date for finalising the support and safety plan	
Signature of site leader	Name:	Signature:
Signatures of other attendees	Name:	Signature:
	Name:	Signature:

APPENDIX 5: Sample letters to parents

Example 1: Where no other victims are suspected

The letter to all parents when there is no suspicion that there might be other victims would deal with the following topics:

1. a statement that the accused person has been arrested and charged but not naming the accused person
2. a statement of the offence with which the accused person has been charged
3. a statement indicating that the site does not suspect that there are other victims
4. an assurance that the Department/Catholic Education SA/Association of Independent Schools of South Australia will keep parents informed
5. a request to keep the matter confidential in order to protect the victim and the victim's family
6. contact numbers of support services for concerned parents
7. a statement that those who have questions or concerns may contact the site leader
8. a statement that the accused person has been removed from the site
9. an assurance that the site is managing the issue without impairing the provision of education and care at the site
10. a request that parents with information that may assist the police investigation to contact police and provision of a contact number.

The letter below uses a teacher as an example of an 'accused person'.

Confidential

Dear Parent/Caregiver

I regret to inform you that a teacher from our school has been arrested by police and charged with [NAME THE OFFENCE].

Police are investigating the matter. The teacher has been suspended from duty pending the outcome of the police investigation and prosecution. The teacher has been instructed not to attend the school. I will keep you informed of the progress of the prosecution.

The information available to the school suggests that there is no need for any concern for any other children at the school.

For the sake of the victim and the victim's family and especially to protect the identity of the victim, please keep this information confidential. I ask you not to distribute this letter, to post it or to display it in any public way including on Facebook or on any other internet site.

If you have any information that may assist the police investigation, please contact [PROVIDE NAME AND TELEPHONE NUMBER OF INVESTIGATING OFFICER].

A relief teacher has been appointed and the classes will proceed as normal.

If you have concerns about the safety and welfare of your child, please feel free to contact me directly at the school. Alternatively, you may seek advice from one of the services below:

- Child and Adolescent Mental Health Services (CAMHS) on 8161 7198
- Kids Helpline on 1800 55 1800.

If you have any questions or concerns, please do not hesitate to contact me.

Yours faithfully
Principal

Example 2: When a group is identified

Where the risk assessment has determined that there is a reasonable suspicion there might be other victims among a group of children or young people who have had contact with the accused person, two letters will be sent.

One letter will be sent to parents of the children or young people who have been identified in the risk assessment process as possible victims.

The other letter will be sent to all other parents at the school.

Both letters will refer to the meetings to be held to give information and instruction to parents. Both letters would deal with the following topics:

1. a statement that the accused person has been arrested and charged but not naming the accused person
2. a statement of the offence with which the accused person has been charged
3. a statement that the accused person has been suspended from duty and directed not to attend the site
4. a statement that a meeting is being called for parents whose children had contact with the accused person, including the purpose of the meeting
5. a statement that there is no evidence at this stage that, apart from the victim, any other child or young person at the site is involved
6. a statement that any parent with information that may assist the investigation should contact police, with provision of contact details of the investigating officer
7. a statement that the site is managing the issue without impairing the provision of education and care at the site
8. a request to keep the matter confidential in order to protect the victim and the victim's family
9. contact numbers of support services for concerned parents
10. a statement that parents who have a concern should contact the site leader or, if the site has one, the school counsellor.

The letters below use a teacher as an example of an 'accused person'. The first letter (to parents of the identified group) can be in the following or similar terms.

Confidential

Dear Parent/Caregiver

I regret to inform you that a teacher from our school has been arrested by police and charged with [NAME THE OFFENCE].

Police are investigating the matter. The teacher has been suspended from duty pending the outcome of the police investigation and prosecution. The teacher has been instructed not to attend the school. I will keep you informed of the progress of the prosecution.

There is no evidence at this stage that any child at the school other than the victim is involved. However, I am concerned about the welfare of those children who have had contact with the teacher. Your child might have had contact with the teacher. I invite you to attend a meeting which will be held at 6.00pm on [INSERT DATE] in the School Hall.

I appreciate that this is short notice but I urge you to attend the meeting. Alternatively, if you are more comfortable meeting with me privately, please contact the school directly.

The meeting will be addressed by a psychologist who has experience working with victims of child abuse. The psychologist will inform you of behavioural signs and possible effects of child abuse and will answer any questions you might have.

For the sake of the victim and the victim's family and especially to protect the identity of the victim, please keep this information confidential. I ask you not to distribute this letter or post this letter on Facebook or on any other internet site.

A relief teacher has been appointed and classes will proceed as normal.

If you have any information that may assist the police investigation, please contact [PROVIDE NAME AND TELEPHONE NUMBER OF INVESTIGATING OFFICER].

If you have concerns about the safety and welfare of your child, please feel free to contact me directly at the school. Alternatively, you may seek advice from one of the services below:

- Child and Adolescent Mental Health Services (CAMHS) on 8161 7198
- Kids Helpline on 1800 55 1800.

If you have any questions or concerns, please do not hesitate to contact me.

Yours faithfully
Principal

The second letter (the letter to all other parents at the school) can be in the following or similar terms.

Confidential

Dear Parent/Caregiver

I regret to inform you that a teacher from our school has been arrested by police and charged with [NAME THE OFFENCE].

Police are investigating the matter. The teacher has been suspended from duty pending the outcome of the police investigation and prosecution. The teacher has been instructed not to attend the school. I will keep you informed of the progress of the prosecution.

There is no evidence at this stage that any child at the school other than the victim is involved. However, I am concerned about the welfare of some children who have had contact with the teacher and am writing separately to their parents and inviting them to attend a meeting. The meeting will be held at 6.00pm on [INSERT DATE] in the School Hall. If you wish, you may also attend the meeting.

The meeting will be addressed by a psychologist who has experience working with victims of child abuse. The psychologist will inform parents of behavioural signs and possible effects of child abuse and will answer any questions parents might have.

For the sake of the victim and the victim's family and especially to protect the identity of the victim, please keep this information confidential. I ask you not to distribute this letter or post it on Facebook or on any other internet site.

If you have any information that may assist the police investigation, please contact [PROVIDE NAME AND TELEPHONE NUMBER OF INVESTIGATING OFFICER].

A relief teacher has been appointed and the classes will proceed as normal.

If you have concerns about the safety and welfare of your child, please feel free to contact me directly at the school. Alternatively, you may seek advice from one of the services below:

- Child and Adolescent Mental Health Services (CAMHS) on 8161 7198
- Kids Helpline on 1800 55 1800.

If you have any questions or concerns, please do not hesitate to contact me.

Yours faithfully
Principal

It might be necessary to adapt each of these letters to the particular circumstances of each case.

Example 3: When a particular group is not identified

When a risk assessment determines that there is a reasonable suspicion of other victims but it is not possible to identify a specific group because all children and young people at the site might have had contact with the accused person, the letter to parents should be in the following or similar terms.

The letter below uses a teacher as an example of an 'accused person'.

Confidential

Dear Parent/Caregiver

I regret to inform you that a teacher from our school has been arrested by police and charged with [NAME THE OFFENCE].

Police are investigating the matter. The teacher has been suspended from duty pending the outcome of the police investigation and prosecution. The teacher has been instructed not to attend the school. I will keep you informed of the progress of the prosecution.

