
TRANSCRIPT OF PROCEEDINGS

**COMMISSION OF INQUIRY INTO THE TASMANIAN GOVERNMENT'S
RESPONSES TO CHILD SEXUAL ABUSE IN INSTITUTIONAL SETTINGS**

**At Hearing Rooms 6A and 7A
Tasmanian Civil and Administrative Tribunal,
38 Barrack Street, Hobart**

BEFORE:

**The Honourable M. Neave AO (President and Commissioner)
Professor L. Bromfield (Commissioner)
The Honourable R. Benjamin AM (Commissioner)**

On 4 May 2022 at 10.09am

(Day 3)

1 MS ELLYARD: Good morning, Commissioners. Our first
2 session today is a panel which comprises Professor Donald
3 Palmer, who appears remotely, and Dr Michael Guerzoni who
4 appears in person. I ask that both of them first be asked
5 to take the affirmation.

6
7 <MICHAEL ANDRE GUERZONI, affirmed and examined: [10.10am]

8
9 <DONALD ANTHONY PALMER, affirmed and examined:

10
11 <EXAMINATION BY MS ELLYARD:

12
13 MS ELLYARD: Thank you. Professor Palmer, may I begin
14 with you; could I ask you again, please, your full name?

15
16 PROF PALMER: Donald Anthony Palmer.

17
18 MS ELLYARD: You're presently a Professor at the Graduate
19 School of Management at the University of California,
20 Davis?

21
22 PROF PALMER: That's correct.

23
24 MS ELLYARD: You've made a statement to assist the work of
25 the Commission dated 12 April 2022; is that right?

26
27 PROF PALMER: That is right.

28
29 MS ELLYARD: Do you have a copy of that statement with
30 you?

31
32 PROF PALMER: I do.

33
34 MS ELLYARD: Are the contents true and correct?

35
36 PROF PALMER: They are.

37
38 MS ELLYARD: And you've marked and attached as an exhibit
39 to your statement a copy of your full curriculum vitae?

40
41 PROF PALMER: That is correct.

42
43 MS ELLYARD: And you've also attached for the assistance
44 of the Commission a copy of an article written by you and a
45 colleague dealing with some of the matters relevant to the
46 work of the Commission?

1 PROF PALMER: That is correct.

2
3 MS ELLYARD: Thank you. May I turn to you, Dr Guerzoni,
4 and ask you again your full name?

5
6 DR GUERZONI: Michael Andre Guerzoni.

7
8 MS ELLYARD: You're presently engaged in academia at the
9 University of Tasmania; is that right?

10
11 DR GUERZONI: That's correct.

12
13 MS ELLYARD: That's the role that you are currently
14 performing?

15
16 DR GUERZONI: I'm a lecturer in criminology but my title
17 is Indigenous Fellow.

18
19 MS ELLYARD: Drawing your attention to paragraph 7 and
20 following of the statement that you've made, could you
21 summarise for us, please, the areas of work that you're
22 engaged in as they relate to the work of the Commission?

23
24 DR GUERZONI: Yes, thank you. I lecture in child
25 protection and juvenile justice which covers material on
26 Ashley Youth Detention Centre, and I also research in the
27 prevention of child sexual abuse in religious
28 organisations.

29
30 MS ELLYARD: As I understand it, you also have a
31 professional interest in the wellbeing of Aboriginal and
32 Torres Strait Islander children?

33
34 DR GUERZONI: That is correct.

35
36 MS ELLYARD: And a personal interest as well; is that
37 right?

38
39 DR GUERZONI: That is correct. I am a descendent of the
40 Trawulwuy People in the northeast of Tasmania and a member
41 of the Tasmanian Briggs Aboriginal family.

42
43 MS ELLYARD: Thank you. You've made a statement to assist
44 the work of the Commission dated 29 April 2022. You've got
45 a copy of that statement in front of you?

46
47 DR GUERZONI: I do indeed.

1
2 MS ELLYARD: There's a minor correction that as I
3 understand it you wish to make to paragraph 74, so I'll
4 invite everyone to look at paragraph 74. Am I right,
5 Dr Guerzoni, that in the final line of paragraph 74 you
6 wish to add a word so that the sentence will read:

7
8 *... rather than to respond solely*
9

10 Insert the word "solely":

11
12 *... to an event of abuse by reporting it*
13 *externally to police.*
14

15 DR GUERZONI: That's correct, and please, an addition of a
16 comma after "abuse".
17

18 MS ELLYARD: Commissioners, that last line should read,
19 with the amendments that Dr Guerzoni wants:

20
21 *... rather than to respond solely to an*
22 *event of abuse, by reporting it externally*
23 *to police.*
24

25 With that amendment made, are the contents of your
26 statement true and correct?
27

28 DR GUERZONI: That is correct.
29

30 MS ELLYARD: The focus of today's session is going to be
31 about questions of organisations and organisational culture
32 and the way in which those matters are relevant to the work
33 of the Commission, but perhaps to begin, we've heard some
34 evidence already this week about the way in which the
35 Commission should regard that cohort of offenders who are
36 motivated actively by a desire to sexually abuse children
37 and might enter organisations for precisely that reason.
38

39 Professor Palmer, you've made it plain in your
40 statement that your area of interest is less to do with
41 that cohort of offenders and more to do with another cohort
42 who you go on to deal with in your statement?
43

44 PROF PALMER: That is correct.
45

46 MS ELLYARD: Dr Guerzoni, you've made the point at
47 paragraph 16 and following of your statement that in your

1 view there are some common misconceptions about the cohort
2 of people who engage in child sexual abuse within
3 institutions, can you tell us a bit what that misconception
4 is?

5
6 DR GUERZONI: There's a common belief that all individuals
7 who abuse children sexually are paedophiles, however
8 criminal logical literature shows us that there's a breadth
9 in the type of offenders we have, and so, by only assuming
10 that it's a paedophile, it means that there's a
11 misunderstanding about the clinical diagnosis, but also in
12 my view it narrows the scope of the people we're looking
13 out for in terms of our prevention efforts.

14
15 MS ELLYARD: And so, would I be right to understand,
16 looking first to you, Professor Palmer, that it's important
17 to consider the ways in which organisations themselves,
18 rather than just the people in them, might be creating
19 circumstances where the abuse of children is possible?

20
21 PROF PALMER: That's correct. As I say in my statement,
22 organisations are what social psychologists refer to as
23 "strong situations", which have a substantial impact in the
24 way people think, feel and behave.

25
26 MS ELLYARD: Thank you for referring to that reference to
27 strong situation; that's at paragraph 11 of your statement.
28 Can I invite you, by reference to paragraph 11 and 12, tell
29 us a bit about what it means to be a strong situation and
30 the ways in which organisations can operate to affect
31 behaviour?

32
33 PROF PALMER: So, any social organisation like the family
34 has structures and processes that shape behaviour within
35 them; we have roles, mother and father, that sort of thing.
36 But organisations have much more refined structures and
37 processes that regulate behaviour; they have administrative
38 systems, rules and regulations, division of labour,
39 separation of responsibilities into tasks, they have a
40 vertical structure, a power structure that includes
41 different positions in the chain of command. We could go
42 on but I think I'll stop there.

43
44 MS ELLYARD: And I want to ask you to expand on a couple
45 of them, professor. One of the structures and processes
46 that you identify at paragraph 14 of your statement is
47 formal authority and also informal power relationships.

1 Can I ask you to expand what you mean by those two
2 different kinds of authority and relationships?

3
4 PROF PALMER: Sure. So, I think most of us who work in
5 organisations are very familiar with the hierarchical chain
6 of command. We learn early on in life that we obey those
7 who are superior to us in the organisations which we are
8 located. If you're in a school you obey the orders of the
9 teacher; the teachers obey the order of the principal, that
10 sort of thing.

11
12 Informal power is rooted in the control of scarce and
13 important resources. So, a coach for example in a sporting
14 club might have little formal authority; they may have a
15 number of people above them in the chain of command, but
16 insofar as they possess expertise that is valued by the
17 club, the ability to train athletes so they're successful
18 on the pitch, that gives them informal power.

19
20 MS ELLYARD: Can another way of gaining informal power be
21 through personal style? You've identified later in your
22 statement at paragraph 44 that the role that charisma can
23 play sometimes, and the Commission has got a number of
24 examples before it where it might not have been the person
25 at the head of an organisation but somehow through personal
26 relationships or charisma they were able to obtain power
27 and avoid detection when they became offenders.

28
29 PROF PALMER: Yeah. So, academics, of course, care a lot
30 about words and definitions and parsing distinctions. So,
31 I think charisma is not a source of informal power unless
32 it's viewed as a resource. So, if a teacher is viewed as
33 charismatic, and part of the reason that is the case is
34 because they are viewed as someone who can inspire students
35 to do particularly well, then they would be considered to
36 possess informal power insofar as they possess that
37 resource which is valued by the organisation.

38
39 Sometimes people viewed as charismatic because they
40 have appealing attributes, status characteristics and that
41 has more to do with the position in informal groups.

42
43 MS ELLYARD: Thank you. Finally, one of the other
44 important structures that you identified at paragraph 18
45 and following of your statement is the question of culture,
46 and can I ask you first to outline what you mean by
47 culture? And then I want to turn to Dr Guerzoni on the

1 same point.

2

3 PROF PALMER: Sure. So, as I said, academics care a lot
4 about definitions and terminology and that sort of thing so
5 we can get involved in disputes about what is culture and
6 what is not culture. But sociologists tend to view culture
7 in a very precise way to mean shared understandings about
8 the way the world is and the way the world should be.

9

10 So, you may have worked in an organisation where the
11 assumption was that the environment is competitive and that
12 we're not here to help one another out, we're here to do as
13 best we can in the tasks we do and we shouldn't bother with
14 what other people are doing: that's an assumption about the
15 state of the world.

16

17 MS ELLYARD: Can I turn to you, Dr Guerzoni, on this
18 question of culture and assumptions that might underpin the
19 way an organisation works. At paragraph 38 and 39 of your
20 statement, linked back to the evidence you've already given
21 about what you say is a misconception about who offenders
22 are, you identify how that misconception can then create
23 cultural attitudes that might be a barrier to protecting
24 children. Can you tell us about that, please?

25

26 DR GUERZONI: Yes, thank you. I would agree with
27 Professor Palmer, it's an underlying assumption which
28 guides how social phenomena or occurrences within an
29 organisational setting is viewed as well as problems within
30 an institution and, from that, regulates what is deemed to
31 be normative practice within an organisational setting.
32 And so, within my research my concern as to understandings
33 of abuse causation is that, when there's a fixed
34 understanding as to what an offender is, that will colour
35 all of the interpretations of institutional policy and
36 procedure towards child sexual abuse and, in turn, it may
37 lead to non-compliance with what is written down in the
38 policies and procedures.

39

40 MS ELLYARD: And so, at paragraph 39 you identify a
41 culture might emerge where people assume that people
42 already inside are safe and the only risk is someone
43 dangerous coming in from outside?

44

45 DR GUERZONI: That's right. So, if there's an
46 understanding that only paedophiles are the ones to be
47 concerned about, and by extension that it's the police

1 check that's the main protective factor for an
2 organisation, it can mean that individuals can see their
3 colleagues as safe by extension because they have already
4 passed through that process of being screened and then
5 being appointed to their role.

6
7 MS ELLYARD: Can I turn to you, Professor Palmer. You
8 identify as well the question of socialisation as another
9 means by which an organisation might operate to influence
10 people's behaviour, including potentially in ways that will
11 blind them to the risks associated with child sexual abuse.
12 It's at paragraph 21 and following of your statement, could
13 I ask you to summarise what we mean when we talk about
14 socialisation in this context?

15
16 PROF PALMER: Well, sociologists who study socialisation
17 have a very specific idea of what it entails, so let's just
18 start with a very brief characterisation of it by saying
19 what it is not, which is socialisation is not simply the
20 imparting of information.

21
22 So, I'm in training to be a court appointed special
23 advocate for foster children and we are getting educated as
24 part of our training in how we are to import ourselves with
25 regard to the different professionals in the foster care
26 system, but to pick up on something that Dr Guerzoni just
27 said, we never discuss the possibility that court appointed
28 special advocates might have inappropriate relationships
29 with children, so there's an implicit assumption in the
30 training which perhaps the trainers don't understand, which
31 is that court appointed special advocates, we call them
32 CASAs, could never abuse a child. That's delivering an
33 assumption about the way the world works that is not
34 conveyed specifically in the training.

35
36 MS ELLYARD: And so, would one aspect of socialisation be,
37 for example, that once someone, perhaps with existing
38 skills and experience comes into an organisation, they
39 might be socialised inside that organisation into certain
40 attitudes or expectations that they wouldn't have had
41 before they entered the organisation?

42
43 PROF PALMER: Absolutely, and my guess is Professor
44 Guerzoni can speak to this if he studies juvenile detention
45 facilities. People who become guards in a detention
46 facility very quickly learn from their peers what the
47 culture of that organisation is and it may be, for example,

1 never trust a child and what they say. That might not have
2 been a view that they held before they took the job as
3 guard in a juvenile detention facility.
4

5 MS ELLYARD: Indeed, Dr Guerzoni at paragraph 83 of your
6 statement you touch on this matter by reference to Ashley.
7 Am I right in understanding that what you're raising there
8 is the possibility that, whatever might be the backgrounds
9 and skills of staff once they arrive at Ashley, their
10 behaviours and attitudes might be changed by that
11 environment?
12

13 DR GUERZONI: Yes, that's right. So, within an
14 organisational setting, as Professor Palmer said, there's a
15 process of socialisation and that can be both formal and
16 informal. Formal would be in training procedures, a
17 mentoring arrangement between a more senior staff member
18 and a junior staff member, but also the literature shows us
19 that there's informal ways of socialisation.
20

21 So, the so-called water cooler conversations,
22 lunchtime conversations, barbecue chats and that kind of
23 thing where informal tips on how to do the job or ways of
24 seeing problems and situations which arise within an
25 organisational setting and how to respond to those. So,
26 they're ways of socialisation, and in the case of Ashley,
27 from reports that I've read from 2015, which I think was
28 the METUS report, the 2016 report by Noetic, and I think
29 there was a 2005 report by the Department of Health and
30 Human Services.
31

32 Each of those, to my understanding, reference a
33 culture which is unfavourable and so it's my assumption
34 based on these facts within these documents that there
35 would be a negative socialisation taking place.
36

37 MS ELLYARD: And that that's why successive generations of
38 staff working at Ashley might continue to exhibit
39 behaviours and attitudes from years past?
40

41 DR GUERZONI: That's my understanding, yes.
42

43 MS ELLYARD: Can I turn to the question of offenders.
44 Each of you in your statements has identified the idea of
45 offenders as being situational offenders rather than people
46 who enter an organisation with a predetermined idea that
47 they will abuse children. Turning first to you please,

1 Professor Palmer, at paragraph 25 and following you talk
2 about this. What do we mean when we talk about situational
3 offenders in the child abuse context?

4
5 PROF PALMER: Well, I think you just described it, which
6 is situational offenders are people who do not have an
7 abiding sexual interest in children, don't enter youth
8 serving organisations with that abiding sexual interest,
9 but once there for reasons related to the nature of the
10 organisation develop an interest often in a specific youth
11 or child.

12
13 MS ELLYARD: Dr Guerzoni, you deal with this at
14 paragraph 28 and following in your statement. When we talk
15 about situational offending, do we mean that it's the
16 environment that causes someone to offend?

17
18 DR GUERZONI: It is, in part, yes. So, a situational -
19 situational factors can lead individuals with pre-existing
20 desires to offend against children to take up that
21 opportunity, but also, as Professor Palmer said,
22 situational factors can over time lead people to criminal
23 decision-making. So, it can mean that the child - sorry,
24 that the employee is placed in a position with a child, for
25 instance a certain duty of care, a certain responsibility
26 so that they're close with the child over a period of time,
27 and the literature says that over that period there can be
28 an erosion of boundaries between the practitioner and the
29 child.

30
31 Others point to the fact that the stressors of the job
32 and the hierarchical nature, and this is within the work of
33 Marie Keenan, who's an Irish criminologist, point to the
34 fact that these can also erode boundaries between the
35 practitioner and the child which leads the practitioner to
36 choose to offend.

37
38 MS ELLYARD: And that's an important point, isn't it;
39 we're not suggesting in any way that the situational nature
40 of offending makes the offending less serious?

41
42 DR GUERZONI: That's right, and I think for those of us
43 who study this field it makes sense, but when we remember
44 what we talked about earlier, that most people understand
45 that only sexual offenders are paedophiles, this material
46 from the criminological literature can be confronting but
47 know we're always saying that there was a choice by a

1 rational decision-maker and it's a horrible crime.

2

3 MS ELLYARD: But as I understand it from what you've said,
4 Dr Guerzoni, and what's in paragraph 29 and following of
5 your statement, when we think about a situational
6 perspective we can be thinking both about matters personal
7 to an offender that make them vulnerable to over time cross
8 a line, but we can also be talking about situations
9 referable to the particular environment or institution in
10 which they're working?

11

12 DR GUERZONI: That's right.

13

14 MS ELLYARD: And perhaps when a maligned combination of
15 those two things will create an opportunity for someone to
16 make the choice to offend?

17

18 DR GUERZONI: Right, so they can be geographical,
19 architectural and social.

20

21 MS ELLYARD: Professor Palmer, is that right, we can think
22 about situational offending occurring both because of
23 matters personal to a person and to their environment?

24

25 PROF PALMER: Yes, that's correct.

26

27 MS ELLYARD: And so, can we turn then to think about what
28 we can do about the institutional aspect of that. At
29 paragraph 32 and following of your statement, Professor
30 Palmer, you have started to deal with this question and
31 thinking about features of an organisation which will
32 create a situation where abuse might be more likely. Can I
33 draw your attention to paragraphs 32 and following and ask
34 you to summarise what we can say about organisations that
35 will make them more vulnerable to abuse occurring?

36

37 PROF PALMER: More vulnerable?

38

39 MS ELLYARD: Yes.

40

41 PROF PALMER: Well, unfortunately, we don't have enough
42 time to talk about all the many ways that organisations can
43 facilitate and make abuse likely, but certainly the
44 organisational culture that we've begun to talk about is
45 one organisational structure which shapes the way people
46 think, feel and behave. So, if guards are socialised to
47 view children as not as human as the rest of us, and that

1 entails partly not being affected by maltreatment, then
2 guards are more likely to treat children as if they don't
3 have the same rights as the rest of us.

4
5 MS ELLYARD: Dr Guerzoni, in your statement you've
6 identified and as you've just summarised, four features
7 that you would - four areas in which institutions might be
8 places where there's a high risk of abuse: structural
9 issues, cultural issues, issues of perception and
10 environmental factors.

11
12 Starting with structural questions which I understand
13 you to refer to in part as the hierarchies in institutions,
14 what's the way in which structural matters in your view can
15 increase the vulnerability of an institution to abuse
16 occurring?

17
18 DR GUERZONI: Yes, thank you. Closed institutions is one,
19 so an institution which is set aside from common people -
20 sorry, members of the public attending and being able to
21 witness what's going on: that's one. But also structures
22 which are very strict hierarchies, large hierarchies where
23 there's a very set chain of command, and we see this within
24 religious organisations in particular. Marie Keenan again
25 talks about this in respect to the Roman Catholic Church.
26 The Anglican Church of Australia also has similar
27 responsibilities, or maybe the military too, where there's
28 a set hierarchy, individuals are institutionalised to see
29 that it's just the next person up who deals with the
30 matter. So, I guess that would be one important part of
31 that.

32
33 MS ELLYARD: Professor Palmer, at paragraph 40 of your
34 statement you talk about the role of authority and you
35 express the view that there's an underestimation perhaps of
36 the extent to which power and authority are relevant
37 factors in institutional abuse. Can you tell us about
38 that?

39
40 PROF PALMER: Well, I believe you're referring to a
41 paragraph where I talk about the different bases of
42 authority in organisations?

43
44 MS ELLYARD: Indeed.

45
46 PROF PALMER: So, most of us work in organisations where
47 the basis of authority is what Max Weber, a famous

1 sociologist, referred to as rational legal phenomenon. So
2 we obey our superiors because we believe they are the owner
3 of the enterprise or they have obtained their position by
4 virtue of demonstrating competence.

5
6 But there are two other bases of authority and one of
7 which is religious authority, and the other is charismatic
8 authority, and both those types of authorities provide
9 those in positions of authority with much wider scope of
10 command. So, my guess is, your superior cannot tell you
11 what to eat and what not to eat, but a charismatic
12 gymnastics coach can tell his or her athletes what they
13 should eat and not eat, when they should go to bed, who
14 they should associate with, these sorts of things.

15
16 MS ELLYARD: Thank you. Can I turn to the question of
17 culture, and we've already touched on culture at a number
18 of points but I'll come back to it because we're concerned
19 about it.

20
21 Dr Guerzoni, at paragraph 52 and 53 of your statement
22 you talk about the role of culture; can you tell us a bit
23 about that?

24
25 DR GUERZONI: Yes. So, a culture as we've described is an
26 understanding of the world around them and how to respond
27 to certain problems or matters which arise within an
28 organisational setting and this is collectively held by
29 individuals within an organisation.

30
31 There's also subcultures as well. So, within large
32 organisations certain departments might have their own
33 cultural understandings, and so, within organisations we've
34 looked at in this field how cultures of secrecy, cultures
35 of self-preservation can emerge within an organisation, and
36 that can lead to individuals not reporting child sexual
37 abuse events and concerns to the authorities.

38
39 But I think what's important, at least in my view to
40 note, is that self-preservation is inherent of every
41 organisation, because it's like an organism, it wants to
42 stay alive and so its individual members over time can be
43 socialised to be concerned about the self-preservation of
44 an organisation or other forms of culture. For example,
45 that children are deviant; that might be a cultural view
46 within an organisation, or if we think about child
47 protection, some people might have the view these children

1 are annoying or not worthy of care. So, an individual can
2 come into an organisation and over time be battered and
3 worn away and be socialised to go from A, being pro
4 children, to B, having these unfavourable views about
5 children over time.

6
7 MS ELLYARD: Professor Palmer, at paragraphs 32 and
8 following in your statement you touch on some of these
9 matters and you identify by way of an example in
10 paragraph 33 there might be features which are not malign
11 in themselves about an attitude of sportsman towards hard
12 work and so forth that might create a culture which, as
13 well as making them work hard at sport, might also make
14 them less likely to complain if they're mistreated.

15
16 PROF PALMER: Yes. So, this is particularly the case of
17 boys where my own personal experience is that it's
18 considered a good thing for boys to tolerate difficult
19 situations, including being bullied, and maybe even
20 physically harmed, that it's good for boys to tolerate
21 that, to stoically accept it and move on; that's a sign of
22 becoming more mature, and it certainly would keep somebody
23 from reporting being abused.

24
25 MS ELLYARD: And as I understand it you've also identified
26 that some of those settings where there might be close
27 contact and benign close contact at first between sports
28 coaches perhaps and young men and young women, that might
29 be the kind of environment where as you say at paragraph 36
30 you treat the children almost as young adults and that
31 might increase the risk of a blurring of boundaries and
32 inappropriate behaviour occurring.

33
34 PROF PALMER: Yes. So, some sports in order for coaches
35 to instruct their athletes they have to be in physical
36 contact with the athlete, as the case would be for
37 wrestling for example or gymnastics or in some case
38 swimming. It's very different than, say, coaching what we
39 call in America baseball or cricket, where there's no need
40 for the coach to be touching the child. Also in some
41 sports children are wearing less clothes than others, and
42 so, these are all cases which would bring the adult into
43 close contact with a child on a repetitive basis, which
44 then could eventually lead to inappropriate relationships.

45
46 MS ELLYARD: Thank you. Dr Guerzoni, the third topic that
47 you identify is what you've called perceptual features and

1 practice and you talk about that at paragraph 54. To some
2 extent we've touched on some of these things but as I
3 understand it you've also identified that there can be
4 circumstances where organisations see child abuse as
5 something that doesn't happen or is a matter of historical
6 record rather than current risk.

7
8 DR GUERZONI: Yes, that's right. So, my field is looking
9 at church responses to abuse and we've seen that in several
10 studies now individuals have the view that it's in the
11 past, and to one extent that's understandable because we
12 know that the Royal Commission has taken place and that was
13 a monumental occurrence in our society, but it means that
14 individuals can have a tick the box view and think, that's
15 done and in the past, but we know that that's not the case,
16 that these crimes are always a risk in our society. And so
17 we see that within some religious institutions the idea of
18 "it will never happen again" or that "it won't happen here
19 because I know the people, I trust the people" and that
20 goes back to what we were saying before about individuals
21 have gone through the hoops of being screened so they're
22 deemed to be safe by individuals within the organisation
23 even though that might not be the case.

24
25 MS ELLYARD: Professor Palmer, at paragraph 31 of your
26 statement you talk about the role of cognitive biases and
27 the ways in which people might in various ways persuade
28 themselves that there's no risk or that what they're seeing
29 isn't what's happening. There's three different ones that
30 you identify, could I ask you to speak to each of them
31 briefly in turn?

32
33 PROF PALMER: You may have to remind me, but I know I talk
34 about cognitive dissonance, and this is consistent with
35 what Professor Guerzoni just discussed, which is our
36 tendency to ignore information which contradicts closely
37 held beliefs either about ourselves or others. So, if
38 information comes to us that a close friend has been
39 behaving inappropriately with a child, there is a tendency
40 for us to ignore that information, to discount it.

41
42 Another cognitive bias which I believe I talked about
43 is discounting the future; is that correct?

44
45 MS ELLYARD: Yes, that's right.

46
47 PROF PALMER: There's no shortage of these, by the way.

1 So, and this is the problem with any deterrence system,
2 which is, typically we hope that if we put monitoring and
3 punishment systems in place, people respond to those things
4 and not engage in the behaviour that we're trying to
5 discourage. The problem is that the benefits of engaging
6 in a behaviour are immediate and the possible consequences
7 of that are far in the future. So, you could imagine a
8 high school teacher succumbing to an attraction to a child,
9 a young adult, feeling they'll never get caught or if they
10 do they probably won't have severe consequences because
11 this is something deep into the future.

12
13 MS ELLYARD: The third one you've identified is motivated
14 blindness, can you tell us about that?

15
16 PROF PALMER: So, this is related to cognitive dissonance
17 in the following respect, which is that if somebody tells
18 us information that, if we paid attention to, would cause
19 us to have to do things which would bring us discomfort we
20 tend to ignore that information. So, in the case of a
21 famous case of child sexual abuse at Pennsylvania State
22 University in the United States an assistant coach came to
23 the head coach and said, "You know, one of our other
24 coaches is abusing a child." Well, if the head coach were
25 to report that, that would cause problems for him and the
26 entire football program, so they're likely to call that
27 information into question, "Are you sure you really saw
28 what you saw?" "Why don't you continue to watch this
29 person, let me know if you continue to see that", and this
30 is one way that reporting is undermined.

31
32 MS ELLYARD: As I understand it, just to follow that
33 point further, professor, what you're identifying there;
34 it's less work for the person who's had a problem drawn to
35 their notice to persuade themselves that it's not really a
36 problem because there's personal consequences for them if
37 they take it seriously and take it further?

38
39 PROF PALMER: Yes, and the key distinction between
40 cognitive dissonance and motivated blindness is that the
41 information is being ignored because of the personal
42 consequences, so you put that well.

43
44 MS ELLYARD: Dr Guerzoni, this seems to raise the question
45 of the extent to which people think of children as being
46 real people with the same rights and opportunities for
47 protection as adults, including adults in positions of

1 power.

2

3 DR GUERZONI: Yes, that's right.

4

5 MS ELLYARD: And so, it follows then, I take it, that part
6 of the key role of policies and so forth in keeping
7 children safe will be policies that have at their heart a
8 core principle that children are human beings just like
9 anyone else?

10

11 DR GUERZONI: Yes, and that is imbued within the culture
12 of the organisation.

13

14 MS ELLYARD: Can I turn then to the question about policy
15 because each of you in your statements have talked about
16 what policies can do but also what policies can't do, the
17 limitations of them.

18

19 Turning first to you, Professor Palmer, at
20 paragraph 45 and following of your statements you describe
21 the way in which organisations sometimes view policies as a
22 complete fix. Can you tell us what that view is and why
23 they're wrong when they think that policies of themselves
24 can do the job?

25

26 PROF PALMER: So there's one general reason and one
27 specific one. The general reason why policies and
28 procedures are not a comprehensive solution is because they
29 only address one aspect of the organisation, the
30 administrative system. So, they don't address culture,
31 they don't address power, they don't address informal
32 groups, they don't address socialisation.

33

34 But there's a specific reason and that is that
35 organisational theorists distinguish between organisations
36 on the basis of the nature of their technology. There's an
37 important concept here which is whether technologies are
38 certain or uncertain. Uncertain technologies make use of
39 procedures for transforming inputs that are less codified,
40 and the inputs themselves are highly variable: that is a
41 prototypical youth serving organisation. Kids are
42 different from one another, vary tremendously between kids
43 and over time. One kid can be different one day than they
44 were the last day and our knowledge about how to process
45 children is relatively uncoded. Those kinds of
46 organisations do not do well with highly specified rigid
47 rules and regulations, because they simply can't be applied

1 effectively to these very highly variable inputs in the
2 context of our relatively imperfect understanding of how to
3 transform kids into the outputs that we're seeking, whether
4 it's a trained athlete, an educated child, an obedient
5 law-abiding kid, these sorts of things.

6
7 MS ELLYARD: Thank you. Dr Guerzoni, you've identified at
8 paragraph 68 in your statement that in your research you've
9 observed organisations tend to have an over-reliance on
10 policy as a solution. Can you tell us about that?

11
12 DR GUERZONI: Yes, thank you. There's an expression that
13 organisational academics use and I'm sure you've all heard
14 it before, it's that culture eats policy for breakfast.
15 And so, we can have an idea that, by introducing policy,
16 that that will mean that everyone in the organisation will
17 automatically follow it. But as we've said before,
18 organisational culture determines the value of policy and
19 procedure, and so, in my research of religious
20 organisations we see that policy can be seen by some as
21 important and valuable; it can be seen by others as a
22 hindrance to the core things that are part of their job or
23 axiomatic knowledge, as Janet Chan from New South Wales
24 calls it.

25
26 And so, yeah, there can be an over-reliance on policy
27 by leadership to assume that they just need to go to the
28 board meeting and pass the policy rather than work with the
29 people within their organisation to socialise the values
30 and the expectations that the policies have within them.

31
32 MS ELLYARD: One of the things that you've identified,
33 Dr Guerzoni, at paragraph 80 and 81 of your statement is
34 that part of the solution perhaps is that it shouldn't be
35 left to an organisation once someone lands in it, to teach
36 them about the importance of safeguarding; that really
37 there's a lot of core knowledge about the risks of abuse
38 and the way to safeguard that ought to be part of the
39 professional training of any person before they enter an
40 institution. Can you tell us about that?

41
42 DR GUERZONI: Yes, thank you, quite right. Janet Chan,
43 again a New South Wales based criminologist, talks about
44 the socialisation of police officers and the importance of
45 imbuing within the educational settings of police officers
46 the values, the behaviours and the expectations that we
47 want our police officers to have on the field, and by

1 extension, Diane Vaughan who's an organisational scholar
2 from the United States mentions that engineers, for
3 example, are imbued with values, ways of seeing the world
4 within their education.

5
6 So, with that said, we know that typically, as we've
7 covered, individuals see child abuse as the product of
8 someone who has paedophilia, and so, unless that's being
9 challenged within an educative setting, an individual will
10 come into their role with pre-existing understandings of
11 why abuse happens, pre-existing understandings of what they
12 should do, and then it's the organisation's role to fix
13 that.

