
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 3 May 2022 at 10.10am

(Day 2)

1 PRESIDENT NEAVE: Thank you, Ms Bennett.

2

3 MS BENNETT: Thank you, Commissioners. The first witness
4 this morning is Ms Tammy Donohue. I'll ask Ms Donohue to
5 come and take a seat in the witness box.

6

7 While Ms Donohue is finding her place, I'll just
8 identify, Commissioners, that we've asked you to make some
9 non-publication orders in relation to this matter and they
10 concern the identification of a doctor and, in addition,
11 while we'll be referring to Ms Donohue's daughter by her
12 name today, and that reflects Ms Donohue's and her
13 daughter's wishes, we will ask the Commissioners to make a
14 non-publication order so that that name can't be published.

15

16 PRESIDENT NEAVE: Thank you, Ms Bennett.

17

18 Yesterday I explained that - I'm sorry, would you like
19 to swear Ms Donohue first?

20

21 ASSOCIATE: You can read out.

22

23 PRESIDENT NEAVE: Yesterday I explained that it will
24 sometimes be necessary for the Commission to make an order
25 which restricts the publication of certain information.
26 Sometimes the Commission will hear information in relation
27 to people who are not accused of child sexual abuse but who
28 may be part of a witness's evidence in other ways; in these
29 circumstances it may not be necessary or appropriate for
30 those people to be identified.

31

32 The next witness, Ms Donohue, has agreed to be
33 identified. However, to protect the identity of a
34 particular person the Commission has decided to make a
35 restricted publication order in relation to that person.

36

37 In the context of the scope of this inquiry the
38 Commission makes this order because it is satisfied that
39 the public interest in the reporting on the identity of
40 that person is outweighed by other considerations, namely
41 their privacy.

42

43 I'll now briefly explain how the order will work and
44 this is relevant to the media particularly, I think.

45

46 The order requires that the witness's daughter's name
47 not be published other than by the Commission or by the

1 witness.

2

3

The order also requires any information in relation to the identity of the paediatrician who is treating the witness's daughter to be kept confidential.

6

7

This means that anyone who listens to or reads the information given by the witness to the Commission must not share any information which may identify that paediatrician. This information is not limited to their name and may include other information which may identify them.

13

14

I make the order which will now be published. I encourage any journalist wishing to report on this hearing to discuss the scope of the order with the Commission's media liaison officer. A copy of the order will be placed outside the hearing room and is available to anyone who needs a copy.

19

20

21

Yes, Ms Bennett.

22

23

MS BENNETT: Thank you, Commissioner.

24

25

<TAMMY ALICE MAY DONOHUE, affirmed: [10.14am]

26

27

<EXAMINATION BY MS BENNETT:

28

29

MS BENNETT: Q. Ms Donohue, thank you for giving evidence today to this Commission. You've made a statement to this Commission, have you read and signed that statement this morning?

31

32

33

A. Yes, correct.

34

35

Q. And its contents are true and correct?

36

37

A. Yes.

38

39

Q. Thank you. Ms Donohue, just to start, you've lived in Tasmania for most of your life; is that right?

40

41

A. Yep.

42

Q. And you have three children?

43

44

A. Yep.

45

Q. And you care for them on your own?

46

47

A. Yes.

1 Q. I'd like to ask you about the eldest of your children,
2 [REDACTED], how old is she now?
3 A. She's 15 years old.
4
5 Q. She has some special needs, can you tell us about
6 those?
7 A. [REDACTED] was born by emergency C-section and a result of
8 that was quadriplegic cerebral palsy, yeah.
9
10 Q. Does that create some challenges for her to
11 communicate with people?
12 A. Mostly when she was younger, but now that she's older
13 she is a lot more content and happy with communicating,
14 yeah.
15
16 Q. Tell us about how [REDACTED] communicates?
17 A. [REDACTED] communicates with yes/no gestures using hands
18 and visuals, all visuals, a pod communication book and an
19 eye gaze communicator also.
20
21 Q. Just so that we can understand, how would [REDACTED] say
22 yes?
23 A. [REDACTED] would say yes if you give her hand gestures
24 looking up, and a no would be to the side (demonstrates).
25
26 Q. She can also, can't she, tell you other things about
27 how she's feeling, is that right?
28 A. Yes.
29
30 Q. Can you give us some examples? Can she tell you about
31 when she's hungry and thirsty?
32 A. When she's hungry she'll make it very obvious, she
33 will turn her head and yell at you until you give her the
34 attention that she wants, yep.
35
36 Q. You've told her that you're coming here today?
37 A. Yes.
38
39 Q. And she knows that you're speaking on her behalf
40 today?
41 A. Yes.
42
43 Q. Is she happy for you to do that?
44 A. She's happy but even though when I do mention it, she
45 does get uncomfortable, but she knows very well, yeah.
46
47 Q. Can you tell us a little bit about how her

1 communication has changed over time. I think you said that
2 she now communicates in this way, how has that evolved over
3 time?

4 A. When [REDACTED] first started school it was a big battle of
5 keeping her at school because no-one could communicate with
6 her and she had separation anxiety, so I could be the only
7 one that could look after her for a long time. But then,
8 once she started using communication - ways of
9 communicating, then it just became so much easier, and she
10 loves school, she loves people, she loves groups, people,
11 she loves everyone; she's a very people-person.
12

13 Q. And so, she used I think you said pod, is that right?

14 A. Yes, it's a pod book.
15

16 Q. Can you tell us briefly how that works?

17 A. It's a book with categories in it and you scroll
18 through the categories to which conversation or what she
19 wants to talk about and she says yes/no and we'll just make
20 our way through that to get her conversation out.
21

22 Q. Did you find that people sometimes assume that they
23 can't understand how --

24 A. Yes, definitely too often.
25

26 Q. Do you think that perhaps for someone who's nearly a
27 16-year-old young woman, they don't realise that there's
28 this vibrant person inside?

29 A. Definitely, yep.
30

31 Q. How does that affect the way she's treated by the
32 adults around her and the professionals around her?

33 A. How does that, sorry?
34

35 Q. How does that affect the way she's treated by other
36 people?

37 A. Yeah, it's very poorly the way she's treated when
38 she's not communicating with the person directly, and the
39 same goes if someone's talking to me rather than her about
40 her and she'll get very upset about that.
41

42 Q. She enjoys art and things, doesn't she?

43 A. Loves art, yeah.
44

45 Q. Commissioners, there's a confidential photograph that
46 I've provided to you that shows [REDACTED] painting so that you
47 are able to see [REDACTED], and again provided with permission

1 because [REDACTED] is not able to be here with us today.
2 There's also a copy in front of you but we won't go to it
3 now.

4
5 I'd like to talk about, so some of those special needs
6 mean that [REDACTED] sometimes needs to seek some medical
7 attention; is that right?

8 A. Yeah.

9
10 Q. And so, she's seen a range of doctors and medical
11 professionals over the years?

12 A. We have but mostly in certain years because we're not
13 the - we're not in and out of hospital all the time;
14 [REDACTED] usually quite well most of the time, she doesn't
15 often get flus or anything like that.

16
17 Q. And there have been times where she's needed medical
18 assistance from the hospital near where you live?

19 A. Yes, definitely, yeah.

20
21 Q. Which hospital is that?

22 A. The LGH.

23
24 Q. That's the Launceston General Hospital?

25 A. Yep.

26
27 Q. She's been there as both an inpatient and an
28 outpatient?

29 A. Yes, both.

30
31 Q. Can you tell us roughly how often she's visited LGH
32 over her life?

33 A. Because she's an outpatient we have our usual
34 appointments with our paediatrician every six to 12 months,
35 or ranging in between, and yeah - I'm trying to get this
36 out right. We're in and out for botox every now and then
37 which isn't often now that she's older and she's looking at
38 spine surgery coming up. Our biggest hospital visits were
39 in 2018 when we went to the Royal Children's in Melbourne
40 for a hip operation, and then we were in Hobart for PEG
41 operation and then we were in and out of the LGH, like, a
42 lot after that and, yeah, a lot.

43
44 Q. We'll come to the 2018 admission in a moment. Before
45 that, you would usually stay with [REDACTED] when she was in
46 hospital?

47 A. Yes, definitely. Before [REDACTED],

1 was born, I would always stay with [REDACTED] overnight.
2
3 Q. And then, you had another child and it became pretty
4 difficult to do that?
5 A. Yes, because I'm not with the father of my second
6 child, yes; single parent.
7
8 Q. And you have two children?
9 A. Three.
10
11 Q. Three children. When you've left [REDACTED] when you've
12 had to go home to your other children and [REDACTED] left at
13 the hospital --
14 A. My youngest is only just turning one, so she's very
15 new, yeah.
16
17 Q. You're trusting the medical staff; is that right?
18 A. Yeah.
19
20 Q. Back before 2018 in the early days, tell me about how
21 you felt about that trust; was it present for you?
22 A. Well, a lot of the time I didn't think I had to worry
23 about it, but I've always had issues with trust in doctors
24 from the start, from the start of [REDACTED] life really,
25 yeah.
26
27 Q. You tell us in your statement that you found
28 interacting with the medical world quite difficult; what do
29 you mean by that?
30 A. Communication, yeah, everything - aspect of
31 communication, everywhere.
32
33 Q. For you and for [REDACTED]?
34 A. Yep, anything and everything around it.
35
36 Q. Do any of the hospital staff working with [REDACTED], have
37 they learned to communicate with her?
38 A. No, the paediatrician barely does.
39
40 Q. Was there anyone when you had to leave [REDACTED] at
41 hospital, was there anyone there who could communicate with
42 her effectively?
43 A. No, well, that's why I'd stay until she was partially
44 asleep or going to sleep, and then I would leave because
45 they would just check in on her every now and then and not
46 treat her like she was - needed that care, and yeah.
47

1 Q. I think you tell us that she was incontinent and
2 needed nappy changes at different times?

3 A. Yep.
4

5 Q. And was that something that you would do when you were
6 there?

7 A. Definitely, yes.
8

9 Q. And when you had to be elsewhere you relied on other
10 people to do that?

11 A. Yeah.
12

13 Q. Do you remember what ward she stayed on when she was
14 staying at LGH?

15 A. 4K.
16

17 Q. I'd like to turn to the 2018 admission. So, can you
18 tell us about when [REDACTED] was admitted to LGH in 2018?

19 A. Yeah. Well, the first time was the hip operation.
20 We'd come back from Melbourne straight to the LGH and they
21 weren't ready for us, they had nothing prepared, anything
22 ready for us, so that was a bit of a downer. And then,
23 after [REDACTED] PEG operation we had constant leaks and
24 ongoing issues with the PEG, and I liaised with Hobart
25 medical and they corrected me that things needed to be
26 fixed up and so we went back to Hobart and got that fixed
27 up. And then [REDACTED] PEG was ripped out here, there and
28 everywhere, like school, after school care, just careless
29 carers. It happens and it happened a lot, and then all of
30 a sudden she came down with sepsis, and I didn't know the
31 signs or symptoms of sepsis when it happened. So, the day
32 before it happened, all I noticed was that she'd rubbed the
33 side of her face on a pillow and she had a slight mark
34 there but she was her usual self. And then the next day I
35 woke up to her and she managed to get herself into a banana
36 position in her bed and she was headbutting the wall all
37 night. So, the infection has caused her to have a
38 puffiness in her eye as well as her hand that she was
39 hitting because she was constantly making this one
40 movement. And then, so that next morning when I found her
41 obviously I rang the ambulance and we were in there for a
42 staph infection from the PEG and that's what it all was,
43 yeah.
44

45 Q. So that was why you were admitted to LGH in 2018?

46 A. M'hmm.
47

1 Q. How long was that admission in the end?
2 A. It was three weeks nearly the last visit, yeah.
3
4 Q. For that three-week period was there anything set up
5 to allow [REDACTED] to communicate with the people caring for
6 her?
7 A. No.
8
9 Q. How do you feel about that when you reflect on it?
10 A. It makes me feel sick, yeah, and horrible, and angry,
11 yeah.
12
13 Q. You were with her a lot of the time, I take it?
14 A. Yeah, always, yeah.
15
16 Q. How did she seem to you when she was on the ward?
17 A. Very distressed, like, I've - yeah, I've never seen
18 her that distressed before and that's why it was so
19 strange.
20
21 Q. What was she communicating to you about how she was
22 feeling?
23 A. That something wasn't right and, yeah, she was
24 uncomfortable, she wanted to come home, is what it was.
25
26 Q. There was someone you now know to be James Griffin at
27 that hospital treating [REDACTED]. You were never introduced to
28 him; how do you know it was him?
29 A. I've known him there over the years, like, you know,
30 all the local nurses and that I know of, I don't know all
31 their names but I recognise their faces, because we're not
32 in and out all the time like, yeah.
33
34 Q. And he was a familiar face around the hospital?
35 A. Yeah, like, I was never friendly friends with that
36 person.
37
38 Q. Did you hear people speaking about using his name to
39 him and?
40 A. I only knew him as "Jimbo" because that's what I'd
41 heard them calling him; I didn't know his name was James.
42
43 Q. Can you tell us about how he interacted with [REDACTED]?
44 A. So, yeah, things started - [REDACTED] started acting
45 strangely around him and, when I asked him about a rash
46 that had started, he wanted to see it, and then when I
47 slightly pulled her nappy down and he's come over and he's

1 tapped her with his hand and said "she'll be right".
2
3 Q. Just to pause there, and I don't seek to cause
4 distress, but he was touching her vagina, was he?
5 A. Yes.
6
7 Q. Did he pause to ask her about what he was about to do?
8 A. No.
9
10 Q. Make any attempt to communicate about --
11 A. No.
12
13 Q. Was it in a private space?
14 A. When I told him that she could use an eye gaze, he was
15 very shocked that day.
16
17 Q. And was that something you mentioned afterwards?
18 A. Yeah, when I had that weird feeling come over me, I
19 said, "Yeah, [REDACTED] will be able to tell me when she gets on
20 her eye gaze", and he's gone, "Oh, she can communicate, can
21 she?" I said, "Yes", and then over that next couple of
22 days was when things got worse.
23
24 Q. Tell me about what got worse?
25 A. Well, after that day I turned up the next day and she
26 was screaming in her bed, sweating. The blinds were all
27 pulled down, and this was the room right outside the office
28 of the ward; like, the office ward, straight across, and
29 all the things were pulled down, the curtains, and I've
30 just barged in there and seen her, and I've like got her up
31 and gave her a cuddle and then I gave her a shower, and she
32 had cream everywhere all over her vagina.
33
34 Q. Just pause there. Had you been responsible for
35 [REDACTED] care since she was born?
36 A. Yes.
37
38 Q. And she was by this stage 15 years old - maybe
39 slightly younger, sorry?
40 A. Yeah a little bit younger.
41
42 Q. How old was she around this time?
43 A. 11, I think.
44
45 Q. 11, sorry. Had she ever been prescribed any cream for
46 her vagina in the past?
47 A. [REDACTED] never had a rash down there in her life, ever,

1 not once.