There is no evidence at this stage that any child at the school other than the victim is involved. However, I am concerned about the welfare of all children at the school because they have all been in contact with the teacher at one time or another. For that reason, I invite you to attend a meeting to be held at 6.00pm on [INSERT DATE] in the School Hall.

I appreciate that this is short notice but I urge you to attend the meeting.

The meeting will be addressed by a psychologist who has experience working with victims of child abuse. The psychologist will inform you of behavioural signs and possible effects of child abuse and will answer any questions you might have.

For the sake of the victim and the victim's family and especially to protect the identity of the victim, please keep this information confidential. I ask you not to distribute this letter or post it on Facebook or any other internet site.

A relief teacher has been appointed and classes will proceed as normal.

If you have any information that may assist the police investigation, please contact [PROVIDE NAME AND TELEPHONE NUMBER OF INVESTIGATING OFFICER].

If you have concerns about the safety and welfare of your child, please feel free to contact me directly at the school. Alternatively, you may seek advice from one of the services below:

- Child and Adolescent Mental Health Services (CAMHS) on 8161 7198
- Kids Helpline on 1800 55 1800.

If you have any questions or concerns, please do not hesitate to contact me.

Yours faithfully
Principal

APPENDIX 6: Support and safety plan for child/young person

Support and safety plan

Note: The following is a guide to the actions and considerations that should be made in supporting a victim. It should be adapted to the age and needs of the victim.

Support categories	Support strategies	Responsible person/s
Internal support	Who has discussed, as appropriate for age, all features of this plan with the child/young person? Has the child/young person been given full opportunity to share his/her view and has this view been respected to the fullest degree possible? What changes to the child/young person's routine are in place to support him/her? For example: – yard duty arrangements – before/after school – timetable – work expectations (special provisions if year 11/12) – attendance arrangements – site-based counselling support. What is the child/young person advised to do if he/she feels unsafe at any time at the site? For example: – advise yard duty teacher – move to front office – report directly to director/principal – go to counsellor's office – access nominated friend – contact parent/caregiver. Which adult at the site will be available for the child/young person to talk with at any time and act as the 'support person'? How does the child/young person access the support person? What signs of stress in the child/young person will be reported immediately by staff to parents/caregivers? How will this communication be made and by whom? What is the agreed verbal response the child/young person will make to questions from others (eg staff, students, parents, friends)? What information is to be given to other relevant staff who must support the child/young person but for whom it isn't necessary or appropriate that they know the details of the underlying event? For example: – other class teachers – relief staff – yard duty staff – front office staff. Who is responsible for informing other relevant staff? Who will keep the child/young person's support person informed of upcoming events, such as court hearings?	

Support categories	Support strategies	Responsible person/s
	How will the child/young person's support person and the parent/caregiver contact person (see below) liaise with each other, if the one staff member does not undertake both roles? Has the child/young person consented to external professionals sharing information with the support person at the site, where relevant to the child/young person's safety and wellbeing?	
Parent/caregiver support and liaison	Who has provided parents/caregivers with counselling support services, verbally and in writing? Which staff member is the contact person for parents/caregivers on all matters associated with the support for the child/young person? How can parents/caregivers contact/access this staff member? What actions are being taken at home to help restore the child/young person's sense of safety and wellbeing? Are the actions at the site complementary to the parents/caregivers' actions? What signs of stress in the child/young person will parents/caregivers immediately report to the nominated parent/caregiver contact? Have parents/caregivers given permission for external professionals to share information with the support person at the site, where relevant to their child/young person's safety and wellbeing?	
Teaching and learning support	Are there any curriculum issues that need to be addressed? For example: – a proposed teaching plan that must be modified to avoid distress to the child/young person – the introduction of a teaching program in order to reinforce particular behaviour. Have these plans been discussed with other professionals supporting the child/young person?	
External support	Which other agencies or professionals are involved with the child/young person or his/her family? What is the nature and length of their support? For example: – How do they liaise with the site? – Have they contributed to the development of this plan/been given a copy? – Have they agreed to liaise with the site? – How is this liaison to occur and through which staff member?	
Plan review	When will the plan be reviewed? Who is responsible for setting a review date? How can the site, child/young person or parents/caregivers initiate a meeting outside of the scheduled review? Have parents/caregivers and child/young person been informed of whom they can raise concerns with if they are not happy with the actions of the site in providing support? Do they have the contact details?	

Support categories	Support strategies	Responsible person/s
Others with a duty of care	Who else needs to know about the plan? For example: – OSHC/vacation staff – Family Day Care provider – boarding/residential staff. What do the child/young person and parents/caregivers agree will be the information given to these individuals? What is necessary or relevant for them to know in order to follow the plan?	
Signatures	The plan is signed by key stakeholders, in particular: – child/young person – parent/caregiver – site leader.	

APPENDIX 7: Course of a criminal prosecution

Note: This is a brief overview only of the steps involved in prosecuting a person accused of a criminal offence. A more detailed account can be found in Chapter 3 of the Royal Commission 2012–2013 Report of Independent Education Inquiry. *The accused person is called 'the defendant'.*

Common to any criminal offences

1. Police investigation

SA Police will investigate alleged crimes that have been reported to them. In the ordinary course of an investigation, police will take statements from the victim/s involved and other witnesses and will interview the defendant. Police need sufficient evidence before the defendant can be prosecuted.

2. Defendant is charged

When the police have reached the stage that they have reasonable cause to suspect that the crime has been committed, they will either arrest and charge the defendant or summons the defendant to appear in the Magistrates Court on a date stated in the summons.

When the defendant has been arrested and charged, he or she will be either remanded in custody or bailed to a date to appear in the Magistrates Court.

3. Classification of the charge

Criminal offences can be classified as summary offences, minor indictable offences and major indictable offences. Generally, summary and minor indictable offences are tried in the Magistrates Court, unless joined with a major indictable offence. Major indictable offences are tried in the District Court and in the Supreme Court.

Summary and minor indictable offences

4. Magistrates Court

The defendant may either plead guilty or not guilty. If he or she pleads guilty, the magistrate will then determine the appropriate penalty.

If the defendant pleads not guilty, the matter will be adjourned for a pre-trial conference. At the pre-trial conference, the magistrate will endeavour to clarify and limit the matters in dispute between the prosecution and the defendant and list the matter for trial on another date. The court may grant such adjournments as are necessary prior to the trial.

A magistrate will conduct the trial and decide whether the defendant is guilty or not guilty. If the magistrate finds the defendant guilty, the magistrate will then determine the appropriate penalty.

The prosecution has a right to appeal against acquittal where the magistrate has made an error of law or fact. A defendant has a right to appeal against his or her conviction, sentence or both. Appeals against a decision made by a magistrate will be heard by a judge of the Supreme Court.

Major indictable offences

5. First appearance in Magistrates Court

Although trials for major indictable offences are heard in either the District Court or the Supreme Court, the first step in the prosecution of a person charged with a major indictable offence is the preliminary examination which is conducted in the Magistrates Court. The purpose of a preliminary examination (or committal hearing) is to determine whether there is sufficient evidence to put the defendant on trial for a major indictable offence.