14
15 However, within religious organisations we've seen
16 that that's seen as an additional component to their main
17 role, and so, the organisation, my argument is, is framing
18 it as not core business, which in turn is socialised as
19 something to protect one's self and the organisation rather
20 than something to be done on an everyday basis.

21
22 So, in order to prevent that my counsel is to imbue it
23 within education at universities, at theological colleges
24 and other places so that the individual knows they already
25 have to do this in their job, so when they come to the
26 organisation they're already prepared to take that on.

27
28 MS ELLYARD: So perhaps to use an analogy from, for
29 example, nursing. Just as when one is training to be a
30 nurse, one learns basic things about anatomy and physiology
31 and how to perform certain technical skills; one should be
32 learning as part of the core training matters relating to
33 child safeguarding so that the person graduates
34 understanding that part of being a nurse is knowing about
35 those things?

36
37 DR GUERZONI: Quite right.

38
39 MS ELLYARD: And they don't have to wait until they arrive
40 at a hospital to be taught about it for the first time as
41 an organisation-specific practice?

42
43 DR GUERZONI: Quite right.

44
45 MS ELLYARD: Professor Palmer, I saw you nodding along
46 with some of what Dr Guerzoni was saying. I'd be grateful
47 for your comment on this idea that, really, leaving aside

1 questions of organisations, there needs to be a degree of
2 core knowledge imbued in people who enter organisations to
3 complement what organisations can then do once people work
4 there.

5
6 PROF PALMER: Well, we've mentioned organisational culture
7 many times already in this discussion. Academics have
8 cultures as well and the culture of sociologists is to be
9 cynical, so I think that's a great idea, but what we've
10 found in the case of police misconduct is often what cadets
11 learn in the academies are unlearned as soon as they show
12 up at the police force and are assigned a trainer on the
13 police force.

14
15 So, I want to be very clear, I think what Professor
16 Guerzoni is talking about is a great thing, but I don't
17 think it's a silver bullet, it's not going to solve the
18 problem in and of itself, we're going to continue to have
19 problems because the organisation is a strong situation and
20 the training can be untrained on the job.

21
22 MS ELLYARD: Thank you. Dr Guerzoni, turning back to you
23 and drawing your attention to paragraph 58 and following of
24 your statement, you identify there that whilst we're
25 talking today about organisations and organisational
26 culture, there's a role for individuals within
27 organisations too to be proactive themselves in relation to
28 child safeguarding.

29
30 DR GUERZONI: That's right. So, within the social
31 sciences we have the debate about structure in agency: is
32 it the organisation's responsibility or is it the
33 individual's? And, too often I think that when there's a
34 crisis within an organisation we can perhaps sometimes move
35 to only blame the organisation rather than say, look, there
36 are lots of individuals who take up an organisation.

37
38 So, I think that individuals every day, in my view,
39 have to be looking out for the signs of grooming, they have
40 to be looking out for things which are odd amongst their
41 colleagues, and they have to be aware of the requirements
42 at law within this jurisdiction and the policies and
43 procedures in respect to child protection within their
44 organisation and be willing to make a movement, rather than
45 have a denial of responsibility, as Sykes and mats(?) would
46 say, you know, "It's not my responsibility, it's my
47 manager's". And I think, if we imbue it within their

1 everyday practice, that might be helpful in this case.

2

3 MS ELLYARD: Can I ask you to comment on some evidence
4 that the Commission's heard and perhaps it's been heard in
5 a lot of contexts, often people are worried about the
6 implications of being wrong; it looks a bit odd but if I
7 report that's a terrible, horrible career destroying thing
8 that I might be falsely accusing someone off, of course it
9 might also be true. How should individuals and
10 organisations try to strike that balance between making
11 this awful accusation and potentially not naming
12 wrongdoing?

13

14 DR GUERZONI: That's a good question, and we all know that
15 in Tasmania everyone is connected in some way - and, I
16 think Dr Salter mentioned this earlier in the week - and
17 so, it's understandable that people would have that
18 concern, but within our legislative framework there's
19 safety for people who report and there's the assumption -
20 my understanding is, within the legislation there's that
21 assumption of good faith as well, and I think that that
22 should be the standard of the organisation; to support
23 people to say, "Look, if you see something, we'll back
24 you", and then, if it's not found to be true, perhaps
25 address it there rather than have a stance where it has
26 been historically that it's known that could never happen;
27 I think we should encourage people to report and then offer
28 them support if perhaps their assessment was incorrect.

29

30 MS ELLYARD: Professor Palmer, can I ask you about the
31 role of leaders in driving cultural change and as distinct
32 perhaps to the role that other parts of an organisation
33 play. At paragraphs 50-56 of your statement you deal with
34 this. How should we understand the role of leaders in
35 organisations in achieving the kind of cultural change that
36 we've been talking about?

37

38 PROF PALMER: Well, to answer that question succinctly I
39 would say there's a distinction between what leaders say
40 and perhaps write down and how they behave, and I think
41 sociologists would typically say that how leaders behave is
42 a lot more important than what they say or write.

43

44 One of the most well-known sociologists of culture,
45 Edgar Schein, lays out five elements of behaviour: the
46 people they hire and fire, the people they promote or
47 demote, the issues that they attend to, how they handle

1 crises, and then just generally how they comport
2 themselves. I think I gave an example when I testified
3 before the Australian Royal Commission of a warden who
4 described watching children in the juvenile prison who were
5 being walked to a van to be taken to court and he noticed
6 that they were being walked barefoot and when he enquired
7 of a guard why they were being walked barefoot, he was told
8 that a year prior one of the children was wearing sneakers
9 and had taken the laces out and tried to hang himself. So,
10 the warden said, "Can't we get them sneakers that have
11 elastic?" That's a behaviour that tells the guards, I'm
12 paying attention to things that pertain to the child's
13 sense of dignity. That's way more important than giving a
14 formal speech.

15
16 MS ELLYARD: Thank you. Can I turn then to the question
17 of oversight and reporting which both of you in different
18 parts of your statement deal with. Perhaps sticking
19 firstly with you, Professor Palmer, at paragraph 60 and
20 following you talk about the roles of internal and external
21 oversight. Can I ask you to speak to those matters?

22
23 PROF PALMER: I believe those are paragraphs where I
24 describe organisations as having the right to investigate
25 misconduct to determine who deserves the privilege to be a
26 member of the organisation, whether that be a student at a
27 university or an athlete in a club, those sorts of things.
28 But when it comes to abuse I think it's important to get
29 those reports as quickly as possible to an external entity,
30 law enforcement, because organisations have a conflict of
31 interest: on the one hand they may want to address any
32 problems that are arising within the organisation, but they
33 also, as Dr Guerzoni pointed out, have a survival instinct;
34 they want to avoid scandal, they want to avoid negative
35 publicity, and so they also have an incentive to diminish
36 the visibility of the report and perhaps to sweep it under
37 the rug.

38
39 MS ELLYARD: Dr Guerzoni, you deal with this at
40 paragraph 69 and following in your statement, and perhaps
41 drawing on the observations from your research, can you
42 comment on the respective merits of internal and external
43 forms of reporting and investigating misconduct?

44
45 DR GUERZONI: Yes, thank you. I'd agree with what
46 Professor Palmer has said, but we see that historically
47 there's been a silencing of individuals and that, in part,

1 is due to the hierarchical nature of organisations,
2 particularly religious institutions. But, in my view, it's
3 important that, where there are allegations of abuse, it
4 must be handled externally and that's not only so that the
5 professionals, namely police, can intervene, but also it
6 prevents conflicts of interest being undertaken within an
7 organisational setting, and I think that gives more peace
8 of mind to individuals within an organisation because they
9 know that it's actually gone out and it's being reviewed,
10 rather than being handled internally by a boss, for
11 example.

12
13 And I understand that the New South Wales Ombudsman
14 has given advice on how to handle complaints and that
15 information is available online, but we see there that
16 there's guidance as to the procedure, so there's the
17 individual concern should be suspended or - they also
18 advise, or move to a role where no children would be
19 present. I would personally prefer that they would be
20 suspended from their position. Then, moving on, if the
21 police make charges, that decision by a court of law would
22 then be taken on by the organisation and that would inform
23 internal procedures as to disciplinary and termination.

24
25 But also, if police do not come to a conclusion,
26 there's options for the organisation to then step in and
27 then to undertake an enquiry of their own about it.

28
29 MS ELLYARD: One of the issues that appears to often arise
30 is that, there might be safeguarding concerns or concerns
31 about the way in which a person's behaving towards a child
32 that aren't going to have sufficient clarity to get a
33 police response but nevertheless do potentially raise
34 profound concerns about the safety of that person to be
35 around children. Isn't one of the potential risks of
36 always sending it out externally is that organisations
37 might then feel, well, now we've dealt with it, unless the
38 police charge the person, they're safe to keep going?

39
40 DR GUERZONI: Yes, I would agree with that position, that
41 would not be uncommon to think that, yep.

42
43 MS ELLYARD: And so, what's the solution then for
44 organisations? They'll need something presumably to
45 complement the role of the police to make sure that
46 whatever the police do, they're not losing sight of their
47 own internal responsibilities.

1
2 DR GUERZONI: Yes, thank you. This is something I'm still
3 thinking through, but looking at the Anglican Church of
4 Australia, they have quite a, in my view, detailed
5 procedure about investigation post police procedure, and
6 so, I think organisations need to make sure that they have
7 a process which offers natural justice, procedural
8 fairness, and is receiving advice from legal professionals
9 and police where relevant, and to look to the examples set
10 by the Royal Commission on how to establish an internal
11 procedure so that in the instance that the professionals -
12 police - don't come to a conclusion, that organisations can
13 advocate on behalf of children and work to their - well,
14 work to justice for children, yeah.
15

16 MS ELLYARD: Thank you. Professor Palmer, you've
17 identified at paragraph 66 and following of your statement
18 the lessons that can be learned from what you've called
19 high reliability organisations, and to perhaps continue
20 this discussion about the way in which organisations can be
21 monitoring themselves as well as relying on external
22 agencies, what is a high reliability organisation and
23 what's the potential lessons that child organisations could
24 draw from those practices?
25

26 PROF PALMER: High reliability organisations are
27 organisations which function with a very, very low error
28 rate. Most organisations that we live in have a relatively
29 high error rate. So, an aircraft carrier which is landing
30 airplanes, it cannot afford an accident. If one plane
31 crashes on landing, there are seven more planes in the air
32 which have no place to land. Each plane is worth 10, 15,
33 \$20 million, so that's a high reliability organisation.
34

35 These kinds of organisations have developed techniques
36 on their own to reduce the rate of accidents. One of the
37 hallmarks of these systems are a heightened attention to
38 small variations from normal practice. So, in the case of
39 youth-serving organisations and child abuse, you might say
40 we'd like them to be high reliability organisations where
41 children never get abused, and one way to do that is to pay
42 close attention to circumstances which you might think
43 could have resulted in abuse but didn't, so we call them
44 close calls.
45

46 MS ELLYARD: So near misses and you make the point that
47 organisations tend to forget either things that almost went

1 wrong or things that were quickly resolved and potentially
2 lose the opportunity to learn how to avoid those things
3 occurring again?
4

5 PROF PALMER: Yes, and so, this links back to Professor
6 Guerzoni's point. What you'd like to do is identify risky
7 situations before you have to report someone to the police.
8 So, before you see them touching a child inappropriately,
9 to notice that maybe they're developing a relationship with
10 that child which is unnecessary for the tasks at hand, an
11 uncommonly close relationship, and you have regular
12 meetings and at that time you could mention, without
13 generating too much uncomfortableness, "You know, I notice
14 you were spending a lot of time with that one athlete and
15 not paying attention to the others; is that a good thing
16 for all of us to be doing?" And you could discuss that.
17 If the person had an abiding sexual interest in children
18 this would not be an organisation that they would like to
19 be a part of because they'd be constantly discussing their
20 behaviour.
21

22 MS ELLYARD: You draw another analogy from the way in
23 which surgeons, for example, another professional where you
24 really don't want to have a miss; it's part of their
25 standard practice to review cases afterwards quite
26 dispassionately and to constructively criticise each about
27 the way in which practice can be improved.
28

29 PROF PALMER: Yes, and so often these near misses are
30 discussed without identifying the individuals involved.
31 Say, here's a case, here is what happened, this is
32 obviously not something we would like to see happen on a
33 routine basis, how might we figure out a way to avoid this
34 happening again.
35

36 MS ELLYARD: And in your view, whether it's in the
37 aircraft context or the surgeon context, those kinds of
38 principles of being alert to potential problems and near
39 misses and having an active strategy of learning from them,
40 that's an approach which organisations dealing with
41 children could usefully take advantage of?
42

43 PROF PALMER: Yes, and getting back to the issue of
44 policies and procedures: the problem with policies and
45 procedures is not that rules and regulations aren't a good
46 thing, but that typically we give all organisations the
47 same policies and procedures as if one size fits all, and I

1 think, if there was one thing that I would like to leave
2 the Commission with, is that, organisations need to - I
3 think Professor Guerzoni would agree, so you should ask
4 him - organisations need to invest in the time to identify
5 the risks that are unique to that organisation and develop
6 ways to mitigate those risks and they're ultimately going
7 to be specific to that particular organisation.

8
9 MS ELLYARD: Thank you, Professor Palmer. You are
10 nodding, Dr Guerzoni, you would agree?

11
12 DR GUERZONI: I would concur, yes. Keith Kaufman's
13 situational prevention model is one model where that could
14 be undertaken.

15
16 MS ELLYARD: Thank you. The last matter that I wanted to
17 cover and it's specific to you, Dr Guerzoni, is at
18 paragraph 87 and following of your statement you offer some
19 comments from your personal and professional expertise in
20 issues affecting Aboriginal children about the particular
21 needs of Aboriginal children, including perhaps
22 particularly Aboriginal children who find themselves
23 involved, as we know they disproportionately sadly are, in
24 the Out-of-Home Care system or in the youth justice system.
25 Can I ask you to tell us your views about the particular
26 needs of those children and how they could be met including
27 within government services?

28
29 DR GUERZONI: Certainly. Literature on Aboriginal and
30 Torres Strait Islander children and their wellbeing really
31 points to the fact that - several Cs: connection to
32 community, connection to country and connection to culture,
33 is not only beneficial for their wellbeing but it's
34 beneficial for educational success, it's beneficial for
35 growing up strong, as Maggie Walter would say. And so, in
36 terms of Out-of-Home Care, my view is that it's important
37 that as much as possible - and this is in agreement with
38 the Aboriginal Placement Principle - that we ensure that
39 indigenous children are within community as much as
40 possible and that they receive care and support which are
41 imbued with cultural elements so as to develop their
42 self-esteem, their self-concept so they can do well at
43 school, and to foster community relationships.

44
45 MS ELLYARD: And you see a particular role for the
46 government in funding or providing some of those supports?
47

1 DR GUERZONI: I would support that, yes.

2

3 MS ELLYARD: For example, you've indicated potentially a
4 role for schools?

5

6 DR GUERZONI: Yes, so my research is more with schools,
7 but we see within those situations that, where teachers are
8 more open to Aboriginal children doing well, that's
9 important in shaping their practice so that Aboriginal
10 children receive the care and support that they need within
11 schools, rather than being seen as someone who cannot do
12 well and therefore the teacher, whether implicitly or
13 subconsciously, does not offer the child the same degree of
14 care.

15

16 MS ELLYARD: You've also identified perhaps some
17 assumptions about Aboriginal parents that might operate to
18 the disadvantage not only of parents but also children?

19

20 DR GUERZONI: Yes, thank you. So, we know that
21 unfortunately Aboriginal men in our country have a bad
22 reputation, there's the stereotype of Aboriginal fathers
23 being disinterested, distant or, you know, a violent
24 parent. But it's important to note that some literature
25 coming out here in Australia is pointing to the fact that
26 there are a number of Aboriginal men who want to be
27 involved with their kids' lives, they want to do the right
28 thing, and they really need support tailored specifically
29 for men rather than general parenting programs which more
30 favour women; and within that, again, there's a theme of
31 wanting cultural connection, to have it rooted within
32 Aboriginal culture for their community, and so, I'd suggest
33 that that's an important consideration as well.

34

35 MS ELLYARD: You've also identified the need for policies
36 in this area to be alert to the legacy of colonialism and
37 the intergenerational effects of that.

38

39 DR GUERZONI: That's right, so a lot of research and
40 government enquiry has pointed to the settler colonial
41 establishment in this country and the ongoing ramifications
42 of colonisation and how it imbues trauma in a lot of
43 indigenous children, and so that by extension changes their
44 behaviour; that's why we have a lot of young people who are
45 indigenous within our Out-of-Home Care and within Juvenile
46 Justice, and so, I think attentiveness to that is important
47 when we see Aboriginal children and the same goes with

1 abuse. There's a tendency to think, you know, there's been
2 the Rudd apology, there's been the Uluru statement: we
3 mustn't think it's all over, it's constant, these
4 structures are constant.

5
6 I think, too, as much as possible we should try and
7 ensure that care programs are here in Tasmania, where I
8 understand that in some instances there has been a
9 preference to moving children external to our jurisdiction

10
11 MS ELLYARD: Thank you, doctor, and thank you very much,
12 professor.

13
14 Commissioners, those are the questions that I had for
15 the panel but I'm conscious there may be matters you wish
16 to raise.

17
18 PRESIDENT NEAVE: Thank you, Ms Ellyard. Any questions?

19
20 COMMISSIONER BENJAMIN: Yes, Dr Guerzoni, you talked about
21 administrations permitting people to report issues, and I
22 think you used an analogy a little later of the shoes which
23 didn't have laces.

24
25 MS ELLYARD: That was Dr Palmer.

26
27 COMMISSIONER BENJAMIN: Sorry. I think you were talking
28 about the permission to support people who needed to
29 report. In Australia there's a real penalty for
30 whistleblowers, isn't there?

31
32 DR GUERZONI: That's my understanding.

33
34 COMMISSIONER BENJAMIN: A heavy penalty and it's a
35 significant cultural thing from what I've heard and seen so
36 far. I think then Dr Palmer talked about changing the
37 leadership, but that's a really hard thing to do, isn't it?

38
39 DR GUERZONI: It is.

40
41 COMMISSIONER BENJAMIN: And, unless you do that, change is
42 not going to occur. And I guess what you were saying, and
43 just so I understand it, is (1) the first thing the
44 organisation has to do is put the child first; is that what
45 you're saying?

46
47 DR GUERZONI: Yes, sir.

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COMMISSIONER BENJAMIN: Dr Palmer?

MS ELLYARD: Professor Palmer, would you agree?

PROF PALMER: Yes, I would agree.

COMMISSIONER BENJAMIN: So, you put the child first and protect the child. The second is to - and I'm not sure of the way - I know the criminal justice system says crime must go first, but I guess it's then the balance of - and it probably makes no difference - (1) report any crime to police or any possible crime to police, and then the third thing is to understand the organisation, whether it's external or internally, but preferably on your evidence externally, examine the circumstances and see whether, I suppose, the first thing it has to do is determine if the child's safe and how you keep the children safe, and then at the same time determine whether that job is a job in which that particular employee should remain?

DR GUERZONI: Yes, sir.

COMMISSIONER BENJAMIN: And do you think that has the capacity to start the changes that you're looking for or that you're seeking?

DR GUERZONI: I do, sir, yes. It is hard, as you've identified, but I think that we've had a lot of research show what we need to do and I think organisations were at a time where they're open to making change, particularly the organisations with who I consult and work with, and so, I think this is the time where such change can take place.

COMMISSIONER BENJAMIN: Professor Palmer, have I got that half right or am I understanding it reasonably well?

PROF PALMER: Yes.

COMMISSIONER BENJAMIN: Sorry, I've got to lean forward, I've been told to lean forward and speak into the microphone because I'm softly spoken. Did you hear what I'd said earlier and what I was thinking through?

PROF PALMER: I did and I agree.

COMMISSIONER BENJAMIN: Thank you.

1
2 PRESIDENT NEAVE: I've got a follow-up question on changes
3 to culture. I wonder whether organisations should think
4 about ways of actually rewarding people who whistleblow and
5 whether that would make a contribution to the terribly
6 difficult task of cultural change, if either of you have
7 got any comments on that and any models for that?

8
9 PROF PALMER: In the United States there's a form of legal
10 suit called qui tam where people who bring a suit, and that
11 suit is joined by the government, they are guaranteed a
12 substantial fraction of whatever civil suit penalties
13 result, and so that is a model for rewarding
14 whistleblowers. In the United States it's restricted to
15 suits where the Government has been defrauded. So, you
16 could imagine something like a qui tam suit being
17 instituted for child abuse. I have my doubts that it would
18 be workable, but that would be a model.

19
20 PRESIDENT NEAVE: Dr Guerzoni?

21
22 DR GUERZONI: Thank you, Commissioner, that's a good
23 question. My thinking, and I admit I need to think through
24 this more; I've only thought through verbal affirmation to
25 individuals within organisational settings, to encourage it
26 consistently throughout the year as something that can
27 happen and would be respected, and to have the person
28 brought alongside and, you know, encouraged, "Thank you for
29 making this report", and to offer counselling if they need
30 after the fact.

31
32 PRESIDENT NEAVE: Thank you.

33
34 COMMISSIONER BROMFIELD: Thank you, Dr Guerzoni and
35 Professor Palmer, it's been an interesting session.
36 Professor Palmer, I've really enjoyed reading your work
37 about the different cultures that can heighten risk for
38 child sexual abuse in institutions, I found it very
39 informative.

40
41 I wonder if from your work about organisational
42 wrongdoing you had any views about what a culture that was
43 child safe would look like or what some of those particular
44 cultural features would be that we should be looking out
45 for if we're doing it well?

46
47 PROF PALMER: So, I think I can provide a relatively

1 succinct answer to your question; the problem is, bringing
2 those cultural elements into a workable relationship to
3 other aspects of an organisation's culture. So, a child
4 safe culture would be one that assumes that children -
5 assumes rather than the penultimate goal of the
6 organisation is to keep kids safe, to have beliefs and
7 values that place child safety above other values of the
8 organisation.

9
10 So, it would be nice if our local soccer club as its
11 primary goal keeping kids safe and developing in a healthy
12 way, but it's primary goal is developing athletes who can
13 win matches. So, the problem is not so much figuring out
14 what a child safe culture would look like but how to
15 institute it alongside other cultural values that the
16 organisation was often created to pursue. Our local soccer
17 club was not created to keep kids safe, it was created to
18 train athletes so that they're successful. Does that make
19 sense?

20
21 COMMISSIONER BROMFIELD: Makes perfect sense. It makes it
22 quite a challenge.

23
24 PROF PALMER: Yes.

25
26 COMMISSIONER BROMFIELD: Thank you. Dr Guerzoni, happy
27 for you to comment on that but I had a specific question
28 for you. You mentioned the importance of
29 culturally-specific programs for Aboriginal dads in
30 relation to parenting. I just wondered if, by extension,
31 that applied; you know, the need for culturally-specific
32 programs were there for things like therapeutic responses
33 to trauma and did you have a view on that?

34
35 DR GUERZONI: Thank you, that's a good question,
36 Commissioner. I was only reading it this week in fact for
37 my lectures. Yes, that is a recommendation that I have
38 seen, but unfortunately I haven't read on it in depth, but
39 I do know that cultural considerations are important so
40 that it's culturally safe, that the indigenous girl or boy
41 feels that they would not be judged or that they would be
42 treated badly because of their indigeneity; that would
43 include cultural elements so that it's of cultural
44 significance for them, yes.

45
46 One thing to note, though, is that we know that, as
47 we've said before I think, about it's not a blanket, that

1 there are different Aboriginal communities in Tasmania who
2 might have different practices and cultures, and so, it
3 requires a place-based response.
4

5 COMMISSIONER BROMFIELD: And currently within Tasmania do
6 you feel that the service system is there to provide that
7 choice for people, for Aboriginal people?
8

9 DR GUERZONI: I don't know enough to comment, sorry.
10

11 COMMISSIONER BROMFIELD: Thank you. That was all for me.
12

13 MS ELLYARD: Thank you very much, Commissioners. Thank
14 you, Professor Palmer; thank you, Dr Guerzoni.
15

16 PRESIDENT NEAVE: We'll take a short break.
17

18 **SHORT ADJOURNMENT**
19

20 PRESIDENT NEAVE: Thank you, Ms Bennett.
21

22 MS BENNETT: Commissioners, the next witness is Professor
23 Helen Milroy who appears remotely and you can see her on
24 the screen now. I ask that she be sworn in.
25

26 **<HELEN MARY MILROY, affirmed: [11.44am]**
27

28 **<EXAMINATION BY MS BENNETT:**
29

30 MS BENNETT: Q. Professor Milroy, thank you for making
31 yourself available to give evidence today. I'm going to
32 just identify your statement. You've made a statement for
33 this Commission; is that right?

34 A. Yes, that's correct.
35

36 Q. You provided an updated statement this morning which
37 you signed because you noted a reputation of paragraphs; is
38 that right?

39 A. I think I doubled on two pages when I scanned the
40 document.
41

42 Q. We've now provided a corrected version, Commissioners,
43 and that will be uploaded into the court book, the hearing
44 book. And the contents of that statement with that
45 deletion is true and correct?

46 A. Yes.
47

1 Q. Thank you, professor. Professor, your qualifications
2 are too numerous to mention but can I identify a few. You
3 were a Commissioner on the National Royal Commission into
4 Institutional Responses to Child Sexual Abuse; is that
5 right?

6 A. Yes, that's correct.

7
8 Q. And before that you worked as a general practitioner
9 and a consultant in childhood sexual abuse at the Princess
10 Margaret Hospital for Children for several years before
11 specialist training in child and adolescent psychiatry?

12 A. Yes, that's right.

13
14 Q. You're currently the Perth Children's Hospital
15 Foundation Professor of Child and Adolescent Psychiatry?

16 A. Yes.

17
18 Q. And a Commissioner with the National Mental Health
19 Commission?

20 A. That particular appointment's finished now, but yes, I
21 was, yep.

22
23 Q. A co-chair to the Million Minds Medical Research
24 Advisory Group and an Honorary Research Fellow with the
25 Telethon Kids Institute?

26 A. Yep.

27
28 Q. Thank you, professor. Are there any other
29 qualifications that you consider to be relevant that I
30 haven't mentioned?

31 A. No.

32
33 Q. Professor, can you start by explaining to the
34 Commissioners and those watching what you can tell us about
35 the impact of sexual abuse on young people?

36 A. Sexual abuse has a profound impact, in fact any trauma
37 in childhood can have a profound impact on development, and
38 there is some evidence to suggest that different types of
39 trauma have a different impact, but generally speaking any
40 significant trauma in childhood, of course of which child
41 sexual abuse is one of those, has a profound impact on all
42 aspects of development. So it's not just about mental
43 health issues, it actually can have an impact on your
44 physical development, meeting developmental milestones, it
45 can impact on your ability to learn at school, to develop
46 good social relationships, for example, and social skills,
47 it can impact on your ability to work.

1
2 So, if you think about it, it just impacts on your
3 whole sort of developmental trajectory throughout childhood
4 and then continue to have this kind of cascading impacts
5 throughout adulthood as well. Obviously things like
6 substance abuse and other sorts of issues that can be a
7 direct result from having experienced the trauma would then
8 also have another level of impact. So, sometimes the
9 impact is purely from the trauma itself, and sometimes it's
10 cumulative over the life-span as more things happen and you
11 get that sort of multiplier effect of the impact as well.

12
13 Q. Can I just explore that for a moment, that multiplier
14 effect. Is one of the multipliers perhaps the way in which
15 a child who tries to disclose their trauma is responded to;
16 is that something that can contribute?

17 A. Yes, it can. So, if a child gets sort of a negative
18 response, then that can also increase the feelings of
19 trauma that they experience; they may feel like the world
20 is not a safe place and no-one can be trusted and that is
21 then in turn going to have another impact on mental health
22 and development and the development of safe and good
23 relationships.

24
25 So, anything that increases the level of trauma that a
26 child experiences puts them at greater risk for adverse
27 outcomes.

28
29 Q. Is another example, professor, we heard some evidence
30 on Monday about a young woman who was the subject of some
31 abuse by a teacher and that caused - her mother described
32 it, she never came back onto an even keel and that caused
33 degradation in her mental health which then caused her
34 admission to hospital, and in that hospital was a
35 paedophile nurse working, and so, her exposure to that
36 sequence of events seems to be related. Is that one of the
37 examples of the multiplier effect you're talking about?

38 A. Yeah, so I think we have to understand that when
39 trauma happens to a child it makes them very vulnerable to
40 other things happening. So, for that young person who
41 ended up in hospital, she would have been particularly
42 vulnerable to control by other people. It's easy for
43 children who have had these traumatic experiences to not
44 feel that they can defend themselves or do anything about
45 it; sometimes they just sort of give up or give in and
46 other things then happen.

1 So, for example, one of the parts of evidence that we
2 have in terms of research is that, for women for example
3 who have had sexual abuse in childhood, they may well end
4 up in quite violent and abusive relationships as adults.
5 And, although we don't know all of the exact mechanisms of
6 how that happens, we know that those early experiences
7 increase your vulnerability in actually experiencing other
8 adverse events later in life and in particular other sorts
9 of forms of trauma.

10
11 Q. I'd like to talk to you then about some of the
12 barriers to disclosure that children might face and you
13 cover this in paragraph 11 of your statement, and I think
14 you identify some of the most significant barriers, I just
15 wanted to explore some of them with you.

16
17 The first one you identify is the notion that it's a
18 taboo topic, it brings stigma and shame with it. Can you
19 tell the Commissioners and the people watching what that
20 really involves?

21 A. I think that it's one of these sorts of topics that's
22 really difficult to talk about, and also, we have no way
23 really of identifying who potentially might be the
24 perpetrator. We do know that by and large most of the
25 perpetrators are male but some women are perpetrators as
26 well, and they can be people that you know and trust which
27 makes it even more difficult to know how to identify these
28 things and what to do about it.

29
30 So, I think it creates a huge amount of distress.
31 Even thinking that a child could be abused in this way is
32 quite abhorrent for most people if they have to think about
33 that idea, and so, there is this taboo, no-one really wants
34 to talk about it, no-one wants to go there, it's a horrible
35 and very traumatic topic to speak about and think about.
36 And as well I think for the child or young person that
37 experiences this type of trauma, it's very, very hard to
38 even know how to begin a conversation in terms of
39 disclosure. They feel ashamed, they feel embarrassed, they
40 feel it's their fault, they don't know how people are going
41 to react. A lot of kids talk about testing the water and
42 if they get a sort of negative response they're not going
43 to go any further because they don't want to really reveal
44 what actually happened, because if they then get an even
45 greater negative response, that's going to increase their
46 feelings of shame. So, it's just a very, very difficult
47 topic in general.

1
2 I think society hasn't really come to terms yet with
3 the fact that these things happen to our children and we
4 need to be far more open to talking about it and preventing
5 it from occurring in the first place.
6

7 Q. Just before your session, professor, Dr Guerzoni gave
8 some evidence that sometimes offenders can be known as
9 quite charismatic or well-liked, and those sorts of
10 characteristics, I understand from your evidence, make it
11 more difficult for the child to disclose. Is that fair?