2

3 Q. Have you ever known of any need to treat her in that
4 way?

5 A. No.

6

7 Q. What did you do when you were in the shower? What did
8 you do then?

9 A. Well, I noticed that she had the injury there, she had
10 skin off down the bottom of her vagina and, yeah, she was
11 just really distressed and at that stage my mum was there
12 with me, and yeah, I made her sit with me while I - I was
13 running in and out of the hospital crying because I just
14 could not understand what was going on with her, and the
15 doctors would not listen to me, no-one was listening to me,
16 no nurse was telling me what was going on, who was putting
17 cream on her, nothing like that; it was all just - keep me
18 out of that, yep.

19

20 Q. That was obviously distressing for you?

21 A. Very, yeah, that's why I called child safety, because
22 I didn't know who else to call.

23

24 Q. Did you ask someone at the hospital to explain?

25 A. Yeah. Yeah, they - ah, they called me at one stage,
26 "Oh, the girl with the Ugg boots", you know, that's how
27 they treated me, yeah.

28

29 Q. Do you feel like they looked down on you a little bit?

30 A. Yes, because I'm a single parent.

31

32 Q. Now, you asked Griffin about the cream and that's the
33 incident you described, is it?

34 A. Yeah, he just shrugged it off, like, they all shrugged
35 it off. And even the [REDACTED] that wrote the notes down
36 for me, and when I said, "No male was to change [REDACTED] from
37 today", he, like, he seen all that, you know.

38

39 Q. Let's go back to that. So, you say that you asked
40 that no males change her from today; tell us about --

41 A. Because she had skin off her vagina and lots of cream;
42 like, it was plastered on there, it wasn't normal, it's not
43 right.

44

45 Q. You didn't know what happened to her, so who did you
46 go to to say you don't want men changing her any more?

47 A. The nurses. It was a [REDACTED] nurse at the time

1 and the head nurse as well, I complained to her, I pulled
2 her over and took her into the kids' toy room and we spoke
3 about the incident where he walked over and tapped her and
4 I asked her, I said, "Have you got a daughter of your
5 own?", because she didn't seem that fussed about it, and
6 she said, [REDACTED], and I said, "Well, how would you like it
7 if a male walked over to her and went like that on her?",
8 and I did it, like, I acted it out. And she's like, "I can
9 make a complaint but, you know, that's all I can do". And
10 she said she could give me a form to put in and that's what
11 she did, and she told me she was going to take complaints
12 further, but whether or not it happened or not, I have no
13 idea.

14
15 Q. Just to go back a moment again, you said that you saw
16 someone write down that no men were --

17 A. Yes.

18
19 Q. -- to be changing [REDACTED] or treating her?

20 A. And no cream, not to put any cream on there any more
21 and no males to be changing her.

22
23 Q. And you saw someone write that down?

24 A. Yes, yep.

25
26 Q. Do you know if that was a direction that got complied
27 with?

28 A. Well, as far as I knew, but they still kept [REDACTED] for
29 that extra week longer for no reason; like, she should have
30 been home with me. I have no idea why they even kept her
31 even longer than they should have.

32
33 Q. By about November of that year, of 2018, [REDACTED] went
34 home with you after she was discharged?

35 A. Yep.

36
37 Q. Was there any further use of the cream after that that
38 you saw?

39 A. No, no, uh-huh.

40
41 Q. So far as you observed, did you see any male nurses
42 nursing her after you asked --

43 A. No, I didn't, nah.

44
45 Q. When you got home, did anybody speak to you about
46 resolving your complaint or responding to your complaints?

47 A. No.

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Q. Has anyone ever reached out to you since?

A. No, they've always been glad to see the back of us, for some reason, yeah.

Q. How did [REDACTED] seem to you when she got home?

A. She was very distressed; for a long time she was hating on me, it was really hard.

Q. Were you able to talk to her about what was upsetting her?

A. (Witness nods.)

Q. Can you tell us a little bit about what she tried to tell you? Sorry, if you need a moment.

A. Yeah. I just asked her if a man was bad, she said, "Yes".

PRESIDENT NEAVE: Are you all right? Would you like to go on or take a brief break?

A. No, it's all good.

MS BENNETT: Q. How did [REDACTED] progress after the months that followed?

A. So, the separation anxiety kind of come back again. Every time I left her she'd be just watching me like a hawk.

Q. Did that slowly abate over time?

A. Yeah, to an extent, but not fully; like, she's always gonna be like that now.

Q. It was about a year later --

A. I'll just mention, mainly in hospital setting, like, yeah.

Q. How is she now, if she needs to go to the hospital?

A. Yeah, she doesn't like going in there, she'll start yelling as soon as we go in through the doors, that's why I said I'd prefer to go to Hobart rather than up there, just for memory side of things.

Q. So, it's LGH specifically that she has an issue with?

A. M'hmm.

Q. Does she react differently to Royal Hobart?

A. She wasn't too bad the last time we went down, we had

1 to get dental work done, and it was pretty good, it was
2 only for the day, yeah.
3
4 Q. It's a big trip for you though, isn't it, coming down
5 from Launceston to Hobart every time she --
6 A. It is a little bit, yeah.
7
8 Q. Do you feel like you're less likely to access the
9 medical assistance in your hometown because of all of this?
10 A. Yes.
11
12 Q. Does that make things harder for you?
13 A. It does, yeah.
14
15 Q. Does it make things harder for [REDACTED]?
16 A. Yeah, for sure.
17
18 Q. It was about a year after [REDACTED] came home that you
19 read about the allegations against James Griffin in the
20 media?
21 A. M'mm.
22
23 Q. Can you tell us how you felt when you read those
24 allegations?
25 A. Well, it was a big reality check and it made me click
26 onto everything and everything made sense from our last
27 day. Yeah, I didn't know his name, so it was like a big
28 shock; it was, yeah, messy.
29
30 Q. I'm sorry, I interrupted you?
31 A. A messy moment, that's for sure.
32
33 Q. What were your concerns after you heard about these
34 allegations?
35 A. Well, everything that we assumed had happened,
36 happened and, if not, worse.
37
38 Q. How does it affect you not knowing precisely what
39 happened?
40 A. I feel like I failed [REDACTED], 100 per cent.
41
42 Q. Did anyone reach out to you about any of your
43 complaints after all that had happened?
44 A. No.
45
46 Q. How does the uncertainty about what happened to [REDACTED]
47 affect your anxiety about leaving her alone?

1 A. Massively, yeah.
2
3 Q. Tell the Commissioners how that's been for you?
4 A. Yeah, she's with me all the time. I can't let her go
5 anywhere, apart from school.
6
7 Q. Do you feel like that's related to what happened?
8 A. Well, we were actually getting somewhere with school
9 and stuff, but after all that - yeah. Sorry. Yeah, it's
10 just too much. Even when she started - we attempted after
11 school care again it was like, nah, the two hours and that
12 was it, she'd be back home again.
13
14 Q. What about with your other children, has it affected
15 you in relation to caring for them?
16 A. No, nah. Apart from, you know, they're always with
17 me, you know, that's just the type of person I am now.
18
19 Q. I think you've said you're reluctant to take [REDACTED]
20 back to LGH; that remains the case even though we know that
21 Griffin's no longer there?
22 A. To stay there, yeah, I would forbid it, yeah.
23
24 Q. And that reduces your options for healthcare for [REDACTED]
25 in Launceston?
26 A. Yeah.
27
28 Q. How do you feel about remaining in Launceston itself?
29 A. I only want to stay here for the next couple of years
30 and then I want to take [REDACTED] somewhere else.
31
32 Q. And is that related to what's happened?
33 A. Definitely, and I believe [REDACTED] will live a happier
34 life somewhere else with her sisters.
35
36 Q. What is it that you'd like to see come out of this
37 Commission of Inquiry?
38 A. Change, yeah.
39
40 Q. What sort of change are you talking about?
41 A. Just more, you know, observant on who you're employing
42 in hospitals, in after school cares, you know, all that,
43 all round, everything.
44
45 Q. Do you feel like the communication and seeing people
46 as being people capable of exercising autonomy is important
47 to you?

1 A. Yeah. Well, that's a common sense thing to me, like,
2 you know, I think all people who can communicate should be
3 able to communicate with everyone regardless of how other
4 people see them, because that's always been the issue with
5 [REDACTED]; it's like, people are observant and they just assume
6 that, you know, she's disabled so she can't do this, she
7 can't think for herself when she can. She always has been
8 able to since she was very young and that's why she was so
9 frustrated when she was little, yeah.

10
11 Q. She can consent to who touches her body, can't she?
12 A. Definitely, yes.

13
14 Q. She can say yes and no?
15 A. M'hmm.

16
17 Q. And she wasn't given that opportunity that day you saw
18 her?
19 A. No.

20
21 Q. You often speak for her; can you tell us what you
22 think [REDACTED] would want to tell the Commissioners if she
23 were here today?
24 A. That everyone's got a voice and, yeah, you just gotta
25 listen; people have to listen.

26
27 Q. Tammy, thank you, we know it's been really difficult
28 for you to come and do this today, we're grateful for your
29 evidence and for your courage in speaking to this
30 Commission. Those are all the questions I have for
31 Ms Donohue today, unless I hand her over to the
32 Commissioners?

33
34 PRESIDENT NEAVE: Thank you, Ms Bennett.

35
36 COMMISSIONER BROMFIELD: Q. Thank you so much for coming
37 today and sharing your story, it's been very moving. I
38 just wanted to come back to: you talked about making the
39 extraordinary decision to call Child Safety Services to
40 protect your child while they were in the hospital. Would
41 you be able to tell us what happened when you called Child
42 Safety Services?

43 A. Yes. So, before I called them my paediatrician at the
44 time said that she wanted to see what support I had to go
45 home with [REDACTED] as well, so I had all my teachers and staff
46 organised and NDIS worker organised to come to a meeting.
47 Well, when I rang Child Safety they said, "Okay, well,

1 we'll send someone along to your meeting that you're
2 having", and they sent someone along, and yeah, she was
3 present at the meeting and, yeah, when I was - during the
4 meeting I mentioned about [REDACTED] injury on her vagina and
5 it was completely dismissed by the paediatrician. [REDACTED]
6 teacher and everyone else was shocked, but yeah, nothing
7 became of that.

8
9 COMMISSIONER BROMFIELD: Thank you.

10
11 PRESIDENT NEAVE: Q. Thank you. Thank you so much. We
12 are so sorry about what has happened to you, it's terrible,
13 and we thank you very, very much for your courage in coming
14 and talking to us and we hope very much that the evidence
15 that we've heard from you and that we will hear from other
16 people will make things better for other children.

17 A. That's it.

18
19 Q. So, thank you very, very much for your great courage
20 in talking to us.

21 A. No worries.

22
23 COMMISSIONER BENJAMIN: Can you pass on our thanks to
24 [REDACTED].

25
26 THE WITNESS: I will do, for sure. Thanks guys.

27
28 PRESIDENT NEAVE: Thank you. So, you're excused now and,
29 yes, a short adjournment.

30
31 **SHORT ADJOURNMENT**

32
33 MS NORTON: Thank you, Commissioners. Before I call the
34 next witness into the witness box may I just indicate, the
35 original timetable for today contemplated a panel
36 comprising both the next witness, Commander Sirec, and also
37 Detective Chief Inspector Yeomans from the New South Wales
38 Police. Unfortunately, Detective Chief Inspector Yeomans
39 has become unavailable at short notice because of a court
40 obligation as part of his duties.

41
42 So, although his statement is before you and can be
43 read by you, I am not calling him today although I hope to
44 be able to call him before you at a later time, but I am
45 very grateful that Commander Hilda Sirec is available and
46 I'll call her now to the witness box.

1 <HILDA SIREC, sworn:

[11.28am]

2
3 <EXAMINATION BY MS ELLYARD:

4
5 MS ELLYARD: Q. Commander, please feel free to take off
6 your mask now that you're in the witness box.

7 A. Thank you.

8
9 Q. I'll ask you first to tell the Commission your full
10 name?

11 A. My full name is Hilda Sirec.

12
13 Q. And you're a Commander in the Australian Federal
14 Police?

15 A. That's correct.

16
17 Q. What's the particular role that you hold in the
18 Federal Police at present?

19 A. So at present I lead the Australian Centre to Counter
20 Child Exploitation and Human Exploitation Operations for
21 the AFP.

22
23 Q. And we can refer to that by the acronym, ACCCE?

24 A. Correct.

25
26 Q. How long have you been the Commander for ACCCE?

27 A. I have been the Commander of the ACCCE since November
28 2021.

29
30 Q. You have made a statement to assist the Commission of
31 Inquiry which is signed by you and dated 28 April 2022.

32 A. That's correct.

33
34 Q. Are the contents of that statement true and correct?

35 A. They are.

36
37 Q. You refer in your statement to two exhibits, the first
38 of which is a copy of your curriculum vitae and the second
39 of which is the copy of an ACCCE research report from 2020
40 relating to online child sexual exploitation. Do you wish
41 that to be part of your evidence today?

42 A. Yes, please.

43
44 Q. Thank you. Commander, may I begin by asking you, by
45 reference to paragraph 6 and following of your statement,
46 to summarise the experience that you've had prior to your
47 current role that's relevant to the issues being considered

1 by this Commission?

2 A. Thank you. So, I joined the Australian Federal Police
3 in 2001 and commenced general duties then doing uniform
4 policing and across that experience came across various
5 crime types inclusive of child abuse and child sexual
6 abuse. In 2006 I commenced work in the Sexual Assault and
7 Child Abuse Team where I spent a number of years
8 investigating adult sexual assault and child sexual abuse
9 and child sexual assault.

10
11 Following that, I worked in that role since 2010, and
12 then worked in countering people smuggling in 2013, and
13 then after that was deployed to Afghanistan to teach Afghan
14 National Police various crime investigation techniques
15 inclusive of homicides, domestic violence and sexual
16 assaults.

17
18 Following that, I returned back to Australia and I
19 worked in the joint Counter-Terrorism Team up until 2019
20 where I deployed to Pakistan where I performed the role as
21 Australia's senior law enforcement officer to deal with law
22 enforcement issues related to Pakistan, Afghanistan and the
23 other Stans in the region and for Australian interests.

24
25 In November 2020, I returned back to Australia where I
26 have commenced my role in the Australian Centre to Counter
27 Child Exploitation.

28
29 Q. Perhaps by reference to paragraphs 14 and 15, how did
30 the ACCCE come to be created and what is its remit?

31 A. So, in 2018 the Commonwealth Government provided
32 additional funding to create the Australian Centre to
33 Counter Child Exploitation. The ACCCE is predicated on the
34 need to drive a collaborative response to deal with child
35 online exploitation, bringing together multi-agencies
36 across the law enforcement streams, also non-government
37 organisations, Civil Service, academia, and other facets of
38 those that are working within child protection to drive a
39 coordinated national response to counter the issues around
40 child exploitation.