6. Declarations date

This is the date, usually within ten weeks from the first appearance of the defendant in the Magistrates Court, set for the prosecution to file in court and serve on the defendant the statements of all the witnesses on whom the prosecution relies to establish the guilt of the defendant. Those statements are called 'declarations'.

The court may grant the prosecution more time to obtain declarations. When all the declarations have been filed, the magistrate will set a date, four weeks after the declarations date, for the defendant to answer the charge/s. That date is referred to as the 'answer charge date'.

7. Answer the charge

On the answer charge date, the defendant will be asked to enter a plea. If the plea is guilty, the defendant will be sentenced by the magistrate* or be committed for sentence to the District Court or the Supreme Court.

If the defendant pleads not guilty and the magistrate finds that the prosecution has established a case to answer, the defendant will be committed for trial in the District Court or the Supreme Court.

If the magistrate is not satisfied that the evidence is sufficient to put the defendant on trial, the magistrate will reject the information and discharge the defendant.

8. Arraignment

The first appearance of the defendant in the District Court or the Supreme Court is called the arraignment. That is when the defendant is charged formally. The charge stated on the information is read out and the defendant will be asked to plead guilty or not guilty. The arraignment will be fixed four weeks after the committal.

If the defendant pleads guilty, the matter will usually be adjourned to a later date for submissions to be made as to the appropriate sentence to be ordered against the defendant.

If the defendant pleads not guilty, the matter will be adjourned to a directions hearing which is held four to six weeks after the date of the arraignment.

9. Directions hearing

Directions hearings are held for the purpose of resolving all the procedural matters that must be attended to before the trial begins. Directions hearings also give the judge the opportunity to explore with the prosecution and the defendant whether the matter can be resolved without having to go to trial. If it cannot be resolved, a trial date will be set. The judge will also hear any preliminary applications; for example, an application by the defendant to be tried by a judge alone. Directions hearings involve only the judge, legal counsel and the defendant. It is not uncommon for a number of directions hearings to take place before the trial.

10. Trial

The prosecutor has to present sufficient admissible evidence to the jury (or judge in a 'judge alone' trial) to prove beyond reasonable doubt that the defendant committed the offences with which he or she has been charged. If not, the defendant will be found not guilty.

If the defendant is found guilty, the judge will hear sentencing submissions from both the prosecutor and the defence lawyer and will then sentence the defendant.

When the jury is not able to agree on a verdict ('hung jury'), there will be a re-trial.

Occasionally, a trial may result in a mistrial because some prejudicial event has occurred during the trial. The trial will then start again with a new jury.

**The relevant parts of the* Statute Amendment (Courts Efficiency Reforms) Act 2012*, which makes provision for the defendant to be sentenced by a magistrate in certain circumstances, commenced on 1 July 2013.*

11. Appeals

The rights of appeal against a conviction or sentence are a little complicated. Broadly speaking, a defendant has to apply for permission to appeal against the conviction and the sentence. The appeal is heard by the Court of Criminal Appeal (CCA), which comprises three judges of the Supreme Court.

The Director of Public Prosecutions (DPP) has no right to appeal against a jury verdict of acquittal. The DPP may, in certain circumstances, apply for permission to appeal against the decision of a judge acquitting a defendant. The DPP may apply for permission to appeal against a sentence that is manifestly inadequate.

Where the CCA allows an appeal against conviction, the conviction will be quashed and the court will either order an acquittal or that the defendant be tried again.

In exceptional circumstances, the High Court of Australia will grant permission to appeal against a decision of the CAA.

APPENDIX 8: Relevant legislation

Note: All relevant legislation can be found at <http://www.legislation.sa.gov.au>.

Children's Protection Act 1993
http://www.legislation.sa.gov.au/LZ/C/A/CHILDRENS%20PROTECTION%20ACT%201993.aspx

Children and Young People (Safety) Act 2017 (SA)
https://www.legislation.sa.gov.au/LZ/C/A/Children%20and%20Young%20People%20(Safety)%20Act%202017.aspx

Criminal Law Consolidation Act 1935
http://www.legislation.sa.gov.au/LZ/C/A/CRIMINAL%20LAW%20CONSOLIDATION%20ACT% 201935.aspx

Education Act 1972
http://www.legislation.sa.gov.au/LZ/C/A/EDUCATION%20ACT%201972.aspx

Education Regulations 2012
http://www.legislation.sa.gov.au/LZ/C/R/EDUCATION%20REGULATIONS%202012.aspx

Evidence Act 1929
http://www.legislation.sa.gov.au/LZ/C/A/EVIDENCE%20ACT%201929.aspx

Summary Offences Act 1953
http://www.legislation.sa.gov.au/LZ/C/A/SUMMARY%20OFFENCES%20ACT%201953.aspx

Summary Procedure Act 1921
http://www.legislation.sa.gov.au/LZ/C/A/SUMMARY%20PROCEDURE%20ACT%201921.aspx

This guideline provides advice for leaders in education and care settings when responding to allegations of sexual misconduct by adults against children and young people. It outlines the actions to be taken and matters to be considered at different stages of the response. The guideline is designed to provide a transparent process to help support the people impacted by sexual misconduct incidents.

Record history

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Approvals

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Status: approved
Version: 2.1
Policy officer: Manager, Critical Incident Response, IMD
Policy sponsor: Director, Incident Management Directorate
Responsible executive director: Chief Operating Officer
Approved by: Director, Incident Management Directorate
Approval date: 16 May 2023
Next review date: 16 May 2026

Revision record

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Approved by: Director, Incident Management Directorate
Approved date: 16 May 2023
Next review date: 16 May 2026
Amendment(s): No policy amendments required currently, policy can continue to be used. Contact details changed.

Version: 2.0
Approved by: Director, Incident Management Directorate
Approved date: 16 June 2020
Next review date: 16 June 2023
Amendment(s): Reference to Section 26 of Education Act 1972 in section 3.3.7 replaced by Section 114 of the Education and Children's Services Act 2019 as of 1 July 2020. The Education Regulations 2012 or Children's Services Regulations 2008 become the Education and Children's Services Regulations 2020 as of 1 July 2020.

Version: 1.0
Approved by: Director, Incident Management Directorate
Approved date: 11 April 2019
Next review date: 11 April 2022
Amendment(s): Change of department name and Chief Executives.

Contact

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Source: Department for Education, Managing Allegations of Sexual Misconduct in SA Education and Care Settings Guideline (May 2023) <https://www.education.sa.gov.au/__data/assets/pdf_file/0006/260475/managing-allegations-of-sexual-misconduct-in-sa-education-and-care-settings.pdf>.