12 A. Absolutely, and I think that's what also makes society
13 a little bit unsure and not confident in knowing what to
14 do, because if we can't trust these people that we think
15 are really nice and contentious and wellbeing and go the
16 extra yard, they could be an offender, then who do you
17 trust? How do you know who to trust? And I think that's
18 what makes this whole area very difficult. It's not like
19 we can have these things to look for and say, okay, stay
20 away from those because they're potential - we just don't
21 know so it makes it very confusing, and unfortunately we've
22 seen many cases where it has been someone who is very
23 charismatic, who knows everybody, is well-liked and
24 well-trusted. So, of course, if a child then tries to say,
25 look, this person did something to me, who's going to
26 believe the child? I think we still have this preference
27 of believing adults over children. Even though we know
28 that both children and adults can lie, we still have this
29 preference of believing an adult's story over a child.
30

31 The other thing that happens in grooming, and I'm sure
32 you're well versed with this topic given this inquiry, but
33 the other thing that happens in grooming is not only that
34 the person becomes friends with everybody and is well-liked
35 and trusted by everybody, but they also set up a negative
36 reputation for the child. So, when the child does
37 disclose, everyone says, "Oh, yeah, but that child never
38 tells the child or that child's a bad child or that child's
39 always getting into trouble." So, not only does the
40 perpetrator ingratiate themselves with everybody so
41 everyone believes and trusts them, they also create this
42 negative experience for the child so if the child says
43 anything no-one is going to believe the child over the
44 perpetrator.
45

46 Q. That links to something which Commander Sirec, an AFP
47 Commander working in this space, said yesterday which was

1 that the grooming can involve eliciting from the child
2 photographs that are later used to blackmail the child or
3 held over the child; is that an example of what you're
4 talking about there?

5 A. Yeah, and there's - I think there's lots of aspects to
6 grooming, which is why it's a really difficult thing
7 sometimes to even identify because it can involve many
8 different aspects. But one of the other things that can
9 happen is, as the grooming continues, you know, the child
10 is groomed as well in a positive way initially before it
11 becomes negative, if you know what I mean. So, the child
12 can be very, very trusting and then you start to get these
13 coercive behaviours and, if they do ask for a photograph
14 and the child then gives it, the child then is made to feel
15 like they agreed to it, and there's this coercive element
16 and so then the child feels that it's their fault and
17 they're to blame, and then of course that's turned around
18 through the grooming to actually make the child absolutely
19 feel to blame and so of course that's going to prevent the
20 child from disclosing because they think they're a part of
21 it or agreed to it or encourage it and that's how they're
22 made to feel.

23
24 Q. You mentioned a bit earlier that children will test
25 the waters, can you give an example of the way children
26 test the waters with the adults around them?

27 A. Yeah, sometimes - particularly depending on the age of
28 the child of course - sometimes they don't really quite
29 know what has happened to them anyway so they don't really
30 know how to talk about what did happen because it's outside
31 any kind of normal developmental experience. And, if they
32 don't know how to do it, they will often talk about - in
33 fact we had these examples given to us by focus groups with
34 children where they talked about, they might bring up an
35 issue of bullying, some sort of bullying incident at school
36 and then they would see how that was dealt with. Now, if
37 it was taken seriously then that sets up trust and the
38 child thinks, okay, if I express a concern someone will
39 follow through. Because we're always telling children to
40 tell an adult, right, but often adults don't do anything
41 and they dismiss the concern. But if the adult will deal
42 with the more minor concern and deal with it well, then it
43 establishes trust for the child and the child may then feel
44 able to reveal the next level of problem that they have.

45
46 Q. It seems to me that might be something of particular
47 relevance in institutions where the institution has a large

1 amount of control over the child's life. Can you tell us
2 about that?

3 A. Yes. So, say in a school situation, for example, if a
4 child brings up an incident of bullying and it's kind of
5 dismissed and nothing happens, and the bullying continues,
6 then the child is not going to trust that if they bring up
7 anything else, that anything's going to happen or keep them
8 safe; in fact, sometimes in institutions if a child
9 discloses they're seen as a dobber, you know, sort of all
10 those negative connotations of actually speaking out and,
11 if that's the culture of the school, where these things are
12 just overlooked and easily dismissed, then the child is not
13 going to feel safe at all. And I think that also
14 perpetuates a greater level then of bullying and problems
15 in the school if that's the culture.

16
17 I also think that for adults as well, they don't
18 always understand that with these sorts of stories you
19 don't get the whole story all at once; you often get it in
20 pieces, and so, the initial concern may not seem very
21 serious. So, if you go, "Oh, that's nothing to worry
22 about, forget about it", you really can't do that with a
23 child because it's very dismissive, and even though it
24 might be a minor concern, for the child it's still a
25 serious concern. So, it's about taking those initial
26 concerns seriously, checking that the child is okay, asking
27 if there's anything else that they're worried about,
28 because if we dismiss it up-front we won't get to the real
29 sorry.

30
31 Q. We hear a number of - and we expect to hear evidence
32 in the coming weeks about people who raised perhaps less
33 serious versions of what was really concerning them, only
34 to try to follow it up later; is that an example of what
35 you were talking about there, that initial response?

36 A. Yeah, and also a child may have a very clumsy way of
37 making a complaint. Now, I don't mean to be provocative
38 here, but a child might say, "I keep getting a sore
39 throat". Now, that might sound very, very minor, but if
40 you then enquire from the child's perspective, "What is
41 that about or what do you mean?" They might be able to
42 tell you in actual fact that they've been assaulted, but
43 the initial attempt at disclosure is very clumsy and very
44 unsophisticated.

45
46 Q. Again, that comes back to something I think that
47 Commissioner Hollonds, the Children's Commissioner, was

1 talking about on Monday, that need to authentically listen
2 to children completely?

3 A. Yes, and a 5-year-old is very different in terms of
4 how they explain things compared to a 10-year-old, compared
5 to a 15-year-old and it goes on. So, in younger children
6 they also have no ability to necessarily understand what
7 the experience was, and so, they don't necessarily have the
8 language to describe it, and that's why sometimes it comes
9 out in a very clumsy or odd way, so I think it's about
10 trying to understand from the child's perspective what
11 they're trying to tell you. I think what we're really bad
12 at doing as adults is jump to the conclusion of what we
13 think the child is telling us instead of allowing the child
14 to try and explain it in their own words.

15

16 Q. We've spoken a little bit about the particular
17 barriers in an institutional setting, and this is something
18 you address at paragraph 12 of your statement. You say
19 there that sometimes institutions may be unwilling to think
20 about child sexual abuse. Why would that be so?

21 A. Well, again, it's part of that societal taboo, I
22 think, and I also think that some institutions probably
23 pride themselves that they do all the right things, but no
24 tuition is ever going to be 100 per cent safe. Even if you
25 have all of the right policies and procedures in place, it
26 only takes one person who wants to do these sorts of things
27 to be part of an institution and create a problem. So, I
28 think that we always have to be on the alert, we can never
29 rest on our laurels, and if you don't think about it, you
30 won't see it and that's one of the problems. If you think
31 everything's fine, everything's safe, you won't look for it
32 and you'll miss those early warning signs, like someone
33 perhaps breaching a code of conduct or some minor events
34 that in isolation aren't really relevant, but when you put
35 all of those minor events together you start to see a
36 picture.

37

38 Q. Is that almost a reverse of the testing the waters we
39 see from a child, is that an adult can test the waters by
40 breaching codes in ways that might not lead to serious
41 consequences for them to see what the response will be?

42 A. Yes. Yes, that's what happens, partly in grooming I
43 think and also in someone testing out to see whether
44 anything's going to happen, and we've certainly seen that
45 in some of the cases that have gone forward to prosecution,
46 that there were all these breaches of codes of conduct and
47 because everyone liked the person no-one thought about

1 reporting it or asking, "Hold on a minute, what's going on
2 here?" Or no-one was held to account. So, even if you
3 have a great policy and really good code of conduct, if
4 people don't follow it and report on it or express concern,
5 then by the time things are disclosed later on down the
6 track, you know, you can go, "Oh look, all those signs were
7 there we just didn't see them".

8
9 Q. Does that feed into keeping records about those
10 breaches and sharing them at relevant times?

11 A. Yeah.

12
13 Q. Can you tell us a little bit about what that looks
14 like?

15 A. I guess what we need to be able to do, without feeling
16 like we're hypervigilant all the time and accusing people,
17 what we need to be able to do is express concern. So, if
18 we're concerned that something doesn't feel right or that
19 these sorts of things are just not quite right in terms of
20 how they should be in someone's behaviour, then it's better
21 if we have an open culture of being able to express concern
22 and maybe increasing education and training or support or
23 supervision so that we tighten in the sort of surveillance
24 that we really sort of want to have. If we have to wait
25 until someone is absolutely convinced that something's
26 wrong, chances are the story is already well and truly down
27 the track.

28
29 Q. Dr Guerzoni was giving some evidence earlier about
30 situations, particular situations leading to offending or
31 making offending more likely, so leaving aside the
32 predators who might seek out children to offend against,
33 people who in a situation become more likely. Is what
34 you're sort of saying that the situation becomes more
35 likely when it's a permissive situation, when you aren't
36 pulled up earlier?

37 A. Yep, yep, and when you kind of know no-one's ever
38 going to say anything and I think that for some
39 institutions, particularly something like a school, if
40 their reputation is prided above child safety, they don't
41 want to hear about concerns because that's going to damage
42 their reputation that they're an unsafe organisation and so
43 things can get dismissed and swept under the carpet and
44 this is where you see language becoming really important as
45 well, in that a child may express something in a certain
46 way in a childhood language but then the way that's
47 interpreted by an adult it lessens the impact of it and

1 suddenly it becomes insignificant.

2

3 Q. I'd like to talk to the period immediately after a
4 child does make a disclosure. So, we've talked about the
5 barriers to that disclosure and then assuming a child makes
6 a disclosure of some form you say in your statement at
7 paragraph 14 that the period immediately after can be a
8 dangerous time for the child. Can you tell the
9 Commissioners and those watching what you mean by that?

10 A. Well, I think that we don't really know what's going
11 to happen, and the child doesn't either. This is a big
12 thing, to tell such a traumatic secret that's incredibly
13 personal and has a lot of, you know, very, very strong
14 emotional feelings associated with it. And so, the child
15 is trusting that it'll be okay and I think that what we
16 often do is say "everything will be okay" when in actual
17 fact it's not. So, the child might be removed from their
18 home for example or their family, they might not be
19 believed in which case they're sent back into an abusive
20 situation, then this aftermath can go on for a very, very
21 long time. And it can even include things like, you know,
22 violence can happen as a result. You know, there have been
23 situations where a person has attempted suicide following a
24 disclosure, and then once that disclosure or investigation
25 has been signalled and people know that something's
26 happened, then the perpetrator may well actually be violent
27 or commit suicide as well. So, I think there's a lot of
28 potential outcomes that can happen and we can never be
29 100 per cent sure about which of those outcomes is going to
30 occur.

31

32 Q. Are you able to assist us in what the best way is to
33 receive a disclosure of that kind, in an institutional
34 setting?

35 A. Yeah. So, I understand - so, coming from a mental
36 health perspective it's a little bit different than coming
37 obviously from a legal perspective and I understand there's
38 this tension in trying to support the child to make them
39 feel safe and comfortable in being able to disclose; at the
40 same time not damaging any evidence that may be required if
41 this is a new disclosure and it is a situation of safety
42 for the child but also about then a criminal investigation
43 that might ensue depending. So, I think we have to be
44 careful that we don't say, "Look, don't tell me all this
45 now because I'm going to ruin the evidence, let's get you
46 to another place". It's the way we handle that so that we
47 don't lose the disclosure but that we also don't go past

1 our boundaries in terms of how we take the information from
2 the child; for example, coercive questioning or leading
3 questions, all of those sorts of things. We want the child
4 to be able to disclose in their own words what actually
5 happened as the first source of disclosure.

6
7 So, I think there are ways of doing that in an
8 institution where we can really support the child in
9 saying, this is a really important story and, you know,
10 you're very brave and encourage them that this is the right
11 thing to do, but also get them to the right people to hear
12 the disclosure and it may be one of the Child Protection
13 Units or the police, you know, depending on what set up
14 you've got in the particular area where the child is.

15
16 I think the last thing we want to do is to stop or
17 close down the disclosure immediately, because we know
18 that, if children feel like they can't speak when they sort
19 of finally got up the courage to do so, then they may not
20 disclose again ever or for some years to come, and of
21 course that's then going to lead to that more punitive
22 impact that we talked about, because often disclosure is
23 part of the step towards also healing and recovery, so we
24 know that it's a pivotal moment in a child's life if
25 they're going to talk about this.

26
27 Q. And so, is it the case that there are positive impacts
28 for the child if they disclose in a mental health sense; is
29 that the way you see it?

30 A. Yeah, so I think when you work with trauma survivors
31 for example, when you are able to hear the story, when the
32 person is able to tell you what happened in their own words
33 and you're able to then explore the impact that that has
34 had on them and you're able to work with them through that
35 story, the actual hearing of the story itself. Bearing
36 witness, for example, is a very, very powerful process for
37 someone: if they feel believed, validated, understood, then
38 it allows them psychologically to move forward. If they're
39 disbelieved, they're shut down, then that's going to
40 increase their feelings of distress.

41
42 Q. And that's one of the multiplier effects that we've
43 talked about that affects the child?

44 A. Yes. But of course if you do it well then the
45 multiplier effect is in the recovery, so you actually get
46 the journey started and you can get this momentum then that
47 builds and then the person has a much better outcome over

1 time.

2

3 Q. And that makes it critical to have those structures in
4 place within the institution to be able to authentically
5 listen to children trying to make a disclosure, is that
6 right?

7 A. Yes, in a safe way, but also meets any sort of legal
8 or other requirements that we have around reporting.

9

10 Q. I just want to talk to you a little bit about what
11 your statement tells us about the compartmentalisation
12 between trauma, mental health services and child sexual
13 assault services. Can you tell us about why you see that
14 as an issue?

15 A. If you look at retrospective evidence around who
16 attends, say, adult mental health services, or drug and
17 alcohol services, by far the majority of people who have
18 very severe illness, whether it's alcohol and substance use
19 or mental illness, often have significant histories of
20 childhood trauma. In some of these surveys they found that
21 it could be sort of 80 per cent of people attending drug
22 rehab may have these sorts of issues in their background.
23 So, it seems to me that clearly there's this very strong
24 association between early trauma and then these later
25 outcomes. And part of the difficulty with mental health
26 services is that they work on dealing with the diagnosis,
27 but trauma is not a diagnosis, trauma is the event that
28 happens, it sets the child on a developmental pathway, it's
29 a huge risk factor for the development of any psychiatric
30 illness you care to mention, but in particular things like
31 post-traumatic stress disorder, anxiety, depression,
32 substance use, eating disorder, suicidality and self-harm,
33 huge array that we commonly see and certainly increasing in
34 frequency particularly over the last 20 years and more so
35 since COVID.

36

37 So, we have this disconnect then in understanding that
38 there's these pathways that children end up on and we don't
39 do enough early intervention once we are aware that these
40 things have happened, nor do we sort of follow through with
41 what is required in order to get the child's development
42 back on track from a trauma perspective as opposed to a
43 diagnosis that you're treating.

44

45 The example that I'll give is, if you have depression
46 say as an adolescent, that the underlying reason for the
47 depression was sexual abuse at an earlier stage in life,

1 and all you do is get treatment for depression, which would
2 be a simple algorithm of treatment, but you never address
3 the original trauma, the depression's not really going to
4 improve or it will recur. So, you have to understand how
5 to treat the underlying drivers of illness, and sexual
6 abuse is a driver.

7
8 Q. You say in your statement it's not enough for services
9 to be trauma-informed, they need to be trauma-competent.

10 A. Yes.

11
12 Q. What's the difference between those two concepts?

13 A. So, the whole trauma-informed movement is about making
14 sure we don't re-traumatise people when they come through
15 services, so it's about understanding that trauma can have
16 an impact on the way a person presents and their behaviour,
17 on their ability to engage, and what we often do in
18 services is just expect people to fit in, and often the
19 things we do to them are quite traumatic. So, for example,
20 in mental health services it's very difficult to admit
21 someone to hospital, it's very difficult to admit someone
22 under the Mental Health Act, for example. That takes away
23 a person's individual power and control.

24
25 So, you know, coming into services and having certain
26 treatments can be very traumatic, and so trauma-informed
27 care is meant to be a whole-of-system approach where we
28 understand the impact of trauma, we try and create a
29 compassionate and safe way for people to transition through
30 services, and we try and reduce the idea of secondary
31 re-traumatisation with that understanding.

32
33 Trauma competency is then being able to deal with the
34 trauma itself, so being able to know what are the best
35 evidence-based models of care for people who have
36 experienced significant trauma, how do you actually
37 incorporate some sort of narrative or bearing of witness or
38 understanding the story and the impact as part of your
39 treatment, and what we often see in services is, there's an
40 understanding that trauma has happened, but then there's no
41 understanding in the treatment plan of what's required, and
42 so, what we don't want is for someone to - especially if
43 it's a child or a young person - to have their depression
44 treated by one person, their substance use treated by
45 someone else, their sexual abuse treated by another
46 service, the family therapy - you could have 10 clinicians
47 for one child. I just think it's nonsense.

1
2 And I do believe that sexual abuse itself is such a
3 driver for a whole array of adverse outcomes, and if you're
4 working in mental health or substance use services and you
5 don't know how to deal with the trauma impact in someone's
6 life, then you are not providing a comprehensive approach
7 to the problem.

8
9 Q. You mentioned there the importance of bearing of
10 witness; can you tell us from the perspective of your role
11 as a Royal Commissioner about how important that was or
12 what your experience of that was?

13 A. It was really important and I just have to say, I
14 really commend everyone that came forward and gave evidence
15 for their incredible courage and determination to make
16 Australia a better place and a safer place for children.
17 But it really was an incredible process for people. I
18 think that, when you've really been heard, and this was
19 often what was said, was that "this was the first time I
20 actually felt heard", and so, I think the way we often
21 listen is only with sort of half the person, because I can
22 imagine in your professional as a lawyer, you're taking a
23 statement, you're writing things down, you're thinking
24 about your next question and you're not really fully
25 present, and I think that what we had the privilege of
26 being able to do is be fully present and actually hear the
27 story and listen as a whole person to what we were being
28 told, and also having the ability to be able to respond to
29 that as a whole person instead of thinking about questions
30 and other things that, you know, take up, occupy half your
31 attention. So, it's to be fully present when you listen to
32 the story, I think, makes a huge difference and I think
33 that was a very powerful process for people.

34
35 Q. Professor, returning then to the trauma competency of
36 the response to child sexual abuse. You tell us in your
37 statement at around paragraph 35 that it's your
38 understanding that Tasmania has a reasonably small Mental
39 Health Service, it's not dissimilar to Western Australia.
40 Now, obviously we're not basing that on any direct
41 comparison, but among the smaller jurisdictions in terms of
42 population size. Can you talk a little bit about the
43 challenges that arise from that smaller workforce?

44 A. Look, obviously as part of the National Mental Health
45 Commission I had much more awareness of the size of
46 different sorts of service systems and the like and
47 Tasmania is definitely a smaller jurisdiction and sometimes

1 it's harder to get workforce and things like that. Equally
2 in WA we're one of the smaller jurisdictions and certainly
3 have had trouble with workforce and the like, but overall
4 in terms of how we've seen mental health services develop
5 in Australia there hasn't been the level of input or
6 funding or resourcing that's been required, (1) to keep up
7 with population but also to keep up with the incredibly
8 increasing demand in regard to child mental health
9 services.

10
11 Part of the problem I think for a place like Tasmania
12 is that you have a number of children that require these
13 more specialist services. So, sometimes if you think about
14 a continuum some kids and families might only need a small
15 amount of support and counselling in order to get back on
16 track, and some people will end up on that continuum where
17 there is a much more severe impact and they are going to
18 require much more comprehensive assessment and they may
19 well then have developed these comorbidities like mental
20 illness or depression or whatever. So, if you don't have
21 the sort of services there to be able to deal with the
22 children and the families in a much more comprehensive way
23 then these children are just going to have that ongoing
24 impact and it may be that they re-present later on down the
25 track in a worse state.

26
27 So, if a child's trauma and the impact that it's
28 having on them and their behaviours and emotions and their
29 thoughts, if that's not dealt with sort of early enough,
30 then you could find that they, you know, try suicide
31 attempt at 15 or 16 and end up in the emergency department
32 repeatedly.

33
34 And we can actually prevent that if we have good
35 wrap-around comprehensive services early enough and long
36 enough. And there's always this tension I think between
37 saying we don't want to create dependency, we don't want
38 children and families to be in services all their life, we
39 don't have to do that, but what we do have to do is provide
40 an adequate dose of treatment or intervention that allows
41 the child and family to move on. However, we also know
42 that trauma has an impact along the life-span because of
43 other developmental issues and life events.

44
45 So, for example, when a child hits puberty this is
46 when all your sort of sexual characteristics start to
47 develop. That is a trigger time. If you've experienced

1 these early trauma around sexual abuse that's a trigger
2 time for you and your trauma is going to be rekindled. So,
3 even if you've done well and even you've had good
4 intervention at the time you might need a top up at puberty
5 because this is a time that's going to trigger you and
6 you're going to need to re-think everything.

7
8 Another really major trigger is when you develop an
9 intimate relationship maybe in later adolescence, or you
10 become a parent. For women pregnancy is a huge issue in
11 terms of rekindling trauma. So even if you do well, you
12 still need to have these services along the life-span to
13 actually cope with different developmental stages and ages
14 and also other life events.

15
16 Another trigger of course for trauma is going to be if
17 you have another traumatic event, maybe you have a car
18 accident or something like that, that's also going to be
19 another trigger, or if you have a loss in the family, a
20 death of a close family member or something like that.
21 These are also triggers.

22
23 So we can't just say that's going to be enough then
24 and there because there is no cure; this is something that
25 will repeatedly come back to you across your life-span.
26 And then in old age, of course, we know that as your
27 defence mechanisms age and as you become less able, I
28 think, to cope with some of the psychological issues that
29 arise, your brain is going to throw up these early memories
30 that you had as a child and you are going to be triggered
31 in old age and I don't think we've really thought about
32 that much in older age services either.

33
34 Q. We hear sometimes, professor, in some of the work of
35 this Commission about people who, having disclosed, don't
36 receive much follow-up from the institutions that they've -
37 that were responsible for them at the time of the
38 offending, and it sounds like your evidence is directed to
39 really identifying the need to continually check in on this
40 person if they would like you to, if it's appropriate, to
41 offer that support in an ongoing way. Is that fair?

42 A. It may not be the institution that they want to check
43 in on them but if they've been engaged in some sort of
44 therapeutic service it's hard to keep re-engaging with the
45 new service, telling your story all over again and starting
46 again. And I think what we do is we actually have services
47 that only get set up really to support people in the short

1 term and if they want to come back a couple of years later
2 they've got to go through the whole rigmarole of
3 re-referral and they might not get the same people, there's
4 no continuity of care, and that in itself can be quite
5 traumatic, and the last thing you really want to do is to
6 make someone tell their story repeatedly to new people,
7 because that in itself can be quite traumatic. So, a way
8 of providing some kind of support and also some continuity
9 of care, and if we can't do that with the same service
10 provider or the same people, then can we do it with some
11 sort of record that goes with them, that they then don't
12 have to keep going over all of the same material again each
13 time. It seems like we get people so far and then we let
14 them go and when they come back we start again instead of
15 being able to build from where we were before.

16
17 Q. I want to turn, professor, and ask if there are
18 particular considerations for First Nations children that
19 you can talk to this Commission about?

20 A. So, I think with the First Nations groups we have to
21 understand it in the context of history and, you know, the
22 sort of genocide of Aboriginal peoples across Australia in
23 terms of the massacres and the loss of life and all of the
24 things that happened historically, so we're not just
25 starting with contemporary child sexual abuse, we're
26 starting with generations of child sexual abuse that
27 happened on missions and sort of quite widespread really
28 across the whole community. So, generally speaking, if
29 you've got one family in a community that may be
30 traumatised, the rest of the community can buffer them and
31 provide support, but when you've got the whole community
32 traumatised you don't have the same capacity or resources
33 to be able to do that. That's what we have for some of our
34 Aboriginal communities, particularly with some communities
35 where the number of children who were removed to
36 institutions through Stolen Generations was very
37 significant and occurred over several generations so the
38 level of transgenerational trauma is much greater, and so
39 you're dealing with a greater trauma load overall.

40
41 In terms of the healing aspects of it, of course we
42 had our traditional healers, we had our own ways of
43 understanding some of these things and how we might provide
44 a treatment. And although they might not have the evidence
45 base to them they kept us in good stead for many thousands
46 of years, so there's a lot to be learned from cultural ways
47 of healing, understanding things that happened to you. And

1 certainly from a lot of people I've spoken with and a lot
2 of the communities I've worked with in mental health, you
3 know, they have some really amazing ways of assisting and
4 supporting a person to go on a healing journey from a
5 cultural perspective, and we also know that having a strong
6 cultural identity, feeling connected to culture, to land,
7 to nature, to ancestry, is a way of providing that healing
8 journey which sits outside of a mainstream mental health
9 response, it's a more holistic understanding of connection.

10
11 Q. Can a culturally competent response, for example, to
12 disclosure or attendance in institutions be important to
13 that?

14 A. Yeah, because there may be different nuances in the
15 way children from First Nations communities relate, how
16 they talk, who they're prepared to talk to, gender issues
17 can be more significant, for example; an older male may not
18 want to speak a female, a female may not want to speak to a
19 male, those sorts of things become more significant
20 depending on the adolescent status as well in terms of law
21 and other sorts of things. They may need a way of engaging
22 that's a little bit different than what we would normally
23 expect for a kid of that age.

24
25 And also I think that there's issues with translation.
26 If kids in some of the remote communities have four or five
27 traditional languages or dialects that they speak, English
28 may be well down the list, and so understanding whether you
29 need an interpreter or how that translation occurs is a lot
30 more important.

31
32 There's also this form of Aboriginal English which
33 sometimes can be misunderstood or misinterpreted. I also
34 think that we still have a lot of ongoing racism and
35 discrimination, and so, you have to make sure that the
36 system is safe for a child because if they already have
37 experienced racism within the system that they're in, the
38 chances of them talking to you about something really
39 personal is very low.

40
41 Q. I think you make a similar point about LGBTIQ+
42 children who might be reluctant to disclose because it
43 might force other disclosures, can you tell us a little bit
44 about that?

45 A. Yeah, so I think this is that whole sort of sexual
46 identity is really fraught and I think as a society this is
47 still a bit of a taboo subject in general, we still don't

1 quite know how to support these kids through schools and in
2 institutions and services. Hopefully we're getting better
3 at it but it still remains a significant problem. If you
4 look at some of the outcomes for kids who have some
5 different sort of sexual identity issues or gender
6 dysphoria, then some of their outcomes are much worse than
7 for other kids in the population. So there's a greater
8 need for sensitivity. And I think that because of
9 sometimes again the shame and stigma and taboo about
10 discussing these issues in childhood, children are less
11 likely to want to speak about these sorts of issues or
12 they're sort of kind of given the message not to in a way
13 from society in that we don't want to hear about this, and
14 so, it makes it harder for them to disclose if they've been
15 abused in some way because it may lead then to a disclosure
16 around their other sexual identity issues.

17
18 Just to be clear as well, sexual abuse can occur to
19 any child. However, the way the child interprets that in
20 terms of what it means for their sexual identity will vary
21 enormously over the child population, and so, it does
22 challenge the child as well in terms of knowing who they
23 are and what their sexual identity is as well, so it's a
24 very, very complicated area.

25
26 Q. Professor, I'm going to ask this one last question, so
27 I don't completely monopolise your time and allow the
28 Commissioners the opportunity to talk to you as well. I
29 wanted to finish by asking you about the resilience factors
30 that you talked about. In our opening Counsel Assisting
31 opened this week by referring to your evidence around hope,
32 and I'd like to finish by talking to you about hope and why
33 that's important and what it means for individuals and for
34 communities and perhaps even a state.

35 A. So, I think that what trauma does for the individual
36 is that it really disrupts the personal narrative, it
37 disrupts the person's ability to understand who they are
38 and their journey through life, and it also destroys the
39 future because you can get trapped in this cycle of trauma
40 and feeling like there's no way out, and I think
41 communities and institutions and everybody can get trapped
42 in that trauma cycle in feeling that it's all very futile
43 and that there is no hope.

44
45 And yet what we were able to see and certainly what
46 I've witnessed in my own career having worked in the trauma
47 area for some decades now, is that I'm always amazed that

1 some people have this innate ability to feel hopeful
2 wherever that comes from, and I think that that helps
3 people to see the future, that they don't have to be
4 trapped within this trauma story or this trauma narrative,
5 that there is actually a way that they can move forward,
6 and I think having hope is a really important aspect of
7 this whole sort of trauma area. Because, sort of, without
8 that then - and look, certainly in services I've heard of
9 plenty of kids saying, "Look, life's not going to get any
10 better so I'm just going to go out in a blaze of glory",
11 and that's a very, very awful state really for a young
12 person to be in if they feel that's all they can do; that
13 there is no life waiting out there for them. And this is
14 what trauma does, this is how trauma impacts on how we feel
15 about our place in the world.

16
17 Well, hope is just one of those things that, some
18 people seem to be born with it, some people seem to be able
19 to learn it over time, but we have to be able to give
20 messages of hope as well because people are really amazing
21 in their ability to survive, to be hopeful, to have hopes
22 for the future and I have to say that most people really
23 are driven by the fact that they don't want these things to
24 happen to other children and so they do want to make a
25 difference. So, I think being able to restore and keep
26 hope is a really important thing.

27
28 MS BENNETT: Commissioners, I could plainly speak to
29 Professor Milroy all day but I will now say those are the
30 questions I have for this witness.

31
32 PRESIDENT NEAVE: Thank you very much, Professor Milroy.

33
34 COMMISSIONER BENJAMIN: Q. Yes, Professor Milroy, Robert
35 Benjamin's my name. I heard what you were saying in
36 relation to a child struggling in a difficult way to make a
37 disclosure and you use the analogy of a child who had
38 constant sore throats and the need for the listener to
39 tease out the answer to, first of all, believe them and say
40 what's behind it, and that kind of clashes with what the
41 legal professional are doing to you at the same time,
42 doesn't it? Where the legal profession are saying, don't
43 lead, don't give answers, and that's hard. I guess that
44 points to really thoughtful and significant training we
45 have to look for in terms of how we train institutions to
46 deal with disclosures. God help parents, I might add, but
47 what are your thoughts on that?

1 A. Yes, I agree and I think that what we can do is try
2 and just help assist people in practising the way they
3 might talk to children about these things. Sometimes for,
4 say a teacher, they may only ever take one disclosure in
5 their entire life but it's going to be really important at
6 the time, and so, it's hard to get a level of confidence in
7 being able to deal with these sorts of things.

8
9 Certainly in clinical services obviously you deal with
10 these things all the time so you can get an ability to
11 increase your confidence, but there are ways of avoiding
12 those leading questions or those sort of coercive type
13 answers that can interfere with evidence. So, just always
14 being able to be curious, and curiosity is something that
15 helps a child to speak out. So, "Tell me a little bit
16 more. What do you mean by that?", but without giving any
17 sorts of answers; it's about being curious about the
18 child's experience rather than asking any sort of leading
19 or yes/no type answers which is unhelpful. It's exploring
20 and being curious about what the problem is rather than
21 being definitive.

22
23 COMMISSIONER BENJAMIN: Thank you.

24
25 PRESIDENT NEAVE: Q. I have a question. You talked
26 earlier in your evidence about how this is a taboo topic,
27 it's not a topic that's well understood in the community.
28 One of our previous witnesses talked about marketing
29 campaigns and how they might be useful to get people to be
30 able to speak about these issues more freely. What's your
31 view about how we break down that taboo, what do you think
32 about, for example, marketing campaigns, carefully
33 constructed obviously; what do you think about those
34 approaches?