41
42 Q. Some of the words that are used in your statement in
43 relation to child exploitation as a form of offending are
44 the words "prevent, disrupt and investigate". We can all
45 understand that it's part of the role of the police to
46 investigate crimes when it occurs, but am I right in
47 understanding that an important aspect of ACCCE's work is

1 actually to stop crimes happening in the first place by
2 either prevention or disruption of people who might
3 otherwise be offenders?

4 A. That's correct. So, the ACCCE is predicated on four
5 pillars: we prevent, we pursue, we protect and we make sure
6 that we have all those elements involved in being able to
7 identify the community needs in regards to the awareness
8 around child exploitation, but also identifying those
9 opportunities where we can prevent the crime and further
10 victimisation at its core.

11
12 We engage with our prevention and engagement teams
13 with multiple stakeholders to raise that awareness and
14 provide techniques and investigative aspects to be able to
15 intercept and interdict crime as it's occurring to disrupt
16 the ongoing effects that's ongoing with crime.

17
18 We certainly foster a victim-centric approach to all
19 our strategies within the ACCCE but also across our
20 prosecutions as well.

21
22 Q. The work of this Commission is focused on responses to
23 abuse in institutional settings and as part of that work
24 the Commission's been made aware that there are cohorts of
25 children in Tasmania, including the cohort of children who
26 live in Out-of-Home Care, that are particularly vulnerable
27 to and have become victims of sexual exploitation including
28 online exploitation, and it's in that context that I want
29 to ask you a bit about this issue.

30
31 Firstly, and I'm drawing your attention to
32 paragraph 21 of your statement, when we speak about online
33 child sexual exploitation, what are we talking about?

34 A. So, we're talking about the scenarios where there are
35 either sexual images or children's genitalia, or situations
36 where children have had sexually suggestive images taken of
37 themselves, all the way up to individuals who are grooming
38 children online to gain access to them. So, we classify
39 child abuse material in its broader scheme for everything
40 under the age of 18, and it relates to everything from
41 procuring, producing, sharing, disseminating any child
42 abuse images related to those children.

43
44 Q. You and I are both using the phrase "child
45 exploitation" and "child sexual abuse material", there are
46 other words that have been used in the past. You make it
47 clear in your statement why the words we are using are the

1 preferred words, can you explain that, please?

2 A. Yes, so in the past and also in historical legislation
3 it was termed "child pornography" and it's been changed in
4 legislation as well that it is more appropriate to term it
5 as child abuse material. Child pornography generally
6 starts to conjure up a legitimacy across offenders, that it
7 is consensual by the child and we make it very clear that
8 any sexualised images or naked images of children are not
9 consent, so we have moved away from the term child
10 pornography and we work very hard with our stakeholders but
11 also any of our media advice that we send out during
12 prosecutions that we refer to the abuse of children; it's
13 not pornography.

14
15 Q. You've made it clear in your statement that one form
16 of online child sexual exploitation cannot just be the
17 sharing of images that also exist, but also predators
18 making contact with children through the internet to
19 potentially persuade them to involve themselves in the
20 creation of sexual images or to become victims to other
21 kinds of sexual abuse. You talk from paragraph 32 of your
22 statement about online grooming; can you tell us about
23 that, please?

24 A. So, online grooming is a situation where we have
25 offenders and predators out there targeting specifically
26 children to be able to either have them coerced into
27 producing naked images of themselves or undertaking sexual
28 acts for their own gratification, or even to the extent of
29 trying to arrange a meeting with that child for the efforts
30 of doing contact child abuse offences.

31
32 It also relates to the fact that these individuals
33 gain trust to these children, but also trust and
34 manipulation to the families and parents and carers as
35 well, so it can be quite sophisticated, people can take
36 quite some time, days and weeks to weave themselves into
37 these children's lives to the point where children
38 initially think that it's quite innocuous to engage with
39 someone, you know, their social friends, friends of friends
40 online, this whole concept of being friends online is
41 totally different to how we would assume friendships and
42 people you trust are in the real world, let's call it. And
43 then, through that process, they start to carve out that
44 trust, remove these children away from their usual social
45 networks and make their - you know, that relationship with
46 an offender quite exclusive, and then to the point of
47 creating some shame and some coercion towards these

1 situations where children feel trapped and feel like they
2 need to comply to some of the offender's requests, such as
3 sending another image or going to the bathroom and sending
4 a naked image, and then that becomes a perpetuating problem
5 for the children, which is very difficult for them to see a
6 way out.

7
8 Q. You make the point in your statement at paragraph 36
9 that, given the two years that we've all lived through,
10 children have been living even more of their lives online,
11 including a lot of their schooling being done through the
12 internet. What have been the potential implications of
13 that for the potential for children to be groomed online in
14 the way that you've described?

15 A. I think it's first good to acknowledge that, I'm sure
16 we wouldn't have had a very positive society without the
17 advent of technology and our ability to engage with each
18 other online over the past two years, but it has provided
19 an additional grounds for offenders to be able to target.

20
21 We have now children spending even more time online,
22 children as young as 3 and 4 are gaining access to the
23 internet and social media, our children are required to
24 undertake all their schooling online as well and our
25 offenders are very quick to identify vulnerabilities and
26 adapt to that situation.

27
28 The issue that we're seeing is the increase in the
29 reports that we received into the ACCCE, and we relate that
30 to the additional time that children have been spending
31 online and offenders being able to take advantage of that.

32
33 Q. Can I ask you to perhaps unpick a little more how
34 offenders gain advantage, because one would have thought,
35 if children are doing schooling online, well then they're
36 interacting with their teachers, there shouldn't be any
37 difficulty because their teachers will be safe. How is it
38 that predators are able to insert themselves into what
39 ought to be a safe online environment for children?

40 A. I suppose online, like I said, it's a fabulous advent,
41 but I think it can be multi-faceted. You can have students
42 obviously watching a tutorial or a lecture, and then with
43 another pop up window they can have a chat function with
44 their friends or their colleagues, and they can have their
45 mobile phone device where they're engaging on different
46 video apps, and they could probably also be gaming at the
47 same time. So, I think children are excellent at

1 multi-tasking, but it's those multi-tasking avenues that I
2 think the offenders are also taking advantage of. They are
3 accessing the same social media sites that we think are age
4 appropriate for young children, such as the 10 to
5 13-year-olds, and adult offenders can access those same
6 sites as well, and they're very good at using the same
7 language as what children are using to make themselves
8 familiar to them.

9
10 So, as our students are obviously learning the
11 critical work through the curriculum, they're also having
12 that ability to engage on that social media side at the
13 same time.

14
15 Q. And so, is there anything that schools can do in
16 relation to the way in which they expect their students to
17 make use of the internet to try and guard against the risk
18 of children entering into spaces where predators might be
19 present?

20 A. Certainly, I think there's opportunity for schools to
21 certainly tap into the online safety resources that are
22 available out there for a more holistic online safety that
23 goes everything from respectful behaviours, to cyber
24 bullying, all the way to child online exploitation. The
25 eSafety Commissioner provides some great resources for that
26 that the schools can access, and particularly for child
27 online exploitation preventing grooming the AFP's
28 ThinkUKnow program where we deliver tailored presentations
29 to schools, teachers, carers and also students.

30
31 In the last year alone we were able to access almost
32 200,000 students across Australia within the pandemic to
33 give those education presentations to children, but I think
34 the schools can definitely, if they haven't already, is
35 really tailor an ability to do the online safety
36 parameters, you know, all the way through their education
37 process from kindergarten all the way through and make that
38 a focus.

39
40 Q. Some of the children whose stories the Commission has
41 heard and are going to hear include children who are
42 perhaps made vulnerable because of family circumstances and
43 don't have present and actively involved parents or are
44 distant in some way from people who might be keeping an eye
45 on them. You mentioned the way in which predators use
46 online media and social media to build connections with
47 children. Would it be fair to say that children who don't

1 have parents who are watching closely who they meet and how
2 they meet might be particularly vulnerable to the kind of
3 attention that a groomer would offer?

4 A. Yeah, that's very fair to say. We certainly, as one
5 of our first tips to give to parents and carers, is that
6 supervision is essential; being able to see what your
7 children are doing online all the time is really critical,
8 but also I acknowledge the fact that sometimes that's an
9 impossible task. Certainly being able to have an eye over
10 the screen 24/7 is very difficult, but we certainly think
11 that those online safety behaviours, the critical
12 discussions that you have between parents and carers and
13 children is really important to foster that because
14 sometimes children might not see what is probably targeted
15 behaviour from online offenders; they might not be able to
16 recognise it immediately themselves, but a parent or carer
17 might be able to say, "No, that doesn't seem right", so
18 having that online dialogue is really critical.

19
20 But I think certainly our experience is that offenders
21 have actively targeted those individuals who seem to be
22 unsupervised online and in more vulnerable scenarios where
23 that trust and that ability to inject themselves
24 meaningfully into that victim's life happens a lot swifter
25 than maybe in other settings where there's real strict
26 parental controls over what children are doing online.

27
28 Q. Commander, you mentioned that in some cases those who
29 groom children online will be grooming them, not just to
30 try and get images, but to create the opportunity for what
31 you referred to as contact offending, so that's actually
32 meeting with the child and abusing the child in person.

33 A. Yes.

34
35 Q. Is that common?

36 A. Yeah, we would certainly see it's very common. We
37 have a lot of situations where offenders are engaging with
38 children online. We work very closely with some of our
39 telecommunication companies and internet service providers
40 and also social media platforms and they are able to
41 identify that offending quite quickly, and we do a lot of
42 proactive investigations to identify that kind of behaviour
43 so we are able to routinely interdict those scenarios, but
44 certainly it is our experience that it's not always trying
45 to get some child exploitation material from the child, it
46 is an effort to eventually meet up with the child to
47 potentially commit other offences.

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Q. You talked about interdicting, you mean disrupt, prevent the offending happening?

A. Correct, so disrupt the offending that's happened at the time, particularly so that the victim doesn't actually end up in the scenario where they're in an unsafe environment with the offender. And, of course, whilst we've disrupted the victimisation, there are still then prosecution aspects that we are able to pursue for the offending that's already occurred, but certainly a big part of our work is that disruption factor.

Q. Can I turn to paragraph 39 and following of your statement. Some research has been done by your organisation about parental attitudes which suggests that there's a substantial percentage of parents who would find it very difficult to even contemplate talking about this kind of topic with their children; is that right?

A. Yeah, absolutely. So, we commissioned some research through the ACCCE that was completed in 2020, and certainly we identified that at least 21 per cent of parents and carers find that it's too sickening to talk about or think about child online exploitation, and 15 per cent of parents and carers also are too embarrassed to talk about it if their child was exploited.

We've also identified that only 52 per cent of parents and carers are actually talking about online child sexual exploitation and safe behaviours online, so there's real criticality for us about reaching that awareness to those cohorts of individuals who don't either discuss it or don't think that it's a problem

Q. Am I right to say that one of the tools that offenders use is to create a sense of shame sometimes for children once they've been exploited to some extent that prevents them from feeling able to disclose that they've been victims?

A. Yes, certainly it's been our experience that some of the tactics that offenders use is that, you know, that coercion and that fear-based messaging to them. So, they've built the trust and they've got that one-on-one engagement with the child, and then all of sudden the content and the conversations starting to towards, "Well, if you don't send me this I'm gonna tell your parents and you're gonna get in trouble because you're talking to me", so they completely wrap every facet of the child's fear

1 around them so it prevents children to actually making
2 those reports.

3
4 Q. And so, at paragraph 40 of your statement you describe
5 a campaign called, Stop the Stigma that's intended to
6 counter the fear and concern that people have. Could you
7 tell us about that?

8 A. Yeah, so in 2021 we brought together some of the
9 leading non-government organisations and personalities in
10 relation to the Stop the Stigma campaign; it's really built
11 around giving a voice to victim-survivors and making sure
12 that they have the right avenues to make reports and that
13 we want them to not be afraid or ashamed, that they will be
14 trusted and they will be believed.

15
16 Some of the research that we did to identify the need
17 through Stop the Stigma is that a lot of children, it takes
18 them at least two decades to come forward and make a report
19 about this, and a lot of children actually don't feel that
20 they will be believed because they've already been told
21 through offender grooming that they won't be believed. So,
22 this is a way to create a voice to make sure that
23 victim-survivors out there can be heard in a national
24 campaign, that they have avenues to report, whether it's
25 through law enforcement or support services, and making
26 sure that their voice is louder than the offenders' voices.

27
28 Q. And so, you've mentioned a podcast series?

29 A. Yep. So, we also created a ten part podcast series
30 Closing the Net. We interviewed over 55 experts within the
31 child exploitation fields, from investigators to support
32 areas to NGOs, all the way to international partners as
33 well about highlighting the trends and issues that we found
34 across child online sexual exploitation, but also some of
35 the avenues of reporting that we've been able to identify.

36
37 The Closing the Net podcast had an amazing reach
38 across the country and has also won awards in relation to
39 its ability to shine a spotlight on what is often quite a
40 difficult topic.

41
42 Q. You also mentioned the Australian Federal Police's
43 ThinkUKnow program, can you tell us a bit about that?

44 A. Yes, the AFP's ThinkUKnow program is a collaboration
45 between Commonwealth Bank, Datacom and the states and
46 territories as well, state and territory law enforcement,
47 and it's off a successful program from the UK that we

1 introduced in 2009, I believe, and it's all predicated on
2 making sure that we build awareness and prevention
3 techniques for children and also parents, carers and
4 teachers.

5
6 So, there's a whole host of resource material on the
7 ThinkUKnow website, and we deliver face-to-face
8 presentations and awareness to our students. We've also
9 trained state and territory police to be able to do that
10 within their communities as well, so it creates a force
11 multiplying reach to be able to work on the typical issues
12 around child online exploitation and online grooming and
13 it's complementary to some of the other broader online
14 safety programs that eSafety deliver.

15
16 Q. Commander, I want to ask you some questions now about
17 the way in which the AFP works with other enforcement
18 bodies and other organisations.

19
20 At paragraph 52 and following of your statement you
21 refer to the joint anti-child exploitation teams which is a
22 taskforce bringing together the AFP and state and territory
23 police departments. Can you tell us about how the JACETs
24 work?

25 A. So, the JACETs were introduced identifying that there
26 is a close correlation between Commonwealth online
27 offending and the need to bring the local resources of all
28 states and territories together to deal with these issues
29 and these crime types. So, the concept of the JACET exists
30 in all states and territories except New South Wales Police
31 where we work very closely with the child protection
32 agencies and law enforcement and New South Wales Police,
33 but the construct of the JACETs is literally to collocate
34 members. For instance in Tasmania we have Australian
35 Federal Police and Tasmania Police. They collocate, they
36 do joint operations together and joint investigations, and
37 it brings the opportunity to bring not only the state
38 resources but the Commonwealth resources to bear that we
39 can gain access to across the whole of the Australian
40 Federal Police but also other states and territory
41 connections.

42
43 So, it's been a really critical way to make sure that
44 we provide all the assets that we have to bear to deal with
45 those Commonwealth offences.