Appendix F: Information on the Teachers Register that can be made publicly available under the *Teachers Registration Act 2000*

Information that must be in the Register (s 25(2))	Particulars that may be included in the published register (s 25(6)(b))	Particulars that are to be made available to 'any person' on the request of that person (s 25(4)(a))	Particulars that may be made available to 'any person' on the request of that person, if the Board considers it appropriate to do so (s 25(4)(b))	Particulars that may be made available to a 'teacher employing authority'* (s 25(4)(c))
(a) full name	●	●		
(b) any former name				
(c) residential address				
(d) date of birth				●
(e) qualifications				●
(f) teaching experience at the time of application				
(g) registration number or limited authority number	●	●		
(h) whether fully registered, provisionally registered or specialist vocational education and training registered	●	●		
(i) date on which registration or limited authority takes effect				
(j) expiry date of registration or limited authority	●	●		
(k) any conditions to which the registration or limited authority is subject			●	
(l) particulars of a limited authority	●	●		
(m) particulars of any suspension of registration or limited authority				●
(n) any other particulars the Board considers appropriate				

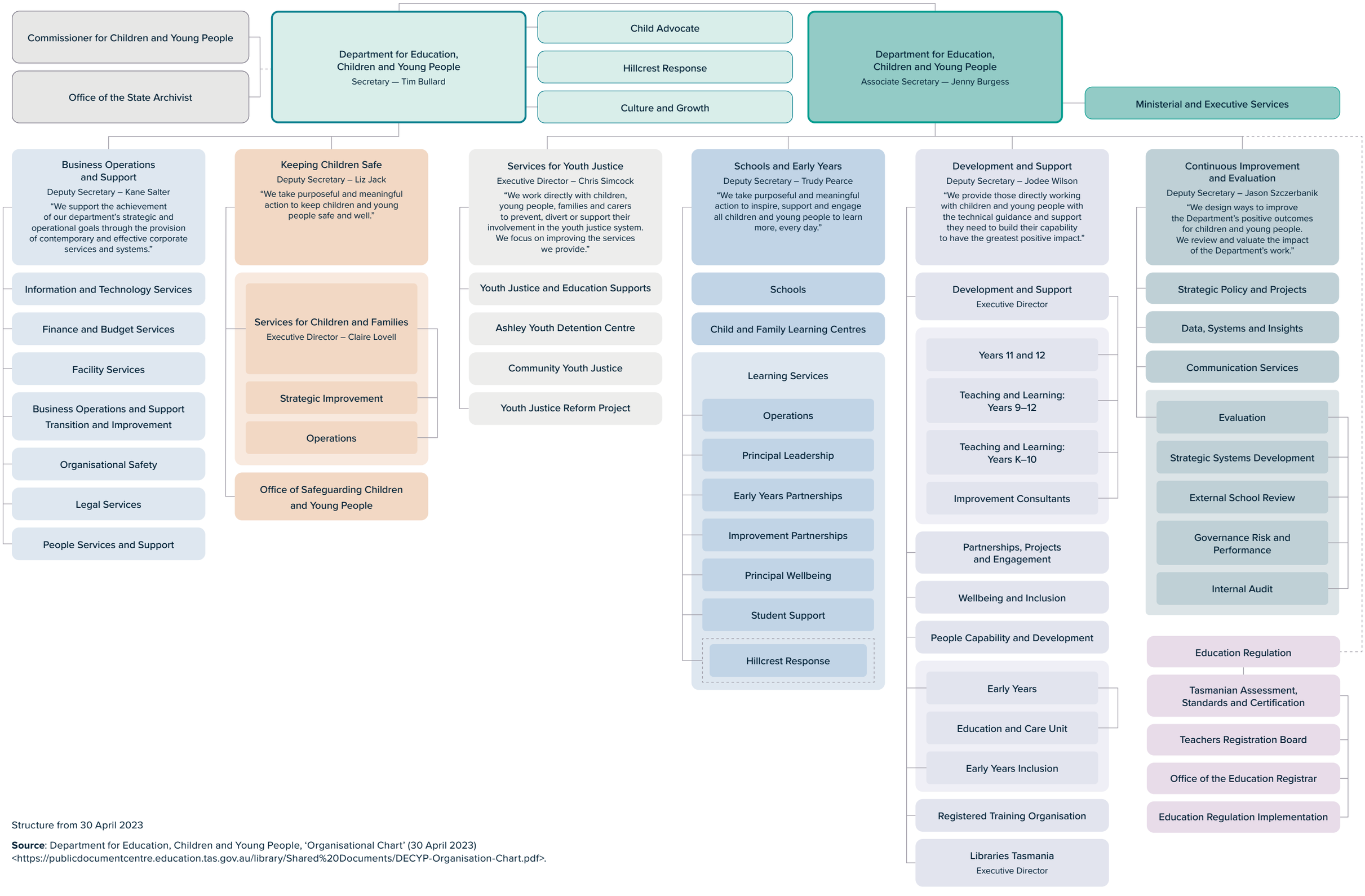
* The Teachers Registration Board may provide any other particulars to a teacher-employing authority to which a teacher (or limited authority holder) consents (Teachers Registration Act 2000 s 25(4)(c)(ii)).

Appendix G: Out of home care—Organisational structure of the Department for Education, Children and Young People (30 April 2023)

Appendix G

On foldout →

Appendix G: Out of home care—Organisational structure of the new Department *for* Education, Children and Young People 30 April 2023



Structure from 30 April 2023

Source: Department for Education, Children and Young People, 'Organisational Chart' (30 April 2023) <https://publicdocumentcentre.education.tas.gov.au/library/Shared%20Documents/DECYP-Organisation-Chart.pdf>.

Appendix H: Methodology used for the calculation of disciplinary process numbers referred to in our report

1 Source data

During our Commission of Inquiry, the State provided us with nine Excel spreadsheet Employment Direction trackers labelled 'ED trackers'.[1] These ED trackers contain department-specific information on disciplinary processes conducted in response to allegations of child sexual abuse and related conduct. We used the latest versions of the ED trackers from the three child-facing agencies—Department of Communities, Department of Education and Department of Health—to calculate numbers in relation to the following:

- Suspensions (both since January 2000 and the announcement of our Inquiry in November 2020)
- Preliminary assessments
- Employment Direction No. 4—Suspension (defined by the State as a subset of the overall number of suspensions)
- Employment Direction No. 5—Breach of Code of Conduct
- Employment Direction No. 6—Inability.[2]

The ED trackers all included the same information:

- Relevant Agency (Column A)
- Agency's internal reference (Column B)
- Name of alleged perpetrator (Columns C and D)
- Output of Agency (Column E)
- Name of complainant(s) (victim-survivor) (Column F)
- Source of complaint (Column G)
- Date Agency received complaint (Column H)
- Date alleged conduct occurred (Column I)
- Preliminary assessment undertaken (Y/N) (Column J)
- Date of preliminary assessment (Column K)
- Date recommendation of ED4, ED5 or ED6 to Head of Agency (Column L)

- Type of ED—ED4, ED5 or ED6 (Column M)
- Date stood down (Column N)
- Position title (Column O)
- Primary location of employment at time of stand down (Column P)
- Describe process of standing down (Column Q)
- Provide reasons for stand down (Column R)
- Provide terms of stand down (Column S)
- Describe allegation(s) against employee (Column T)
- Action taken or outcomes after stand down (Column U)
- Date of action taken or outcome (Column V)
- Associated actions (for example, referral to Tasmania Police or the Registrar of the Registration to Work with Vulnerable People Scheme) (Column W)
- Date of associated action (Column X)
- Investigator (Column Y)
- Status (finalised, ongoing) (Column Z).

There were, at times, discrepancies between the data provided to us by the Tasmanian Government through the ED trackers and the numbers provided by Secretaries of the Departments in their evidence and statements, or differences in the methodology adopted to calculate figures.[3] We have highlighted these discrepancies throughout our report as relevant.