35 A. I think we need to think about it in terms of a number
36 of different levels and layers. So, for example, I think a
37 marketing campaign as a general population awareness is
38 probably a good thing and often what we hear from people is
39 that, when they saw someone who's a bit of champion, maybe
40 someone's well-known who then talks about their own
41 personal history, it gave them the courage to come forward
42 and speak about what had happened to them. So, I think
43 that at that sort of population level that's good. But I
44 think we also lack training and real understanding about
45 these issues in most of our human services and most of our
46 clinical services.

1 So, for example, at universities in all the training
2 courses for doctors, social workers, psychiatrists,
3 psychologists, everyone who's going to be working in this
4 area, the level of content around these sorts of issues is
5 generally pretty low. And so, even quite recently we were
6 trying to do - we've got a trauma research team at the
7 Perth Children's Hospital as part of the Telethon Kids
8 Research Institute trying to actually increase our evidence
9 and understanding and better interventions in this area,
10 and we were trying to work with one of the paediatric teams
11 around looking at the impact of trauma in this particular
12 medical condition and they didn't want to screen for it,
13 they didn't even want to ask about it. So, that's today,
14 you know. So, I think we need to think about it in terms
15 of levels and systems.

16
17 So, yes, we need something for the population level,
18 but we also need to target and have specific strategies and
19 training in all of the other systems that work with
20 children and potentially work with people, so schools need
21 their response, all the clinical services need their
22 training, so I think it's got to be multi-faceted if it's
23 going to be effective.

24
25 PRESIDENT NEAVE: Thank you very much, Professor Milroy,
26 that was really most helpful, and you're excused now.

27
28 THE WITNESS: Thank you very much.

29
30 MS BENNETT: Commissioners, perhaps I'll let Ms Ellyard
31 call the next witness.

32
33 MS ELLYARD: Commissioners, if it's convenient we're going
34 to continue straight on with the next witness, Professor
35 Sally Robinson. I'll ask her to come into the witness box.

36
37 <SALLY ANTOINETTE ROBINSON, affirmed and examined: [12.33pm]

38
39 <EXAMINATION BY MS ELLYARD:

40
41 MS ELLYARD: Q. Thank you, Professor Robinson, as you
42 make yourself comfortable I'll ask you to tell us again
43 your full name?

44 A. My name is Sally Antoinette Robinson.

45
46 Q. And you're presently employed as a professor of
47 Disability and Community Inclusion at the College of

1 Nursing and Health Sciences at Flinders University?

2 A. Yes.

3

4 Q. You've made a statement to assist the work of the
5 Commission which is dated 26 April 2022. Have you got a
6 copy of that statement with you?

7 A. I do, thank you.

8

9 Q. Are the contents of that statement true and correct?

10 A. Yes.

11

12 Q. You've identified in your statement at paragraph 7 and
13 attached a number of relevant publications which bear on
14 the issues that you discuss in your statement?

15 A. That's right.

16

17 Q. And you've also identified and marked as Exhibit 2 a
18 number of relevant articles that you've also drawn on to
19 provide your evidence?

20 A. Yes.

21

22 Q. At paragraph 12 of your statement you identify some of
23 your current areas of research. Could I ask you to
24 summarise, please, the areas that you're working on that
25 have relevance to the work of this Commission?

26 A. Yes. The work that I do is distinctive, I suppose, in
27 that we work with children and young people with disability
28 in ways that enhance their participation and their voice in
29 the research. We work with people with disability as
30 co-researchers and our work privileges the voice of young
31 people in our research.

32

33 Q. At paragraph 12 you identify that you're particularly
34 interested in environmental and systematic factors and how
35 they lead to violence and abuse for people with
36 disabilities.

37 A. We're really interested in the connections between
38 people's individual experiences and what they mean for
39 changing environments and systems that people live in.

40

41 Q. One of the pieces of work that you refer to and that
42 you've attached as Exhibit 15 is some research that you did
43 for the National Disability Commission. Can you tell us a
44 bit about that research?

45 A. Yes. That was a project called Feeling Safe, Being
46 Safe and it was about understanding how children and young
47 people who had significant support needs understood safety

1 in their lives. For ethical reasons, it wasn't appropriate
2 to go and talk to children and young people with
3 significant support needs about their experience of
4 violence and abuse, and we learnt a lot in that project
5 about how approaching people in a more global way, children
6 and young people in a more global way, helped us enter into
7 conversations with them about the things that were safe and
8 not safe in their lives and, from that, how we could really
9 build in our own learning about implications for systems
10 and structures from children's own understandings about
11 safety.

12
13 Q. I'm going to ask you some questions that as I
14 understand it your answers will in part arise from that
15 research that you've done. Do I understand that you're
16 also engaged in a current research project with another of
17 the witnesses that's attending the Commission today,
18 Professor Moore?

19 A. That's right.

20
21 Q. Can you tell us a bit about that?

22 A. Yes, we're doing an Australian Research Council
23 project called Ethical Practice Involving Children. That
24 is a big study which is about the experiences of children
25 and practitioners in three different contexts: in schools,
26 Disability Services and Out-of-Home Care services. My part
27 of the project is specifically around Disability Services,
28 but I can talk a little bit about the broader implications.

29
30 The other area that I didn't really mention is the
31 work that I do around domestic and family violence and the
32 experiences that children with disability have in
33 that context which is relevant for today's conversation.

34
35 Q. I'm going to ask you some questions about that, thank
36 you. So, you've made it plain that your area of research
37 interest and expertise relates particularly to children and
38 young people with disability. That's a phrase we've all
39 used a lot so far. When we use that phrase, what's the
40 cohort of children that we're talking about? I take it
41 that they're not a homogenous group?

42 A. I'm really glad that you asked that question. There's
43 a real tendency to think about the population of children
44 with disability but it's such a diverse mixed group, and
45 so, when I talked before about the Feeling Safe, Being Safe
46 study that was specifically talking about kids with higher
47 support needs who used services a lot across different

1 parts of their lives. But Helen's evidence just before
2 talked about a whole different group of children and young
3 people, and I think it illustrated really nicely just how
4 diverse people's needs and their experiences are.

5
6 There is a very wide range of children and young
7 people, from people who - I think you had evidence
8 yesterday about a young woman or a girl's experience who
9 had very high and complex support needs, through to a
10 really interesting group of young people that we work with
11 a lot who don't have a diagnosis, they don't necessarily
12 have an identification at all as being people who've got
13 disability; the kids who are bumping along in school who
14 are not doing so well, who have got learning deficits that
15 have been identified with at school, but neither they or
16 their families identify as being children with disability.
17 Through to people who are sort of in the middle of that
18 range. It's a very broad, diverse range of people, so lots
19 of different populations, lots of different
20 identifications, some people who are proud of their
21 disability, some people who feel a lot of shame.

22
23 Q. One of the things you also mention in your statement
24 is that included sometimes in the cohort of children with
25 disabilities are people who have been given diagnoses in
26 relation to behaviour but perhaps properly understood that
27 behaviour is evidence of underlying trauma and not actually
28 a disability at all?

29 A. The work that we've done and other people have done
30 around the connection between disability and trauma, I
31 think, is really interesting, and I think Helen's work is
32 very important there as well and pointed in very
33 significant ways to the way that you can't unpack
34 disability and trauma from each other, and sometimes we try
35 to do that. Our work in domestic violence really showed
36 that practitioners in domestic and family violence
37 services, as soon as families talked about their children
38 having disability were really keen to say, ah, that's an
39 NDIS issue, kids go off to NDIS, but that was not
40 necessarily the issue that was confronting families and,
41 once disability was identified in the children trauma was
42 not explored with the kids or the families because they
43 were in the disability bucket. And across several of our
44 studies that's been the case: once people receive the label
45 of disability then the exploration or the experience or the
46 understanding around trauma really drops.

1 Trauma-informed practice, or I really like the
2 trauma-competent practice that Helen raised, is in its
3 infancy in disability and there are very few practitioners
4 who are skilled in that kind of practice and it's something
5 that I'll probably return to as we keep talking.

6
7 Q. We will. You make the point at paragraph 16 of your
8 statement that children and young people with a disability
9 are at an increased risk of being exposed to sexual abuse,
10 but as I understand it we know that to be true but there's
11 not particularly good evidence about that, and you've made
12 some comments in your statement about the implications of
13 not having good evidence. Can you talk to us about that?

14 A. Yeah, sure. Well, there's lots of reasons that we
15 don't have good evidence, partly because some children just
16 will never be able to tell us because of the nature of
17 their support needs, because of the way that people live
18 quite service-dominated lives and we've heard a lot already
19 this morning about the way that power works in institutions
20 to make it very difficult for children to talk about what's
21 happened to them.

22
23 And the fact that people have complex and intersecting
24 challenges in their lives and so disability might not be
25 front of mind for them. There's a whole series of other
26 factors that I'd call situational vulnerabilities. I've
27 heard us talking about vulnerability a bit this morning and
28 it's a good point for us to touch on probably when talking
29 about children with disability. My own view is that
30 children with disability aren't inherently vulnerable
31 because of their disability. You know, having Down's
32 Syndrome doesn't make you vulnerable to sexual abuse, but
33 the sort of situations that children with disability are
34 more often in make them situationally vulnerable more often
35 than other children might be, and so that sort of leads
36 into some of the other risk factors that children with
37 disability are exposed to many more services than children
38 without disability, for example, so they're likely to be on
39 their own with other adults that aren't known well to them,
40 that they don't have trust relationships with, for example,
41 they live lives that are more likely to be
42 service-dominated than other children. They are expected
43 to be compliant. All children are expected to be compliant
44 to an extent but the expectations of compliance are higher
45 often for children with disability, and when they're not
46 compliant they are more likely to be subject to behaviour
47 management techniques.

1
2 And the sort of dominant ablest approach to disability
3 means that when children, especially children who don't
4 have articulate voices, when they do protest and they're
5 likely to use behaviour or to not be able to explain well
6 what's causing them distress, it's likely to be put down to
7 being a factor of their disability rather than potential
8 trauma as a cause.
9

10 Q. The Commission's heard from a number of witnesses so
11 far about the extent to which institutions sometimes make
12 assumptions about children being less reliable, less likely
13 to tell the truth, assumptions implicit or otherwise about
14 children and their experiences being less valuable than the
15 experiences of adults, and I would imagine that that's a
16 compounding issue then when disability is brought into the
17 picture?

18 A. Absolutely, yes. I think that's also because our
19 institutions don't have a terribly strong history of making
20 information available and accessible to children with
21 cognitive disability or to children generally, but where
22 the information hasn't been made available to children
23 about things that they need to know, about their own
24 bodies, about the way that communication works, all sorts
25 of things, it's harder for children to have access to that
26 information too.
27

28 Q. You touched on the evidence that the Commission heard
29 yesterday from the mother of a child with high support
30 needs arising from her disabilities and the horrific
31 experiences that her daughter and she had had in the
32 Launceston General Hospital, and a particular perpetrator.
33 At paragraphs 32 and onwards of your statement you talk
34 about the broken touch radar, this question of the
35 difficulties that are imposed on children who, by reason of
36 legitimate support needs, are getting touched all of the
37 time and the implications for then knowing when and how to
38 complain if the touch is wrong. Can you tell us about
39 that?

40 A. That came out of our research and also some UK
41 research with children and young people with disability
42 where children with high physical support needs and also
43 support needs due to multiple disability, experience people
44 touching them from when they get up in the morning to when
45 they go to bed at night. One of the examples out of the
46 Child Abuse Royal Commission study was a young person who
47 had high physical support needs and he was also receiving

1 speech therapy, and the therapist who was working with him
2 talked about the fact that that therapy extended to putting
3 her hand inside his mouth to adjust his tongue even, and
4 so, there wasn't a part of his body that wasn't touched,
5 and in that context it was very difficult - she reflected
6 that his touch radar, what was a safe space and a not safe
7 space was so fundamentally different from other children.
8 And she was reflecting on how hard it would be to teach
9 safe touch, not safe touch, for someone who needs concrete
10 information and needs the information broken down.

11
12 And in other UK research people talked about their
13 sense of bodily integrity really being broken down there as
14 well when they received personal care assistance every day,
15 and sometimes from people who they don't know as well, you
16 know, with the casualisation of our industry too.

17
18 Q. One of the things that you've identified and it's part
19 of the service-dominated lives of children is that
20 sometimes the support needs of the child mean that the
21 family sometimes has a high level of dependence themselves
22 on care being provided by providers, and sometimes an
23 incentive not to complain or to accept concerning levels of
24 care because of the implications of services being
25 withdrawn. Can you comment on that?

26 A. Yeah, that's right, and I guess that's the
27 intersection between children's family life and what
28 happens in the way services are funded and provided. So,
29 with the National Disability Insurance Scheme when children
30 receive funding for services that happen in their home
31 around their personal care supports, support workers can
32 come in and provide personal care supports and things that
33 assist their families. It's an entrenched difficult issue
34 for most families to receive reliable, consistent workers
35 who don't change often. So, getting a reliable pipeline of
36 workers is a real problem and dealing with organisations
37 and keeping a consistent relationship that doesn't change
38 over time is something that a lot of families talk about as
39 a continuing issue. So, dealing with all of that change
40 and churn is a real issue and it's something that's a
41 fundamental problem in terms of training workers, in terms
42 of maintaining trusted relationships for children, and in
43 terms of keeping a stable number of people that children
44 can talk to if they have concerns.

45
46 Q. But does it also raise, thinking about some of the
47 evidence we heard earlier on about wilful blindness and

1 things of that kind, sometimes it might be very difficult
2 for a family to contemplate saying they don't want a
3 particular carer to come any more because they're concerned
4 because the implications of sending that carer away might
5 be the loss of a significant kind of support that their
6 child and their family is relying on?

7 A. Yes, and also the fact that they just simply may not
8 be able to find another person, so both of the levels.
9

10 Q. At paragraph 38 and following in your statement you
11 talk about taking an ecological approach to how we think
12 about preventing child sexual abuse, and you talk about an
13 ecological approach, firstly assuming that children are
14 active agents, and then putting the child at the centre and
15 then considering circles moving out from the child. Can I
16 ask you to just describe briefly the four levels that you
17 describe and then I'm going to ask you some more specific
18 questions of systems and how they work.

19 A. I really like ecological approaches because they make
20 gut sense. So, the idea of the child at the centre is
21 about the child and the way they understand themselves and
22 their relationships. The next level out is the informal
23 relationships that kids have with their families and their
24 peers, their networks.
25

26 Next level out is the services, the sort of formal
27 relationships with all of the people who get stuff done,
28 and then at the outside is the culture, the societal mores
29 and rules, systems, the things that glue all of the inside
30 bits together; the things that we say make things okay and
31 not okay.
32

33 Q. One of the things you identify is that sometimes,
34 thinking I think at that outer level, society accepts
35 things being done to children with disability that society
36 wouldn't accept in other contexts. So, in paragraph 44 you
37 give an example of a child who was being expected to travel
38 in a certain way; can you tell us about that?

39 A. I think this is a really interesting example; that was
40 the Feeling Safe, Being Safe study again. A mother talked
41 about how she was being pressured quite hard for her son to
42 take a taxi to school and back again, and this was being
43 put forward as a thing that would really relieve pressure
44 on the family, and her son was not able to speak, he was
45 not able to move. And her reflection on that was, I would
46 never put my other son, my older son, my 12-year-old son in
47 a taxi on his own with a man he did not know. Why on earth

1 would I put my 10-year-old son who can't speak, can't move,
2 can't tell me if anything goes wrong in a taxi with a
3 series of people who he doesn't know? So there's sort of
4 normative expectations about what's okay for children with
5 disability and what's okay for children without disability;
6 it was really quite stark when brought into the --
7

8 Q. And so that's an example of a system being designed to
9 suit the service provision but not at all having in mind
10 what the child's interests might be?

11 A. Yes, I thought so.
12

13 Q. You give another example at the end of your statement,
14 a very sad story of a young man who was forced to go into
15 care because of his behaviours being too difficult for his
16 mother and the way in which visits between his mother and
17 he were arranged. Can you tell us about that?

18 A. That was a terrible situation, where the young boy had
19 been in care and his mother had worked very hard to have
20 him restored into care, and they had both experienced
21 severe trauma and as time went on they had no support
22 really around trauma supports, and his behaviour became
23 more and more difficult for them both to manage, and she
24 very reluctantly relinquished him into the care of Child
25 Protection and he went into a group home arrangement. When
26 she did that, she lost any entitlement to how much she
27 could see him, and the service provider decided that one
28 hour per month - one hour per fortnight initially was the
29 amount that they could spend time together. And he became
30 very distressed at the end of each of those visits at the
31 end of the fortnight, and so, the decision of the service
32 provider was to reduce it to half an hour per month.
33

34 Q. Not a solution that would have seemed to be in his
35 interests or thinking about his interests as being at the
36 centre of things?

37 A. No, not for either of them, yeah, and unsurprisingly
38 she reported that his distress had only increased as a
39 result.
40

41 Q. So we come to the question of policies, and at
42 paragraph 46 and following you identify some current policy
43 issues and I'm paraphrasing you but you identify the extent
44 to which children with disabilities are not in substance,
45 although perhaps they are in name, in the view in the front
46 of the mind of policymakers. Can you tell us about that
47 issue?

1 A. Children with disability have got a great presence in
2 statement of principles, but we're really lagging in
3 movement beyond statement of principles into enacting
4 practice for children and young people with disability.

5
6 It's a really good time right at the moment because
7 we're right at the intersection of three national policy
8 documents: we've got the Australian Disability Strategy,
9 we've got the National Statement on Protecting Australia's
10 Children and the incoming National Policy on Protecting
11 Women and Children, but we're yet to see the action plans
12 that actually activate what happens for children with
13 disability.

14
15 Up until now we've seen statements of principles about
16 the way that they matter, but not how that actually results
17 in attention for children with disability.

18
19 Q. One of the key things that the Commission is keen to
20 do as much as possible is listen to the voices of children
21 and a number of witnesses so far have told us about that
22 importance, and so I want to ask you some questions about
23 what children have told you through the work that you've
24 done.

25 A. That's correct.

26
27 Q. And particularly in relation to the work that you've
28 done asking children with disabilities what it is that
29 makes them feel safe, including safety in the sense of
30 safety from child sexual abuse. At paragraph 60 and
31 following of your statement you discuss each of the four
32 things that were identified and, as I understand it, the
33 four key issues that children talked about as priorities
34 for being safe were: physical safety, emotional safety,
35 having their access needs met, and feeling capable. I want
36 to ask you about each of them first. Physical safety, it
37 feels obvious, but when children talked about physical
38 safety, what were they meaning?

39 A. I'll just preface this by saying that this was a
40 fairly substantial study that we did with young people with
41 disability that really underlined how incredibly capable
42 young people were when we sat with them and really listened
43 to what people's ideas and strategies were. So, this model
44 of safety was developed from the young people's own ideas
45 and priorities about what they needed to feel and be safe.

46
47 So, when they talked about physical safety, it was

1 sort of a baseline, it was you know, young people felt safe
2 when they had somewhere safe to be, when they were out of
3 danger, when they had someone who they could stick with,
4 and when they weren't mistreated; it was something that
5 they didn't really pay a lot of attention to but in its
6 absence it really mattered.

7
8 Q. And as I understand it from paragraph 61 of your
9 statement emotional safety was a very consistent theme in
10 the groups that you had?

11 A. That was the biggest and most important thing that
12 people really stressed. So, they talked a lot about
13 trusting relationships, being able to develop them, being
14 able to maintain them, being able to sustain them; feeling
15 comfortable, and those sorts of relationships comprised
16 feeling known, feeling respected, feeling valued, and the
17 mutuality of that with other people. That's not to say
18 that people always had that, and so, the absence of that
19 caused a significant amount of pain to people. And the
20 lack of that caused them a lot of difficulty because that
21 was really poorly responded to by service systems. They
22 didn't really see that - young people saw that service
23 providers didn't put a lot of energy or attention into
24 their emotional life, their emotional wellbeing.

25
26 Q. As I understand it some young people identified that
27 they might try and get that emotional safety through
28 behaving in challenging ways but then their behaviour was
29 misunderstood by those they were trying to get emotional
30 comfort from?

31 A. Yes, that's right.

32
33 Q. Turning to the third, access needs, which is about
34 accessibility to the community and to live the kind of
35 broad life that children without disabilities can lead, you
36 include in your statement a reference relating to a café,
37 it's not a big example but perhaps a meaningful example of
38 what children meant when they talked about this idea of
39 access needs.

40 A. Yeah, they talked about physical access but also
41 emotional, psychological access, which means essentially
42 being expected, feeling welcome and being missed if you're
43 not there. So, the example of the café was one young man
44 who talked about how, "When I come into a café I don't want
45 everybody to rush around and move all the tables and make
46 this big space and a huge fuss when I walk in; I want it
47 already set up so that it's - I'm welcome there, I'm

1 expected there, I'm not someone special, I'm part of the
2 community".

3
4 Q. And then feeling capable. You've already mentioned
5 that your experience was that in fact young children with
6 disabilities are very capable. What did it mean when they
7 said that part of them feeling safe was feeling capable?

8 A. That was about feeling that young people were around
9 people who were open to the fact that they had strategies;
10 had this spirit of curiosity about working with them to
11 develop their strategies, to help them to build their
12 capability in using their strategies, their capacity to use
13 their strategies, but it wasn't about being independent, it
14 was about working collaboratively and knowing when to step
15 in and help. But when help was needed, to use that in a
16 complementary way, not to take over from young people; to
17 work in a problem solving way with young people, so that
18 they were using their own agency, but they had someone
19 working in alliance with them around complicated issues.

20
21 Q. One of the things that you identify, and perhaps it's
22 a theme that emerges from the evidence that we heard
23 yesterday from Ms Donohue is, sometimes children with
24 disabilities don't get the chance much to practise being
25 capable and are shielded from the opportunities to
26 participate as fully as they can because of a well-meaning,
27 perhaps, concern by parents and caregivers that they're at
28 risk.

29 A. Yeah, I don't want to present this as a
30 straightforward thing because these were people's fantastic
31 ideas and strategies, but there were lots of barriers to
32 people implementing these things, partly because they
33 didn't get the chance to practise them, and not everybody
34 had really terrific ways of implementing their strategies
35 because of that lack of opportunity and because of systems
36 barriers too.

37
38 So, for example, people's fears got in the way of
39 being able to implement strategies and the lack of
40 education about where risk actually really sat. You know,
41 people talked a real lot about stranger danger but not very
42 much about risk that was closer to home; they're quite
43 tricky conversations to have, and the lack of resourcing
44 and skill building that sat with the people around them was
45 quite apparent because a lot of people's knowledge came
46 from TV, not from other places.

1 Q. I want to turn to some questions about protective
2 measures, and at paragraph 73 and following of your
3 statement you identify that, whilst of course we want to
4 make sure that children are appropriately resourced to
5 stick up for themselves, it's actually unrealistic and
6 deeply unfair to expect children themselves to be the ones
7 who keep themselves safe from child abuse?

8 A. Absolutely, and the more significant the disability
9 that children have, the harder it is for them to stick up
10 for themselves, especially for kids who lead
11 service-dominated lives because the power difference that
12 they live with is very stark. And, you know, this sphere
13 of influence is very small; I mean, all children's sphere
14 of influence is quite small, but for them it's even
15 smaller.

16
17 There was some research done with children who were in
18 quite disadvantaged circumstances back in 2005 that really
19 did a great job of showing the effects when you educated
20 the child and everybody around the child, which created
21 multiple places for children to go. So, well informed
22 education for the kids, but also for teachers, for parents,
23 for key community people like community police and the
24 difference that that made to children in being able to talk
25 about sexual assaults and other kinds of harms in their
26 lives.

27
28 Q. You identify at paragraph 75 that one of the
29 advantages of educating communities and institutional
30 communities perhaps like schools is, apart from anything
31 else, perpetrators who might otherwise enter the system
32 know that people have knowledge and have a capacity to
33 detect them but also, as you've said, there's more people
34 who know what to look out for and who know what to do if
35 they see anything of concern.

36 A. Yeah, that's right, and some of that goes to culture,
37 some of the points that were made earlier about changing
38 culture, and building some of the skills of reflective
39 practice that might go alongside training and education so
40 that people are reflecting on what they're learning and how
41 they can implement it in their own particular context.

42
43 Q. At paragraph 83 and following of your statement you
44 talk about the question of trusted adult relationships, and
45 the Commissioners have heard from a number of witnesses so
46 far the importance of children having a trusted adult and
47 that's obviously the research you've heard as well, but you

1 make some comments that what we know children want of a
2 trusted adult who sticks with them is precisely how the
3 system sometimes doesn't work, particularly where a
4 disclosure is made. Can you give us your reflections on
5 that?

6 A. Because some children with disability are more
7 socially isolated than other children, where they might
8 find an adult who understands their communication, who they
9 have trust with, where they've built a bond, if they are
10 able to find a way to confide in that person, to then be
11 moved on from that person to another person that they don't
12 know I think is a bigger breach than for some other kids
13 who might be able to have - who have less barriers around
14 communication or around other sort of disability-related
15 issues that children might have; and so, to lose that
16 connection to that person, I think it's very important that
17 that doesn't happen for kids.

18
19 Q. So the argument might be, well, they chose to disclose
20 to their personal care attendant, but the personal care
21 attendant doesn't know how to support them through the
22 disclosure process, they're not trained in trauma-informed
23 practice; it's in the child's interests to move them on to
24 see this counsellor and that doctor and so forth. As I
25 understand it, that isn't what children want?

26 A. No, they want that person to go, at the very least, a
27 warm - a warm person to go with them to build that next
28 relationship.

29
30 Q. And so, you identify that there's a need then for old
31 people who might be interacting with a child and who might
32 be the person the child chooses to confide in, all of those
33 people need to be skilled up to know what to do if they're
34 the one the child chooses to trust?

35 A. Yeah, I don't think it's just about disclosure though.
36 I think, if we know in a very conservative estimate that a
37 third of children with disability are experiencing a
38 significant kind of abuse, everybody needs to be skilled in
39 trauma-informed practice; that there's no reason for us not
40 to have that as a fundamental basis of practice.

41
42 Q. Can I ask you then about the specific question of sex
43 education for children with disabilities, and you've
44 answered some questions about this in your statement at
45 page 86 and following, perhaps could I ask you to reflect
46 briefly on perhaps the myths that people have about what
47 children with disabilities need to know about sex and the

1 implications of those myths for children being safe?
2 A. Yes. There's this horrible dual myth that they don't
3 need to know anything and they should be protected from it,
4 or they're going to be wildly promiscuous if they are
5 educated about it. As a result children with disability
6 are often excluded from sex education classes in their
7 mainstream schools or, if they're in special schools, sex
8 education classes aren't provided, or they're so watered
9 down that kids don't get the information that they really
10 need, so they're about biological puberty or they're so
11 basic that kids really aren't getting the depth of
12 relational education that they need around sexuality and
13 identity and relationships, and all of the stuff that other
14 kids get around sort of masturbation and sex and all the
15 actual full range of education that children get as
16 teenagers.

17
18 So, there are some resources that are available for
19 children with cognitive disability, but by no means are
20 they dispersed across all school environments and it's very
21 important that they are because, first of all it's a right,
22 but second of all, it's protective for children to have
23 that sort of education at an age appropriate level in the
24 same way that other children have it.

25
26 There's absolutely no evidence that children with
27 cognitive disability play out those myths about promiscuity
28 and all of those sorts of things, but the need for
29 appropriate education that's tailored to the needs of
30 people with cognitive disability is vital.

31
32 Q. You've given us some information in your statement at
33 paragraphs 99 and following about harmful sexual
34 behaviours, so the cohort of children who might include
35 children with disabilities who act in ways that are
36 problematic in terms of being developmentally inappropriate
37 or potentially harmful to other children, and one of the
38 things that you identify is the possibility that those
39 behaviours might need to be understood as trauma responses
40 and not necessarily motivated by any ill-will or intent on
41 behalf of the child. Can you talk to us about that?

42 A. I go back again to the high rates of sexual abuse that
43 children with disability are known to experience and the
44 fact that we can't discount the fact that sexually harmful
45 behaviour in children with cognitive disability is trauma
46 responsive.

1 Some work that we did with practitioners who work with
2 teenagers with sexually harmful behaviours was really
3 interesting, in particular listening to them talk about the
4 diagnoses that children had been labelled with, and the
5 fact that a lot of the kids that they said they worked with
6 came with this constellation of diagnoses that had been put
7 one on top of the other, and some of their early work with
8 the kids often involved peeling these diagnoses off that
9 were often quite inaccurate and had been put on from kids
10 quite young in response to things that had happened in
11 their trauma backgrounds. So, kids who had very, very
12 complex, difficult backgrounds and very traumatic
13 backgrounds, and it goes back I guess to the earlier
14 comment that we were talking about, about the intersections
15 between trauma and disability and how tangled all of those
16 things are.

17
18 Q. At paragraph 110 of your statement you talk about some
19 work that you are involved with funded by ANROWS and the
20 reflections that you had when you saw the way in which
21 children and young people with disability were regarded
22 during the processes of support for family violence. Can
23 you tell us about that?

24 A. Yeah, sure. In that study we were quite concerned
25 that with the absolute best of intentions early
26 intervention domestic violence prevention services were
27 responding to the needs of families by calling on NDIS
28 resources to meet the needs of children rather than being
29 able to support children's trauma-related needs, and
30 domestic violence services take a whole-family approach and
31 the idea of domestic and family violence responses is that,
32 through supporting the mother, you support her healing and
33 she's then able to support her children.

34
35 For kids with disability there's a fairly fundamental
36 problem there; that some of the trauma in the children that
37 we met and the families that we met was so extreme that
38 they were enacting the trauma of behaviour that they had
39 experienced in their family through the perpetrator in
40 their family; the things that the families were living with
41 were really desperate. It wasn't an NDIS issue, it wasn't
42 about the - I mean, there was a real tangled web, I guess.
43 NDIS were saying it wasn't an NDIS issue, but the
44 disability and family violence services were saying it
45 wasn't a family violence issue either because it wasn't
46 coming through the stream of funding that the family - so
47 these poor kids were really caught in between because it

1 was the need for trauma counselling that was causing the
2 violent behaviour.

3
4 Q. And this raises an issue that the Commissioners have
5 heard a number of times, that because of funding and
6 governmental structures and other things, children might
7 live with complex needs, but each of those needs is
8 potentially met through a different service funded by a
9 different person --

10 A. Absolutely.

11
12 Q. -- and provided in a different way. Is there any
13 solution to that problem?

14 A. In this project we found that these kids were
15 continually slipping between the cracks and, if they were
16 in the care of Child Protection, sometimes that made it
17 even worse although it should have improved it because they
18 should have been taking financial responsibility for
19 meeting the needs of the children.

20
21 I mean, a holistic approach is needed to meet the
22 needs of those children. Funding streams in domestic
23 violence that actually focus on children, meeting
24 children's needs. Some domestic violence services now have
25 children's workers who come alongside the family and have a
26 focus on the children, which is a good advance. There's
27 some pilot programs in South Australia now which are
28 looking at what children's workers can offer in the
29 domestic and family violence context, but the fundamental
30 problem about the splintering of funding is a real issue,
31 yeah.

32
33 Q. And again, an issue which arises from the fact that
34 services are built starting from who pays for them perhaps,
35 starting from the point of view of who's going to need
36 them?