46
47 Q. And so, does that mean that as well as the

1 Commonwealth offences which you've referred to, the joint
2 taskforce is the opportunity to skill up, perhaps,
3 state-based police forces who are investigating state
4 criminal offences involving child abuse?

5 A. Yes, certainly. Through the coordinating role that
6 the AFP gets to offer because we are within every state and
7 territory, we are able to gain trends and techniques from
8 other law enforcement agencies, particularly our
9 international agencies who have been dealing with these
10 crime types for a long time as well and we can bring all
11 those in, those skill sets and those uplift of capabilities
12 to the various state and territory agencies.

13
14 The Tasmania JACET has access completely to the ACCCE
15 which is housed in Brisbane, it also has access to the
16 child protection investigation workshops where we bring
17 other state and territory agencies together to learn from
18 each other.

19
20 Q. One of the things that you refer to in your statement
21 later on is about funding that's been made available to the
22 AFP through the National Strategy that's going to include
23 additional funding for the AFP to work on some of these
24 issues.

25
26 How might Tasmanians expect to see their own law
27 enforcement capabilities improve through that funding? Is
28 any of it going to resonate in the services and capacities
29 in Tasmanian?

30 A. Yes, certainly, I believe so. So, under the National
31 Strategy to prevent and respond to child sexual abuse which
32 was Commonwealth and national action plans under that, the
33 AFP received additional funding to uplift our law
34 enforcement efforts across the country.

35
36 In the Tasmanian context we certainly see the
37 additional access to victim ID specialists so that there
38 will be actual resources that will be dedicated to work
39 closely with the Tasmanian JACET to identify victims
40 quicker and to be able to provide those capabilities that
41 we have developed through the ACCCE in a faster way.

42
43 We also have access to technology detection dogs, so a
44 specialist resource that we can deploy to search warrants
45 to identify concealed electronic data devices, all the way
46 from a SIM card to USBs, to be able to make sure that we
47 don't leave any evidence behind in some of these search

1 warrants.

2
3 They will also have access to the Australian Victim
4 Identification Database, or AVID. So, AVID has been
5 created through the ACCCE to be able to download and
6 harvest all the child abuse material that has been
7 collected through seizures across the country and with
8 Tasmania we will give them complete access to that, the
9 training and the laptops required to do that so that
10 through various search warrants any child abuse material
11 that is located will go into this database. Anything that
12 has been seen previously won't have to be re-seen by an
13 investigator and our investigators here in Tasmania will be
14 able to concentrate more on the unseen previously images to
15 identify victims earlier, so they can spearhead their
16 investigations and not have to worry about what has been
17 duplicated in the past.

18
19 Q. That will also, presumably, have ongoing benefits in
20 not forcing people who might be in those images to be
21 contacted again or in any way re-traumatised in relation to
22 images that have previously been investigated?

23 A. That's exactly right. We found through the ACCCE as
24 well a big pillar of what we do is the health and wellbeing
25 of our investigators and our support agencies, so ensuring
26 that our investigators only have to look at the minimum
27 amount of child abuse materials means they're able to
28 conduct more investigations, that they have a mental
29 well-being that is more conducive to be able to do tailored
30 investigations, and they're not spending excessive amount
31 of time on looking at child abuse material that has already
32 been categorised and seen before.

33
34 Q. At paragraph 63 of your statement you refer to an
35 AFP-led investigation into an online network of child sex
36 offenders which it did include, as I understand it,
37 ultimately at least one arrest made in Tasmania. Can you
38 tell us about that please?

39 A. So, Operation Arkstone began in February 2020 and it
40 was as a result of one report from the National Centre For
41 Missing and Exploited Children, and for context the ACCCE
42 received last Year 33,000 reports. So, from one report in
43 New South Wales they identified an online child sexual
44 abuse syndicate that were also committing child abuse
45 offences in the real world, and these individuals were
46 connected to childcare centres as well, so they were
47 gaining access to children in New South Wales for the

1 purposes of procuring child abuse material.
2

3 That operation went across the whole of the country
4 and identified to date one of the largest child abuse
5 syndicates within Australia and, as has been mentioned,
6 there was one case, an arrest made in November 2021 here in
7 Tasmania related to that as well.
8

9 So, over the course of the investigation and as of
10 28 January 2022 the investigation has resulted in over
11 1,340 charges being laid and 56 children victims identified
12 and removed from harm.
13

14 Q. Thank you, Commander. You've made it plain in your
15 statement that the ACCCE doesn't just collaborate with
16 other law enforcement bodies, it's also part of your remit
17 to collaborate and work constructively with other partners
18 in the space of broadly child protection.

19 A. Yep.
20

21 Q. By reference to paragraphs 59 and following of your
22 statement, can you tell us about how the AFP and ACCCE in
23 particular works with other parts of the system that exist
24 to protect children?

25 A. So, identifying that there were a lot of individuals
26 that were working within child protection, the ACCCE in its
27 creation to be that collaborative hub, that kind of gravity
28 to make sure that there was somewhere where people who work
29 and operate in child protection can go towards was
30 critical.
31

32 We identified that a lot of the non-government
33 organisations and the Victim Support agencies have been
34 doing critical work for a large number of years, and we
35 just needed to connect that work with the disruption and
36 the awareness and the prevention awareness-raising work,
37 and also the prosecution work that we were doing.
38

39 It's really identifying that there's a lifecycle of
40 online child exploitation and if we can make sure that we
41 target our resources and our efforts towards the prevention
42 and the awareness-raising side, we can hopefully reduce and
43 counter the actual victimisation and the offenders having
44 that access to victims.
45

46 Q. I imagine there's a lot involved in trying to achieve
47 complete coordination across the country at Federal and

1 state levels.

2 A. Certainly. Yeah, it is quite a voluminous environment
3 and I think it's nice to see so many agencies out there
4 trying to make sure that they are focused on protecting
5 children and diverting efforts towards that; making sure
6 that we plug into all those correctly can sometimes be a
7 challenge.

8
9 We certainly work very collectively on it, we've
10 worked very hard through the ACCCE over the four years that
11 we've been there to harvest all that information and be
12 able to make sure we collate all that together, but
13 certainly we are constantly making sure that we reach out
14 to those agencies that are doing some isolated work, and we
15 certainly like to foster the notion that, you know,
16 collectively we can create a fourth multiplier, we can
17 amplify efforts rather than agencies doing things
18 individually going forward.

19
20 I think the National Strategy, the Commonwealth and
21 the National Action Plans will be another evolution of that
22 coordination part, and we certainly work very hard through
23 the ACCCE to make sure that we are aware of all the
24 different avenues that people are fighting this crime and
25 making sure that we plug into it.

26
27 Q. I wanted to ask you a more specific question about
28 online exploitation before I take you to another topic.
29 One of the case studies that the Commission's going to be
30 considering here and it's by no means as we understand it
31 an isolated incident, is offenders using the online
32 environment to groom or predate upon children that they
33 already know in the real world, so there might have been a
34 connection made through some legitimate online contact
35 whether as a friend or some holder of some office, but then
36 the mode of exploitation is online. Is that something that
37 you're familiar with?

38 A. Yeah, so we've had certainly cases where the online
39 groomer has certainly been known to the victim,
40 particularly around being a friend of a friend or a distant
41 relative, or, you know, other associations and they've used
42 the online exploitation as a way to introduce this child
43 to, I suppose, innocuous ways to engage with this
44 individual; you know, posing photos and things like that,
45 and then slowly creeping them into more suggestive images,
46 all the way to procuring sexualised images and using that
47 as a way to then coerce the child. So, there are certain

1 circumstances where we know that the online offending
2 that's been occurring is as a result of someone connected
3 to the child.
4

5 Q. And so, once the connection's made with the child it
6 sounds like the pattern of tricking the child into
7 gradually participating in sexualised behaviour, it's the
8 same modus operandi as that used by people who introduce
9 themselves to children over the internet?

10 A. Yeah, certainly, because the internet offers a little
11 bit more secrecy on connections. Instead of offenders
12 having access to a child only at certain circumstances
13 throughout a day or a week or the like, they can foster
14 that connection with a child through direct messaging, or
15 "here's my phone number, let's stay connected, let's stay
16 in touch", or "here's my phone number in case you can't
17 reach your parents so make sure you take this" and then
18 that connection continues outside.
19

20 Certainly from my perspective we focused on the online
21 connections that are occurring, but we can infer from what
22 we see through the communication between an offender and a
23 victim certainly there has been some connection outside the
24 online world that has precipitated that first connection
25 online.
26

27 Q. And in some cases would that mean that the offender
28 has had quite a legitimate reason to know and have contact
29 with the child in the real world, but then is misusing that
30 legitimate connection in the online space?

31 A. Yes, certainly, that has been our experience, and
32 equally to that extent offenders are grooming parents and
33 carers and making sure that they're familiar and trusted
34 with the parents and carers and offering a legitimacy to
35 why they are then reaching out to children.
36

37 Q. You mentioned grooming the parents; is social media a
38 means by which parents can find themselves perhaps tricked
39 into believing that they know someone, when in fact they
40 don't know them?

41 A. Yeah, absolutely. We find through social media and
42 being able to glean some information about a family
43 situation or a school that a child would go to. We've seen
44 a situation where an offender has become a social media
45 friend to the parents by citing that their child also goes
46 to the school, so they create a familiar ground upon which
47 they can communicate with each other; again, a legitimacy

1 around this offender saying that their child also goes to
2 the school, so they bond on that sort of connection, and
3 then through that complete trust by the family and carers
4 by virtue of social media friendship that they've, you
5 know, almost shared images and photos and then passed that
6 and translated that trust down to the child.

7
8 Q. I want to turn now, Commander, to ask you some
9 questions about one of your former roles and to ask you
10 about some of the things that the Commission is also aware
11 emerging from the evidence of Detective Chief Inspector
12 Yeomans. You've indicated that between 2006 and 2010 you
13 particularly worked in the ACT in the area of sex abuse
14 offences, including child sex abuse offences.

15
16 One of the things that you say in your statement at
17 paragraphs 46 and onwards is that over the time you worked
18 in that environment you observed some improvements in the
19 way in which what can be quite a brutal justice system
20 operates to protect victims.

21
22 Can I ask you first perhaps to give a snapshot of an
23 example of where perhaps earlier in your time the system
24 didn't work well and wasn't particularly trauma-informed to
25 protect a child who'd been the victim of child abuse?

26 A. Yes, certainly. In one of my early cases from when I
27 worked in the child abuse and sexual assault team I
28 interviewed a 5-year-old female girl who disclosed that her
29 stepfather had been sexually assaulting her and this was
30 done in front of - the disclosures were occurring in the
31 interview in front of the mother, and there was sufficient
32 information and corroboration there to take the matter to
33 court.

34
35 However, the victim by that time was 7 years old and
36 had to give evidence-in-chief physically in court at the
37 ACT courts, which in person, in view of the offender, and
38 also cross-examined to that extent. The difficulties
39 around the cross-examination was, you know, around the
40 memory recall, the specific details that the 5-year-old
41 disclosed at the time and how they referenced that
42 disclosure and corroboration versus to how they articulated
43 themselves two years later was problematic for the courts,
44 and there were no specific rules around the
45 cross-examination and the way that the victim could
46 actually have access to protections whilst giving their
47 evidence.

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Q. So that must have been a very difficult experience. It's trite to say it must have been horrific for that child?

A. It was to the extent where the mother who obviously had realised that she'd brought a person into their home that had sexually abused their child, but felt like she didn't - you know, at a lot of stages the mother didn't know she wanted her child to keep going, she didn't think it was going to be worth the prosecution outcome for the trauma that this was applying to the child.

Q. During the time that you were working in this area in the ACT did you see some improvements in the way in which the evidence of children and their treatment in court was managed?

A. Yes, certainly subsequent to that and then since the out years of my time there the process of evidence-in-chief interviews were introduced into the Evidence Act, where children are able to give their evidence under a video recording, however long it takes and how many times it takes, and that is now introduced through a - as long as the person taking the interview has done the appropriate training and is done to the standard that's required, that is the evidence-in-chief played to the court. And then cross-examination, not only the rules around cross-examination, that it needs to be done in a respectful and in a way not to continue the trauma of the victim, but it's done via CCTV, so the victim no longer - at least in the ACT - doesn't have to be within the same court arena as the offender.

Q. One of the things that Detective Chief Inspector Yeomans has talked about in his statement, and there's a trial of this as well in Tasmania at the moment, is the use of what's called a witness intermediary, so people who meet with a witness to try and get a sense of the best way to communicate with a child to encourage them to give their best evidence.

You touched in your anecdote earlier about the different ways in which a child expressed herself at age 5 and age 7 and the implications of that. From your own observation have you had anything to do with witness intermediaries yourself?

A. Not specifically witness intermediaries that are accepted through the court process, but certainly through

1 Victim Support individuals and child protection agencies,
2 and we work very closely with child psychologists to be
3 able to identify the best way to engage with the child for
4 the evidence that they are about to provide. But
5 certainly, the process of witness intermediaries and
6 getting the best out of understanding the child and
7 therefore the best out of the evidence is certainly a
8 positive step forward.

9
10 Q. Because children, and thinking sometimes about quite
11 young children, it's very different to question a child
12 than to question an adult about anything, particularly
13 sensitive things like sexual abuse?

14 A. Absolutely, and it's really critical to identify, you
15 know, what is the child's background, how do they
16 communicate themselves, how do they link what's happened to
17 them with their communication style, and being able to
18 provide those critical ways of different sort of cognitive
19 abilities that children have and making sure that we are
20 able to assess and get the best information from them.

21
22 Q. Thank you very much, Commander. Commissioners, those
23 are the questions that I had for the Commander, noting that
24 there's material before you from Detective Chief Inspector
25 Yeomans, but you may have some questions yourself?

26
27 PRESIDENT NEAVE: Thank you, Ms Ellyard. Any questions?

28
29 COMMISSIONER BENJAMIN: Q. Yes, you talked about
30 children being contacted by people they knew in positions
31 of trust and using that trusted position to gain access to
32 them through their technology. Do you have any suggestions
33 or ideas how you can perhaps prevent that person from
34 contacting - or first of all, should you prevent that
35 person or people generally from having contact outside the
36 scope of their profession? And, if so, what is the best
37 way to do it? Say a teacher or a police officer or a
38 doctor or somebody along those lines?

39 A. Yeah, and that's a very good question but a very
40 complicated one. I suppose, you know, the whole notion of
41 what we would teach generations of children about stranger
42 danger and the like, and what is the concept of a trusted
43 individual versus, you know, what is a friend is very
44 difficult to navigate.