2 Suspension numbers from January 2000 to February 2023

We applied the following methodology to determine the number of suspensions that occurred from the period January 2000 to February 2023 by respective department.

2.1 Department of Communities

Analysis was conducted on the most recently provided version of the ED tracker for the Department of Communities.[4] Column 'S' (labelled 'Provide terms of stand down') was filtered to include all cells referencing the terms 'suspended', 'suspension', 'CD8' (which was the predecessor to ED4) or 'ED4', and to exclude all blank cells and cells containing the terms 'NA', 'N/A' or 'alternative duties' as it was unclear whether those entries recorded a suspension.

The number obtained was 23.

To obtain the number of suspensions specifically relevant to out of home care, column 'S' (labelled 'Provide Terms of Stand Down') was filtered to include all cells with references to the terms 'suspended', 'suspension', 'CD8' or 'ED4'. Blank cells and cells containing the terms 'NA', 'N/A' or 'alternative duties' were excluded as it was unclear whether those cells recorded a suspension. Then column 'E' (labelled 'Output of Agency') was filtered to include all cells referencing the terms 'Child Protection', 'Child Safety Services' or 'Rostered Carer and Support Worker', and to exclude all cells referencing the term 'AYDC'.

The number obtained was 4.

2.2 Department of Education

Analysis was conducted on the most recently provided version of the ED tracker for the Department of Education.[5] Column 'S' (labelled 'Provide Terms of Stand Down') was filtered to include all cells referencing the terms 'suspended', 'suspension', 'CD8', 'ED4' or 'remain away from workplace', and to exclude all blank cells and cells containing the terms 'N/A', 'NA', 'RWVP registration suspended' or 'advised of substance allegation, asked to immediately leave workplace' as it was unclear whether those entries recorded a suspension.

The number obtained was 43.

2.3 Department of Health

Analysis was conducted on the most recently provided version of the ED tracker for the Department of Health.[6] Column 'S' (labelled 'Provide Terms of Stand Down') was filtered to include all cells referencing the terms 'suspended', 'suspension' or 'ED4', and to exclude all blank cells, cells containing the term 'N/A', 'NA' and cells where there was no mention of suspension or ED4 as it was unclear whether those entries recorded a suspension.

The number obtained was 26.

Refer to Figure H.1 for a graphical representation of these numbers.

3 Suspension numbers from November 2020 to February 2023

We applied the following methodology to determine the number of suspensions that occurred from the period November 2020 (the date of the announcement of our Inquiry) to February 2023 by respective department.

3.1 Department of Communities

Analysis was conducted on the most recently provided version of the ED tracker for the Department of Communities.[7] Column 'S' (labelled 'Provide Terms of Stand Down') was filtered to include all cells referencing the terms 'suspended', 'suspension', 'CD8' (which was the predecessor to ED4) or 'ED4', and to exclude all blank cells and cells containing the terms 'N/A' 'NA' or 'alternative duties' as it was unclear whether those entries recorded a suspension. Then column 'N' (labelled 'Date Stood Down') was filtered and all dates from November 2020 onwards were selected.

The number obtained was 10.

3.2 Department of Education

Analysis was conducted on the most recently provided version of the ED tracker for the Department of Education.[8] Column 'S' (labelled 'Provide Terms of Stand Down') was filtered to include all cells referencing the terms 'suspended', 'suspension', 'CD8', 'ED4' or 'remain away from workplace', and to exclude blank cells and cells containing the terms 'N/A', 'NA', 'RWVP registration suspended' or 'advised of substance allegation, asked to immediately leave workplace' as it was unclear whether those entries recorded a suspension. Then column 'N' (labelled 'Date Stood Down') was filtered and all dates from November 2020 onwards were selected.

The number obtained was 20.

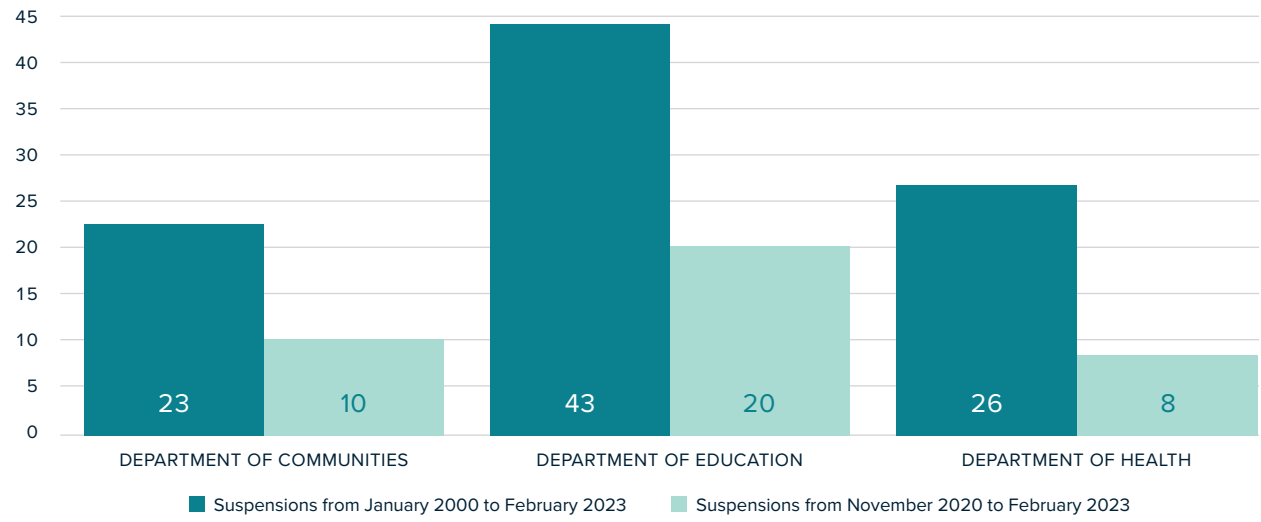
3.3 Department of Health

Analysis was conducted on the most recently provided version of the ED tracker for the Department of Health.[9] Column 'S' (labelled 'Provide Terms of Stand Down') was filtered to include all cells referencing the terms 'suspended', 'suspension' or 'ED4', and to exclude blank cells, cells containing the term 'N/A', 'NA' and cells where there was no mention of suspension or ED4 as it was unclear whether those entries recorded a suspension. Then column 'N' (labelled 'Date Stood Down') was filtered and all dates from November 2020 onwards were selected. The entry '05/05/2021 Note employee was already stood down for separate matter (not child related)' was included.

The number obtained was 8.

Refer to Figure H.1 for a graphical representation of these numbers.

Figure H.1: Suspensions by department for the period January 2000 to February 2023 and for the period November 2020 to February 2023[10]



Source: Tasmanian Government, *ED trackers supplied by the Tasmanian Government in response to Commission notices to produce*, 2023.

4 Preliminary assessment numbers

We applied the following methodology to determine the number of preliminary assessments from the period January 2000 to February 2023 by respective department.

4.1 Department of Communities

Analysis was conducted on the most recently provided version of the ED tracker for the Department of Communities.[11] Column 'J' (labelled 'Preliminary assessment undertaken (Y/N)') was filtered to include 'Yes', 'No', 'unknown' and blank cells were excluded.