37 A. That's right.

38
39 Q. Professor, perhaps as my last question, you'll be
40 aware that part of the role of this Commission is to make
41 recommendations to the Tasmanian Government about
42 appropriate systems and policy changes that will better
43 protect children in instructions from the risks of child
44 abuse or respond to them if it occurs. Bearing in mind
45 your comments about children with disability being present
46 a lot in statements of intent but not necessarily present
47 in the substance of the work, is there anything in

1 particular that you would wish the Commissioners to have in
2 their minds as they go about that task of framing
3 recommendations?

4 A. Thank you. I think it's really important that the
5 Tasmanian Government look to how the state picks up the
6 needs of children with disability outside of the NDIS,
7 because so much of children's lives is lived outside of the
8 NDIS. Looking at how to prevent this sort of continuing
9 falling between the cracks that happens to children who
10 experience violence, that we don't continue to sort of push
11 children off and think the NDIS will sort that out, because
12 the NDIS doesn't sort it out. The NDIS is not a trauma
13 response service, it's not designed for that, and they're
14 very clear about that, and so, they just keep pushing
15 people back.

16
17 But the problem is, every time they push people back,
18 it takes them six months to do that, and six months is a
19 long time for a child, and then it takes another six months
20 to sort something out, and things get worse and worse and
21 spiral and spiral. So, whatever can be done at a state
22 level to improve holistic support for children and young
23 people, I think, is very important, and to connect in a
24 responsive way to the three national policy frameworks that
25 I mentioned before really matters.

26
27 The other thing that I just would mention is that, the
28 way that funding for children with disability is
29 progressively going is around individualised support to
30 children, and there are lots of opportunities and strengths
31 in that, but there are risks also around child sexual
32 abuse, in that, children can be alone with a single
33 provider, a single worker; in that, organisations are more
34 likely to have individual workers who don't come together
35 for reflective practice and strong supervision and
36 training, and that there are sole providers who are working
37 on their own without any oversight at all, and so
38 increasingly in the disability sector that's sort of a
39 developing picture and all those things constitute risk to
40 children with disability.

41
42 Q. So whereas in the past a lot of those workers might
43 have been part of larger non-government organisations which
44 screened and supervised and supported; that's not the way
45 the funding and the system is going?

46 A. And the funding - yeah, the funding also is quite
47 restricted for the investing and training of workers, yeah.

1 And, of course, children and young people have very little
2 authority to have input into what happens in the way that
3 all of that is offered, so they get Vegemite or peanut
4 butter level choices but very little input into those
5 bigger level decisions.

6
7 MS ELLYARD: Thank you, professor. Commissioners, those
8 are the questions that I have for Professor Robinson.

9
10 COMMISSIONER BROMFIELD: Q. Professor Robinson, thanks
11 so much for coming today and for the work you do in this
12 really important area. I had a few questions for you.
13 When you were speaking about the disproportionate rates of
14 child sexual abuse that children with disability experience
15 and then talked about how they had then I guess the double
16 jeopardy of then also missing education about sexual health
17 and presumably then how to disclose, does this mean that
18 children with disability might actually not even have the
19 language or the words to describe what's happening to them?
20 A. Absolutely, yes. Yeah, that's exactly what it means.

21
22 Q. And does that present differently for different types
23 of disabilities?

24 A. Yeah, that's a good point, it does, yeah. So,
25 children with cognitive disability are particularly
26 affected by that problem because there's not adapted
27 materials for them in schools generally.

28
29 Q. Is, I guess, that disproportionate risk considered in
30 things like children who might be restricted to an eye gaze
31 board or to using Auslan; are there the words?

32 A. No, I don't think so, I think anybody who needs
33 anything that's out of the ordinary; so, people who might
34 need easy read materials, for example, so quite limited
35 adaptations really that are needed. And I think there are
36 a huge number of students who would benefit from broken
37 down materials that are more concrete, so students who have
38 English as a second language, for example, or there are a
39 lot of students who would really benefit from more
40 accessible materials.

41
42 Q. So, in having more accessible material for kids with
43 disability, we could help a whole lot of kids, so thank
44 you.

45 A. Yes.

46
47 Q. Often the case. I also wanted to just pick up the

1 NDIS, again thinking about this disproportionate risk for
2 kids with disability to abuse and neglect. Given that
3 disproportionate risk, have you seen disability services
4 pick up with maybe greater gusto the National Principles
5 around Child Safe Organisations, or is there some
6 challenges in that regard?

7 A. The Ethical Practice Involving Children study that
8 we're doing at the moment was interesting in looking at
9 that. One of the organisations we used as a case study had
10 a really interesting approach - let me rephrase that. One
11 of the organisations involved in that research showed that
12 they'd relied overly on policy and not enough on the
13 interpretation of the connection to the thinking that the
14 workers needed to do to apply that to a really complicated
15 ethical decision, and so, just that sort of blanket, here's
16 the policy, I'll apply it the way it needs to go, and the
17 outcome for the young person was quite devastating as a
18 result.

19
20 So, I can't comment more broadly about whether
21 disability organisations as a rule are applying the child
22 safe principles, I suspect that there is a whole spectrum,
23 but certainly in the ethical practice study we're seeing
24 organisations relying on the letter of the policy.

25
26 Q. Maybe I could put it differently. From your
27 experience working in the disability sector and with
28 disability services do you see an awareness within those
29 services of that heightened risk and additional strategies
30 being taken as a consequence?

31 A. No, I don't.

32
33 COMMISSIONER BROMFIELD: Thank you. I didn't have any
34 further questions.

35
36 PRESIDENT NEAVE: Thank you, very, very much for your very
37 helpful evidence and your excused and we'll now break,
38 thank you.

39
40 **LUNCHEON ADJOURNMENT**

41
42 PRESIDENT NEAVE: Thanks, Ms Norton.

43
44 MS NORTON: Good afternoon, Commissioners. In the first
45 session after lunch today we are going to continue the
46 theme carrying over from this morning of looking at
47 institutional risk factors and the next witness is

1 Associate Professor Tim Moore who I'll ask to come up to
2 the witness box and be sworn in. He's going to speak in
3 particular about institutional risk having regard to his
4 participatory research with children and young people.

5
6 <TIMOTHY PETER MOORE, affirmed and examined: [2.12pm]

7
8 <EXAMINATION BY MS NORTON:
9

10 Q. Mr Moore - Associate Professor Moore, I should say,
11 can you state your full name again please?

12 A. Timothy Peter Moore.

13
14 Q. And you are currently the Deputy Director at the
15 Institute of Child Protection Studies at the Australian
16 Catholic University?

17 A. That's correct.

18
19 Q. You've made a statement for the benefit of the
20 Commission dated 28 April 2022?

21 A. I have.

22
23 Q. Have you reviewed that statement recently?

24 A. I have.

25
26 Q. And is it true and correct?

27 A. Yes.

28
29 Q. Thank you. Associate Professor Moore's statement can
30 be found at folder C, tab 13 of the hearing bundle.

31 Associate professor, I believe you have in front of you a
32 copy of the statement along with the five exhibits?

33 A. That's right, yes.

34
35 Q. Are you able to identify that they are the correct
36 exhibits, just take a look at them, and if they are the
37 correct exhibits I'll just ask you to hand that complete
38 version over to Ms Rolfe.

39 A. Yes, they are.

40
41 Q. You outline in your statement at paragraphs 4 to 8
42 your professional background, and Exhibit 1 to your
43 statement is your CV. By way of overview, you have a
44 background as a youth worker?

45 A. That's right.

46
47 Q. And you worked in that sort of role for about 10 years

1 from 95 to 2005?

2 A. That's correct.

3

4 Q. And then you moved over into an academic role?

5 A. Yes.

6

7 Q. Particularly with a focus on participatory research?

8 A. That's correct.

9

10 Q. Can you just explain in very general terms what
11 participatory research involves?

12 A. So, my stream of research really is about engaging
13 children and young people in research about their lives.
14 So, instead of relying on adults or other proxies to speak
15 on children's behalf and to give us a picture of how
16 children understand and experience the world, we work with
17 children and young people directly. So, our research
18 gauges children and young people in interviews and focus
19 groups and the like, but we also try to work with them in a
20 more engaged way, so we might have advisory groups or peer
21 researchers or what have you, so young people not only have
22 an opportunity to have their say but also to shape what we
23 do, how we do it and then how the research is received.

24

25 Q. Thank you. And why is it that it's so important in
26 this area that we listen to children and young people's
27 perspectives on safety?

28 A. I think, although for a long time people have been
29 doing participatory research, it's only been really in the
30 last 20 years or so that we've started to really appreciate
31 that children understand and experience the world in
32 different ways to adults, and the way that children
33 encounter particular problems and challenges, including
34 child sexual abuse, but things like family and domestic
35 violence or problems in their families around mental health
36 and drug and alcohol issues and the like. We've always had
37 assumptions that we know what's going on for children and
38 young people, but participatory research has really shown
39 that children actually experience things quite differently
40 and that that has an impact on, I think, the policy
41 responses that we need to have.

42

43 For example, when talking about safety, children tell
44 us that they prioritise feeling safe and that they believe
45 that adults have a focus on reducing risks and the like, so
46 in much of our recent work children have been saying that
47 it's really important for adults to recognise that we need

1 to be able to feel safe within organisations, not only so
2 that we can have good outcomes, but also that we have
3 confidence in adults, so we are able to come forward and
4 say, this isn't okay or I've been hurt or harmed or things
5 need to change. So, I think it's really important to get
6 insights into how children and young people are
7 understanding something so that we can make sure that the
8 responses we have are actually responsive to their needs,
9 and also reduce the likelihood of unanticipated
10 consequences. So, you know, kids are often saying, "Yeah,
11 adults get things right a lot of the time, but sometimes
12 they do stuff that makes life worse for us, can we
13 therefore be part of the process so we can ensure that that
14 doesn't happen?"

15
16 Q. In listening to what you've just said it strikes me
17 that undertaking this sort of research and then using it to
18 inform policy design is a form of co-design really?

19 A. That's right.

20
21 Q. I'd like to talk to you in much greater detail about
22 the learnings from your research, but before we get into
23 that can I just start by asking you: you conducted similar
24 research for the National Royal Commission; is that
25 correct?

26 A. That's right, that's correct, yes.

27
28 Q. And you've been engaged to conduct participatory
29 research to inform the work of this Commission?

30 A. That's right.

31
32 Q. I appreciate that you are still in the process of
33 performing your analysis on the Tasmanian data, but are you
34 able to offer any broad observations particularly having
35 regard to what the Commonwealth research told you five or
36 so years ago and what you're seeing in the Tasmanian
37 research now?

38 A. Yeah, sure.

39
40 Q. Any similarities or points of difference?

41 A. Yeah, sure. So, done a number of studies focusing on
42 safety. We were really delighted with the National Royal
43 Commission into Institutional Responses to Child Sexual
44 Abuse's commitment to listening to children and young
45 people. So, they commissioned a series of research
46 projects including the piece that Sally was talking about
47 earlier on.

1
2 So, we had the broad piece of work which engaged
3 children and young people in focus groups across the
4 country, and then followed up with an online survey where
5 we asked children about their perceptions of safety,
6 whether or not they believed their organisations had what
7 we described as child-informed indicators of safety
8 climate; so, the things that kids felt they needed to be
9 safe and to feel safe in organisations and how they wanted
10 adults to respond if they had a safety concern including
11 child sexual abuse.

12
13 And then, throughout that piece of work it became
14 quite clear quite early on that young people, children and
15 young people with disability and young people in
16 residential care had other safety concerns that really
17 needed to be explored further. So, Professor Sally
18 Robinson conducted the piece looking at children and young
19 people with disability and we did other another piece
20 looking at children and young people in residential care,
21 so as you said we are delighted too to be able to do some
22 work for the TAS Commission where we've worked with 59
23 children and young people across Tasmania within schools,
24 healthcare settings and hospitals, Youth Detention and
25 out-of-home and residential care.

26
27 So, I think there are a number of key things that came
28 through the original piece of research which has been very
29 much echoed within the Tasmanian context, that children and
30 young people see their vulnerabilities in relation to not
31 only some inherent challenges, that they're smaller and
32 weaker and what have you, but also they recognise that
33 they're probably vulnerable to abuse because of the way -
34 using my language - they're positioned in society. You
35 know, they say from very early on, you're told that adults
36 are always right, you're told that you have to listen to
37 adults and respect adults and do what adults tell you to
38 do, and that children as part of that are seen as being
39 naive or ignorant or that they make things up or don't
40 understand things or what have you, and they felt that that
41 makes them vulnerable because adults can take advantage of
42 that situation, you know, because they're getting mixed
43 messages all the time.

44
45 So, for example, in a broad study kids were saying,
46 "At school we learn about our bodies and that no-one can
47 force us to do things that make us uncomfortable, but every

1 Christmas we go over to granny's place and have to kiss
2 Bertha who's got a hairy lip and makes us feel
3 uncomfortable", so there's these mixed messages that kids
4 are getting all the time, and that really their sense of
5 what's okay and what's not okay is often gazumped by adults
6 who tell them to do things that don't play out in that kind
7 of way.

8
9 They also felt that, in addition to the way that
10 they're positioned in their relationships with adults, that
11 they felt there was an organisational aspect too; that in
12 organisations adults always listen to each other, adults
13 look out for each other. They felt that they were as
14 children being bullied by a particular adult, or harassed
15 by a particular adult or what have you, that that adult
16 probably is using those same behaviours with others. So,
17 you know, adults won't stick up for you because they don't
18 want to have the repercussions.

19
20 And then young people were aware that sometimes adults
21 found it difficult to talk to children about tough stuff
22 and therefore may be dismissive of their situation, and
23 that came through again in the interviews and focus groups
24 we did with children and young people in Tasmania. We had
25 some - and I'm in the process of analysing the data at the
26 moment, so it is quite present for me at the moment.

27
28 I do have to say that, with the young people,
29 particularly in foster care, out-of-home care and Youth
30 Detention, these are kids who have been hurt time and time
31 again, and a lot of the young people were sitting with this
32 pain and were saying, "We need you to realise how much this
33 affects our lives and not dismiss it because", they said,
34 "sometimes adults find it too hard to talk about this
35 stuff, so they say 'We don't want to have to cope with it,
36 we're not going to deal with it' and push it to the side".
37 But the kids said, "This is our lives, these things are
38 impacting on our lives, on every part of our lives", as
39 Helen and others mentioned this morning, "on my sense of
40 self, my sense of safety, my sense of place in the world,
41 and until you act up as adults and say, actually, this
42 isn't okay and we're going to work with you to find
43 solutions, this stuff's going to continue".

44
45 So, in addition to inherent vulnerabilities, children
46 and young people definitely talked about some of the
47 vulnerabilities that are entrenched in society within broad

1 cultures but also within the organisations that children
2 and young people interact with.

3
4 Q. Thank you. Let's go with that theme and that is zoom
5 out for a minute and look at institutional risk factors in
6 a general sense. You talk in your statement at
7 paragraph 41 about four different types of risk factors:
8 individual, group, cultural and systematic. I'm going to
9 come back to individual factors but I'd like you to address
10 the Commissioners on group, cultural and systematic factors
11 through the lens of Out-of-Home Care, because I understand
12 you've done a lot of research in that area, and perhaps if
13 we could start with group factors. You talk in your
14 statement at paragraph 46 about the perennial issue of
15 placement in Out-of-Home Care settings. Can you explain
16 why that's a risk factor?

17 A. Sure. If you don't mind I'll just take one step back
18 a little. So, obviously with young people who are in
19 Out-of-Home Care predominantly these are young people who
20 have experienced maltreatment either in their families or
21 in the past, they've got trauma and they're often
22 demonstrating this trauma in the way that they interact
23 with others and the like. Some of that is internalised
24 where kids are self-harming and hurting themselves and
25 others, they're lashing out and hurting others.

26
27 We know from the international literature but very
28 much played out in the research of the National Royal
29 Commission and this piece of work, that one of the threats
30 that young people feel is most pressing in out-of-home and
31 residential care is physical violence amongst young people
32 there and sometimes peer sexual abuse that occurs.

33
34 And I suppose, if we look at the residential care
35 placement we see all the things that Donald and others
36 talked about this morning playing out. You've got kids who
37 are quite damaged and traumatised who are lashing out at
38 those around them; you've got young people who don't have a
39 lot of trust in the system, who don't necessarily have a
40 lot of trust in adults, who feel incredibly powerless and
41 feel like they don't necessarily have ways of expressing
42 themselves in appropriate and healthy and safe ways, and
43 therefore they're more likely to demonstrate some of these
44 problematic behaviours and also more likely to experience
45 some of those behaviours.

46
47 At a systems level we've always had that issue of

1 matching and mixing. We know in Australia that the numbers
2 of foster carers have reduced significantly over time and
3 that there's lots of kids who are ending up in residential
4 care placements.

5
6 Now, I want to say that residential care can be the
7 best place for some children and young people and lots of
8 kids who have gone through residential care grow and heal
9 and thrive, but lots of children and young people in
10 residential care don't have that experience. So, I think
11 what plays out in residential care with the mixing and
12 matching, we can't find appropriate places for some kids so
13 we put them together and we know that the kids who end up
14 in residential care are often those young people with
15 disability, young people with more significant behavioural
16 issues and mental health problems, and unfortunately we
17 often put them into residential care units where staff
18 themselves are under-trained, under-supervised and
19 unsupported, which means that they're not always able to
20 act in trauma-competent ways that Helen was talking about
21 this morning. So, you know, in lots of ways there's this
22 powder keg of challenges that mean that many of our kids
23 don't experience residential care as a safe period of their
24 lives.

25
26 Q. You mentioned before, I think, and you certainly
27 discuss it in your statement, the prevalence of harmful
28 sexual behaviours in Out-of-Home Care settings. Can you
29 speak to the Commissioners about some of the features of
30 those settings that explain why harmful sexual behaviours
31 are particularly common there?

32 A. Yeah, sure. So, in the international literature
33 people have done some fairly intense work in residential
34 care settings really to go, why is this happening?
35 Obviously we've got kids who are in pain who are sitting
36 together and there's that old maxim of hurt people, hurt
37 people, hurt people, so you've got kids who are hurting
38 each other out there.

39
40 But there are particular cultural aspects I think of
41 some residential care units that, I suppose, exacerbate
42 some of those risks. So, we know that in some residential
43 care units children and young people are sort of either
44 cast as being asexual or hypersexual and the ways that the
45 organisation sets up the relationships between the young
46 people and each other and with workers can foster that and
47 can foster unhealthy types of expressions.

1
2 I know Lorraine Green and others in the UK, for
3 example, have sort of talked about environments that foster
4 this hypersexual, hypermasculine kind of behaviours amongst
5 the young people, and it's really this dog eat dog world
6 where young people say, "To protect myself I have to lash
7 out at others before they lash out at me". In regards to
8 sexual behaviours, young people sometimes use sex as a way
9 of asserting themselves in these pecking orders. Others
10 use it as a way of expressing their sexuality.
11

12 I think one of the things that we've been pondering
13 over time is around, how do young people develop a sense of
14 healthy sexual development, and what are some of the things
15 that stop young people from acting on some of their urges,
16 which all of us, including children and young people
17 experience. What sorts of things curb their behaviours?
18 Again, if you look at some of the lives of some of these
19 children and young people who have been potentially
20 sexually abused or physically harmed in their family
21 environments, we put them through a system that discourages
22 children and young people to have their intimacy needs met.
23 When I'm talking about intimacy I'm not talking about
24 sexual intimacy necessarily, I'm talking about to feel
25 loved and cared for, to be hugged, you know, to feel like
26 someone's demonstrating their care and love for you in this
27 physical kind of way. Kids are often denied that within
28 the system and therefore don't know what's okay and what's
29 not okay and how to express themselves.
30

31 And, you know, young people sometimes say that their
32 only way of understanding relationships is based either by
33 TV, neighbours and what have you, or their experiences with
34 their parents or their families where things weren't okay,
35 or have this idealistic view that they know is not going to
36 be achieved.
37

38 So children and young people tell us that they're not
39 trying to excuse some of the problematic sexual behaviours
40 that are occurring in these settings but say, well, we
41 don't know what's okay and what's not okay and how do we
42 deal with that.
43

44 I think also children and young people in those
45 settings often have a problematic view of what happens in a
46 normal relationship and as part of that where sex sits
47 inside that. So, we've had young people in the past who

1 have talked about the fact that, you know, from a young age
2 you're desperate to have a girlfriend and to show that that
3 person's your girlfriend you have to have sex with them and
4 this is the way that you have a sexual relationship. So,
5 yeah, I think it's views on what is appropriate, what's not
6 appropriate, what a relationship looks like can be often
7 skewed and we don't, I think as a system, do well in
8 talking to children and young people broadly about sex and
9 sexuality and relationships, but in particular those kids
10 where we've got in residential care.

11
12 Q. In a situation like that where you have a young person
13 who's in care and who hasn't had those basic needs for
14 intimacy met in a healthy way, what added vulnerability
15 might that person have when, for example, somebody from
16 outside the care environment starts taking an interest in
17 them, starts giving them gifts, those sorts of grooming
18 behaviours?

19 A. That's a significant issue and I think there's been
20 quite a bit of work done in Victoria because it was an
21 issue that was raised very much so within the Out-of-Home
22 Care system there, that there was a lot of sexual
23 exploitation that was occurring there, and talking to some
24 of the young women who had experienced that, they said,
25 "Yeah, I was desperate to be loved, to have someone to take
26 notice of me, to show - to tell me that I was beautiful and
27 valuable and what have you, so, when somebody started to
28 show me that affection I, you know, jumped in". It didn't
29 start off as a sexual relationship, seemed quite
30 appropriate, but then things, you know, over time it
31 developed into something that was problematic.

32
33 And, the young women that we spoke to about this
34 talked about the fact that because the system asexualises
35 them and says that sex is not okay in any kind of instance,
36 that they didn't feel like they could talk to carers or
37 their child protection workers or what have you about what
38 had happened because they felt that they'd be judged or, in
39 worst case scenarios, be kicked out of their residential
40 care settings. So, young people got into this situation
41 and went, "I don't know how to get out of it and I'm
42 worried about the consequences of raising a concern about
43 it for me and my situation".

44
45 Q. That leads into another point that you discuss in your
46 statement about particular cohorts of children who are
47 vulnerable, and you talk about relationships of dependence.

1 Can you elaborate a bit on that?

2 A. Yes, I think as Professor Robinson was talking about
3 earlier today, there are particular groups of young people
4 who are, not necessarily service-reliant, but have the
5 system deeply involved in their lives and often they need
6 workers and people around them to provide them with things
7 that they wouldn't get in their families or other
8 communities or what have you.

9

10 Young people have told us that, if they're worried
11 that raising a concern might mean that they're exited from
12 care or if they become homeless or what have you, then they
13 do voice a reluctance to come forward and say, "This isn't
14 okay". Children and young people also tell us that when
15 they've been hurt or harmed for so much of their lives
16 often they don't feel worthy of a response and go, "Well,
17 you know, maybe I just need to put up with it. Maybe I
18 don't deserve any better", and as a result I think that
19 influences their own help-seeking and their ability to
20 disclose and to be able to have some of these issues
21 resolved.

22

23 Q. I think you have an example which I'll invite you to
24 share with the Commission about a boy in Out-of-Home Care
25 and how it was that he came to understand that he was in an
26 abusive relationship.

27 A. Yeah, so this was a young person that we met through
28 the work that we've been doing for the Tasmanian
29 Commission. We had a young person who had experienced
30 physical and sexual abuse in his family. He was placed
31 into foster care, where there was fairly - sorry, I
32 probably should have pre-empted my discussion today by
33 saying that all of my work is around children and young
34 people's perspectives, so this is how they understand
35 what's going on around them. Not to discount their truth,
36 but to say that sometimes there are things that are going
37 on around them that they may not be aware of, and I'll come
38 back to that later.

39

40 But this young person experienced abuse at home, went
41 into foster care, had some fairly neglectful - maybe that's
42 the better way of responding - carers who didn't know how
43 to work with him and his trauma, were fairly punitive in
44 regards to his behaviour, so he'd lash out or he
45 alternatively forgot to say "thank you "for them making him
46 dinner at night so they would lock him out of the house and
47 not feed him for two or three days at a time. He thought

1 that that was what parenting was about because that was his
2 experience in the past, and he said it was only when he
3 went on Facebook and found a young parents page where they
4 were talking about what's okay discipline and what's not
5 okay discipline, did he go through the list and went, oh,
6 hang on a minute, all these things in the not okay list are
7 things that have happened to me while I'm in care. So, he
8 said he didn't understand, he didn't have an expectation,
9 and he thought that adults in the system thought that he
10 would know these things and be able to raise them, but he
11 said it was just totally off his radar.

12
13 Q. That, I think, is an example of the way in which - the
14 corollary of the example you've given points to the
15 protective value of healthy relationships and the educative
16 value of them. You speak also in your statement about the
17 healing function of healthy relationships; can you
18 elaborate on that?

19 A. So, I think - look, you asked before about what's
20 different about this piece of work and the work that we've
21 done for the Royal Commission, the National Royal
22 Commission. I think young people were more adamant in the
23 interviews and focus groups we did, particularly those who
24 had been in Out-of-Home Care or Youth Detention, about the
25 fact that their life was characterised by trauma, and a lot
26 of the young people spoke with frustration about this
27 assumption in the system that, if you're not safe at home,
28 put you in a new place and everything will be great; you
29 know, you won't experience trauma any more and you'll heal
30 and recover and grow. Young people said that wasn't the
31 case, you know, particularly those young people who had
32 terrible experiences at home, terrible experiences in care,
33 and often were exited into independent living where they
34 had no-one around them.

35
36 So, young people said that they were desperate to have
37 people in their lives who cared for them, who loved them,
38 who showed them affection, who they knew they could trust
39 if things went wrong. And, although there was lots of
40 stories of young people who had been hurt or harmed in the
41 system, there were amazing stories too of carers and the
42 like who had gone above and beyond.

43
44 There was a young person who had spoken about a
45 critical incident in his residential care unit, he was
46 exited into homelessness and had been treated pretty badly
47 by the system and by coincidence he had ran into one of his

1 foster carers who he had when he was 4 years old, and they
2 recognised him and went, "What is going on?" He said,
3 "This is what's happened to me". They said, "You're coming
4 home with us, I know the rules say that you can't, but
5 we're going to help you, we're going to get you back on
6 your feet". And he said, how powerful was it; every Monday
7 night he goes to their place and has dinner, and they say,
8 "What's going on, how can we help you, how can we ensure
9 that you're getting some stability and the like", so those
10 enduring powerful people are so important for our kids.

11
12 You know, I think I've flagged in my statement that
13 one of the unintended consequences of some of the child
14 safety work is that we are obsessed about adults and we see
15 adults primarily as threats to children and young people,
16 but every child needs to have those important people in
17 their lives who can be their champions who are going to
18 protect them, you know, who are going to take on that role
19 of looking out for them, being an advocate when they've
20 been hurt or harmed and who's going to help them in regards
21 to recovery and growth.

22
23 And I think, just to finish off that, I think children
24 and young people in this study said that, "Yes, I
25 understand that I might only have short periods in Youth
26 Detention or short periods in a particular foster care
27 placement or what have you, but I've been part of this big
28 system all my life, so it's not okay for you to say we
29 can't provide therapy therefore you're not going to get
30 it". We have to say, "Over this time you've spent in the
31 system someone needs to provide that to you so that you can
32 recover", because a number of the young people we spoke to
33 who are a little bit older were saying, "In a couple of
34 years' time I'm going to be by myself and I'm not going to
35 be able to deal with this stuff and you may not be
36 responsible for the abuse that happened when I was at home,
37 but if stuff happened to me while I was in care you've got
38 a responsibility to help me heal and grow otherwise you've
39 failed me and set me up to fail into the future".

40
41 So, you know, I think there was this pervasive anger,
42 I think, amongst a lot of young people who had gone through
43 tough stuff. They said, "You know, I was removed from home
44 because I was unsafe and you put me into an unsafe
45 situation. So, they're saying, okay, one of the messages
46 for the Commissioners - that's how we finish off most of
47 the interviews - is we want to heal and grow and we need a

1 system to help us to do that.

2

3 Q. That leads nicely into another point I wanted to ask
4 you about and that is, I understand you draw a distinction
5 between Child Safe Organisations and child safe systems.
6 Can you speak to that in the context of out-of-home care?

7 A. Yeah, sure. So, it's one thing that we've sort of
8 been thinking a little bit more about in reflection on
9 things we've been hearing from children and young people,
10 and I think it leads on from that last conversation we've
11 had, that rather than organisations just saying we need to
12 look internally and what we're doing for kids who are part
13 of our particular service or what have you, we need to go,
14 how are we creating a system around kids that is child safe
15 as well?

16

17 I was incredibly pleased to hear how many children and
18 young people talked about the Commissioner for Children and
19 Young People and the advocate for children in Out-of-Home
20 Care; sounded like some of the kids had them on speed dial
21 and would contact them all the time, but there were other
22 kids who didn't know anything about it and they said, "If
23 something was happening in my organisation and I was
24 unsafe, I couldn't tell a carer, I couldn't tell a worker
25 because adults stick together and adults don't necessarily
26 respond to that stuff, so I would call Kids Helpline" or
27 someone else who they realised might not really have a role
28 in doing that.

29

30 So, I think a child safe system responds to kids'
31 safety needs and obviously in this context the healing and
32 growth, that there are advocates and allies who are outside
33 who are accessible, who are trusted by these children and
34 young people, and that we have an eagle eye view around
35 what kids need to be safe and to feel safe and go, okay, if
36 it's not being provided in an organisation, where else can
37 it be provided, which means that we need to have joined up
38 stuff; when kids say they need therapy, then an
39 organisation needs to say how do we work with CAMHS, how do
40 we work with others so that some of these things aren't
41 there.

42

43 If workers in a residential care unit are reluctant to
44 have a particular type of relationship with children and
45 young people and express it through hugging and all those
46 sorts of things, then how do we find those natural
47 appropriate trustworthy people so that young people can

1 have those needs met as well, so taking a broader view.
2 Because I think sometimes the child safe work can be
3 sometimes too insular and I think also, while we're talking
4 about it, unfortunately I think we miss an opportunity when
5 pushing for child safe orgs where it's just focusing on how
6 institutions respond to abuse that occurred within the
7 institution, rather than saying how do we respond to kids
8 who have been abused outside of that institution, and how
9 do we take responsibility, not for resolving things,
10 because schools aren't necessarily in the best position to
11 do therapeutic work or what have you, but go, actually this
12 is a kid who's part of my organisation who needs this sort
13 of support, what do I need to do to help facilitate that in
14 the longer run.

15
16 Q. You referred to CAHMS there and there was an exchange
17 that took place yesterday between Commissioner Bromfield
18 and Professor McDermott from CAHMS and it was in relation
19 to an example of a child who had been in and out of home
20 care or short-term placements, 14 or so, and the complex
21 trauma that that individual no doubt brought into care and
22 that's probably been exacerbated over their lifetime in
23 care, and the fact that there was discussion about the fact
24 that a service provider like CAHMS can face difficulties
25 with scarce resources in terms of tackling really complex
26 trauma.

27
28 Is looking at child safe at a systematic level one way
29 of trying to assist children in that situation?

30 A. Yeah, absolutely, and I can't say that I know the
31 Tasmanian system well enough to make comment on it, but I
32 do know from previous work in other jurisdictions where
33 agencies like CAHMS or other mental health services say we
34 can't work with a particular child because they're in an
35 unstable or chaotic space at the moment, so that has to
36 change before we can provide them any therapeutic
37 responses. That's not okay because it means that some of
38 our kids will never get support.