45
46 I suppose what I'd say around that is that we're
47 always going to have situations where children are going to

1 have to have connection and contact to more than just their
2 parents or their carers to be able to make sure that, if
3 something happened to their parents and carers, they still
4 have avenues to contact someone outside of that sort of
5 circle, but critical it would be about the parents and
6 carers who introduce these people of trust into their
7 children's lives, that they know exactly to what extent
8 that connection is, what conversations are happening.
9

10 I think it's probably responsible that, every time a
11 trusted adult is making a connection to a child, that they
12 inform the trusted carer or parent about that so that there
13 is no isolated communication outside what the parents and
14 carers know. And just also making sure that children have
15 the best tools at their disposal to understand what is
16 untoward contact versus what is accepted contact and who to
17 report to when that's not within their understanding.
18

19 Q. Should there be some requirement in an employment
20 contract or an employment relationship of that trusted
21 person restricting their ability to contact the child
22 outside the scope of that trusted area?

23 A. Yeah, I mean, there's certainly the opportunity for
24 that. I know certainly within a policing context our
25 connection to any child has to be done through a trusted
26 adult to that child, a parent or carer; of course, in a
27 classroom setting where you've got a kindergarten and the
28 teacher that becomes a lot more difficult because they are
29 in a trusted setting to do that. But definitely, if that
30 connection goes towards online, making sure that there is a
31 standard, I would suggest, that parents and carers are
32 aware that there is to be no direct contact to children
33 outside the accepted scope.
34

35 Q. Thank you. My second area, since you've opened the
36 door I'll jump through, is you talked about the
37 recognition, facial or whatever recognition it was. I take
38 it from what you've said that that's really advanced over
39 the last few years, and what happens if you've got a child
40 from previous investigations or in some intelligence area
41 and that face comes up again, your technology can match the
42 faces rather than have individual police officers
43 endeavouring to do that; is that the case or is that kind
44 of stuff I picked up from the television and know nothing
45 about?

46 A. No, it's certainly evolving, it's getting a lot
47 better. At this stage we are still heavily reliant on an

1 investigator being able to identify victims and evidence
2 within the background of a photo or an image. Certainly,
3 as soon as we've identified that and can apply a hash
4 value, basically a digital fingerprint, that is able to
5 then correlate against other similar images that are
6 brought up.

7
8 In terms of different images of the same victim, we
9 certainly have some sophisticated algorithms and software
10 to be able to identify that that is the same person, but
11 the technology has to sort of continually evolve so that
12 side-on images and dark and light images and the like are
13 picked up.

14
15 However, what we're doing with the Australian Victim
16 Identification Database is a lot of these images that are
17 circulated online, as you can appreciate, are shared with
18 other online sex offenders. They would procure images from
19 10 years ago and put them into series and they would share
20 and create their own kind of language around, you know,
21 this is the series of 5-year-old with a balloon or
22 something, and there will be multitudes of images.

23
24 What we've been able to do is, all those images that
25 have been seen before, if they are identified through a
26 seizure of an offender, say tomorrow, we will be able to
27 identify that that's already been seized and categorised;
28 that investigator doesn't have to re-look at those images
29 and they can concentrate on what hasn't been seen before in
30 case there are additional victims that we aren't aware of.

31
32 COMMISSIONER BENJAMIN: Thank you.

33
34 PRESIDENT NEAVE: I've got a follow-up question on that
35 before I ask Commissioner Bromfield.

36
37 Q. That would presumably mean that, even if there is no
38 longer an offender who could be investigated, that if there
39 were potential victims of that offender who had posted
40 images online, it might be possible for the AFP to work out
41 whether those were the same victims as in other
42 photographs. Have I understood that correctly?

43 A. Yes, certainly. And, you know, as you can appreciate
44 a lot of these victims don't get located around the world
45 for many years, so unfortunately our victim identification
46 specialists have actually seen victims grow up in these
47 child abuse images --

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Q. Yes, of course.

A. -- in these child abuse images from 5 to 10 years old. So, certainly even if there are no offenders anymore to locate that have procured that, we can certainly still focus on identifying victims and if they happen to come up, whether it's in other offender material or just through the dark web where you've got dark web forums sharing this material, we still target our efforts to identifying a victim.

PRESIDENT NEAVE: Thank you. I'll ask Commissioner Bromfield, I've got a couple of questions, but I'll ask her first.

COMMISSIONER BROMFIELD: Q. Thank you, Commissioner Neave, and thank you for your evidence. You mentioned Operation Arkstone, and I gather from that there were people who were in legitimate child-related employment in childcare centres who used their employment to gain access to children and produce child abuse materials.

In your view, is this a vulnerability that institutions that are serving children need to be alert to?
A. They should certainly be alert that that can actually happen. I think we haven't seen the prevalence of it to the extent that we would suggest under Operation Arkstone has given us quite a horrific understanding of that syndicate and what they were doing. I certainly see from the multitude of investigations that we are carrying out, that we aren't seeing, you know, childcare centres for instance targeted as a way to gain access to children, but it certainly is an avenue for offenders to gain access to children and exploit.

Obviously, there's a lot of rigor, guidelines and regimes around employment around childcare centres and schools and the like, but we'd certainly ensure that our engagement with that sector of the community is paramount so that they're aware of vulnerabilities that can occur through some individuals trying to gain employment through childcare centres to get access to children for sure.

Q. Would you consider that risk to be greater in institutions where perhaps there's less other staff present? So, for example, Out-of-Home Care where there may be one or two carers in a household?

1 A. Certainly potentially. I would suggest that any sort
2 of avenues where there are vulnerabilities where there
3 isn't the ability to oversight and gain those insights of
4 vulnerable persons, yeah, every vulnerability like that
5 that exists should be something that is considered.
6

7 Q. In an institution where this vulnerability is
8 exploited and the worst does happen, what is the
9 responsibility of that institution to work with ACCCE to
10 help to identify victims?

11 A. If it's related to online sexual exploitation or
12 online grooming that's translated we would work with either
13 the relevant state and territory JACET that's working in
14 there and the ACCCE would provide that back end support to
15 make sure that they - not only we harvest all the evidence
16 that's available and provide all the Victim Support that's
17 needed, but also the awareness and education raising that's
18 required so we can critically do that through ACCCE to make
19 sure that, if they weren't aware of the online safety
20 parameters and resources available to them, we'll make sure
21 that they are.
22

23 Q. If through child-related employment child abuse -
24 children are accessed and child abuse materials are made,
25 those victims that are identified through that, should they
26 or their families be contacted once they're identified?

27 A. Yes, so they are contacted through the investigation
28 process and that's done by state and by territory and the
29 requirements of connection to parents and carers and
30 victims through that, but the local investigation team, be
31 it through the JACET or other child protection agencies
32 will make those connections and we will just make sure
33 that, from the ACCCE perspective, that we can offer that
34 support as required.
35

36 COMMISSIONER BROMFIELD: Thank you, that's all my
37 questions. Thank you.
38

39 PRESIDENT NEAVE: Q. Thank you, Commander, I have a
40 couple of different questions now. You've spoken about the
41 role that ACCCE plays in terms of a collaborative hub and
42 the relationship it establishes with a whole lot of
43 different groups, including police forces, other
44 organisations in states and territories, academics and so
45 on.
46

47 I wonder if you could talk a little bit more about the

1 challenges that creating those collaborative relationships
2 give rise to and how you've tackled that? I mean, are
3 there structural ways of doing it or what's the best way?
4 And I should say that I'm thinking particularly of having
5 different government departments within a State, for
6 example, which have responsibilities for some aspects of
7 child sexual abuse, and one of the things we will obviously
8 be looking at is how you get people to work together. So,
9 any helpful comments on that we'd find very useful to us, I
10 think?

11 A. Absolutely, thank you, it's a really good question. I
12 think prior to the ACCCE there didn't seem to be that sort
13 of central area where a lot of especially non-government
14 organisations and other agencies such as the school
15 industry or health or the like didn't know where to go
16 nationally to be able to sort of coordinate their efforts
17 on things.

18
19 So what we found was really critical was using
20 individuals that are trained in that engagement piece, so
21 our prevention and engagement team really offers that
22 opportunity so that all the non-government organisations
23 that we engage with have an opportunity to be heard, that
24 they have a responsibility to also input their ideas and
25 steer the way that they want the ACCCE to go.

26
27 We're also governed by a board of management which has
28 all the different agencies involved in listening to how
29 we're sort of developing strategies and also giving
30 approval for some of those strategies and making sure that
31 we are also there to provide assistance to some of these
32 non-government organisations as they're trying to develop
33 their own strategies, their own niche lines that they want
34 to seek government support from and making sure that we're
35 available to provide our experience through there.

36
37 I know that a lot of the non-government organisations
38 particularly, they all vie for funding and it sometimes can
39 be seen as quite competitive because, you know, funding is
40 always a premium when it comes towards making sure that
41 your advocacy and your agenda in that particular
42 organisation has the right resources to perpetuate.

43
44 But what we do through the ACCCE is be able to bring
45 those agencies together and they start complementing each
46 other. So, if one agency is particularly doing like a
47 support stream, then the other agency coming in can say,

1 okay, that's being done, we don't need to go down that
2 line, how about we look at a niche capability such as
3 looking at online services or looking at legislation
4 advocacy, so we can almost divide and conquer by bringing
5 these agencies in together.
6

7 We found that really successful to the extent where,
8 whilst they are all vying for their own funding streams,
9 they'd be far more successful in attaining those funding
10 resources because of the complementary work that they've
11 been able to identify, rather than having multiple
12 proposals go forward with the exact same strategy and
13 agenda.
14

15 Q. So you're saying a whole range of organisations are
16 represented on your board and that encourages the dialogue?

17 A. Certainly. We have a stakeholder group and we have
18 the stakeholder group come together three to four times
19 a year where they join up on, not only the individual
20 strategies but what they want to work collectively on, so
21 it develops that sort of coordination and being able to
22 look at some - you know, one particular organisation might
23 have additional resources in a particular state that they
24 can help another organisation that they don't have as much
25 equity in and the like. And, it doesn't take away from the
26 isolated work that they still have, you know, their board
27 requires them to do, but their work in the ACCCE allows
28 them to look at everyone's opportunities and enhance that.
29

30 I think the biggest challenge for us is that there are
31 quite a lot of organisations out there that want to do work
32 within child protection. We can't possibly bring everyone
33 in on the same agenda otherwise, you know, you're crippled
34 by the enthusiasm in the room, let's call it, but we
35 certainly look for those right agencies that are going to
36 be on board with the collaboration that's required as well;
37 some agencies don't necessarily see the value in
38 collaborating across agencies, they have a very niche
39 requirement so they foster that on their own, which is
40 okay, but we bring those like-minded individuals together
41 and it helps us steer a complementary narrative so that
42 agencies don't feel like they have to identify or come up
43 with new ways to help protect children in the online world
44 or whatever, so they have the access to all those
45 resources.
46

47 And what we've also found as being really valuable is

1 that, again, resources are a scarcity for some of these
2 agencies and whatever we can help build from the law
3 enforcement side to help them connect them to schools,
4 correct them to broader parts of the community, connect
5 them to remote communities, we can foster that for them, so
6 hopefully creating a false multiplication effect for them.

7
8 Q. That's very helpful, thank you. Now, my other
9 question relates to something quite different. This is
10 terribly difficult work for the people who are within your
11 organisation, your centre. What are your policies about
12 circulation of officers? Do you have people moving in and
13 out? Because obviously people build up an expertise but
14 you don't want people to be worn down by the work; if they
15 do it for too long they may become less effective, so how
16 do you balance those requirements of expertise and
17 protection really?

18 A. It's a great question and to be honest, broadly law
19 enforcement grapples with that all the time.

20
21 Q. Yes.

22 A. But what we've found is - first I'll start on with the
23 fact that through the ACCCE we developed a world-leading
24 health and wellbeing strategy to the extent that Interpol
25 have asked for our health and wellbeing strategy and it's
26 all predicated on certainly an opt-in only environment.
27 So, it's one of the few areas within law enforcement,
28 certainly within the AFP, where you can't be forcibly
29 transferred to work in child protection, it's an opt-in,
30 and so you're getting in people that want to be part of it.

31
32 We have in-house psychological and wellbeing support.
33 Everything that was built within the ACCCE, its
34 architecture and its internal design was all predicated on
35 health and wellbeing of individuals, all the way to the
36 extent where we have all the operational work happening on
37 the top floor, and they don't even have a kitchen so they
38 have to go downstairs and work and eat outside their work
39 environment. So, we dissect them away so that there's no
40 bad environments where they're eating in front of, you
41 know, doing their work, so it's all about those little
42 1 per cent things that our psych and health wellbeing
43 experts have told us to do.

44
45 Other aspects is about that really open and frank
46 dialogue that we encourage our members to have with each
47 other. It could be quite confronting for individuals

1 coming in and listening to when they talk about
2 investigative techniques or when they've seen something
3 horrendous online, but the building itself is built around
4 the investigators and the specialists in mind, so they can
5 feel free and discuss this without having to go to another
6 area, you know, or take these sort of issues home or
7 anything like that.

8
9 We have that really open dialogue where individuals
10 who want to leave the area because of other factors, it is
11 a no questions asked; we thank them for their extensive
12 service and help place them moving on from the area, making
13 sure that we're connected to them even post their work in
14 the role so that they don't - so they're not continually
15 affected by it.

16
17 But by and large I haven't seen any research to date
18 that has indicated that actually looking and working within
19 child exploitation material is the causational factor of
20 people having to move on or have stress. Quite often it's
21 all the extraneous factors involved, such as court matters,
22 failed prosecutions, ongoing legislative questions and, you
23 know, leadership bureaucracy which my job is to make sure
24 that I minimise that for them. Often it's those issues
25 that they can't pinpoint about what is affecting them that
26 tends to be the broader issue.

27
28 Our investigators and specialists, they know when they
29 see something horrific online or within a cache of an
30 offender's material, that they don't like it, they don't
31 feel well from it and they can understand why they don't
32 feel well from it, so there's a cause and effect
33 attribution that can happen immediately, but all the
34 extraneous stressors that happen around them that they
35 can't pinpoint about maybe why they don't feel so great
36 that day, that can sometimes translate into additional
37 stressors moving out.

38
39 In our experience, not only in Australia but also
40 globally, people stay in this role for over 20 years. Some
41 of our Interpol colleagues have been working in victim ID
42 specialisation for over 20 years and for them it's making
43 sure that they have the meaning of the work and every time
44 that there's an opportunity to identify a victim or remove
45 a victim from harm or find a perpetrator, it really
46 sustains them. So, we certainly make sure that it's a
47 case-by-case victim, not every individual is cut out for

1 this type of work, and we make no negativity towards people
2 who can't do this role, even if they've joined the police,
3 certainly it's not for everyone but those that are in it
4 they're highly passionate and they do an extraordinary
5 amount of work and we certainly build as much health and
6 wellbeing around them as possible to make sure that it's
7 done on their terms.

8
9 Q. In another context I have observed that sometimes
10 people who are very good at this sort of work but have a
11 whole lot of other pressures like children and all of those
12 sorts of things have to leave because they can't be
13 accommodated because of the other things in their lives,
14 for example, flex time or being able to take time off to
15 take your children on holiday and that sort of thing. How
16 much flexibility is there in the working conditions?