The number obtained was 24.

4.2 Department of Education

Analysis was conducted on the most recently provided version of the ED tracker for the Department of Education.[12] Column 'J' (labelled 'Preliminary assessment undertaken (Y/N)') was filtered to include 'Y' and 'Yes'. Blank cells, 'NA' and 'N' were excluded.

The number obtained was 48.

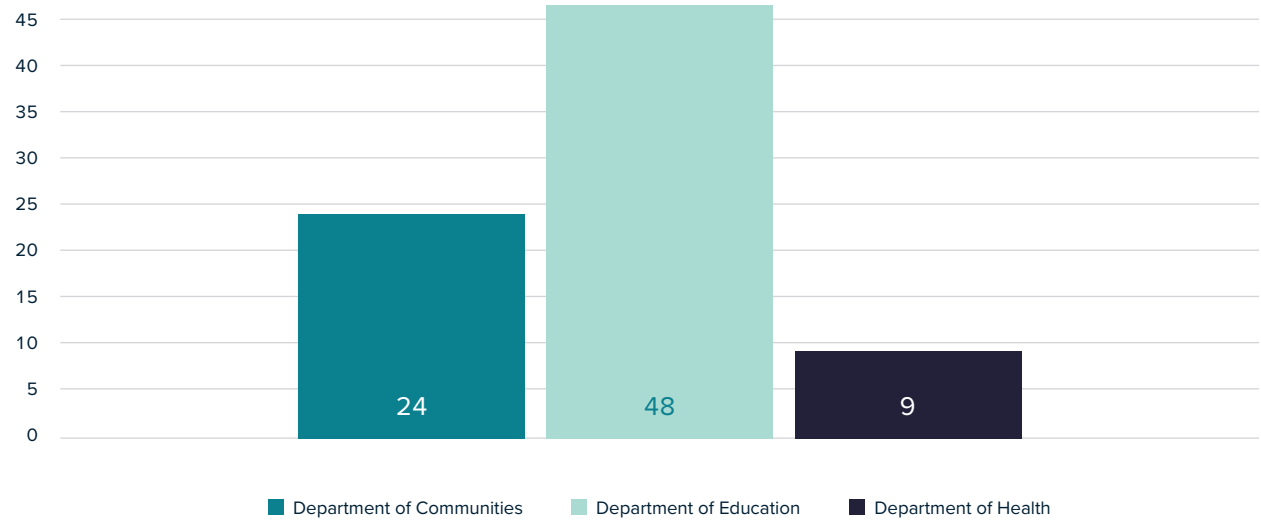
4.3 Department of Health

Analysis was conducted on the most recently provided version of the ED tracker for the Department of Health.[13] Column 'J' (labelled 'Preliminary assessment undertaken (Y/N)') was filtered to include anything with 'Y', 'No', 'Pending' and blank cells were excluded.

The number obtained was 9.

Figure H.2 provides a graphical representation of these numbers.

Figure H.2: Preliminary assessment numbers by department from January 2000 to February 2023[14]



Source: Tasmanian Government, *ED trackers supplied by the Tasmanian Government in response to Commission notices to produce*, 2023.

5 Employment Direction No. 4—Suspension numbers

We applied the following methodology to determine the number of Employment Direction No. 4—Suspension that were conducted from the period January 2000 to February 2023 by respective department.

5.1 Department of Communities

Analysis was conducted on the most recently provided version of the ED tracker for the Department of Communities.[15] Column M (labelled 'Type of ED – ED4, ED5 or ED6') was filtered to include 'ED4' and 'CD8'. The terms 'N/A' and 'referral for ED4/ED5', 'suspended with pay' without a reference to ED4 or CD8, and blank cells, were excluded.

The number obtained was 19.

5.2 Department of Education

Analysis was conducted on the most recently provided version of the ED tracker for the Department of Education.[16] Column 'M' (labelled 'Type of ED – ED4, ED5 or ED6') was filtered to include 'ED4 suspension', 'ED4', 'ED4/ED5', 'ED4, ED5', 'ED4 & ED5', 'ED4 and ED5', 'ED5 & ED4', 'ED5 and ED4', 'ED5, ED4', 'ED5/ED4'. The terms 'NA' and 'referral for ED4/ED5', and blank cells, were excluded.

The number obtained was 38.

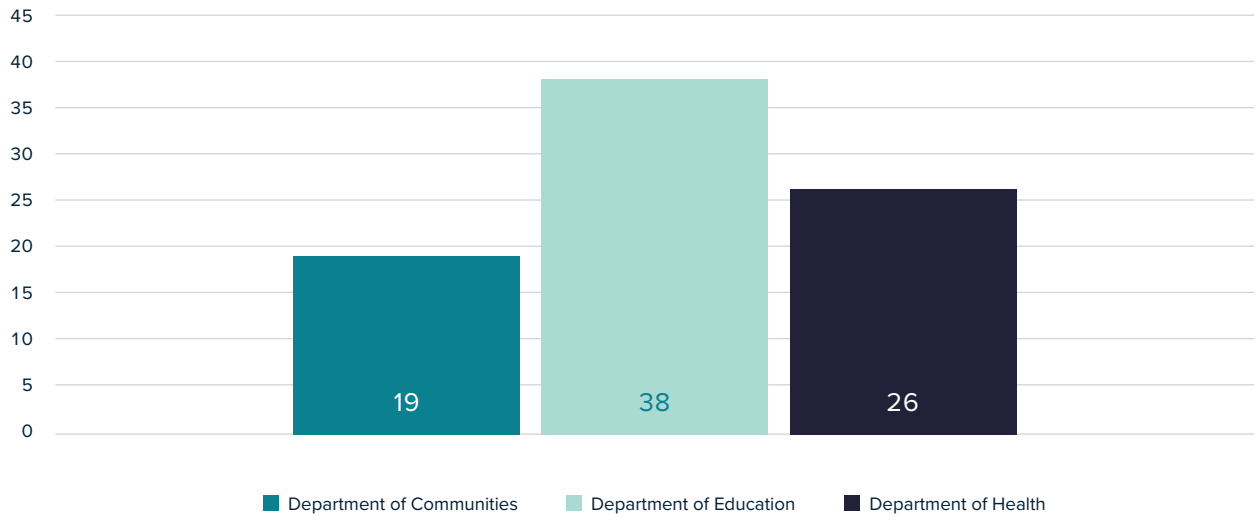
5.3 Department of Health

Analysis was conducted on the most recently provided version of the ED tracker for the Department of Health.[17] Column 'M' (labelled 'Type of ED – ED4, ED5 or ED6)' was filtered to include 'ED4 suspension' or 'ED4' and 'ED4 suspension – pending ED5/5 investigation (not commenced)'. The terms 'N/A', 'Pending', 'Stood down (not suspended)' and 'ED4 not applied', and blank cells, were excluded.

The number obtained was 26.

Figure H.3 provides a graphical representation of these numbers.

Figure H.3: Employment Direction No. 4—Suspension numbers by department from January 2000 to February 2023[18]



Source: Tasmanian Government, *ED trackers supplied by the Tasmanian Government in response to Commission notices to produce*, 2023.