39
40 Similarly within, say, the Youth Justice System we
41 constantly hear Youth Justice Centres saying, our kids
42 aren't in for a long period of time and they're only on
43 remand so we're not going provide them any rehabilitative
44 work. That's not okay because some of these kids might be
45 in 12 times and spend extensive periods of time within
46 those detention centres. We have to think, are these
47 policies, are these practice approaches actually meeting

1 kids' needs at an organisation level and, if they're not,
2 how do we provide those services and support so that
3 no-one's dropping out. Because, travesty's maybe
4 overstating it, but I think there is a travesty that the
5 kids who need the most support are being denied that
6 because of the way that the system operates.
7

8 Q. You made reference there to Youth Justice and it
9 strikes me that a number of the features that make children
10 in Out-of-Home Care more vulnerable have parallels in Youth
11 Justice. Can you speak to that?

12 A. Yeah, so I'm not going to make reference to the
13 interviews that we did with young people in Youth Justice
14 necessarily, just because there were only three of them and
15 I don't want to be in a situation where their identities
16 are raised, but absolutely. You know, in other work that
17 I've done in Youth Detention Centres in other
18 jurisdictions, there are characteristics, they are closed
19 organisations. I think Donald Palmer was talking about
20 those before, that there isn't a lot of other outsiders
21 coming in and spending time with young people there,
22 there's not always a good oversight, which means that the
23 culture within that setting can sometimes both not have
24 external scrutiny, but also sometimes they can be quite
25 insular.
26

27 And, you know, we've seen in other detention centres
28 where there are problematic behaviours particularly amongst
29 staff and young people where those behaviours aren't
30 challenged because it's kind of, this is the way that we do
31 things. I will say that one young person we spoke to in
32 Tasmania said that they felt that that was a problem with
33 the setting here; that, even when new good workers came in,
34 sometimes they felt like those workers were being bullied
35 or brought into this culture that wasn't necessarily - or
36 wasn't, let's name it - wasn't child safe or appropriate
37 and what have you.
38

39 So, I think the closed nature, the cultural stuff's
40 there, and bringing it back to the first set of comments
41 that I made around children, the way that children are
42 positioned: you know, I think we often talk about children
43 as being innocent or naive, but conversely we talk about
44 young people as being deviants or dysfunctional or what
45 have you, so construct them in a way that dehumanises them
46 as well, and we see that play out in Youth Detention
47 centres where young people are seen as criminals or what

1 have you, and therefore adults in those services can go,
2 actually, maltreatment's okay because that's what they
3 deserve, so it's about going, how do we change those
4 cultures? If we saw those kids in detention as being
5 amazing and wonderful or what have you, that's one thing;
6 but if we see them and say these are kids who are
7 traumatised, these are kids who are hurting, these are kids
8 who are in pain, this is what we need to be doing with them
9 and this is why they're lashing out in this particular way,
10 then I think things would be quite different.

11
12 Q. Is that looking to the cause rather than the symptom?

13 A. Absolutely, absolutely, yeah.

14
15 Q. I know you've been listening to the evidence over the
16 course of the morning and the Commission has heard from
17 Professors Robinson and Milroy about the particular
18 vulnerabilities of First Nations people and also people
19 living with a disability. I'm interested to ask you about
20 compounding vulnerabilities and if I could put a
21 hypothetical to you of the acute vulnerability that
22 somebody might face in Youth Justice, where they come from
23 an Aboriginal background, are living with a disability and,
24 let's say, has also been in and out of care prior to being
25 in Youth Detention. Can you talk about the situation of
26 that person?

27 A. Sure. I'll probably start by saying that, although
28 I've seen some pretty unsatisfactory, maybe, detention
29 centres, I've seen or have read about particular settings
30 that are amazing. You know, say, for example, I work quite
31 closely with some groups in the US that are doing some
32 amazing stuff with First Nation young people over there,
33 where they've created a culturally safe environment for
34 these young people --

35
36 PRESIDENT NEAVE: Q. Can I just interpose there. Are
37 there any Australian examples that we should be looking at?

38 A. Only to say that my Youth Justice research experience
39 is quite limited, so I probably only looked at - had
40 interactions with three or four. I can take it on notice
41 and provide you with some things, if that's helpful?

42
43 PRESIDENT NEAVE: Thank you.

44
45 THE WITNESS: So, young people in those environments
46 flourish, you know; they have workers often from their
47 communities who take charge of them, who give them - sorry,

1 who see the value in that child and also sees culture as
2 protective and goes, okay, how can we build up your
3 cultural identity, and as part of that your sense of self,
4 your sense of worth, your sense of hope in the future, and
5 how can we build that into the way that we're working.

6
7 Unfortunately in detention centres where we don't have
8 those sorts of things young people are absolutely more
9 vulnerable. If young people see their cultural background
10 as being a source of derision or what have you through
11 racism, discrimination, then that's going to compound their
12 sense of worthlessness and their lack of confidence in the
13 adults and the organisation in itself. If they're
14 struggling with issues of sexuality or if their sexuality
15 is ridiculed or what have you, then again, they're not
16 going to come forward and say "this is going on for me"
17 because sex and sexuality is something that's seen as
18 shameful or something that they need to hide. So, again,
19 there's multiple barriers for these kids to be able to say
20 this isn't okay and to get the support that they need.

21
22 Q. I'm sure the Commissioners - it's heartening to hear
23 that it doesn't have to be so and we'd certainly be
24 assisted by any suggestions that you have about models
25 where the previous example has been the case.

26 A. I'm sure there'll be criminologists who will appear
27 before the Commission, but I think it is that, if we have
28 pain-based models where it's about punishment and causing
29 kids pain in the hope that that will change their
30 behaviours, we know that doesn't work. If it's about
31 rehabilitation and if it's about understanding trauma,
32 helping kids respond to trauma and building a new sense of
33 themselves and what they could become, then the
34 trajectories are quite different and their experience while
35 they're in detention is quite different too.

36
37 Q. Thank you. I'd like to speak to you in a bit more
38 detail about your research and some of the information that
39 you've learned through that. Can you begin by telling the
40 Commissioners the sort of language that children use when
41 they talk about safety on the one hand, what are synonyms
42 for safety, and also the sort of language that they use to
43 describe people who feel unsafe, for example?

44 A. So, in regards to synonyms, you know, children often
45 talk about their bodily response to a person, place or
46 experience. They talk about butterflies in their tummy or
47 being like I am at the moment with sweaty palms or what

1 have you, or you know feeling in your shoulders or what
2 have you, so it's a bodily response, the implications of
3 which would be good to talk about.
4

5 They also are aware that they have a behavioural
6 response; you know, so sometimes they can't rationalise and
7 go, this person's unsafe, but they go, "Oh wow, I'm
8 responding in a funny way to this person, maybe they're not
9 okay". The implication for children and young people is
10 that they say that because they've got a different language
11 or a different way of understanding safety adults don't
12 respond very well.
13

14 Kids often, in lots of interviews and focus groups in
15 the national study, talked about creepy adults and talked
16 about going to their parent or someone in the school or
17 what have you and saying, "This person's creeping me out
18 and freaking me out and I don't want to be with them". And
19 the adults say, "What did they do?" And they say, "They
20 just freaked me out", and they say, "Wait until the adult
21 does something and then come to us". The young person
22 says, you know, in situations some young people recalled
23 scenarios where teachers were having inappropriate
24 relationships with students and, prior to that coming out,
25 you know, a number of young people had gone to the
26 principal and said, "This teacher's creepy and weird and we
27 don't like him". The principal had said, "Well, come
28 back", and the young women were incredibly frustrated
29 because they said, if this principal had taken notice then
30 maybe things would have been different.
31

32 Now, the young people were very clear, they said,
33 people shouldn't be sacked because they creep young people
34 out, but maybe if that principal had gone, "Actually, I
35 wonder if things are okay, maybe I'll watch out, maybe I'll
36 ask other young people in the school, are you okay, and
37 maybe I'll ask some of my staff to watch out as well",
38 maybe things would have been different in that scenario, so
39 it's about that bodily response
40

41 COMMISSIONER BROMFIELD: Q. My recollection of Associate
42 Professor Moore from that research was that, when you
43 actually asked the young children about - you were curious
44 as Professor Milroy suggested about what that looked like,
45 young people gave very sophisticated answers that showed
46 they were very attuned to safety. They gave examples such
47 as adults who stood too close to them, who talked about

1 inappropriate - made inappropriate jokes or told them
2 private information that they didn't feel a teacher should
3 share with them. So, some very, very concrete things that
4 I would have thought represented grooming behaviours.

5 A. Yes, absolutely. But young people - those young
6 people also said that they felt that adults didn't respond
7 because those adults hadn't seen that behaviour, and that
8 they felt that because it wasn't an adult raising that
9 issue that the seriousness of that situation wasn't
10 appreciated.

11
12 So, you know, young people are really aware that
13 sometimes they get it wrong, but they want adults to go,
14 actually we do know quite a lot about this and we think we
15 know what the best response is, please involve us in that.

16
17 MS NORTON: Q. Can I ask you this: one of the themes
18 that is coming through in the work of the Commission is
19 that perhaps one of the reasons why institutions are -
20 hamstrung's not quite the right word, but are overly
21 cautious in responding to complaints like that or concerns
22 like that from children, is that the institutional response
23 is seen through a disciplinary lens. If we think about a
24 school environment as an example, it's seen as a
25 disciplinary issue, the consequences of disciplinary action
26 can be significant for a teacher, and so, that sets the bar
27 quite high in terms of the sorts of concerns that the
28 school will act on.

29 A. Yep.

30
31 Q. I think some of - tell me if I'm right about this:
32 that there's an alternative way of looking at it, which is
33 not looking at it from a disciplinary point of view but
34 from a safety point of view, and I'd be interested to know
35 if you have any suggestions about how systems can be
36 designed so that those concerns are listened to and acted
37 on appropriately, but we're not in a situation where
38 there's a disciplinary investigation commenced every time a
39 student thinks a teacher's weird.

40 A. Yep. So, Professor Robinson referenced the EPIC Study
41 before, the Ethical Practices Involving Children Study,
42 where we're looking at disability services, schools,
43 residential care settings, asking both children and young
44 people and workers around what are some of the practices
45 that foster children and young people's sense of safety,
46 happiness and wellbeing, and Professor Robinson spoke a
47 little bit about some of the disability services.

1
2 In the resi care space it's quite interesting, where
3 we had residential care units and organisations that had
4 kind of gone - we're a learning institution, we're going to
5 create a culture of calling each other to account where we
6 are curious and go, why did this play out in this
7 particular way. Both the workers were appreciative of the
8 fact that people are having these conversations and the
9 organisation were going, actually, this is quite a good way
10 of monitoring what's going on.

11
12 The workers appreciated it particularly because within
13 that environment they're having to make all these really
14 tough decisions all the time and often they didn't
15 necessarily have an ethical framework to work with, so they
16 talked about the fact that they appreciated it, and the
17 managers in those organisations did go, actually, this is a
18 way of recasting some of this safety stuff, you know. So,
19 we're not going to put you through a formal process if
20 we're worried about the workers' behaviours, as in, we're
21 not going to put the workers through that, but we are going
22 to have those curious conversations and we are going to
23 challenge you and we are going to create an environment
24 where it's not staff complaining or critiquing their peers,
25 but asking questions and flagging where they don't think
26 things are quite right. So, it was just changing, I
27 suppose, the way that that organisation operates and they
28 said that that was really quite helpful for them.

29
30 I totally, having worked in youth services and managed
31 youth services, I totally understand that there is a
32 hesitation to respond to all of children and young people's
33 concerns because as young people say, sometimes they don't
34 get it right, but I think it does behove us to be more
35 critical and to be more observant and to take kids
36 seriously - take more seriously than we have in the past.

37
38 Q. On the subject of grooming and boundary breaches, are
39 there any examples or learnings from your research about
40 the need to further educate children and young people about
41 those sorts of risks?

42 A. I think it's fair to say that, besides probably three
43 or four young people in some of the focus groups within the
44 school settings, no student's really talked about adult
45 child concerns. Most of the young people when we pushed
46 them and said that the Commission's being set up because
47 they're worried about some of the relationships that

1 teachers have had with students and what have you in the
2 past, kids went, oh, we'd never really talked about that
3 and it's kind of off our radar.
4

5 They talked at the end in the summary section where we
6 asked them to come up with some messages for the
7 Commissioners around what needs to change, they went,
8 "We've got to change sex ed and healthy relationship
9 training, because it's all about" - as Professor Robinson
10 mentioned before, you know, around STIs and pregnancy and
11 what have you. Sometimes it's about consent and peer
12 harassment, but it's never about adults and it's never
13 about adults that we know. So, absolutely, we need to
14 change that because many of the young people weren't aware
15 of it.
16

17 Young people in Out-of-Home Care, Residential Care,
18 Youth Justice, seemed to have a greater appreciation of the
19 risk but not what to do and not how to respond or seek
20 support if they're in that scenario.
21

22 Q. It strikes me that sometimes perhaps adults don't have
23 those conversations with children and young people because
24 they're uncomfortable conversations perhaps for the adults
25 as much as the children. Has your research gone into those
26 sorts of matters?

27 A. Yeah, I think children and young people's perspectives
28 are that adults are uncomfortable talking about sex and
29 sexuality and things that cause the adult some vicarious
30 pain, I suppose, is the best way of saying it. They say,
31 "Adults don't like coming across a child who's in pain,
32 they want to fix it all, and go, you're going to be better
33 and off you go". Similarly, they're not happy to have
34 uncomfortable conversations with kids around sex and
35 sexuality because of the adults' discomfort with it. Young
36 people often say, "We don't care, we don't need to talk
37 about this", so it's the adults that are the ones that
38 aren't willing to have these conversations, so I think that
39 came through quite strongly.
40

41 And I think that point about adults not being good at
42 encountering kids who are experiencing pain probably can be
43 brought up to the community level as well. You know, I
44 sort of reflect on some of the incidents where kids have,
45 you know, been murdered or have experienced significant
46 family violence or what have you, the way we talk about it
47 in the media, the way we talk about it in the community.

1 Rightly we often talk about the impact for mums or if mums
2 have been murdered or children have been abused or what
3 have you, but I think that we find it difficult to have
4 these conversations to say that this has actually gone on
5 and I think as a result either we recast the issue or use
6 euphemisms and things which aren't helpful for children and
7 young people broadly.

8
9 Say, for example, I'm intrigued by some organisations'
10 responses to the National Commission's work and the Child
11 Safe Standards in particular, you know, standard 7 I think
12 it is, is around children and young people's participation.
13 So, a number of schools have said that the way we've done
14 that is demonstrated that we want to hear from kids about
15 their safety is to have a safety day and kids have said
16 that they're worried about their safety in the parking lot
17 after school, so we did a co-design session with them on
18 redesigning the parking lot. That's fantastic, that's
19 good, that's a concern of kids, they've responded to it.

20
21 But the intent of the National Standards and
22 principles is around preventing and responding to child
23 sexual abuse, so we need to - we want to be doing stuff
24 with kids around parking lots, but how do we have
25 conversations with kids around child sexual abuse and child
26 sexual abuse prevention and should we be ticking off that
27 organisation saying they're doing participatory work with
28 kids around safety because they've talked about what's
29 going on in the parking lot? So it's going, maybe they've
30 built the confidence up in kids, maybe they've built
31 connections as part of that work, maybe they've felt
32 affirmed and valued in having the opportunity to work with
33 adults to find a solution to this safety problem that
34 they've identified together, but I'm not sure that kids are
35 necessarily making that link, and that, for me, is a little
36 bit worrisome.

37
38 Q. I suppose another reason why adults might be hesitant
39 to have difficult conversations with children and young
40 people is out of some kind of well meaning concern that
41 they might frighten the child or that the child's not -
42 it's too sophisticated a concept for them. As somebody who
43 seems to me to have made a living out of having
44 uncomfortable conversations with children, how do you
45 approach those conversations? How should we approach them?
46 A. I get just as stressed and anxious with all these
47 conversations as anyone else, but I probably need to be

1 really clear. I think there are situations where having
2 these conversations with kids can be uncomfortable and
3 distressing for the child. I think there are some
4 situations where children aren't aware of things and there
5 are some risks in venting it to children without proper
6 scaffolding and support and what have you, so my rule of
7 thumb is always, find out from children and young people
8 what they know already and go from there and that's the
9 approach that we've taken with this research and a lot of
10 the work that we've done, often because adults freak out
11 and go, "We don't want to talk about it. We're not sure
12 about you as researchers going in and talking to kids about
13 this stuff because that's not okay", so we talked about
14 safety: what does it mean to be safe? What are some of
15 your safety concerns? Kids listed them all and if they
16 talked about interpersonal safety risks, if they talked
17 about adult stuff then we talked about that and we went
18 down that path. If kids didn't talk about stranger danger,
19 if they didn't talk about teachers who are abusing kids or
20 what have you, we didn't go there, unless young people were
21 at a point where we felt that it would be okay for them to
22 talk about it, so rule of thumb with the young people in
23 schools, only 15 and 16 year-olds, so we said you might
24 have heard about the Tasmanian Commission of Inquiry, the
25 Commissioners are wanting to know about sexual abuse, are
26 you okay for us to talk about it. If they said "yes" we
27 talk about it; if "no", we didn't.

28
29 So, it's about giving them choice and control as well.
30 So start with what they know, give them lots of choices,
31 give them lots of outs, and then go, okay, I'm not going to
32 leave you in a situation where you're feeling unsafe or
33 where you're worried, how do we respond to it?

34
35 So, using an analogy from research, one of the
36 pioneers of child abuse research, David Finkelhor, one of
37 the things that he does in a number of his maltreatment
38 studies is he has a little questionnaire at the end of the
39 survey to see whether or not children and young people who
40 have been asked questions about sexual abuse feel
41 comfortable talking about it if they've experienced
42 distress and what have you and if they need any support as
43 a result of their participation.

44
45 Kids who have experienced child sexual abuse rarely
46 say that they found talking about it, or in this case doing
47 surveys about maltreatment, distressing or uncomfortable

1 and that if they do experience that it's short-lived and if
2 they had known how they would feel and the things that they
3 talked about would they choose to do it again, almost
4 absolutely everyone said that they would.

5
6 There was a risk though. Finkelhor showed that some
7 kids who hadn't experienced abuse who had been asked about
8 abuse said that they found it somewhat uncomfortable
9 because they hadn't realised that that could be going on
10 for their peers. So, I think we as adults do need to be
11 mindful of it, we need to be tentative, we need to put in
12 scaffolds, we need to ensure that kids are safely able to
13 participate, but we can do that and we need to work
14 together to build our confidence to be able to have these
15 conversations with kids because they're desperate to have
16 them

17
18 MS NORTON: Thank you. Possibly my last question for the
19 afternoon before I see if the Commissioners have anything
20 that they'd like to ask you. There's been a lot of
21 evidence given today by you and others about the importance
22 of cultural factors in terms of encouraging people to come
23 forward and disclose or express their concerns. What sort
24 of an environment do children need in order to feel safe to
25 disclose?

26 A. So, it's interesting; I was involved in the research
27 that helped guide the National Principles, and am pleased
28 with the fact that they've been established, but it was
29 really quite interesting that what children and young
30 people thought were the characteristics of a child safe
31 organisation, what they wanted and needed was very
32 different, and often it was about how they felt and how -
33 sorry, what was achieved through all these initiatives that
34 have been put in place by adults. They wanted to feel
35 safe, they wanted to feel valued and respected, cared for;
36 they wanted to feel as if they have rights, and adults were
37 taking those rights seriously; that they wanted adults to
38 see it as adults' responsibility for keeping kids safe, but
39 that kids had a role in being able to shape that.

40
41 Within those environments children and young people
42 said that they were more likely to be able to identify
43 issues themselves but would feel more comfortable coming
44 forward. If they felt that adults were able to have these
45 uncomfortable conversations then they were more likely to
46 come forward. Children and young people told us both
47 firsthand accounts where they had reflected on their own

1 experience of coming forward, but also other young people
2 who hadn't experienced abuse talked about what they think,
3 thought their school or hospital or whatever would do if
4 they raised a concern: most of them said that they wouldn't
5 be believed. Many didn't have confidence that adults would
6 know what to do, that adults would do the right thing and
7 that there wouldn't be consequences.

8
9 So, for many of the children and young people we spoke
10 to the culture is about creating an environment where kids
11 are safe and feel safe, but where they have confidence in
12 the adults and the organisation, and I suppose one of the
13 things that children and young people have suggested to the
14 Commissioners, is that, there's not much point doing stuff
15 to keep us safe if we don't see it and we don't experience.
16 So, children said, say if we use the example of the Working
17 with Children Checks, kids said, "My God I didn't realise
18 that everyone's got one of those things and why has no-one
19 ever told us?" Kids are mindful with white vans and the
20 like in Queensland. There was a focus group where young
21 people were saying, you know, "Our school is useless, they
22 would have absolutely no idea about what to do if this was
23 a situation that unfolded here". The teacher in the room
24 said, "Well actually, we've done all this training and
25 we've done this, that and the other and there's a new
26 patrol and every afternoon at 3 o'clock the police drive
27 by". And the kids say, "What do you mean, nobody told us,
28 and we're the ones who are affected by this and we're the
29 ones that need to know and until we know we won't have
30 confidence in you", and the confidence is important
31 because, "We'll only come to you if we're confident that
32 things will improve as a result of that".

33
34 MS NORTON: Commissioners, are there questions for
35 Associate Professor Moore?

36
37 COMMISSIONER BENJAMIN: I do.

38
39 Q. Dr Moore, in a hypothetical situation, in a closed
40 institution such as a school or a hospital or out-of-home
41 care, or Youth Detention, if a child were bullied and/or
42 induced to provide inaccurate or favourable information to
43 authorities, what would be the impact of that, do you
44 think, upon most children and what does it tell you about
45 the institution?

46 A. A hypothetical. Young people who are in similar
47 situations in our research unfortunately are in two groups,

1 I think: one group who went, yeah, of course, you know,
2 adults talk all the time, organisations talk all the time
3 about prioritising our safety and, you know, that this
4 stuff is real and we're going to manage it, and that if
5 there's openness and transparency then things are going to
6 change and what have you, but we've been let down that many
7 times, that's just how it's going to be. Others would feel
8 incredibly - in fact, there was one, I was just trying to
9 think what the quote was, one young woman who talked about
10 it in the school context who said, you know, kids would be
11 incredibly angry and let down and they would feel as if
12 they were totally alone. You know, one young person said,
13 people tell us all the time to go and talk to a teacher or
14 adult if we've been hurt or harmed, and if that person says
15 to us I don't believe you or we're not doing anything or
16 we're going to put your needs below the needs of the
17 organisation or what have you, they'd be up in arms and
18 they would feel totally hopeless or rejected. In fact, one
19 young person said if I was in that situation I'd probably
20 end up in a mental health ward because it would just be the
21 last nail in the coffin for them.

22
23 So, absolutely, young people would feel rejected and
24 let down and, you know, either angry or frustrated or their
25 sense of worthlessness or hopelessness would be compounded
26 by the behaviours of that adult or the organisation.

27
28 COMMISSIONER BENJAMIN: Thank you.

29
30 PRESIDENT NEAVE: Questions?

31
32 COMMISSIONER BROMFIELD: No, thank you. Thank you for
33 your evidence today, Associate Professor Moore.

34
35 MS NORTON: Before the witness is stood down, I'm sorry to
36 end such a fascinating session with a very mundane matter,
37 apologies for this. I understand that you didn't hand up
38 Exhibit TM-5 in the bundle before. Can you just confirm
39 that that is the final exhibit?

40 A. Sure. This is Professor Robinson's, yes.

41
42 MS NORTON: If you could hand that over to Ms Rolfe. If
43 the witness could be stood down, please.

44
45 PRESIDENT NEAVE: A short break, please.

46
47 **SHORT ADJOURNMENT**

1
2 MS BENNETT: Commissioners, I'm about to call four
3 witnesses to speak together in a panel, and before I do
4 that, and I'll guide that discussion to assist the
5 Commission, I'd just like to explain the purpose of the
6 panel.
7

8 The panel comprises a number of people who operate or
9 assist in operating what is colloquially known as the ARL,
10 the Advice & Referral Line, and as you will hear, it's a
11 point of reference for mandatory reporters and others, any
12 Tasmanian who has concerns around children in the state,
13 and we'll go through precisely what it does.
14

15 What I wanted to emphasise by way of introduction,
16 Commissioners, is that the purpose of this panel is to
17 understand the way in which the ARL works and how we are to
18 understand the way in which the different policies and
19 procedures fit together.
20

21 In coming weeks, Commissioners, you may hear some
22 evidence and stories about some concerns relating to the
23 ARL and they are not matters that I'm exploring today.
24 Today is about understanding how it works and we are
25 grateful that those who are able to give us that
26 clarification and that detail have come to give evidence
27 today.
28

29 Having thus clarified the purpose of this afternoon's
30 session, could I ask that Ms Galanos, Mr Stopczynski,
31 Ms Churches and Ms Hales come to be sworn in.
32

33 <ZAHARENIA GALANOS, sworn:

[3.37pm]

34 <JUREK STOPCZYNSKI, affirmed:

35 <EMILY CHURCHES, affirmed:

36 <RACHEL HALES, affirmed:
37
38
39
40

41 MS BENNETT: Thank you for all giving evidence today.
42 Ms Hales, starting with you, could you please tell the
43 Commissioners your full name, professional address?
44

45 MS HALES: Yes, so Rachel Hales. Professional address,
46 Level 4, Carruthers Building, St John's Park in New Town.
47

1 MS BENNETT: You've made a statement to assist the
2 Commission today and that is a statement of 12 pages plus
3 attachments; is that right?

4
5 MS HALES: Yes, that's correct.

6
7 MS BENNETT: Have you read that statement lately?

8
9 MS HALES: I have, yes.

10
11 MS BENNETT: Is it true and correct?

12
13 MS HALES: Yes, it's correct.

14
15 MS BENNETT: Ms Churches, turning to you, can you tell the
16 Commissioners your full name and address, professional
17 address.

18
19 MS CHURCHES: Emily Churches at Level 4, Carruthers
20 Building, St John's Park, New Town.

21
22 MS BENNETT: Ms Churches, you've made a statement for the
23 benefit of this Commission which effectively adopts the
24 statement of Ms Hales. Is that correct?

25
26 MS CHURCHES: That is correct.

27
28 MS BENNETT: Mr Stopczynski, you have made a statement for
29 this Commission. Is that right?

30
31 MR STOPCZYNSKI: That's correct, yes.

32
33 MS BENNETT: I'll first just ask you to tell the
34 Commissioners your full name and professional address.

35
36 MR STOPCZYNSKI: Jurek Stopczynski, Suite 3, Level 1, 175
37 Collins Street.

38
39 MS BENNETT: Your statement also effectively adopts the
40 statement of Ms Hales; is that right?

41
42 MR STOPCZYNSKI: That's correct.

43
44 MS BENNETT: Is that statement true and correct?

45
46 MR STOPCZYNSKI: Yes.

47

1 MS BENNETT: Ms Galanos, could you please tell the
2 Commissioners your full name and professional address?

3
4 MS GALANOS: Zaharenia Galanos, Level 1, 2 Salamanca
5 Square?

6
7 MS BENNETT: Ms Galanos, you've not made a statement to
8 the Commission, you've attended to assist the Commission
9 today in understanding the work of the ARL; is that right?

10
11 MS GALANOS: Correct.

12
13 MS BENNETT: Could you please tell the Commissioners your
14 position.

15
16 MS GALANOS: At the moment I'm the acting director for
17 Children and Family Services but my substantive role is the
18 manager for the Strong Families, Safe Kids Advice
19 & Referral Line.

20
21 COMMISSIONER BENJAMIN: I'm sorry, I must be getting on a
22 bit, I didn't hear you.

23
24 MS GALANOS: My substantive role is the manager for the
25 Strong Families, Safe Kids Advice & Referral Line.

26
27 COMMISSIONER BENJAMIN: Thank you.

28
29 MS BENNETT: That Strong Kids and - sorry, could you say
30 that --

31
32 MS GALANOS: Strong Families, Safe Kids.

33
34 MS BENNETT: And Strong Families; that's what I'm
35 referring to as the ARL, that's its full name?

36
37 MS GALANOS: Yes.

38
39 MS BENNETT: Thank you. I want to just make sure I
40 understand each of your roles. So, Ms Hales, you work for
41 Baptcare, and Baptcare through a contractual arrangement
42 provides some of the operator services which operate the
43 ARL?

44
45 MS HALES: Yes, that's correct.

46
47 MS BENNETT: So that means the people taking the phone

1 calls?

2

3 MS HALES: (Witness nods.)

4

5 MS BENNETT: Ms Churches, you work for Mission Australia
6 in a similar role?

7

8 MS CHURCHES: Correct.

9

10 MS BENNETT: And, Mr Stopczynski, you're in the same
11 category working for Mission Australia?

12

13 MR STOPCZYNSKI: Mission Australia as regional leader for
14 Tasmania.

15

16 MS BENNETT: Do any of you on the panel, and I'll go
17 through each one at a time, you are not yourselves
18 operators of the phone, let's just be clear. Can you tell
19 me, Ms Hales, where you sit in the hierarchy of the people
20 dealing with this at Baptcare?

21

22 MS HALES: So my role is non-government manager so I
23 oversee all of the Mission Australia and Baptcare teams so
24 that's the people that are on the phones, their practice
25 leaders and all our community liaison officers across the
26 state.

27

28 MS BENNETT: Ms Churches, you have a similar role I
29 understand?

30

31 MS CHURCHES: So, my substantive role is as Mission
32 Australia practice leader so I support the six ARL workers,
33 Mission Australia delivering Strong Families, Safe Kids
34 contract on behalf of government.

35

36 MS BENNETT: Mr Stopczynski, can you tell the
37 Commissioners what your role is?

38

39 MR STOPCZYNSKI: My role is regional leader for Tasmania
40 so I have strategic and operational oversight of everything
41 Mission Australia do in Tasmania with the Advice & Referral
42 Line being one of those services.

43

44 MS BENNETT: Ms Galanos, you've told us your role, can you
45 tell us what it means in relation to the ARL's operations
46 day-to-day.

47

1 MS GALANOS: So I have responsibility day-to-day for all
2 staff and our contracted partners with the Advice
3 & Referral Line, so as the Manager I have direct
4 line management supervision of our community liaison
5 functions across the service.
6

7 MS BENNETT: What is the purpose of the ARL so far as you
8 can tell us, Ms Galanos?
9

10 MS GALANOS: So, the purpose of the ARL is, well, we
11 brought together the functions of the previous intake
12 service across the gateway and the collective resourcing
13 around the child safety intake teams together to deliver
14 child safety wellbeing functions across Tasmania, so we're
15 effectively the front door for child safety wellbeing
16 across Tasmania.
17

18 MS BENNETT: And so, is it the case that a mandatory
19 reporter discharges their function by calling your line?
20

21 MS GALANOS: Correct.
22

23 MS BENNETT: They could discharge that function in a
24 number of ways, couldn't they?
25

26 MS GALANOS: They could call directly to the service or
27 they could make an online contact as well.
28

29 MS BENNETT: I just want to make sure I understand the
30 structure, so what I'm going to do is outline what I
31 understand it to be from your statement, Ms Hales, and then
32 I'll check in with you that I've understood it correctly.
33

34 So, there are six teams of ARL operators, is that
35 right?
36

37 MS HALES: Yes, that's correct.
38

39 MS BENNETT: What do you call each team?
40

41 MS HALES: Team 1, team 2, team 3, team 4.
42

43 MS BENNETT: And each team has six operators and one
44 practice leader; is that right?
45

46 MS HALES: Approximately six operators, yeah.
47

1 MS BENNETT: It varies a little bit?

2
3 MS HALES: Yeah, it does, yeah.

4
5 MS BENNETT: And one practice leader and, Ms Churches,
6 you're one of those practice leaders?