17 A. Complete. We have a very flexible environment where
18 we've got individuals that work, you know, split shifts,
19 they work part-time, and because the online exploitation is
20 truly borderless sometimes the timing of where individuals
21 need to work actually serves us well, because we have our
22 international community that, you know, whilst we're asleep
23 they can pick up the slack and whilst they're sleeping we
24 can do work. So, if we've got individuals that need to
25 work between 10pm and 4am in the morning because that suits
26 their family dynamic, go for it.

27
28 The only difficult thing is that a lot of the work
29 around victim identification and child exploitation
30 material can't be done from home, it needs to be done in
31 the workplace, so that is the limiting factor. This whole
32 evolution that we've had about the work from home concepts
33 has really revolutionised some of the work that is
34 happening outside the online child exploitation field, and
35 certainly there's some work that our members can do from
36 home when it allows for it, like doing up a statement or
37 doing personal administration, you know, time recording and
38 the like, but the actual critical work that they do must be
39 done in the workplace.

40
41 PRESIDENT NEAVE: That's extremely helpful. Thank you
42 very much, Commander, we've really enjoyed your evidence,
43 it's been really interesting, thank you.

44
45 THE WITNESS: Thank you, I really appreciate the
46 opportunity to come and give evidence.
47

1 MS ELLYARD: Thank you, Commissioners, I'll invite you to
2 stand down until after the lunch break.

3
4 **LUNCHEON ADJOURNMENT**

5
6 MS NORTON: I'd like to call Jillian Maxwell and Kathryn
7 Fordyce to give evidence.

8
9 **<JILLIAN RUTH MAXWELL, sworn: [1.41pm]**

10
11 **<KATHRYN LOUISE FORDYCE, affirmed and examined:**

12
13 **<EXAMINATION BY MS NORTON:**

14
15 MS NORTON: Thank you both for joining us to give evidence
16 today. Ms Maxwell, I'll begin with you, can you state your
17 full name, professional address and occupation for the
18 Commissioners.

19
20 MS MAXWELL: The professional?

21
22 MS NORTON: Professional address.

23
24 MS MAXWELL: Jillian Ruth Maxwell, 31 Tower Road,
25 New Town, and I'm the CEO of the Sexual Assault Support
26 Service.

27
28 MS NORTON: Ms Maxwell, you've previously made a statement
29 for the benefit of the Commission dated 22 April 2022; is
30 that correct?

31
32 MS MAXWELL: That's correct.

33
34 MS NORTON: Have you reviewed that statement recently?

35
36 MS MAXWELL: Yes.

37
38 MS NORTON: Do you have any corrections you'd like to make
39 to that statement?

40
41 MS MAXWELL: Just the one that was pointed out around the
42 trauma informed principles.

43
44 MS NORTON: At paragraph 39 of the statement.
45 Commissioners, I should say, Ms Maxwell's statement is at
46 folder C, tab 10, and the correction is in relation to
47 paragraph 39. What's the correction, Ms Maxwell?

1
2 MS MAXWELL: Just that, it's not in relation to harmful
3 sexual behaviours, it's the BlueKnot Foundation
4 trauma-informed principles.

5
6 MS NORTON: So, if we amend that first sentence in 39 to
7 say:

8
9 *When I say trauma-informed, I'm referring*
10 *to the BlueKnot Foundation principles of*
11 *trauma-informed practice.*

12
13 Would that be accurate?

14
15 MS MAXWELL: Yes.

16
17 MS NORTON: Thank you. In every other respect is your
18 statement true and correct?

19
20 MS MAXWELL: Yes.

21
22 MS NORTON: Ms Fordyce, can you now state your full name,
23 professional address and occupation for the Commissioners?

24
25 MS FORDYCE: Kathryn Louise Fordyce, 112 Wilson Street,
26 Burnie, and I'm the Chief Executive Officer of the North
27 and Northwest Sexual Assault Support Service that's also
28 known as Laurel House.

29
30 MS NORTON: Thank you. Now, you've prepared a statement
31 for the benefit of the Commission as well. At this stage
32 that's an unsworn statement, I understand.

33
34 Commissioners, the unsigned version of this statement
35 is at folder C, tab 5, along with exhibits. Ms Fordyce,
36 have you reviewed that statement recently?

37
38 MS FORDYCE: Yes.

39
40 MS NORTON: And is it true and correct in every particular?

41
42 MS FORDYCE: Yes.

43
44 MS NORTON: Would you like to, while you're sitting there,
45 sign the statement so we've got a formal copy of it?

46
47 I might just get you to hand that to Ms Rolfe. Thank

1 you.

2

3 Ms Maxwell, if I could go back to you, would you like
4 to tell the Commission a bit about your professional
5 background relevant to your current role as CEO of SASS?

6

7 MS MAXWELL: Sure. Gosh, it was a long time ago now. I'm
8 a former police officer. I joined in 1988 and left in
9 2001. I studied social work and psychology, two degrees.
10 I worked in community development and education with
11 Volunteering Tasmania and was their state manager for
12 seven years, and then was lucky enough to get this position
13 seven years ago with SASS.

14

15 MS NORTON: Thank you, Ms Maxwell. Ms Fordyce, would you
16 like to give a similar history to the Commissioners,
17 please.

18

19 MS FORDYCE: Sure. I'm a speech pathologist by trade and
20 graduated in 2000, I think, and have worked almost
21 exclusively in the disability sector as a speech
22 pathologist, as a trainer, as a behaviour support
23 practitioner and as a manager of an autism-specific early
24 learning and care centre, and then northwest services that
25 involved supported independent living, community support
26 and Allied Health services. And then, most recently,
27 approximately 12 months ago, took over as the CEO of Laurel
28 House.

29

30 MS NORTON: Thank you, and Commissioners, you will see
31 from Ms Fordyce's statement that she does speak to some of
32 the insights that she has in relation to the particular
33 vulnerabilities of people living with a disability in
34 relation to the risk of child sexual abuse. We won't get
35 to those matters today but it's a very worthy read and
36 there will be a session on disability later in the week.

37

38 What I'd like to focus on to begin with with each of
39 you is to get a sense and to draw out some more detail
40 about the services that SASS provides in the north and the
41 northwest - sorry, SASS in the south, Laurel House in the
42 north and northwest, starting off in relation to the
43 support services, and understanding that there are also
44 primary prevention and there's an educative role as well.

45

46 So, perhaps if I start with you, Ms Maxwell, perhaps a
47 silly question to start with, but where does the north end,

1 the north and the northwest end and the south begin?
2

3 MS MAXWELL: That's not a silly question. Basically, in
4 terms of our counselling and support service which is
5 funded through State Government, similar - well, the same
6 as what Laurel House get, we service the 62 phone district.
7 So, there's a 64?
8

9 MS FORDYCE: 63 and a 64.
10

11 MS MAXWELL: So, 62, so that's how the state's divided in
12 terms of that.
13

14 MS NORTON: Thank you. That's not an answer I was
15 expecting but it's very helpful. If somebody with a 62
16 phone number comes to SASS having experienced a sexual
17 assault, what services can SASS offer to that person?
18

19 MS MAXWELL: Well, initially they come through our intake
20 process and they're triaged, and depending on the wait list
21 as to when they can access a counsellor, we work with the
22 client and try and match them appropriately to an
23 appropriate counsellor, then depending on their needs and
24 the complexity of their trauma and the outcomes they want
25 is to how long they engage with our service. But there's
26 counselling involved and quite often some case management
27 with other services; it could be mental health, alcohol and
28 drugs, police, it could be basically a number of services,
29 so we'll engage with those as well.
30

31 MS NORTON: Ms Maxwell, you say in your statement that
32 SASS currently employs 48 staff, two of whom are full-time.
33 Can you speak to the Commission a bit about the particular
34 qualifications that you look for in counselling staff and
35 any difficulties that you might experience with recruiting
36 people with the right skill sets?
37

38 MS MAXWELL: Sure. I might have to get you to --
39

40 MS NORTON: Of course, one at a time.
41

42 MS MAXWELL: Basically, the counsellors that we employ,
43 the essential qualifications is either a degree in social
44 work, psychology or counselling, and usually they need, you
45 know, a few years' experience in the field and be quite
46 comfortable and knowledgeable around trauma-informed
47 practice, so it's quite a rigorous interview and

1 recruitment process.

2
3 In terms of difficulty recruiting, probably about
4 seven years ago, yes, but probably the last three years we
5 actually have people approaching us from interstate and
6 within the state wanting to work for us and our retention
7 rate is extremely low. So, we've had staff there that have
8 worked for over 10 years and it's not uncommon.

9
10 MS NORTON: Do you have any sense of why that has shifted
11 in more recent years, the ability to attract staff?

12
13 MS MAXWELL: Yes. We've worked really hard on our culture
14 internally. We're a very flexible workplace, hence the
15 reason why most of the staff are part-time, given the
16 nature of the work, and sometimes we've had staff that have
17 worked for us for four days, then they need to take a
18 little step back so they go back to two days and get some
19 other work and then they're ready to step back in, so it's
20 really important for us that we have a really flexible
21 workplace around that.

22
23 We've worked really hard on building a framework where
24 staff can see that there's options for progression and more
25 experience and stepping up into leadership roles, and it's
26 just a great place to work and the staff often comment,
27 especially the new staff coming in and can see why there's
28 lots of experienced staff there that don't want to leave,
29 so we really pride ourselves on culture.

30
31 MS NORTON: Ms Maxwell, in your statement you say that an
32 average caseload for a full-time employee, accepting that
33 most of your employees are part-time, but an average
34 caseload for a full-time employee is 30 clients. Can you
35 give the Commissioners an idea of whether that's a
36 manageable workload, whether it's high, low, in the scheme?

37
38 MS MAXWELL: Well, the average of 30 is manageable. At
39 the moment we're asking them to have more than that because
40 of our wait list. So, you know, there are tensions with
41 that and we have to be aware that there are stressors
42 placed on our staff as a result.

43
44 Quite often - we did some benchmarking interstate and
45 other services usually have KPIs of four clients a day,
46 whereas we only have three because of the case management
47 and the complexity of the trauma and the stories the staff

1 need to hear. We made the decision a few years ago that
2 three was more than enough and the extra work in terms of
3 case management, notes, reports for courts, things like
4 that, also take time.

5
6 And, I was really conscious early on in my CEO role
7 that staff were staying back late catching up, so we felt
8 it was really important that they did it in work time and
9 not be expected to work longer hours.

10
11 MS NORTON: That sounds like a very employee-friendly
12 policy; has it had implications for wait lists at SASS?

13
14 MS MAXWELL: Yes, it has. I think over recent years with
15 our primary prevention work and the fact that we've spent a
16 lot of time promoting our service, and Sexual Assault
17 Awareness Month which has just finished, that's been
18 running for three years, people know that we're out there
19 now, and COVID's had a big impact on us.

20
21 So, for instance, over the last six years we've
22 increased our referrals by 162 per cent, and in the last
23 financial year, not counting this one we've almost
24 finished, of that 162 per cent, 44 per cent was in that
25 one year, and we've already exceeded that this year.

26
27 MS NORTON: You may not be able to answer this question,
28 but can you give the Commissioners any idea about what your
29 current wait list looks like and how long a priority or a
30 less urgent referral might sit on the wait list?

31
32 MS MAXWELL: Sure. We prioritise children, so there's
33 very few children on the wait list, and when I talk about
34 the wait list, it's not like other services where they sit
35 there until there's a counsellor. We have intake and
36 crisis workers who are in constant communication with
37 clients. We offer crisis appointments and help them
38 regulate their trauma responses, and they can call us 24/7,
39 so it's not like they're just sitting there.

40
41 But, to answer your question, we've probably got at
42 the moment around 90 on our wait list, and depending on
43 when we exit other clients, sometimes they're waiting six
44 to eight weeks to access a counsellor - allocated to a
45 counsellor.

46
47 MS NORTON: But in the meantime they will have access to

1 24/7 counselling that's available to anyone?

2

3 MS MAXWELL: Absolutely, and crisis appointments, yes.

4

5 MS NORTON: Can that present difficulties for somebody who
6 comes forward who's dealing with complex trauma and would
7 like to be allocated to someone to work therapeutically on
8 an ongoing basis, can there be difficulties in having
9 access to a one-off crisis appointment where you
10 effectively open Pandora's box and you don't know what's
11 going to come out?

12

13 MS MAXWELL: Yes, it can. I'm not a counsellor and I
14 don't know what happens behind those doors in terms of a
15 therapeutic response, but I do know that, you know, quite
16 often I hear the counsellors talking that clients don't
17 have to tell the whole story, they can just talk about how
18 to regulate their responses, and the counsellors sit with
19 them and do a case management plan on the outcomes that
20 they want. So, it's very diverse and client-centric, but
21 in terms of the crisis appointments, they're really about
22 just helping them regulate and keeping them in a holding
23 pattern until they're allocated.

24

25 MS NORTON: Thank you. And, forgive me, I should know
26 this, but where are your offices based? I know you've got
27 one in New Town; do you have other offices around the
28 state?

29

30 MS MAXWELL: Yes. We have - our main office is in
31 New Town and we have an office in Burnie, but that's for
32 redress, and we have an office co-located with Mission
33 Australia who are our partners in delivering the Harmful
34 Sexual Behaviours Program where we have a worker located
35 there.

36

37 MS NORTON: Whereabouts is that, sorry?

38

39 MS MAXWELL: In Launceston. We also have two workers
40 co-located in the Community Health Centre at Huonville. We
41 have outreach where we have counsellors from New Town going
42 out to the regional areas.

43

44 MS NORTON: Focusing on the support services that you
45 provide, not in relation to harmful sexual behaviours, I'd
46 like to come back to that or the redress services, but
47 therapeutic support services: is access relatively even

1 across the south of the state or are there people in some
2 parts of the south that have greater access issues?

3
4 MS MAXWELL: In terms of access issues, I know that people
5 struggle with transport, so we actually provide free bus
6 tickets or taxi vouchers for them to come to our service.
7 And, sometimes we work with other services that might be
8 engaged with the client and our counsellor will actually go
9 out to that service so the client can access support with
10 our counsellors there so they don't have to travel in.
11 But, I mean, that takes time. You know, when we've got a
12 counsellor travelling, say, to the Southern Midlands, it
13 might mean they only see two clients for the day and not
14 three, so it does impact our service, but we feel it's
15 really important that we go somewhere where the client
16 feels safe and accessible.

17
18 MS NORTON: Thank you. Ms Fordyce, if I can come to you.
19 So, Laurel House is to the north and northwest, what SASS
20 is to the south. Can you talk about your services
21 offering, whether it's comparable to that offered by SASS?

22
23 MS FORDYCE: Yeah. So, in lots of ways lots of the things
24 that Jill has said apply in the north and the northwest.
25 We have three offices, one in Launceston, one in Burnie and
26 a small satellite office in Devonport, and similarly we
27 have counsellors based in those locations that are
28 providing specialist trauma counselling for
29 victim-survivors of sexual assault, including victims of
30 child sexual abuse, and the secondary victims, so family
31 members and other people that have had victims disclose
32 their sexual harm.