6 Employment Direction No. 5—Breach of Code of Conduct numbers

We applied the following methodology to determine the number of Employment Direction No. 5—Breach of Code of Conduct that were conducted from the period January 2000 to February 2023 by respective department.

6.1 Department of Communities

Analysis was conducted on the most recently provided version of the ED tracker for the Department of Communities.[19] Column 'M' (labelled 'Type of ED – ED4, ED5 or ED6') was filtered to include 'ED5', 'ED6', 'ED5 investigation' and 'CD5 investigation'. The term 'No CD5 process', and blank cells, were excluded.

The number obtained was 26.

6.2 Department of Education

Analysis was conducted on the most recently provided version of the ED tracker for the Department of Education.[20] Column 'M' (labelled 'Type of ED – ED4, ED5 or ED6') was filtered to include 'Commissioners Direction No. 5', 'Commissioner's Declaration No. 5' , 'ED5', 'CD5', 'ED4/ED5', 'ED4, ED5', 'ED4 & ED5', 'ED4 and ED5', 'ED5 & ED4', 'ED5 and ED4', 'ED5, ED4', 'ED5/ED4'. The terms 'Referral for ED5' and 'NA', and blank cells, were excluded.

The number obtained was 50.

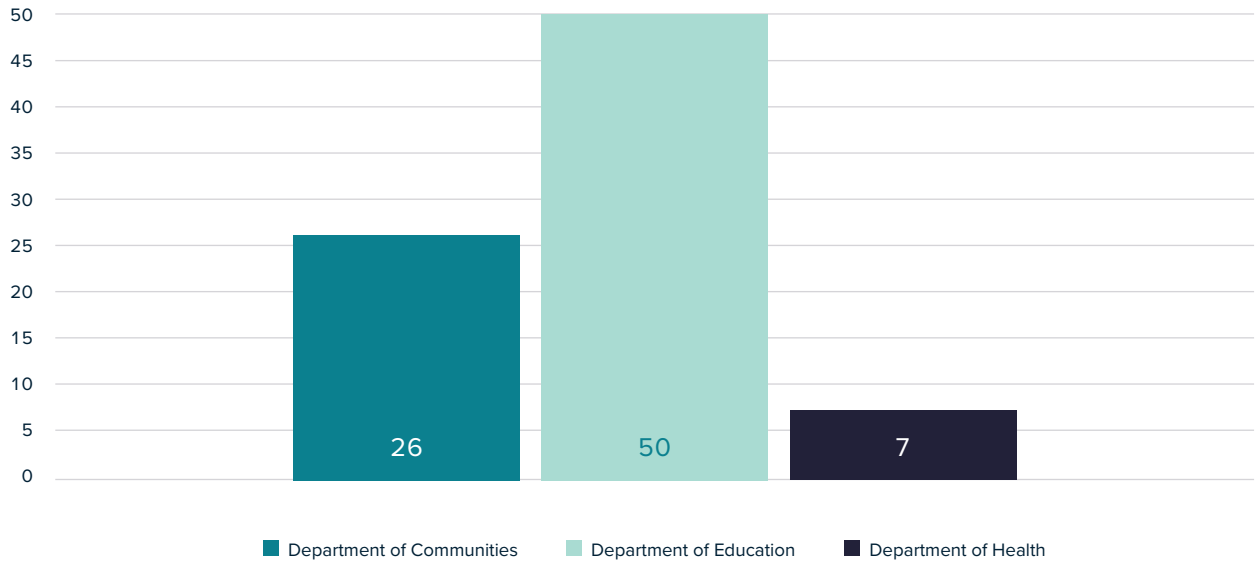
6.3 Department of Health

Analysis was conducted on the most recently provided version of the ED tracker for the Department of Health.[21] Column 'M' (labelled 'Type of ED – ED4, ED5 or ED6') was filtered to include 'ED5' and 'ED5 investigation'. The terms 'pending ED5', 'ED5/6 pending', 'N/A', 'Pending' and 'Stood down' were excluded.

The number obtained was 7.

Figure H.4 provides a graphical representation of these numbers.

Figure H.4: Employment Direction No. 5—Breach of Code of Conduct numbers by department from January 2000 to February 2023[22]



Source: Tasmanian Government, *ED trackers supplied by the Tasmanian Government in response to Commission notices to produce*, 2023.

7 Employment Direction No.6—Inability numbers

We applied the following methodology to determine the number of Employment Direction No. 6—Inability that were conducted from the period January 2000 to February 2023 by respective department.

7.1 Department of Communities

Analysis was conducted on the most recently provided version of the ED tracker for the Department of Communities.[23] Column 'M' (labelled 'Type of ED – ED4, ED5 or ED6') was filtered to include 'ED6'.

The number obtained was 0.

7.2 Department of Education

Analysis was conducted on the most recently provided version of the ED tracker for the Department of Education.[24] Column 'M' (labelled 'Type of ED – ED4, ED5 or ED6') was filtered to include 'ED6'.

The number obtained was 1.

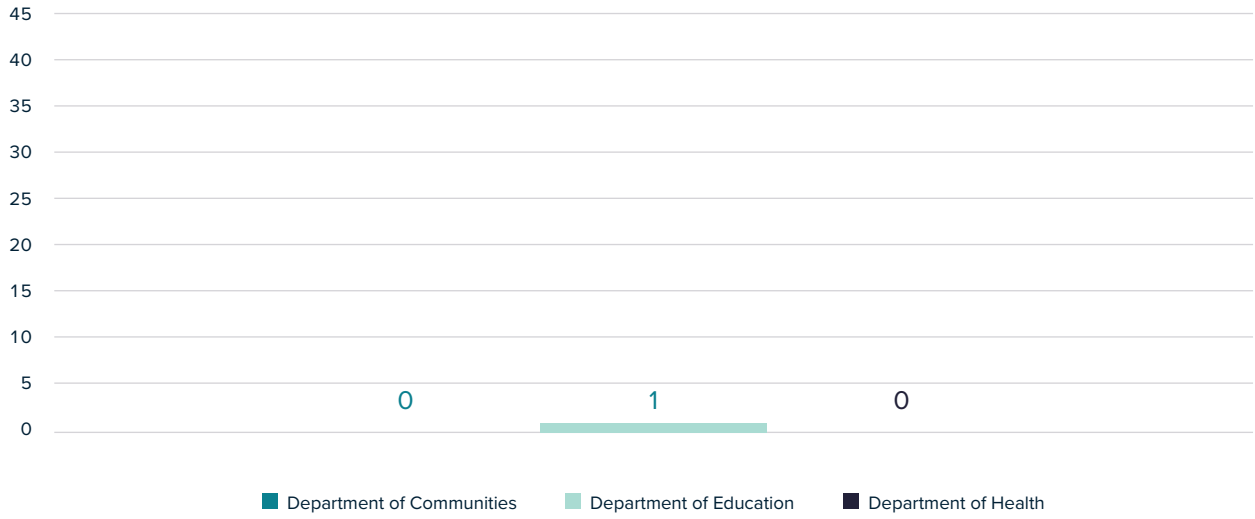
7.3 Department of Health

Analysis was conducted on the most recently provided version of the ED tracker for the Department of Health.[25] Column 'M' (labelled 'Type of ED – ED4, ED5 or ED6') was filtered to include 'ED6'. The term 'ED5/6 pending (not commenced)' was excluded.