7
8 MS CHURCHES: That is correct.

9
10 MS BENNETT: Now, there are one team comprised of Baptcare
11 employees; is that right?

12
13 MS HALES: Yes, that's right.

14
15 MS BENNETT: So that's the operators and the practice
16 leader are all employees of --

17
18 MS HALES: Yes.

19
20 MS BENNETT: Ms Churches, for Mission Australia that's the
21 same, is it, there's one team of operators and you are a
22 practice leader?

23
24 MS CHURCHES: Correct.

25
26 MS BENNETT: Thank you. And then there are, Ms Galanos,
27 four what I'll call CSS and by that I mean child safety --

28
29 MS GALANOS: Child safety wellbeing workers.

30
31 MS BENNETT: What do you call them?

32
33 MS GALANOS: We'll collectively refer to them as ARL
34 workers if that's easier.

35
36 PRESIDENT NEAVE: Sorry, I didn't catch that.

37
38 MS GALANOS: ARL workers.

39
40 MS BENNETT: And what I mean, those are employees of the
41 state.

42
43 MS GALANOS: Yes.

44
45 MS BENNETT: So there are two teams which comprise
46 entirely what I'll call NGO staff, non-government
47 organisation staff, and four teams comprised entirely of

1 state staff?

2

3 MS GALANOS: Yes.

4

5 MS BENNETT: I understand that. And all of those people
6 are based in Hobart; is that right?

7

8 MS GALANOS: Yes.

9

10 MS HALES: Yes.

11

12 MS BENNETT: Mr Stopczynski, they all have the same
13 qualifications or perhaps you can tell me from the
14 perspective of Mission Australia what the qualifications
15 are of each of the operators in each team?

16

17 MR STOPCZYNSKI: So, the qualifications would be the same
18 and we aim for generally a bachelor of, or a degree, so a
19 bachelor of social work or anything along those lines or a
20 diploma with equivalent experience and significant
21 experience with units across case management, et cetera.

22

23 MS BENNETT: You just referred to experience; do you mean
24 academic experience so that the diploma has in it units
25 concerned with caseworking, or do you mean you've got field
26 experience in child protection or similar?

27

28 MR STOPCZYNSKI: Ideally both, but the qualifications
29 would have the units within them, but we would also look at
30 people who have had experience in the field in those areas.

31

32 MS BENNETT: Roughly, are you able to say roughly what
33 proportion of your operators have field experience?

34

35 MR STOPCZYNSKI: I might defer to Emily for the current
36 team.

37

38 MS CHURCHES: All our current staff have got
39 qualifications and experience.

40

41 MS BENNETT: Are you able to say the kind of experience
42 that they have?

43

44 MS CHURCHES: Working in - a number of them are working in
45 not-for-profit services working with children, families or
46 youth.

47

1 MS BENNETT: And, Ms Hales, can you say if that's the same
2 with Baptcare?

3
4 MS HALES: Yes, it's the same.

5
6 MS BENNETT: So the minimum qualifications are academic;
7 is that right?

8
9 MS HALES: Yes.

10
11 MS BENNETT: And there's no minimum qualification of
12 practical experience?

13
14 MS HALES: So, if the degree was the diploma or
15 equivalent, if it's not a social work degree the
16 expectation, as Jurek said, would be that they have a
17 placement, practical placement within that diploma that
18 involves case management within the child and family field.

19
20 MS BENNETT: So, the academic qualifications are
21 sufficient to be employed, the practical experience is
22 preferred?

23
24 MS HALES: Yes.

25
26 MS BENNETT: Ms Galanos, is there anything different from
27 the perspective of state employees?

28
29 MS GALANOS: No, it's exactly the same, so Bachelor of
30 Social Work, Diploma of Community Welfare or other tertiary
31 quals at diploma or above level which includes units of
32 case management.

33
34 MS BENNETT: Just to pause there, are the staff that are
35 employed on the ARL, are they exclusively employed with the
36 ARL or do they interchange with Child Protection staff?

37
38 MS GALANOS: There is movement that can occur across the
39 child safety space and the Advice & Referral Line, yeah.

40
41 MS BENNETT: What I'm trying to understand is, are they
42 considered interchangeable?

43
44 MS GALANOS: Yep, they hold the same qualifications in the
45 child safety space but if we have interest in movement from
46 the ARL into child safety there's discussions around how
47 that works. So, if you're employed in the ARL you're in

1 the ARL and if there's PD and movement we do that as well.

2

3 MS BENNETT: Are they considered two divisions of the one
4 department?

5

6 MS GALANOS: An arm of the one department, yes, yep.

7

8 MS BENNETT: Is the ARL considered an arm of the
9 department and CSS considered another arm or are they
10 considered --

11

12 MS GALANOS: Together but the work and work flow moves
13 from the ARL into the broader Child Safety Service.

14

15 MS BENNETT: The broader Child Safety Service, is that
16 co-located with ARL workers to any extent?

17

18 MS GALANOS: We have a community liaison function across
19 the state, so we've got a complement of about 21 FT(?) at
20 community liaison level that move in and out of the Child
21 Safety Service across the state.

22

23 MS BENNETT: That's really helpful. So, that's the
24 operator level, so those are the people on the phones
25 day-to-day, and in addition your practice leader, like you
26 Ms Churches, are the people who will be providing advice
27 and assistance on assessment and we'll come to that in a
28 moment, but they're the day-to-day operators, is that fair?

29

30 MS CHURCHES: Is it worth mentioning the practice
31 managers?

32

33 MS GALANOS: Yes.

34

35 MS BENNETT: I'm just about to move to practice managers.
36 The next person is a Practice Manager, and Ms Churches, as
37 I understand it, your role reports to a Practice Manager;
38 is that right?

39

40 MS CHURCHES: Each two team has a Practice Manager that
41 oversees clinical oversight and support for the cases
42 within that team, as well as professional development
43 opportunities and such.

44

45 MS BENNETT: Ms Hales, is it the same in Baptcare, that
46 there are practice managers that sit a level above the
47 practice leader?

1
2 MS HALES: Yes, that's correct. So, there's three
3 practice managers in total, the Advice & Referral Line and
4 each oversees two teams, so they're assigned two specific
5 teams.
6
7 MS BENNETT: Ms Galanos, are they your employees?
8
9 MS GALANOS: They're government employees, yes.
10
11 MS BENNETT: So the staff at the ARL level report up to
12 the CSS staff or the State Government staff; is that right?
13
14 MS GALANOS: Sorry, repeat that?
15
16 MS BENNETT: Your operators, operator teams, they all
17 report up to a Practice Manager?
18
19 MS GALANOS: Practice leader.
20
21 MS BENNETT: Sorry, practice leader. Each team's got its
22 own practice leader, doesn't it?
23
24 MS GALANOS: Correct.
25
26 MS BENNETT: And each practice leader reports to a
27 Practice Manager?
28
29 MS GALANOS: Correct.
30
31 MS BENNETT: And in every instance a Practice Manager is a
32 state employee.
33
34 MS GALANOS: That's correct.
35
36 MS BENNETT: Is their role entirely or exclusively
37 associated with the ARL?
38
39 MS GALANOS: Indeed, yes.
40
41 MS BENNETT: Is there the same movement between the ARL
42 and CSS?
43
44 MS GALANOS: At Practice Manager level?
45
46 MS BENNETT: At Practice Manager level.
47

1 MS GALANOS: Less so.

2

3 MS BENNETT: What are the qualifications of Practice
4 Manager level employees.

5

6 MS GALANOS: Practice Managers also generally social work
7 backgrounds, Allied Health.

8

9 MS BENNETT: Are there any requirements or are these
10 preferences?

11

12 MS GALANOS: They're requirements as they come through -
13 requirements, yep.

14

15 MS BENNETT: Do they have any experience in the field?

16

17 MS GALANOS: Yes.

18

19 MS BENNETT: What sort of experience do they have?

20

21 MS GALANOS: At least five years' experience in the child
22 safety field and generally at leadership level as well.

23

24 MS BENNETT: Let me then go to, do they get promoted up
25 from the operator level, do they usually come through doing
26 operator work or do they come laterally?

27

28 MS GALANOS: At Practice Manager level?

29

30 MS BENNETT: Yes.

31

32 MS GALANOS: Generally we see movement from frontline ARL
33 workers into practice leader positions and over time into
34 practice management but we've had external movement into
35 the Practice Manager level from different fields, yes.

36

37 MS BENNETT: Now, I'm receiving a note to ask you to speak
38 up a little bit.

39

40 MS GALANOS: Sorry.

41

42 MS BENNETT: No, that's okay, we'll slow down and speak
43 up. Now, each Practice Manager reports to a principal
44 Practice Manager, is that right?

45

46 MS GALANOS: Correct.

47

1 MS BENNETT: And they're also government employees?

2
3 MS GALANOS: Correct.

4
5 MS BENNETT: And they are not exclusively engaged with the
6 ARL; is that right?

7
8 MS GALANOS: So the principal Practice Manager that
9 overseas our practice managers in the ARL sits slightly
10 separately to the ARL operational business, so they provide
11 clinical practice, oversight and management of the practice
12 managers within our service.

13
14 MS BENNETT: So, is there one principal Practice Manager
15 at any given time?

16
17 MS GALANOS: No, no, there's five across the state but one
18 oversees the ARL Practice Manager group.

19
20 MS BENNETT: And what are the others doing?

21
22 MS GALANOS: They have oversight around the child safety
23 Practice Managers embedded in those teams.

24
25 MS BENNETT: So they're all the same level at the child
26 safety level?

27
28 MS GALANOS: Yes.

29
30 MS BENNETT: And one of them is allocated to ARL?

31
32 MS GALANOS: Yes.

33
34 MS BENNETT: Does that lead to sort of greater synergies
35 between those agencies, is that why?

36
37 MS GALANOS: Yes.

38
39 MS BENNETT: And that's designed to create engagement and
40 seamless transitions?

41
42 MS GALANOS: Absolutely, yes.

43
44 MS BENNETT: I understand. And does that person, the
45 principal Practice Manager of the ARL, have clinical
46 qualifications?

47

1 MS GALANOS: They would have social work background
2 mostly.

3
4 MS BENNETT: While we're establishing who's who. Let's
5 turn to the community liaison officers. Ms Hales, is there
6 a community liaison officer employed by Baptcare?

7
8 MS HALES: Yes, there are.

9
10 MS BENNETT: How many are there?

11
12 MS HALES: So we have, in terms of Baptcare we have one
13 full-time split between two people in the south, two in the
14 north, and that's it for Baptcare, and then Mission
15 Australia have two in the northwest of the state and one in
16 the south, yeah.

17
18 MS BENNETT: Is that right, Mr Stopczynski?

19
20 MR STOPCZYNSKI: Yes, it is, yes.

21
22 MS BENNETT: Can you tell me, Mr Stopczynski, what their
23 role is?

24
25 MR STOPCZYNSKI: So, the community liaisons have, I
26 suppose, a multi-faceted role, one is to be I suppose a
27 front-facing arm of the Advice and Referral Team out in the
28 community, they would hold community education sessions,
29 they will also act as a second worker when required to do
30 in person visits, they will essentially be, yeah, a
31 front-facing regional contact for those people and also be
32 a liaison with the family support services and in the
33 not-for-profit sector as well as others in the regions.

34
35 MS BENNETT: So, I just want to place these in the
36 structure and it might be that we need to go through the
37 assessment process before we can do that, but at this stage
38 is it the case that the community liaison officers have a
39 role in effectively raising the profile of the ARL? Is
40 that part of their role?

41
42 (All panel members nod.)

43
44 MS BENNETT: Ms Galanos, does the state have community
45 liaison officers as well?

46
47 MS GALANOS: Yes, we do.

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MS BENNETT: How many do you have?

MS GALANOS: So we've got one community liaison officer in the north, we've got three in the northwest and three in the south.

MS BENNETT: Ms Hales, would you accept that part of that role is to promote the availability of the ARL?

MS HALES: Yes.

MS BENNETT: Make sure people know about it?

MS HALES: Yes.

MS BENNETT: There's another function that's been referred to that seems to be connected with investigations or meeting or assessments; is that right?

MS HALES: Yeah, so the liaisons may go and do an assessment where a family are better placed to do that in person rather than over the phone, so that could be because they have difficulty with the phone or there's difficulty getting in touch with them, or just, it's better for them to actually have that in person across the state. So, because the phone line is based in the south, sometimes in the regions the liaison officers will actually go and do some of that initial conversation essentially with the family to see what their needs are and what needs to happen next.

MS BENNETT: Ms Galanos, how does that meet CSS's community outreach or community service provision?

MS GALANOS: So, it's a finite resource across our community liaison group, and they are incredibly proactive in heading out into the community co-locating with other services and raising the profile around the Advice & Referral Line, but it's difficult in terms of given there's only a small number of them.

MS BENNETT: Isn't it one of the roles of CSS to be carrying out welfare checks and those things? I'd like to understand how the community liaison officers when it should be done by them and when it should be done by CSS?

1 MS GALANOS: I guess it's quite a flexible approach in the
2 community liaison space. So, as Ms Hales mentioned,
3 heading out and supporting some of that assessment work,
4 but working in partnership with the regional child safety
5 teams as well where the need arises. So, there's quite a
6 flexible approach around how they carry out their duties,
7 if that makes sense.

8

9 MS BENNETT: And so, sometimes are the liaison officers
10 carrying out CSS functions effectively?

11

12 MS GALANOS: They would do that with them, to support
13 them, yep.

14

15 MS BENNETT: Those that are employed by the state, are
16 they ever the same person doing the two roles?

17

18 MS GALANOS: No.

19

20 MS BENNETT: There's always a delineation in the role?

21

22 MS GALANOS: Yep.

23

24 MS BENNETT: Sometimes, can it be a little bit difficult
25 to tell which role is being carried out?

26

27 MS GALANOS: I guess it could, yes, but in terms of a
28 flexible approach we're trying I guess as best to deliver
29 the most appropriate service and if a liaison person by
30 agreement can do that with child safety, that's how we'll
31 engage.

32

33 MS BENNETT: I'd like to go through a phone call getting
34 received and let's see if we can work this through now that
35 we've got the structure. Ms Churches, I might start with
36 you. A phone call is received. Let me just pause to ask
37 this question. If it's received at 5.30, if a phone call
38 comes in at 5.30, where does it go?

39

40 MS CHURCHES: It goes to the after hours service which is
41 run by child safety.

42

43 MS BENNETT: So, Ms Galanos, back to you, who's answering
44 that phone call at 5.30pm.

45

46 MS GALANOS: No, it's an on-call child safety
47 representative and they would be responsive to acute

1 matters that occur after hours, so generally the day
2 service when ARL return manage the day-to-day work.

3
4 MS BENNETT: So what's an acute matter that would be
5 responded to?

6
7 MS GALANOS: So it might be a priority one notification or
8 an immediate risk issue that requires acting on that
9 evening.

10
11 MS BENNETT: Let me return to that when we come to the
12 priority one matters a bit later, but that's helpful.

13
14 Returning then to you, Ms Churches, let's assume the
15 phone call is received at 4.30. Is it simply random which
16 of the teams will receive it?

17
18 MS CHURCHES: That is correct.

19
20 MS BENNETT: So there's not any regional specific focus
21 for any team?

22
23 MS CHURCHES: No.

24
25 MS BENNETT: There's also an online notification system;
26 is that right?

27
28 MS CHURCHES: That is correct.

29
30 MS BENNETT: Could I ask the operator to bring up
31 COM.0001.0037.0020. Ms Hales, is this the most common
32 method of contact, the online version or is it telephone?

33
34 MS HALES: Telephone would be the more common.

35
36 MS BENNETT: Looking at this, and perhaps this will come
37 to a question I'm about to ask, this suggests that
38 65 per cent come through email.

39
40 MS HALES: Police referral, so that's separate to the
41 online contact form.

42
43 MS BENNETT: I see, so that's the online contact form is
44 one, email is another. My other question about this
45 document is, are we talking now about every phone call or
46 is there a filter that's been applied between the phone
47 call and ending up in this table? And I might direct that

1 to you, Ms Galanos?

2

3 MS GALANOS: I was just going to note, the data here is
4 from prior to ARL becoming operational, so that's 2017 from
5 what I can tell there.

6

7 MS BENNETT: All right. Let me go back then to our phone
8 call. We've got our phone call, it's 4.30 in the
9 afternoon. At that stage, Mr Stopczynski, can you tell me,
10 is it a contact, is it a communication, is there a
11 difference?

12

13 MR STOPCZYNSKI: To be honest, it's probably best to - I'm
14 not operational on that front so probably best to speak to
15 Emily.

16

17 MS BENNETT: Perhaps I'll ask Ms Churches?

18

19 MS CHURCHES: It would be a contact.

20

21 MS BENNETT: And what's a contact?

22

23 MS CHURCHES: A contact is when somebody has made contact
24 with us to either discuss concerns, worries around safety
25 wellbeing for children or young people.

26

27 MS BENNETT: Is it fair to say, Ms Hales, that a contact
28 and a conversation, a communication I should say, take you
29 down two different pathways; is that right?

30

31 MS HALES: Could you clarify what you mean by two
32 different pathways?

33

34 MS BENNETT: So when it's a contact there's been no
35 assessment yet, has there?

36

37 MS HALES: That's correct.

38

39 MS BENNETT: So you might close that contact straight
40 away. When it becomes a conversation, what is it?

41

42 MS HALES: So, every contact that comes in we would refer
43 to as a conversation being opened. So, anything that gets
44 opened within the CARDI system which is the initial system
45 that we use within ARL, we call that a conversation so it's
46 replaced the old language of "notification".

47

1 MS BENNETT: But there will be some contacts that never
2 become conversations, is that right?

3
4 MS HALES: They would all become conversations.

5
6 MS CHURCHES: The expectation is that every contact would
7 become a conversation, a new conversation if there wasn't
8 already a conversation opened, or something with child
9 safety response, case management response.

10
11 MS BENNETT: Is that your expectation, Ms Galanos?

12
13 MS GALANOS: Correct.

14
15 MS BENNETT: So the conversation or contact will always
16 end up with a record created in the system you call CARDI?

17
18 MS HALES: Yes.

19
20 MS BENNETT: That system is an ARL system, is that right?

21
22 MS HALES: Yes.

23
24 MS BENNETT: And Baptcare, Mission Australia and the state
25 all have access to the same system?

26
27 MS HALES: Yes, correct.

28
29 MS BENNETT: Ms Galanos, are there parts of the system
30 that are accessible only to state employees?

31
32 MS GALANOS: Not the child safety system, but external
33 systems, just state employees.

34
35 MS BENNETT: There's then an initial assessment, I
36 understand, by reference to Ms Hales' statement at
37 paragraph 26 and I'll ask the operator to bring up
38 TDCT.0002.0004.50-2. You tell us that the initial
39 assessment is undertaken by reference to the TRF. What's
40 the TRF?

41
42 MS HALES: So that refers to the Tasmanian Risk Framework.

43
44 MS BENNETT: Is that right, is it, at this stage when
45 you're receiving a phone call you'll be applying the TRF?

46
47 MS HALES: Yeah, it's one of the frameworks that will be

1 used to drive that professional judgment around what
2 happens.

3
4 MS BENNETT: While we're doing that, another --

5
6 COMMISSIONER BROMFIELD: Do you mind if I just clarify?

7
8 The TRF, is that applied when the contact, the
9 conversation, is still within the CARDI information
10 management system or is that applied once it's transferred
11 into the Child Protection information system?

12
13 MS HALES: So, both. So, when it's in CARDI it's not
14 built into the system, it's used as a framework to support
15 decision-making. When it's transferred into Super Switch,
16 which is the child safety system, it's built into that
17 system as part of that assessment.

18
19 COMMISSIONER BROMFIELD: Thank you, Ms Bennett.

20
21 COMMISSIONER BENJAMIN: What does that mean for the
22 operator? They fill out something on the screen and it
23 goes into the CARDI system and then goes into the Child
24 Protection system, is that right, automatically or is that
25 something --?

26
27 MS HALES: Not automatically, so everything that comes
28 into ARL will be in the CARDI system so that's one that
29 we're always using. Only if we're making a referral into
30 child safety - a further assessment essentially, if there's
31 deemed to be current risk or potential future risk to a
32 child, then one of our ARL operators would put that into
33 the CBIS system and they can work on it from there.

34
35 MS BENNETT: I might have not given the numbers correctly,
36 so I'll try again. TDCT.0002.0004.50-2. That's a process
37 which has three domains. The first domain is information
38 gathering, the second is analysis and the third is
39 judgment. Is that broadly what you mean when you talk
40 about the Tasmanian Risk Framework?

41
42 (All panel members nod.)

43
44 MS BENNETT: So, information gathering stage, that means
45 the person doing the initial assessment is going to gather
46 some information; is that right?

47

1 MS CHURCHES: Yes.

2

3 MS BENNETT: And they're going to do that by way of a
4 conversation, is that right? Sorry, I should direct my
5 questions a little bit more. Ms Churches, they'll start a
6 conversation and they'll be first gathering some
7 information about the notification.

8

9 MS CHURCHES: The contact, yes, absolutely.

10

11 MS BENNETT: There are five categories you've identified
12 that will inform that information gathering, I'll read them
13 out because we can't put them on the screen. The child and
14 young person, the parents, the sources of harm, the
15 opportunity for harm and the networks. They're the
16 categories of information that you'll gather?

17

18 MS CHURCHES: Yes, absolutely.

19

20 MS BENNETT: Can I ask, when you talk about source of
21 harm, what is encompassed within the sources of harm? When
22 you're thinking about gathering information about the
23 source of harm, what kind of information are you trying to
24 gather?

25

26 MS CHURCHES: Where that source of harm might be sitting
27 in relation to the child, the relationship, and therefore
28 the potential impact for current and future risk.

29

30 MS BENNETT: And is that capturing, for example,
31 associations of the child with institutions?

32

33 MS CHURCHES: It may, yes.

34

35 MS BENNETT: In what circumstances would it?

36

37 MS CHURCHES: In what circumstances?

38

39 MS BENNETT: Well, let me put it another way, let me try
40 to illustrate it by reference to a hypothetical. A parent
41 calls and says, "I'm very worried about my child, they've
42 been acting strangely. I don't know why but ever since
43 they've come back from school camp they just seem withdrawn
44 and self-involved and I can't get through to them anymore,
45 I'm really worried that something's happened". Let's talk
46 through about what would happen with that call. What sort
47 of information would you be trying to get from that parent?

1
2 MS CHURCHES: We'd be trying to explore with the parent
3 what other issues might be happening for the child, what
4 other family influences may be impacting, their engagement
5 with school. We would also want to speak with school and
6 explore what those concerns or impacts, whether there's any
7 historical mental health concerns, whether there's concerns
8 that we have on our records through our very comprehensive
9 recording of information in the history for the family that
10 may allude to or indicate possible other risks that could
11 be resurfacing for the family. Friendship networks,
12 support networks that they may be engaged in.

13
14 MS BENNETT: Now that's a lot for the initial contact,
15 isn't it, Ms Churches?

16
17 MS CHURCHES: It is, but we look holistically at all
18 individual cases so, we really want to be able to touch
19 base at a number of points to assess the safety and the
20 wellbeing for the child.

21
22 MS BENNETT: At the end of that call you'll have enquiries
23 that you'll want to make, I take it?

24
25 MS CHURCHES: That's correct.

26
27 MS BENNETT: Ms Galanos, taking this hypothetical further
28 forward. The person has reported a child who seems
29 disengaged following a school camp, the parent is worried
30 about them. There's more investigations pending before a
31 risk is identified or referred to; is that right?

32
33 MS GALANOS: Say that again?

34
35 MS BENNETT: So what will happen after that first
36 conversation?

37
38 MS GALANOS: The staff in ARL would touch base with the
39 Department of Education, we'd look at the networks, who
40 that young person might already be engaged with and make
41 enquiries through those lines.

42
43 MS BENNETT: So the mother who's made the phone call, what
44 will she be told, Ms Galanos, about what's happening next
45 after she's raised this?

46
47 MS GALANOS: Will be a conversation before that call is

1 entered around what is the next stage of information
2 gathering, so she should leave that conversation knowing
3 what those next steps are going to be, and even contracting
4 with a call back to keep her in the loop around what's
5 happening.

6
7 MS BENNETT: Are there timeframes around the call back?

8
9 MS GALANOS: Well, we'd do that at the end of that call,
10 so we'd contract with the mum that we might get back to her
11 in a couple of days potentially depending on what follow-up
12 we need to undertake.

13
14 MS BENNETT: I think this is the Tasmanian risk framework
15 and I'd ask that the graphic be displayed. So, we're in
16 the information gathering stage now which is that first
17 box, is that right?

18
19 MS GALANOS: Yep.

20
21 MS BENNETT: So that could take several phone calls,
22 couldn't it?

23
24 MS GALANOS: Yep.

25
26 MS BENNETT: And we've heard some evidence today about how
27 children sometimes slowly disclose. Now, how do you manage
28 that? You're on the end of a phone line, how does the ARL
29 manage that investigation process? Sorry, I'll ask
30 Ms Hales first.

31
32 MS HALES: Well, in terms of disclosures or in terms of?

33
34 MS BENNETT: Well, in terms of information gathering, it
35 seems like that can be quite a complex task when it comes
36 to child sexual abuse; is that right?

37
38 MS HALES: Yes.

39
40 MS BENNETT: And you might not have a clear disclosure; is
41 that right?

42
43 MS HALES: Yes, correct.

44
45 MS BENNETT: So, in the example I've given, it's not a
46 clear disclosure but it's a concern raised by a parent that
47 could lead to a disclosure; is that fair?

1
2 MS HALES: Yeah.

3
4 MS BENNETT: And so, what does the ARL do in response to
5 the possibility of a disclosure that hasn't yet been made?

6
7 MS HALES: So, our primary role at the Advice & Referral
8 Line is to make sure that that family have access to the
9 supports that they need. So, whether or not there is a
10 disclosure, if that mother, for example, is worried that
11 something has happened, there are services that we can put
12 her in touch with, as we spoke about before, Department of
13 Education to do some of that follow-up, but our role is
14 very much around ensuring the immediate safety, and in this
15 instance with the hypothetical, there's not a disclosure,
16 we're just a little bit worried something may have
17 happened, and making sure that they've got the right
18 supports to meet that need.

19
20 MS BENNETT: And so, there will need to be some more
21 assessment before you identify precisely what that need is;
22 is that right?

23
24 MS HALES: Yeah, potentially.

25
26 MS BENNETT: Then, who carries out those further
27 investigations?

28
29 MS HALES: Again, it depends on the conversation. So, it
30 may be that mum feels comfortable connecting, you know,
31 with those next things or even talking to the school
32 herself, so we very much as part of that conversation talk
33 about who is best placed to talk to the family; if there's
34 someone that already has a relationship, is that better
35 than an Advice & Referral Line worker contacting them out
36 of the blue, you know, that they don't know. And, once
37 there is risk identified, if we through that conversation
38 and through those follow-up calls we identify there is
39 actually risk to that child that can't be ameliorated,
40 that's when we'd be considering a referral down to Child
41 Safety in the regional teams.

42
43 MS BENNETT: So, you're effectively referring the mother
44 to the school to make further enquiries if she's
45 comfortable to do that?

46
47 MS HALES: Or we may do that as well, and we normally

1 would follow up with the school as one of our general phone
2 calls that we would make if a child is of school age.

3

4 MS BENNETT: If the parent says to you, "Okay, I'll call
5 the school", do you then follow up again with them to see
6 how that went?

7

8 MS HALES: It depends on the level of worry and what the
9 agreement is with that mum or that caller.

10

11 MS BENNETT: Let me shift my question a little. Does the
12 system require that you call them back again?

13

14 MS HALES: No.

15

16 MS BENNETT: So there'll be individual discretion about
17 whether the caller calls them back?

18

19 MS HALES: Yes.

20

21 MS BENNETT: Would you accept that that, Ms Hales, would
22 involve a degree of variability across teams?

23

24 MS HALES: I would say variability across contacts more
25 than across teams, so all of the workers would, in the
26 system, in the details page there is a box essentially
27 about what the caller would like to happen next, and that's
28 where we do our agreements and log what has been agreed
29 with that caller. So, some may not want a return call at
30 all, they might be very happy with what's happened, the
31 child is safe, they're happy with the advice that's been
32 given; others may like that feedback loop.

33

34 PRESIDENT NEAVE: Can I just add to the hypothetical?
35 Let's assume that the mother who rings has got pretty poor
36 English, is not very confident about contacting the school.
37 What happens then?

38

39 MS HALES: We would contact the school to support her.

40

41 PRESIDENT NEAVE: So, you'd get in contact with the
42 school?

43

44 MS HALES: Yes, and we also have access to Interpreter
45 Service's as well; if there is difficulty with
46 communication around any of that sort of thing we can do
47 that for the phone calls as well as any follow-up

1 conversations that need to happen, and that's where we were
2 talking about the liaison officers earlier; that's
3 sometimes a situation where it might be easier to have that
4 face-to-face conversation.

5

6 PRESIDENT NEAVE: What about the contact with the child,
7 that's further down the track, but when would that happen?
8 Would you have a role in that or would that be something
9 that was done at the school level?

10

11 MS HALES: Advice & Referral Line wouldn't always have a
12 role in having direct contact with the child; it would
13 depend on the circumstance.

14

15 PRESIDENT NEAVE: So, that would be delegated, in a sense,
16 to the school?

17

18 MS HALES: Yeah.

19

20 PRESIDENT NEAVE: Sorry, can I just go on one more?

21

22 MS BENNETT: Yes.

23

24 PRESIDENT NEAVE: Let's assume that you got three or four
25 calls from parents whose children went to that school which
26 disclosed a degree of concern about their children; would
27 you be able to link that in any way through your systems?

28

29 MS HALES: Yes.

30

31 MS GALANOS: Yes, we would. Yeah, we would see - sorry to
32 jump in - the pattern, the call, what's coming through and
33 we'd engage with the school around that circumstance.

34

35 PRESIDENT NEAVE: Okay, thank you. I'm sorry if I cut you
36 off, Ms Bennett.

37

38 MS BENNETT: No, please. To follow on from the
39 President's question, can I ask the operator to bring up
40 COM.0001.0037.0027, and I believe this to be a screenshot
41 of CARDI; it might be out of date but you can tell me. Is
42 that a screenshot of the CARDI system?

43

44 MS CHURCHES: Yes.

45

46 MS BENNETT: Could I ask the operator to zoom in on the
47 three boxes at the bottom of the page. The Commissioners

1 will see, there's the initial contact box, there's the
2 child family details, there's a summary; that's the first
3 line. Then below that, if we could zoom in. I'm grateful
4 to the operator. We'll see there the three text boxes and
5 that's where you would record the details of the
6 conversation that you're having?

7
8 MS GALANOS: Correct.

9
10 MS BENNETT: And so, in order to search across
11 notifications or conversations, you would need to -
12 everyone would need to be using the same keywords around
13 the school, wouldn't they, or would they?

14
15 MS HALES: In the - well, you can't see there now - the
16 bit above where it has the contact, we would be - so, all
17 of the data that we pull around professionals actually
18 comes from the CBIS system from Child Safety, so it would
19 actually list the school there.

20
21 MS BENNETT: So, if we could just zoom into the top three
22 now: we've got the "initial contact", then the
23 "child/family", and then "summary". So, which one of those
24 boxes is it?

25
26 MS HALES: So, the initial contact bit would be where it
27 would show which school it was that was contacting us.

28
29 MS BENNETT: Okay. So, I see there "contact",
30 "relationship to family", "family aware of call", "caller
31 can be revealed", and then two boxes of "source and
32 service". So, there are drop-down menus for schools?