33
34 Our team, like Jill's, is comprised of degree
35 qualified social workers, psychologists and degree
36 qualified counsellors. We have, as a senior management
37 team, determined that we may if an appropriate person
38 approached us or applied would consider employing a mental
39 health accredited occupational therapist to add to the kind
40 of diversity of the counselling team, but at this stage
41 occupational therapists and psychologists being in short
42 supply, it's much more difficult to attract those people.

43
44 So, our team, similarly we're offering that
45 counselling support both in our offices but also within
46 outreach locations in a range of locations: George Town,
47 Beaconsfield, Olveston, Smithton.

1
2 We have had some challenges at times accessing or
3 offering outreach supports in some of the more remote
4 locations, so on the West Coast in Circular Head on as
5 frequent a basis as we would like it to be on the East
6 Coast and on the islands, and certainly that's something
7 that, as soon as we're having any challenges with an
8 increase in referrals or some movement of staff, that it
9 becomes more difficult to provide those outreach supports
10 because, like Jill said, you might be travelling for
11 two-and-a-half hours, three hours, if you're heading to the
12 West Coast to see one or two clients; but obviously, we're
13 really cognisant of the fact that people may have
14 experienced sexual violence within the context of their
15 home environment - not that that's relevant to this
16 inquest - but they may not have a safe environment in which
17 to participate in phone or online counselling, and so,
18 outreach services play a really important role in that kind
19 of local support.
20

21 Like SASS, we would offer support and counselling
22 within environments where someone feels comfortable,
23 particularly for children where perhaps ongoing access to
24 counselling would be limited by having to come to our site
25 for counselling. So, we have good relationships with a
26 number of schools across the region where we might provide
27 counselling on site in an appropriate location, which
28 reduces the need for children to have their parents engaged
29 in the process of participating in counselling, but also
30 allows them to kind of not miss out on school in seeking
31 support for the trauma they've experienced through child
32 sexual abuse.
33

34 MS NORTON: Thank you. Are you able to comment on average
35 caseloads? I don't think that's in your statement, you may
36 not have that information to hand, but to the extent you're
37 able to comment on how they might compare to SASS, that
38 would be helpful.
39

40 MS FORDYCE: Sure. Certainly, like Jill, the majority of
41 our counsellors work part-time and we do find that that's a
42 really common experience because of the complexity of the
43 caseloads, because of the nature of the work. Our
44 counsellors often either work part-time or hold another
45 position in perhaps a less challenging environment in their
46 other days where they're not working for us.
47

1 Typically our counsellors would see between three and
2 four clients per day, but then that would differ on other
3 days where they might be doing outreach and seeing two
4 clients per day.

5
6 I wouldn't be able to say specifically what that
7 equates to in terms of the number of clients on a caseload
8 for an individual person, but could come back if that
9 needed to be.

10
11 MS NORTON: Thank you, that's been helpful. You say,
12 Ms Fordyce, in your statement and it's consistent with
13 Ms Maxwell's evidence, that Laurel House prioritises
14 children.

15
16 MS FORDYCE: Yes.

17
18 MS NORTON: And as at 31 March of this year there were 44
19 people on your wait list: 30 in the northwest and 14 in the
20 north. As an aside, is it fair to infer - that's a
21 snapshot in time - but is it fair to infer that access is a
22 bigger issue in the northwest than it is in the north?
23

24 MS FORDYCE: It can vary. So, the current data as at the
25 end of April is 40, so not significantly different. The
26 north, we have more demand for service, it's more
27 population and we have more demand. We probably have had
28 over time more difficulties with recruitment and retention
29 in the northwest, and so, we've been through a period of
30 recruitment over the last six months and that has then led
31 to the fact that we've been a little under-staffed in the
32 northwest comparatively to the north and have been
33 providing support to the northwest from the north, so
34 having staff travel up to provide support in Devonport from
35 Launceston.
36

37 We've now got a number of new staff that are reaching
38 capacity because, like Jill, we're really cognisant of
39 not - this is a really difficult space to work in and
40 providing people with adequate training and supervision and
41 support, and slowly taking on a caseload in order to not
42 burn them out, we want to retain people in this sector,
43 people that are passionate about supporting
44 victim-survivors, and so, that's very much the work that
45 we've been engaged in and so we're seeing I guess the
46 fruits of that now with the number of staff that we've put
47 on in the last little while kind of reaching their

1 capacity. I expect in the next few weeks that that
2 difference between the north and the south will level out -
3 the north and the northwest, apologies.

4
5 MS NORTON: If we just take - so, you said it's 40 on the
6 wait list presently. Do you know whether there would be
7 any children on the wait list currently?

8
9 MS FORDYCE: There would be but, like Jill, we would
10 prioritise children ahead of adults even if there were
11 adults that had significant consequences as a result of
12 their sexual violence, so the wait times for children are
13 much less than they would be for adults.

14
15 MS NORTON: Are you able to give - you may not be, but are
16 you able to give the Commissioners any idea of what you
17 would expect an average wait time to be for a child on the
18 wait list?

19
20 MS FORDYCE: No, I have overall, but I could get that
21 information for the Commission. Overall our children are
22 always prioritised as high, and at the moment with our
23 April data, in the northwest the range of time that people
24 have been waiting in the northwest is between 22 and 33
25 days, and in the north the range of people that have been
26 prioritised as high is between 1 and 10 days that they've
27 been on that wait list for counselling. All of those
28 clients, like Jill's team, have had an initial appointment
29 with an intake and assessment team, they've had ongoing
30 contact from our team in terms of regular check-ins, and
31 they're also able to, like Jill's team, seek a crisis
32 appointment or to dial the 1800 number and get immediate
33 support 24-hours a day.

34
35 MS NORTON: Thank you. You say in your statement, at
36 paragraph 23, that the wait lists at Laurel House are much
37 better now than they were a couple of years ago. Are you
38 able to explain to the Commissioners why they've improved?

39
40 MS FORDYCE: I think, certainly one component of that is
41 that the Department of Communities provided some additional
42 injection of funding to Laurel House and also to SASS for
43 the FY21 year. We also had received some additional
44 funding in the year prior to that in relation to additional
45 injections because of COVID and the recognition that during
46 COVID there was an increase in sexual and family violence,
47 so those additional staffing - additional funds to support

1 staffing is certainly part of the picture.

2

3

4 I think there would potentially be some - there's been
5 quite a bit of movement in the Laurel House team and I
6 think it takes some time for people, like I was mentioning
7 before, to be at their capacity and to be being able to
8 move through caseload in a way that addresses the wait
9 list. So, I think in the last - since I've been the CEO
10 we've done quite a lot of recruitment and the expectation
11 is that we'll be able to kind of keep those wait lists as
12 low as possible, assuming that we don't see dramatically
13 more increases in referrals, but sadly that seems to be the
14 pattern and, like Jill, we've seen considerable increases
15 in referrals year-on-year over the last five years.

15

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MS NORTON: Can I ask you - I'll just throw this question open to both of you - can you speak to the Commissioners about the importance of timely access to support services for survivors, and in particular survivors of child sexual abuse?

MS FORDYCE: I guess we know that victim-survivors, that that first contact that they have or after their first disclosure, the need to provide support and to help them understand what they're experiencing can help to set them up to be successful in their interactions with police, with the medical fraternity, with their family, and a lot of what our team do is support victim-survivors, whether they're children or whether they're adult victims of historic child sexual abuse, has helped them to normalise their experience and to help them understand through psychoeducation that their experience is to be expected when they've experienced something that is not normal.

And so, I think that that support that's provided in those early days that helps them realise that, however they're responding is okay, however they're responding is normal, and that there are people here to help, can just set them up to be much more successful through the course of their recovery.

MS NORTON: Do you have anything you'd like to add, Ms Maxwell?

MS MAXWELL: Yes. I would add that, given that we were a service delivery during the Royal Commission as well, that one thing we noticed, and we still have clients as a result

1 of that, that over the years if they're adults now and
2 they've been victims of institutional sexual abuse, that
3 the stories that we hear of the amount of times they try
4 and seek help and disclose and either feel not heard,
5 believed or silenced, if they're seeking support from a
6 service like ours and they can't access a counsellor for
7 some time, it's just another story they have of delays and
8 feeling unheard and unsupported, so I think it's really
9 important that they have access quickly.

10
11 MS NORTON: I suspect that you would both ideally like not
12 to have wait lists at all. What would it take to reduce
13 your wait lists to zero? Is it just a matter of funding or
14 is it more complex than that?

15
16 MS MAXWELL: For us, we've got a budget submission in, so
17 fingers crossed for the budget later this month, but in
18 that we outline the extra funding we need. We haven't had
19 an increase in core funding that I know of, particularly
20 over the seven years I've been there and even prior to
21 that. Given that our referrals have gone up 162 per cent,
22 I think it's really important that that budget submission
23 is treated seriously. We've outlined that we can get the
24 wait list down to below 10 with the extra increase that
25 we're asking for.

26
27 But I personally feel that the impact that, if we are
28 really serious about primary prevention, and our mission at
29 SASS is to eliminate sexual violence in Tasmania, we'll
30 only do that through education and having a community that
31 feels comfortable talking about consent and talking about
32 sexual violence, but I guess the other end of that means -
33 and we've seen this - that our statistics go sky high
34 because people that haven't been able to talk about that or
35 haven't been able to access a service or know that there's
36 a service there to support them do and they access it,
37 which is really, really important.

38
39 So, I think in the short-medium term we'll see
40 increases, and I think it's important that we collect that
41 data in a way that we represent that to government and
42 they're responsive to that, but in the long-term hopefully
43 with investment in primary prevention we will see it go
44 down

45
46 COMMISSIONER BENJAMIN: Ms Maxwell, just to help me out,
47 you've talked about the figures. You've said there was no

1 increase in core: do I take it that it increases in
2 accordance with the 2.5 per cent or whatever government
3 does each year, but whilst your numbers increased by
4 160 per cent, the core remains pretty well as it is; is
5 that the effect of that?
6

7 MS MAXWELL: Yes, correct, yes.
8

9 COMMISSIONER BENJAMIN: And then you get special funding
10 for other bits and bobs?
11

12 MS MAXWELL: Correct.
13

14 COMMISSIONER BENJAMIN: But it may dry up at the end of
15 the period.
16

17 MS MAXWELL: Yes, well, there's a lot of work to be done
18 approaching the three-year contracts to ensure that we
19 still have funding to deliver services and keep our
20 qualified staff, so there's a lot of work involved.
21

22 COMMISSIONER BENJAMIN: Ms Fordyce, I note you're nodding
23 your head as well; does that apply?
24

25 MS FORDYCE: Yes, Jill's been in her role longer and
26 understands the history of the funding. Similarly I
27 imagine our funding has been the same in terms of no
28 increase in core funding, but these last few years we've
29 had this top up one-off funding given to us by the State
30 Government that has allowed us to address - and Jill got
31 some of that funding as well - has allowed us to address
32 kind of part of the increases that we're seeing, but yeah,
33 we definitely, like SASS, would like an increase in our
34 core funding.
35

36 COMMISSIONER BROMFIELD: Just to follow up from that,
37 I believe that there were some challenges in terms of staff
38 attraction and retention when it is annual one-off funding.
39

40 MS MAXWELL: Well, I mean, you know, while we're
41 appreciative of any money we get, and the one-off funding
42 we got last year from State Government was great and it
43 hugely helped, but staff - until the budget's released and
44 we know whether that's continued, staff worry about their
45 roles, yeah.
46

47 MS NORTON: Thank you. I'd like to now ask you some

1 questions about institutional child sexual abuse which is,
2 of course, the focus of this Commission of Inquiry, and I
3 do so appreciating that your clients presumably, your
4 institutional clients, comprise both children who have made
5 recent reports of child sexual abuse and adults who have
6 come forward as adults to report child sexual abuse during
7 their youth.

8
9 Are you able to each give the Commissioners a sense of
10 the proportion of your clients who come from a background
11 of institutional abuse as opposed to another type of sexual
12 abuse or setting?

13
14 MS FORDYCE: I can certainly make some very basic
15 assumptions.

16
17 MS NORTON: Thank you.

18
19 MS FORDYCE: So, I guess implementing a trauma-informed
20 approach, we sometimes don't - or quite often don't ask for
21 the specifics of the perpetrator or the location of the
22 abuse; the focus, I guess, of the trauma-based counselling
23 is really to support the sequelae of consequences of the
24 abuse, so sometimes that means we don't have the specifics
25 of who was the perpetrator.

26
27 The data that we have for people that are currently
28 accessing our counselling is that we only have data about
29 the perpetrator in 53 per cent of the cases, and only a
30 small subset of those have indicated perpetrators that are
31 from institutional settings. So, we could certainly do a
32 lot more analysis and get to more detailed figures, but it
33 is a much smaller subset than sexual abuse of children that
34 is occurring by known perpetrators that are within family
35 settings or within other contexts.

36
37 MS NORTON: Thank you, and Ms Maxwell, is it a similar
38 picture at SASS?

39
40 MS MAXWELL: Yes, it is, yes.

41
42 MS NORTON: Can I ask you both to speak, to the extent you
43 are able to, about the particular impacts that
44 institutional child sexual abuse can have on a child both
45 as children and through their lives and comparing it, to
46 the extent the comparison is available, comparing it to
47 abuse in other settings?

1
2 MS MAXWELL: I think that's difficult because it doesn't
3 matter what type of sexual abuse somebody experiences, it's
4 extremely traumatic and the trauma that they experience,
5 whether it's high or low, is right for them. But in terms
6 of the child sexual abuse particularly in institutions, I
7 know for our service over the years we provide a service to
8 Risdon Prison and we started off with a counsellor just
9 visiting part-time over there and it's grown so much we've
10 got three counsellors almost full-time going to the prison
11 to provide services to prisoners that have been victims of
12 child sexual abuse in particular and, as a result of that
13 abuse, they're finally seeing that the choices they've made
14 in their lives have resulted in where they're living at the
15 moment. So, it has a huge impact on their lives and quite
16 a lot of the ones that we've seen were victims of child
17 sexual abuse within Ashley historically. So, there's a
18 lack of trust with institutions, a lack of - high
19 dependency on drugs and alcohol to cope with their trauma,
20 and hence the life of crime, so yeah, it has a big impact.

21
22 MS NORTON: Ms Fordyce, anything to add, and in particular
23 in relation to that idea of institutional betrayal and the
24 compounding effect that that can have on a victim-survivor?

25
26 MS FORDYCE: Yeah, certainly I think any victim of child
27 sexual abuse has an experience that somebody that should
28 have been caring for them, that somebody that was an adult
29 and that should actually have the best interests of
30 children at the heart of their interactions has betrayed
31 them and I think that for the victims of child sexual abuse
32 within institutional settings, I guess there's sometimes
33 some solace in that it wasn't a family member; you know, it
34 wasn't somebody that you necessarily have to maintain an
35 ongoing relationship with, which in some cases in familial
36 child sexual abuse that may need to be the case.