The number obtained was 0.

Figure H.5 provides a graphical representation of these numbers.

Figure H.5: Employment Direction No. 6—Inability numbers by department from January 2000 to February 2023[26]



Source: Tasmanian Government, *ED trackers supplied by the Tasmanian Government in response to Commission notices to produce*, 2023.

Notes

1 Department of Communities, 'ED tracker' (Excel spreadsheet), 5 December 2022, produced by the Tasmanian Government in response to a Commission notice to produce; Department of Communities, 'ED tracker' (Excel spreadsheet), January 2023, produced by the Tasmanian Government in response to a Commission notice to produce; Department of Education, 'ED tracker' (Excel spreadsheet), 5 December 2022, produced by the Tasmanian Government in response to a Commission notice to produce; Department of Education, 'ED tracker' (Excel spreadsheet), 24 January 2023, produced by the Tasmanian Government in response to a Commission notice to produce; Department of Education, 'ED tracker' (Excel spreadsheet), 22 February 2023, produced by the Tasmanian Government in response to a Commission notice to produce; Department of Health, 'ED tracker' (Excel spreadsheet), 5 December 2022, produced by the Tasmanian Government in response to a Commission notice to produce; Department of Health, 'ED tracker' (Excel spreadsheet), January 2023, produced by the Tasmanian Government in response to a Commission notice to produce; Department of Health, 'ED tracker' (Excel spreadsheet), February 2023, produced by the Tasmanian Government in response to a Commission notice to produce; Department of Police, Fire and Emergency Management, 'ED tracker' (Excel spreadsheet), undated, produced by the Tasmanian Government in response to a Commission notice to produce.

2 Department of Communities, 'ED tracker' (Excel spreadsheet), January 2023, produced by the Tasmanian Government in response to a Commission notice to produce; Department of Education, 'ED tracker' (Excel spreadsheet), 22 February 2023, produced by the Tasmanian Government in response to a Commission notice to produce; Department of Health, 'ED tracker' (Excel spreadsheet), February 2023, produced by the Tasmanian Government in response to a Commission notice to produce.

3 Refer to, for example, Department of Communities, 'ED tracker' (Excel spreadsheet), January 2023, produced by the Tasmanian Government in response to a Commission notice to produce and Letter from Michael Pervan to the Commission of Inquiry, 10 February 2022.

4 Department of Communities, 'ED tracker' (Excel spreadsheet), January 2023, produced by the Tasmanian Government in response to a Commission notice to produce.

5 Department of Education, 'ED tracker' (Excel spreadsheet), 22 February 2023, produced by the Tasmanian Government in response to a Commission notice to produce.

6 Department of Health, 'ED tracker' (Excel spreadsheet), February 2023, produced by the Tasmanian Government in response to a Commission notice to produce.

7 Department of Communities, 'ED tracker' (Excel spreadsheet), January 2023, produced by the Tasmanian Government in response to a Commission notice to produce.

8 Department of Education, 'ED tracker' (Excel spreadsheet), 22 February 2023, produced by the Tasmanian Government in response to a Commission notice to produce.

9 Department of Health, 'ED tracker' (Excel spreadsheet), February 2023, produced by the Tasmanian Government in response to a Commission notice to produce.

10 Department of Communities, 'ED tracker' (Excel spreadsheet), January 2023, produced by the Tasmanian Government in response to a Commission notice to produce; Department of Education, 'ED tracker' (Excel spreadsheet), 22 February 2023, produced by the Tasmanian Government in response to a Commission notice to produce; Department of Health, 'ED tracker' (Excel spreadsheet), February 2023, produced by the Tasmanian Government in response to a Commission notice to produce.

11 Department of Communities, 'ED tracker' (Excel spreadsheet), January 2023, produced by the Tasmanian Government in response to a Commission notice to produce.

12 Department of Education, 'ED tracker' (Excel spreadsheet), 22 February 2023, produced by the Tasmanian Government in response to a Commission notice to produce.

13 Department of Health, 'ED tracker' (Excel spreadsheet), February 2023, produced by the Tasmanian Government in response to a Commission notice to produce.

14 Department of Communities, 'ED tracker' (Excel spreadsheet), January 2023, produced by the Tasmanian Government in response to a Commission notice to produce; Department of Education, 'ED tracker' (Excel spreadsheet), 22 February 2023, produced by the Tasmanian Government in response to a Commission notice to produce; Department of Health, 'ED tracker' (Excel spreadsheet), February 2023, produced by the Tasmanian Government in response to a Commission notice to produce.

15 Department of Communities, 'ED tracker' (Excel spreadsheet), January 2023, produced by the Tasmanian Government in response to a Commission notice to produce.

16 Department of Education, 'ED tracker' (Excel spreadsheet), 22 February 2023, produced by the Tasmanian Government in response to a Commission notice to produce.

17 Department of Health, 'ED tracker' (Excel spreadsheet), February 2023, produced by the Tasmanian Government in response to a Commission notice to produce.

18 Department of Communities, 'ED tracker' (Excel spreadsheet), January 2023, produced by the Tasmanian Government in response to a Commission notice to produce; Department of Education, 'ED tracker' (Excel spreadsheet), 22 February 2023, produced by the Tasmanian Government in response to a Commission notice to produce; Department of Health, 'ED tracker' (Excel spreadsheet), February 2023, produced by the Tasmanian Government in response to a Commission notice to produce.

19 Department of Communities, 'ED tracker' (Excel spreadsheet), January 2023, produced by the Tasmanian Government in response to a Commission notice to produce.

20 Department of Education, 'ED tracker' (Excel spreadsheet), 22 February 2023, produced by the Tasmanian Government in response to a Commission notice to produce.

21 Department of Health, 'ED tracker' (Excel spreadsheet), February 2023, produced by the Tasmanian Government in response to a Commission notice to produce.

22 Department of Communities, 'ED tracker' (Excel spreadsheet), January 2023, produced by the Tasmanian Government in response to a Commission notice to produce; Department of Education, 'ED tracker' (Excel spreadsheet), 22 February 2023, produced by the Tasmanian Government in response to a Commission notice to produce; Department of Health, 'ED tracker' (Excel spreadsheet), February 2023, produced by the Tasmanian Government in response to a Commission notice to produce.

23 Department of Communities, 'ED tracker' (Excel spreadsheet), January 2023, produced by the Tasmanian Government in response to a Commission notice to produce.

24 Department of Education, 'ED tracker' (Excel spreadsheet), 22 February 2023, produced by the Tasmanian Government in response to a Commission notice to produce.

25 Department of Health, 'ED tracker' (Excel spreadsheet), February 2023, produced by the Tasmanian Government in response to a Commission notice to produce.

26 Department of Communities, 'ED tracker' (Excel spreadsheet), January 2023, produced by the Tasmanian Government in response to a Commission notice to produce; Department of Education, 'ED tracker' (Excel spreadsheet), 22 February 2023, produced by the Tasmanian Government in response to a Commission notice to produce; Department of Health, 'ED tracker' (Excel spreadsheet), February 2023, produced by the Tasmanian Government in response to a Commission notice to produce.