33
34 (All panel members nod.)

35
36 MS BENNETT: Is that only if the notifier comes from a
37 school?

38
39 MS HALES: Yes - well, if a professional's called from
40 anywhere it would be in CBIS, essentially. So, any new
41 person that contacts in from, as an example, Sexual Assault
42 Support Service for example or a worker from there it's
43 actually put into CBIS and the information is drawn from
44 there.

45
46 MS BENNETT: And so, if the local soccer club is the
47 concern, "I've got a concern about the coach at the local

1 soccer club", does the local soccer club appear there?

2

3 MS HALES: It would depend, so the initial contact --

4

5 MS BENNETT: And so, if it's the mother calling, the mum
6 calling --

7

8 MS HALES: Yes, it's the mum calling, mum would be the
9 initial contact.

10

11 MS BENNETT: And the mother's concerned about the soccer
12 club. Does the soccer club come up there?

13

14 MS HALES: Not in the initial contact, no.

15

16 MS BENNETT: Does it come up in the free text boxes?

17

18 MS HALES: In the summary, would we put?

19

20 MS CHURCHES: Yeah.

21

22 MS GALANOS: Absolutely.

23

24 MS BENNETT: And the ARL worker needs to elect to record
25 the name of the soccer club in the same way. And, if they
26 don't record it in the same way in the free text box, it
27 would be impossible to pick it up on a global search?

28

29 MS GALANOS: Yeah.

30

31 MS BENNETT: So, to extrapolate that back to a school,
32 again, if a notifier - again a parent - has concerns about
33 a school, the school won't end up in the initial contact,
34 it will end up in the summary; is that right?

35

36 MS HALES: Yeah, sorry, that's correct. That's right, if
37 the mum, yeah.

38

39 MS BENNETT: And again, we're in the world of the free
40 text box, and so, we're dependent upon the operator
41 entering the details the same way and spelling it the same
42 way?

43

44 MS HALES: Yes.

45

46 MS BENNETT: And it's fair, isn't it, that that's a
47 limited system for being able to identify institutional

1 problems, isn't it?

2

3 MS HALES: Yes, it is.

4

5 MS BENNETT: And that's something that needs to be updated
6 or upgraded?

7

8 (All panel members nod.)

9

10 MS BENNETT: Returning now to a slight variation on my
11 hypothetical. Let's assume now that I am a teacher who
12 attended the school camp, so the same school camp that's
13 been the subject of your earlier notification, and I call
14 and I say, "I've been on a school camp recently and I saw
15 teacher X go into the tent of this child a couple of times
16 in the night and I feel strange about it". Now, my first
17 question is, is that going to link with the notification of
18 the mother?

19

20 MS CHURCHES: If the name of the child is known, yes.

21

22 MS BENNETT: Thank you, okay. And, if the name of the
23 child isn't known, then it won't get linked necessarily,
24 you're dependent on the free text box?

25

26 MS CHURCHES: Yes.

27

28 MS BENNETT: The school identity itself won't necessarily
29 get you there?

30

31 MS CHURCHES: No.

32

33 MS BENNETT: Okay, thank you, that's really helpful.

34

35 Now I've diverted us from the initial assessment but
36 I'd like to return to it because I don't think that at this
37 stage we've finished and I'd like to understand when an
38 initial assessment finishes. Because, when do you finish
39 the assessments necessary to conclude the risk level for
40 this child? Can this go on for weeks?

41

42 Ms Galanos, I'll start with you.

43

44 MS GALANOS: It can do. I think it's important for us to
45 be clear that throughout the life of an initial assessment
46 or a contact as it progresses through the ARL there are
47 points of consultation and advice-seeking that our

1 frontline workers will grab from their practice leaders and
2 Practice Managers. So, a frontline staff member isn't do
3 that on their own. So, if they become unsure or want to
4 seek some clarity on next steps, they'll use the
5 consultation process throughout the service to gain support
6 around next steps.

7
8 MS BENNETT: Ms Hales, at this point, are you looking at
9 different computer systems with information about the
10 subject of the notification?

11
12 MS HALES: Yes. So, as part of that information-gathering
13 we would, as Ms Churches mentioned before, we'd look at our
14 history but also attempt - well, with the non-government
15 stuff we don't have access to all of the systems that we
16 need, but places like the Family Violence system and, yep,
17 Department of Education - what other systems would they be
18 looking at?

19
20 MS CHURCHES: SIMS and Connect for Safety.

21
22 MS HALES: And Connect for Safety. So, with some of these
23 systems, because we are non-government staff, we need to
24 actually ask our government counterparts to access those
25 for us because we don't - we don't have logins.

26
27 MS BENNETT: Okay, so you would then go to one of your
28 government --

29
30 MS HALES: Colleague, yeah.

31
32 MS BENNETT: -- colleague, and they would get you access
33 to, for example, the TasPol, Tasmanian Police database and
34 they'd give you the information that you've requested?

35
36 MS HALES: That's right.

37
38 MS BENNETT: And, Ms Galanos, that information-sharing is
39 part of your arrangement with Tasmania Police, that you'll
40 provide that information to the ARL operators for that
41 purpose?

42
43 MS GALANOS: Yep.

44
45 MS BENNETT: Are the NGO ARL operators acting or carrying
46 out statutory functions? Mr Stopczynski, can you tell me,
47 do you have a view about that?

1
2 MR STOPCZYNSKI: Yes, for that portion of it, yes; yes,
3 they are.
4

5 MS BENNETT: Do you know what statutory function's being
6 carried out by the NGO?
7

8 MR STOPCZYNSKI: Not specifically off the top of my head.
9 Section 17?
10

11 MS BENNETT: Section 17 of the Children, Youth and
12 Families; is that correct?
13

14 MR STOPCZYNSKI: That would be correct, yes.
15

16 MS BENNETT: Ms Galanos, is that right from your point of
17 view?
18

19 MS GALANOS: Yes.
20

21 MS BENNETT: And, Ms Hales, is that the same for Baptcare?
22

23 MS HALES: Yes.
24

25 MS BENNETT: Now I want to understand when the police get
26 called. So, we've got our initial assessment and that can
27 go on for weeks. Let's return to my hypothetical and let's
28 say that the teacher who saw the student and the teacher in
29 the tent says - well, let me pause actually.
30

31 Ms Churches, I don't want to put you on-the-spot, but
32 would you at that point assess there's a risk that that
33 child's been abused?
34

35 MS CHURCHES: We wouldn't assess that the child's been
36 abused, we'd assess that there's indicators of possible
37 harm, which would require further assessment.
38

39 MS BENNETT: And then you would then carry out the further
40 assessment?
41

42 MS CHURCHES: Yes.
43

44 MS BENNETT: Would that involve then speaking to the
45 teacher who is said to have gone into the tent?
46

47 MS CHURCHES: No.

1
2 MS BENNETT: You'd speak to other children?

3
4 MS CHURCHES: No, we wouldn't speak to other children.
5 We'd explore with the person that was contacting us in
6 relation to that. We would obviously look at what was on
7 our system as well for consideration of who else might be
8 part of that support network who we could touch base with
9 to see if there were any other concerns. For example, that
10 child may have had contact with - or the family may have
11 had contact with ARL in the past and they may have been
12 linked in with a school social worker, so we may follow up
13 with a school social worker to explore how that child or
14 young person is currently travelling. We very much utilise
15 indicators of harm at this point in time, because it is
16 very early stage and there's clear procedural documents in
17 relation to identifying and how to work through those
18 indicators of harm.

19
20 We would then consider a police referral, even if it
21 was for an FYI only. As our MOU and protocol with Tasmania
22 Police, it wouldn't be a call, it would be a written
23 documentation which is completed by the ARL worker, within
24 quite a short period of time is the expectation. That
25 would then be sent through to their practice leader to
26 review and endorse and send through to Crime Management
27 Unit north, south or northwest depending on which region it
28 was relevant to.

29
30 MS BENNETT: So, if your notifier is a mandatory reporter
31 who says - and I'll direct this to you, Ms Hales - who
32 says, "I'm a teacher, I have a mandatory reporting
33 obligation. I saw the teacher coming in and out of the
34 tent, I know he's been texting this child outside of hours,
35 I feel like there's something very wrong going on here".
36 Dogs that go to the police or are you going to assess it
37 further?

38
39 MS HALES: We're going to do both. So, we would make that
40 referral to police, but we would also be looking into risk
41 and safety for that child and other children.

42
43 MS CHURCHES: And we would also be looking on our system
44 to ensure there was - check with that person, the alleged
45 perpetrator, to see if there was any information or intel
46 we had on him as well - or her depending, or them.

47

1 MS BENNETT: Including via the Tasmania Police website?

2

3 MS GALANOS: Yes.

4

5 MS BENNETT: Would that also encompass any intervention
6 orders, family law orders, those sorts of matters would all
7 feed in? I direct that to you, Ms Galanos.

8

9 MS GALANOS: So, we'd be using our Family Law Court
10 liaison to grab that material, but as it relates to details
11 for this teacher coming in and out of the tent, we'd be
12 looking at our Child Protection information system to see
13 whether or not they're known and have history in our system
14 as well.

15

16 MS BENNETT: So, the fact that it's come from a mandatory
17 reporter who's done it because they have a belief will
18 influence the way that you deal with the report?

19

20 MS CHURCHES: Well, to be honest, if it was anyone, we'd
21 treat it with the same respect and regard regardless. It
22 could be a volunteer; we would still assess.

23

24 MS BENNETT: So, the thing that's changed, I guess,
25 between my original hypothetical, where the teacher saw the
26 other teacher go in and out of the tent - I added in the
27 text messages, but is that - because earlier when we were
28 talking about it, it was leading to assessment, but now
29 we've gone straight to the police and I'm wondering what's
30 tipped it the interim?

31

32 MS CHURCHES: The indicators of harm were increasing.

33

34 MS BENNETT: And, is that the text messaging?

35

36 MS CHURCHES: It's a number of instances that create
37 question, which is what we'd be providing to police for
38 their information.

39

40 MS BENNETT: And, I'm not being critical of that, I'm just
41 trying to understand, it seems like there's a spectrum.

42

43 MS CHURCHES: Yes.

44

45 MS BENNETT: And somewhere on that spectrum the risk would
46 be assessed at a point of notification to police, but it
47 seems like there's not much between it, if I can put it

1 that way; is that fair? Could different operators reach a
2 different view about the same scenario?

3
4 MS CHURCHES: Yes, but our protocol and our communications
5 I suppose, and the process requires that, if there's any
6 allegation of potential criminal activity, we are required
7 to complete a police referral. If the decision is to not
8 go with that based on that, where are we on the line, so to
9 speak, there would need to be a rationale for that which
10 would need to be case noted on the file.

11
12 MS BENNETT: And that's a matter of clinical discretion
13 for the Practice Leader or the Practice Manager; who holds
14 that discretion, Ms Churches?

15
16 MS CHURCHES: It would be between the ARL worker and their
17 Practice Leader.

18
19 MS BENNETT: Ms Hales, you say in your statement at
20 paragraph 31:

21
22 *If a crime has been identified a referral*
23 *to police be made as part of the work done*
24 *by ARL within the above timeframe.*

25
26 So, are there circumstances where the notification to
27 police will take place days later?

28
29 MS HALES: No. Our best practice would be once we have -
30 so, we don't need to substantiate that a crime has
31 happened; as soon as we're made aware that a crime could
32 have been committed, that would be the point that the
33 worker would be doing that referral.

34
35 MS BENNETT: You don't take any steps to substantiate that
36 allegation before you send it to police; you simply --

37
38 MS HALES: That's not our role, no. So, as long as we
39 have information that that could be there, our MOU is that
40 we would send that through and we will update them with
41 additional information if we continue to complete an
42 assessment and further information comes from that, then we
43 would update them with that information.

44
45 MS BENNETT: We talked a lot about the qualifications of
46 ARL workers, this might be a good moment to talk about the
47 training of the ARL workers. I understand that the ARL

1 operators have a six-month training program; is that right?

2

3 (All panel members nod.)

4

5 MS BENNETT: Ms Hales, can you tell us about how intensive
6 that training is?

7

8 MS HALES: Yes. So, all our workers, whether
9 non-government or government, all do the same induction
10 program. There is a component that is specific to the
11 Advice & Referral Line that was designed for us, and there
12 are other components that are for all child safety officers
13 as well. The reason it goes for so long is because it's
14 obviously run in face-to-face training as well as online,
15 so those trainings will come up periodically and staff will
16 be registered for them and as part of that induction, yeah,
17 it will go over a period of months. I think the training
18 face-to-face is about 10 to 15 days off the top of my head.

19

20 MS CHURCHES: Correct.

21

22 MS HALES: As well as the online components as well, and
23 then throughout that period that new - we'll just call them
24 a new staff member essentially - would be doing regular
25 check-ins with their practice leader as well around their
26 progress.

27

28 MS BENNETT: Looking at paragraph 31, you tell us there
29 that, in the latter part of the paragraph:

30

31 *If the matter is assessed as a priority 3,*
32 *"identified risks to the child are not*
33 *immediate, and a planned approach should be*
34 *taken within 14 calendar days to respond to*
35 *the concerns". It will be referred to CSS*
36 *within 14 days.*

37

38 And then, to skip a line, we go down and then we see
39 the last sentence:

40

41 *If a crime has been identified, a referral*
42 *to police will also be made as part of the*
43 *work done by ARL within the above*
44 *timeframe.*

45

46 So what I'm trying to grapple with is, does that mean
47 that, if there's an alleged crime but no immediate risk, is

1 the referral to police within those longer timeframes?

2

3 MS HALES: Best practice, it would still be done as soon
4 as possible. I think what I meant there --

5

6 MS BENNETT: I accept best practice; I think what I'm
7 looking for is, what's common practice?

8

9 MS HALES: Yeah, I think what I meant there was more that
10 it would be done by ARL and not left to do at Child Safety,
11 it's information for us to send through.

12

13 MS BENNETT: Okay, so it's not the case that you will
14 necessarily do that as part of your close out, you refer to
15 the police, you don't wait. As soon as you identify the
16 potential for a crime --

17

18 MS HALES: Yeah, that's correct.

19

20 MS BENNETT: When we're talking about training one thing
21 that's become clear to the Commission in the evidence it's
22 been hearing this week is that the indicia, the indicators,
23 of a crime when it comes to child sexual abuse can be
24 difficult to identify. Are the ARL operators trained in
25 the identification of child sexual abuse?

26

27 MS CHURCHES: They are trained in indicators of harm; both
28 physical and sexual abuse is covered off on that. We use a
29 traffic light system which all the staff are trained and
30 provided with resources, in which they all share with
31 families in that case that you spoke of earlier. The
32 family might be provided with information or sent out to
33 them a copy of indicators of harm, the traffic light
34 system, so that they can be aware of what to look for and
35 what to be considerate of in assessing the child's
36 wellbeing or any deterioration in their wellbeing.

37

38 MS BENNETT: And those are tools that generally have been
39 developed in the family safety context; is that right?

40

41 MS CHURCHES: That's correct.

42

43 MS BENNETT: So, they're not specifically adapted to the
44 identification of risk of child sexual abuse in
45 institutional contexts?

46

47 MS CHURCHES: No.

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MS BENNETT: Just for the sake of the transcript, Ms Galanos, that's right, isn't it?

MS GALANOS: Correct.

MS BENNETT: Anyone who has a different view can speak up now. I'll leave it there in a moment because I'm conscious of the time.

The other matter I wanted to check with you concerns the closure reasons, and if I could ask the operator to go to TDCT.0002.0004.0026, page 13. I just wanted to check that I've understood this document correctly.

While we're doing that, can I confirm with each of you - and I'll start with you, Ms Galanos - that the assessment is the same whether it comes from, for example, Ashley Youth Detention Centre, will it go through the same process that we've described?

MS GALANOS: Yes.

MS BENNETT: It's not dealt with by different people?

MS GALANOS: No.

MS BENNETT: Are the indicators of harm seen differently because of the place that the notification is coming from?

MS GALANOS: No, we'll still - we'll assess in the same manner.

MS BENNETT: Mr Stopczynski, do you agree with that?

MR STOPCZYNSKI: Yes.

MS BENNETT: And, Ms Churches, that's your experience?

MS CHURCHES: Yes.

MS BENNETT: And, Ms Hales, your experience at Baptcare as well?

MS HALES: Yes.

MS BENNETT: And that relates really to, again, the

1 linking of the instances. If there were multiple instances
2 arising from one institution, that would change the risk
3 profile, wouldn't it, Ms Hales?

4

5 MS HALES: In terms of the level of risk that we felt was
6 present, yes, it would.

7

8 MS BENNETT: And, Ms Churches, you'd agree with that,
9 wouldn't you?

10

11 MS CHURCHES: That is correct.

12

13 MS BENNETT: Ms Galanos?

14

15 MS GALANOS: Agree.

16

17 MS BENNETT: Mr Stopczynski?

18

19 MR STOPCZYNSKI: (Witness nods.)

20

21 MS BENNETT: And yet, the system doesn't necessarily
22 permit that linking at this stage?

23

24 (All panel members nod.)

25

26 MS BENNETT: There's nodding. Is that right? Can I ask
27 one of you to say "yes" for the transcript?

28

29 MS CHURCHES: Yes.

30

31 MS BENNETT: Thank you. I won't take you to those further
32 documents, the question I had is that, in one of the
33 documents that's been provided to this Commission it
34 identifies a reason for closure as:

35

36 *The identified issues include historical or*
37 *potential harm to a child and assessment*
38 *indicates these worries can be adequately*
39 *addressed through family support.*

40

41 Is that your understanding of a proper closure of a
42 notification, Ms Hales?

43

44 MS HALES: And, is that in CBIS or in CARDI or both?

45

46 MS BENNETT: That's in CARDI, I believe.

47

1 MS HALES: Yes, that's right.

2

3 MS BENNETT: So, when we say it's historical, let's assume
4 that somebody tells you about this school camp and this
5 teacher visiting the tent has now moved overseas and lives
6 in Switzerland: would you close the notification for that
7 reason? Can I ask you, Ms Churches?

8

9 MS CHURCHES: Yes.

10

11 MS BENNETT: And, Ms Hales?

12

13 MS CHURCHES: Once we've done police referrals and
14 ensuring all those actions have been completed, yes, we
15 would.

16

17 MS BENNETT: Okay. So are you still doing the assessment?

18

19 MS CHURCHES: Look, what we would do is, we would follow
20 the processes depending where the referral came from;
21 obviously, if the referral came from TAS Police we're not
22 going to send a referral through to them. But if it was
23 something coming from a different source, we would complete
24 those, if you like, mandated requirements which we have as
25 an MOU with TAS Police and then we would close it because
26 there is no ongoing harm to that child at this point in
27 time. We would also record the alleged perpetrator on our
28 data system as a person believed responsible so that we've
29 ensured that, if they do come back to the country, we at
30 least have a record which feeds through to the Department
31 of Justice as a flag.

32

33 MS HALES: And it may be that we do make some referrals
34 out to universal services; if there was, for example, that
35 child in that historical circumstance was still
36 experiencing some trauma or some sort of behaviour related
37 to that, there'd be an opportunity to provide supports to
38 that family as well before closure.

39

40 MS CHURCHES: Correct.

41

42 MS BENNETT: I have got two final questions for you and
43 I'll ask you each in turn. Ms Hales, I won't ask you to
44 repeat what's in your statement about what could be
45 improved about the ARL. Is there anything additional that
46 you'd like to tell the Commission that could be improved
47 about the ARL?

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MS HALES: Outside of the statement?

MS BENNETT: Outside of the statement.

MS HALES: No, I don't think so.

MS BENNETT: Okay. Ms Churches, what would you like the Commission to know about how the ARL could function better?

MS CHURCHES: Improved collaboration with other key services areas I think is really important, and not just at the state base but nationally as well.

MS BENNETT: Thank you. Mr Stopczynski, is there anything you'd like to tell the Commissioners about what could be improved about the ARL?

MR STOPCZYNSKI: Without delving too much into funding and those sort of details, the role of a community liaison is incredibly important, and to have resourcing and adequate resourcing in that space out in community is really vital.

And, with the ARL being designed as an Advice & Referral service, the availability to refer to those universal services is also incredibly vital. I know we spoke a lot about child safety and those services, but the family support sector is a really key player in that space, and for the Advice & Referral Line to be an effective early intervention service, which is what it was designed to be and how it should operate, we need that sector to be adequately resourced to be able to be the early intervention before things end up repeatedly referred or coming back to Child Safety.

MS BENNETT: Ms Galanos, is there anything you'd like to tell the Commissioners about how the ARL could work better?

MS GALANOS: I think we've had a lot of success in our co-location model and particularly with our specialist liaison areas in Family Violence. I think, if we had particular practice support in this area dedicated as a liaison I think, you know, the benefits for our team by way of practice would be amazing. So, in amongst everything that my colleagues have already said, specialist liaison support and greater referral pathways back out to community services, absolutely.

1
2 MS BENNETT: Thank you. I'd like to thank you all for
3 your candour and assistance today, it's been of enormous
4 help, I think, to the Commissioners. The final question I
5 have is whether you would be open to the Commissioners
6 visiting your advice line at the call centre?
7

8 MS GALANOS: Of course, yes.
9

10 MS BENNETT: Well, we'll pop in sometime. May it please
11 the Commissioners, those are the matters that I sought to
12 raise with this panel.
13

14 PRESIDENT NEAVE: Thank you, Ms Bennett.
15

16 COMMISSIONER BENJAMIN: Just so it's clear to me,
17 Ms Hales, in terms of the training, if somebody's employed
18 - and I'll lean forward, I'm being told to keep my voice
19 up, I have the same problem at times - the new employee
20 starts on day one, or perhaps has a couple of days
21 training, then does the 10 or 15 days over that first
22 six months; is that right?
23

24 MS HALES: Yes.
25

26 COMMISSIONER BENJAMIN: Then for the first four weeks they
27 shadow or are shadowed by an existing trained employee?
28

29 MS HALES: Yes, that's correct.
30

31 COMMISSIONER BENJAMIN: Then the level of responsibility
32 for that employee increases incrementally over that five or
33 six-month period. Is that essentially how it works?
34

35 MS HALES: Yes, that's correct. So, they would shadow
36 another worker initially so that they're learning how
37 people are on the phone, and then, when they do get to the
38 point where they're ready to start taking some calls an
39 experienced worker would sit with them to do that over that
40 period as well until it's deemed that they're experienced
41 enough to be doing that by themselves.
42

43 COMMISSIONER BENJAMIN: Thank you. Ms Galanos, do we know
44 what department you are at the moment given the changes in
45 recent times?
46

47 MS GALANOS: We're still the Department of Communities,

1 yes.

2

3 COMMISSIONER BENJAMIN: It still exists but it's in a time
4 of change; is that right?

5

6 MS GALANOS: Indeed, yes.

7

8 COMMISSIONER BENJAMIN: Yes, thank you.

9

10 COMMISSIONER BROMFIELD: Thank you all for explaining
11 this, and I know that the work you do, any intake call
12 centre, it's really hard work and there's a lot of calls.
13 First of all, I just wanted to thank you for taking the
14 time out of the practice context and explaining things to
15 us.

16

17 I had a couple of questions, one is actually a
18 follow-up from Robert's questions, Commissioner Benjamin's
19 question. That process for the training, is that exactly
20 the same for the State Government employees? So, is it
21 conceivable that they might come into the ARL, not as their
22 first day of work for the department, but potentially from
23 one of the regional offices?

24

25 MS GALANOS: They could do, yes. Some of them already
26 have had - it might be an existing child safety officer
27 wanting to express an interest to move within - to the
28 Advice & Referral Line, so they would already have had the
29 beginning practice and the general induction that all child
30 safety officers receive. But I will say, they will receive
31 the ARL-specific induction as well on top of what they've
32 come with.

33

34 COMMISSIONER BROMFIELD: What's kind of the more common
35 pathway: day one newbie into the ARL or day one is
36 somewhere else within the department?

37

38 MS GALANOS: New staff member actually, yeah.

39

40 COMMISSIONER BROMFIELD: New staff member is the most
41 common?

42

43 MS GALANOS: Yeah, from external.

44

45 COMMISSIONER BROMFIELD: Following up on this, you
46 mentioned it's the child safety officers who are in the
47 regional offices, they get the beginning practice - I can't

1 quite remember what you said it was called, I think it was
2 beginners practice training?

3
4 MS GALANOS: Yes.

5
6 COMMISSIONER BROMFIELD: And then there's the ARL-specific
7 training. If you're a newbie and ARL is your first
8 appointment in the department, do you, if you're a State
9 Government employee, get the beginning practice training?

10
11 MS GALANOS: Absolutely.

12
13 COMMISSIONER BROMFIELD: And the ARL-specific training?

14
15 MS GALANOS: Yes.

16
17 COMMISSIONER BROMFIELD: And if you're from Baptcare or
18 Mission Australia, do you get the Child Safety beginning
19 practice training and the ARL?

20
21 MS HALES: Yes, we have access, yes, access to all the
22 same things, so they'll have both as well.

23
24 COMMISSIONER BROMFIELD: So, access means, yes, you
25 complete or you can?

26
27 MS HALES: Yes, they complete it, yes.

28
29 COMMISSIONER BROMFIELD: Okay, great, thank you. Now,
30 that's kind of everything I had about qualifications and
31 training. Just coming back to that very first example that
32 Ms Bennett provided, where the first contact was from mum
33 and she just wasn't getting through to her teenager any
34 more after a school camp. It's pretty amorphous; I mean,
35 it could be that they had fight with their friends or - it
36 was really, really quite detailed.

37
38 Now, I imagine that it would take about two hours to
39 do that assessment and then you may have additional
40 outbound calls. Would it be normal to do a full assessment
41 and then do follow-up calls with that level of information?
42 Would it be common, I should say?

43
44 MS CHURCHES: I mean, it's not done at that one point in
45 time, it's done over a - graded over the next week, I would
46 suggest; so, emailing the school trying to get some more
47 information from them. It may be that it can be closed at

1 that point in time if mum is just after information and
2 advice, which may be one option that we consider, because
3 we are a brief intervention service at the end of the day.
4 So, we can always encourage people if they have any new
5 concerns, "If you find out any new information, mum, please
6 give us a call back. Are you okay with that?"
7

8 So, it's not necessarily that we will start unpacking
9 everything depending on the level of indicators of harm
10 that came through because, as you say, it could be a myriad
11 of things which have created this changed behaviour, and we
12 certainly don't want to jump the gun with inappropriate
13 responses either or invasive interventions for the child or
14 young person.
15

16 So, it would just be exploring bit by bit. It's very
17 much a conversational approach, but that conversation is
18 gathering pieces of information from different sources, and
19 working with the individuals is key to identify what they
20 believe needs to happen next; if, obviously, we have graver
21 concerns than they do, that will require further
22 investigation or assessment as we like to refer, but it
23 wouldn't happen at any one point in time, it happens over a
24 period of time.
25

26 COMMISSIONER BROMFIELD: I know you're a practice lead,
27 you're not on the call, but if it were hypothetically you
28 were on the phone or you were advising one of your people
29 who are on the phones for that case, what would you do? If
30 no other information gave you any flags that came up in
31 that conversation with the mum, what's your instinct on
32 that one? What do you think you'd be doing? Would you be
33 giving mum the traffic light information and saying, "Call
34 us if there's anything else? There's not much we can do
35 now", or?
36

37 MS CHURCHES: Absolutely, I'd be exploring the when this
38 change started, if there's any other variable that might
39 have changed in the child's life; really, just inviting a
40 conversation to broaden the scope so that we have a greater
41 understanding of those different elements of wellbeing for
42 the child or young person and what might be happening for
43 them: friendship networks, is there any change in that. If
44 I was still quite concerned I would be contacting the
45 school trying to explore if they are linked in with a
46 social worker, because we also do not want to be
47 unnecessarily invasive. Which means, if they have got a

1 better person in their life who's better positioned to
2 start exploring that safely with the child or young person
3 in a trusting relationship, that would be the source that
4 we would contact to do that with. Because we know, as a
5 stranger walking in there, it's highly unlikely we're going
6 to get a disclosure of information, so we'd use the
7 networks around that child or young person to help try to
8 unpack what might be happening now.

9
10 Because, I mean, sexual abuse is one, but it could be
11 other things are going on as well, so we'd still want to be
12 able to explore that: whether or not they need a referral
13 from mental health support; whether there could be AOD
14 issues which are impacting on them, so we want to look at
15 broadly at what might be happening, but working as well to
16 empower the people who are there in that support network,
17 being the mum in this case.

18
19 COMMISSIONER BROMFIELD: It's potentially very resource
20 intensive. We've heard earlier this week that in CAMHS
21 they're having to make really difficult choices sometimes
22 about who to prioritise services for. Do demands on the
23 Advice & Referral Line ever determine the level of
24 intensity of your response, particularly for things that
25 might be more vague like this? I'm not trying to trick you
26 here either.

27
28 MS CHURCHES: No, that's a fair question, and it
29 definitely is sometime a matter of balancing that for the
30 workers on the floor who can have anything from 15 to 25
31 conversations opened at any time, and you've got concerns
32 for a 3-year-old who there's no eyes over this child, and
33 there's concerns in relation to family violence and other
34 complicating factors in the home, versus a 14-year-old who
35 is going to school and is engaged; that's going to have a
36 lower level, I suppose, of immediate risk potentially to
37 it. But it depends, and this is what makes it hard is,
38 every single case needs to be looked at individually on its
39 own circumstances.

40
41 But, yes, we are grateful that we have been approved
42 by the department for additional funding for an additional
43 team and acknowledging that the Advice & Referral Line's
44 goal was to have people call, call easily and call early:
45 they are, the data is demonstrating that, the demand is
46 something that we're having to constantly negotiate.

1 COMMISSIONER BROMFIELD: Thank you. I have one last
2 line of questioning. With Ms Bennett's example of the
3 teacher calling about observing the other teacher going in
4 and out of the tent and then the text messages. If we took
5 those same behaviours and we said that someone had seen a
6 carer going in and out of a bedroom without explanation and
7 seeing text messages to a child in residential care, would
8 that be assessed differently or treated differently?
9

10 MS GALANOS: So, if we're talking about a child or young
11 person within care, the ARL wouldn't necessarily manage
12 that, we'd be referring straight to the region for their
13 response and follow-up directly given they're allocated
14 there.
15

16 COMMISSIONER BROMFIELD: Okay, great, thank you.
17

18 MS GALANOS: So, they'd be making their assessments from
19 the regional perspective as opposed to ARL.
20

21 COMMISSIONER BROMFIELD: And so, you wouldn't be applying
22 then the three boxes or the TRS?
23

24 MS GALANOS: Look at safety and initial assessment process
25 just within the regional perspective, yeah.
26

27 COMMISSIONER BROMFIELD: So, they'd be doing it at the
28 region?
29

30 MS GALANOS: They'd be doing, yeah, within the Child
31 Safety Service.
32

33 COMMISSIONER BROMFIELD: Would the threshold be the same,
34 the threshold for concern be the same for allegations for a
35 child in care versus allegations for a child within their
36 family of origin?
37

38 MS GALANOS: So, we'd be managing the risk and safety,
39 well, differently; it wouldn't sit within the ARL service,
40 it would be the child safety teams managing that, but
41 they'd be looking at all those - each concern in that way,
42 yeah.
43

44 COMMISSIONER BROMFIELD: Thank you, that's my exhaustive
45 list, I really appreciate you responding.
46

47 PRESIDENT NEAVE: Thank you for all the hard work that

1 you're doing and thank you very much for appearing today
2 and explaining to us how the ARL operates.

3
4 **AT 4.47PM THE COMMISSION ADJOURNED TO**
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