37
38 Whereas, I guess, the distrust in institutions, the
39 distrust then, I guess, in how that institution handled the
40 sexual assault and then the confidence in any further
41 systems that might proffer to offer support is, I guess,
42 much more impacted and so that confidence that the
43 victim-survivor may have in any institution, whether it's
44 government or otherwise, that they will act in the best
45 interests of that person is really damaged and can have all
46 of the consequences that Jill has talked about.

47

1 MS NORTON: Ms Maxwell, in your statement you talk - I'd
2 like to talk about some issues that arise in particular
3 institutional contexts, and you mentioned before Ashley
4 Youth Detention Centre. In your statement, at about I
5 think it's paragraph 55, you talked about the need for
6 community-based organisations to have in-reach, if you
7 like, to provide therapeutic treatment to young people in
8 institutions like Ashley. Can you talk about the reasons
9 why that's particularly important?

10
11 MS MAXWELL: An example is how we've developed over time a
12 working relationship with, say, the prison, and that took,
13 you know --

14
15 MS NORTON: Sorry, Ms Maxwell, I'll stop you there. This
16 is the program in relation to Risdon, the adult prison?

17
18 MS MAXWELL: Yes, that's correct, and that took several
19 years of developing trust, not only with the staff there
20 and establishing our credibility, but also with the inmates
21 themselves, and most of our referrals from there now are
22 through word-of-mouth.

23
24 Over the years we've had clients come to us as a
25 result of being victims of child sexual abuse within
26 Ashley, and that can be historically or, you know, as
27 recent as the past five years. And, I can't see why a
28 detention centre for young people can't work in a similar
29 model as to one for adults, where they allow specialist
30 organisations like us in to work therapeutically with the
31 survivors in there, and that way they're developing that
32 rapport and relationship with our counsellors, so when
33 they're released from the centre they've already got that
34 and they're not having to wait until they're released to
35 engage, because it just doesn't happen. So, I just feel
36 quite strongly that there should be specialist services
37 being able to access and having the young people referred
38 to those services and going in and supporting that.

39
40 MS NORTON: It sounds like you can't see an in principle
41 reason why that in-reach model couldn't be available
42 through Ashley or indeed one of the new centres that's due
43 to replace Ashley?

44
45 MS MAXWELL: Correct.

46
47 MS NORTON: You say in your statement that you've offered

1 in-reach services to Ashley over the years but those offers
2 haven't been taken up. Do you have any insight into why?

3
4 MS MAXWELL: No.

5
6 MS NORTON: Ms Fordyce, do you have any comments you'd
7 like to make about provision of services within Ashley? I
8 know that you talk in your statement at paragraph 66 about
9 a program that Laurel House recently ran at Ashley in
10 relation to harmful sexual behaviours; would you like to
11 tell the Commissioners about that?

12
13 MS FORDYCE: Yeah, sure. I think, in relation to Ashley
14 and any Out-of-Home Care setting and, you know, potentially
15 youth detention in the future, I think what needs to be
16 recognised is that children often don't disclose sexual
17 abuse until they're older, and I think that there needs to
18 be a focus - I know that Michael Salter talked about this
19 yesterday - around secondary prevention and recognising
20 that there is a subset of members of the community, young
21 people, that are at higher risk of having either
22 experienced sexual violence, sexual abuse, or likely to
23 experience sexual abuse in the future either in an
24 institutional setting or from their peers in an
25 institutional setting, or in future relationships, and I
26 think that it's really critical that that therapeutic
27 support is offered to address the range of needs of young
28 people.

29
30 I think the program that we offered was not
31 specifically about harmful sexual behaviour, it was more
32 about kind of exploring consent, exploring inappropriate
33 sexual behaviour, talking to the young people about, you
34 know, how they may best interact with their peers and with
35 others; more of a primary prevention focus than
36 specifically addressing, you know, developing a plan about
37 harmful sexual behaviour in the sense of how other harmful
38 sexual behaviour programs would be addressed.

39
40 I think in that setting the feedback was really
41 positive, that the staff appreciated the opportunity to
42 have other people provide perhaps some of the same
43 encouragements and coaching that they may have been
44 offering around appropriate interactions with peers and
45 with staff, and I think that openness that members of our
46 team, and I imagine Jill's team, in being able to talk
47 frankly and fearlessly with young people about their rights

1 about consent, about what's okay and what isn't, as well as
2 then doing that in a trauma-informed way that provides them
3 with pathways to support, that that kind of holistic
4 wrap-around support that's not only addressing the support
5 needs of the young people but it's supporting the other
6 people that are supporting the young people, so every
7 opportunity throughout a day is a learning opportunity or
8 an opportunity to reinforce those good messages about
9 consent, because that kind of sheep dip approach of going
10 in and providing a program and then leaving, and then not
11 building the capacity of the people within that service,
12 whether it's a school or Ashley or any service, is having
13 everybody talking from the same song sheet and supporting
14 children and young people and the staff around the
15 expectations, is what I believe is really critical.
16

17 MS NORTON: It sounds like you would agree then that
18 there's certainly scope for more interaction between
19 external services and Ashley Youth Detention Centre?
20

21 MS FORDYCE: Absolutely.
22

23 MS NORTON: Can I ask you both about conflicts of interest
24 in small communities; this is possibly a bigger issue in
25 the north and northwest, though I'm sure it comes up in the
26 south as well. How do services like yours deal with - I'll
27 just give you a hypothetical. We'll be hearing later in
28 the Commission's hearings about James Griffin. Now, he was
29 a very well-known person within the Launceston community.
30 If, say, at Laurel House you had somebody come forward, a
31 victim-survivor come forward to one of your counsellors and
32 disclose, and that counsellor happened to know Mr Griffin,
33 or indeed any perpetrator, how would that be dealt with at
34 Laurel House?
35

36 MS FORDYCE: Because all of our counsellors
37 are degree-qualified and typically they're registered with
38 their professional organisation, they're all bound by Codes
39 of Ethics in relation to how they may declare conflicts of
40 interest, and then we obviously have within our own
41 organisation conflict of interest policies that make it
42 clear that people need to disclose in an intake meeting.
43

44 So, typically we would receive a referral. What would
45 happen is, the nature of the victim-survivor, you know, who
46 they are and who their parents are and what details we know
47 would be talked about with our counselling team. If people

1 know that particular victim or their family or have got
2 some kind of association with the perpetrator, they would
3 not be allocated to that client.
4

5 So, often as much information as we can have at that
6 intake point is really critical because, particularly in
7 northwest Tasmania, and we've got a number of counsellors
8 that have been lifelong northwest residents, so they are
9 connected to the community and know lots of people, so
10 there's lots of very careful monitoring of that.
11

12 Also then, as the therapeutic relationship emerges we
13 may get more details about a perpetrator or other
14 relationships that become, as the victim-survivor feels
15 more comfortable to share details, we may become aware that
16 a conflict of interest exists and at that point our
17 counsellors would use their judgment as to whether that
18 moment is an appropriate time to have that disclosure; they
19 would typically try and wrap up a conversation and then
20 they would seek support from the seniors in the team as to
21 how we're then going to manage that moving forward. And
22 then that most often would then involve a discussion with
23 the client about the conflict of interest but in a way
24 that's kind of managing the level of distress and providing
25 reassurance around our role and our professional
26 responsibilities in relation to being confidential and not
27 sharing any information that has happened in counselling.
28

29 Our counsellors would provide information at that
30 initial stage in terms of what the limits of
31 confidentiality are as well, particularly I guess when
32 we're working with young people, children and young people,
33 where we have mandatory reporting obligations. Those
34 conversations are had with young people very early in the
35 interactions or with parents of children very early on so
36 that they're aware that there may be times that we need to
37 share information that has been talked about in a session,
38 but certainly that that would not involve engaging with
39 sharing any information with perpetrators that they might
40 disclose in an appointment.
41

42 MS NORTON: Thank you, and Ms Maxwell, anything you'd like
43 to add about conflicts of interest?
44

45 MS MAXWELL: Well, I support what Kathryn said. We're
46 pretty clear at SASS that the client is our focus. So, we
47 have safeguarding children and safeguarding adult client

1 policies. Counsellors have case reviews regularly with
2 their senior practitioner. Similar with intake, you know,
3 the more information we get, we try and allocate to the
4 appropriate counsellor. So, we have a pretty rigid process
5 in terms of, what we do is for the client. So, if we saw a
6 conflict of interest, we would act in the best interests of
7 the client rather than anybody else.

8
9 MS FORDYCE: If I may?

10
11 MS NORTON: Yes.

12
13 MS FORDYCE: I guess some of the challenges that we've
14 experienced in regional and remote locations often relates
15 to the challenge that we have in terms of trying to create
16 access to service, so by having, say, outreach at a
17 location that would be accessible to clients, but then
18 maintaining the confidentiality of those victim-survivors.

19
20 So, [REDACTED] one of our counsellors engaged with a man
21 who was Aboriginal. We indicated that we might be able to
22 offer outreach services in a location that would be more
23 culturally sensitive for him, and he indicated that that
24 wasn't something that he wanted because there was, you
25 know, I guess a risk in that, that people may be alerted to
26 his experience of having experienced child sexual abuse.
27 So, there's a really fine balance around that, and I guess
28 in regional and remote areas that experience in reporting
29 to police as well, in terms of, often police, you know,
30 they're connected.

31
32 You know, when somebody parks their car outside the
33 police station in the small regional and remote locations,
34 people know whose car's whose, and so some of those things
35 are not as anonymous as victim-survivors may want them to
36 be initially, and I think there's also a real balance for
37 us around wanting to create an environment where
38 victim-survivors know that it's not their fault and that
39 they don't have to be ashamed to come to a service that has
40 Laurel House on the door or is about them seeking support
41 for the sexual harm they've experienced, but also
42 maintaining their anonymity while they need and want that
43 anonymity. So, yeah, the regional aspects are much more
44 complicated in that regard.

45
46 MS NORTON: Understandably. That probably leads in quite
47 nicely to another topic that I wanted to discuss, which was

1 Multi-Disciplinary Centres. It strikes me in what you're
2 saying that having a one-stop-shop to access a range of
3 services might be one way to overcome some of those
4 barriers concerned with anonymity.

5
6 I know, Ms Maxwell, you talk about the importance of
7 Multi-Disciplinary Centres in your statement, would you
8 like to elaborate for the Commissioners?

9
10 MS MAXWELL: Sure, it's a little bit redundant now given
11 the recent announcements by government, but they've agreed
12 to establish two centres at this stage here in the south
13 and the north. We've been advocating for this for probably
14 six out of my seven years in SASS. I was fortunate enough
15 to go and look at some of the centres in Victoria
16 many years ago, and so, government have now committed to
17 the Multi-Disciplinary Centres.

18
19 There are so many advantages as you're probably aware,
20 but for me it's how a survivor can walk through the door
21 accessing our service and, working with a counsellor - and
22 sometimes, you know, it's taken us several years for a
23 person to be ready and want and choose to report to police
24 and seek justice through that process, and to navigate
25 separate buildings, separate suburbs, different people all
26 involved retelling stories; that doesn't happen in a
27 Multi-Disciplinary Centre, that all happens with ease -
28 well, that's the idea of it. So, we are huge fans of this.

29
30 My only concern is that the funding for the
31 Multi-Disciplinary Centres, if they're going to be
32 state-of-the-art and house the appropriate services, I'm
33 not sure the funding allocated at the moment will do that,
34 but hopefully through the pilot that will highlight where
35 more money needs to be spent; but, yes, that's already been
36 announced, so very excited.

37
38 MS NORTON: I'm sure. One potential model as I understand
39 it that's being considered would see a single
40 Multi-Disciplinary Centre for victims of sexual abuse,
41 child abuse and family violence: do either of you have any
42 comments or concerns about the co-location of services for
43 people in those different cohorts?

44
45 MS MAXWELL: No, I don't, no. You know, the centres on
46 the mainland, all the Sexual Assault Service, the Support
47 Service, is co-located. I'm not sure that will happen here

1 given that the money committed, we might not be able to do
2 that, which is a concern for me, but I'll go with what I've
3 got. But on the mainland they've got all their service.
4 So, for instance the one in Geelong, they've got the whole
5 Sexual Assault Service in there, and then they merged with
6 Family Violence, they've got police, Child Safety, so I
7 don't see any issue with that at all.

8
9 PRESIDENT NEAVE: There is one issue that I perhaps might
10 ask you to comment on in relation to that, and I'm familiar
11 with the MDC in Geelong.

12
13 One concern is that family violence can swamp the
14 sexual assault area because there's more family violence
15 than there is sexual assault, or at least child sexual
16 assault; did you want to make any comments on that?

17
18 MS MAXWELL: Sure. I think it's going to be really
19 important that we're aware of the learnings. For us, it's
20 really important that we are seen as a specialist service
21 outside of family violence.

22
23 PRESIDENT NEAVE: Yes.

24
25 MS MAXWELL: We've got probably a quarter of our clients
26 that experience either currently or historically family
27 violence where sexual assault's been intertwined in that,
28 but there's so much external, so I think it's going to be
29 really important that we work and be conscious of that
30 up-front.

31
32 PRESIDENT NEAVE: Right, okay. Thank you.

33
34 MS NORTON: Ms Fordyce, I wanted to ask you a question.
35 You said Multi-Disciplinary Centres are one way in which
36 trauma-informed practices can be used. You also give an
37 example in your statement of a great example of
38 trauma-informed policing. You don't need to worry about
39 getting all the detail right because, of course, it's in
40 your statement, but if you could give the Commissioners an
41 overview of that particular interaction and why it was so
42 beneficial for your client?

43
44 MS FORDYCE: Sure. I guess that the circumstance happened
45 in the northwest Coast, and I think that the nature of
46 small numbers of staff in our team, small numbers of
47 police, we're able to establish really strong working

1 relationships in a way that means that it is very common
2 that police will come and take statements at our building
3 when, like Jill has mentioned, you know, after considerable
4 contact with our counsellors a victim-survivor is ready to
5 do so.
6

7 And so, in this particular instance I had a previous
8 knowledge of this particular client and the counsellor was
9 absent, so I sat in on this police interview, which would
10 be quite unusual given my role usually. But the experience
11 that I had was that this particular police officer offered
12 choices throughout, you know, spent a lot of time engaging
13 with this particular individual who had a disability around
14 their interests throughout requested consent, to where the
15 police officer sat, just at every point the principles of
16 trauma-informed care were being undertaken.
17

18 The police officer was really clear about their
19 choices, really clear about their role, and did so in a way
20 that immensely respected the person for their bravery, told
21 them that they believed them, that they were going to
22 investigate this further, and created an opportunity for
23 that particular victim-survivor to disclose some historical
24 sexual abuse that the counsellor was not aware of, you
25 know, so the nature of that exchange was incredibly
26 powerful to see, somebody who is working within the
27 constraints and the processes of the police system but
28 doing so in a way that is bringing all of that learning
29 into how to really create a trusting and respectful
30 relationship and a relationship that gives the power back
31 to the victim-survivors where they, through the abuse, have
32 lost some of their power.
33

34 MS NORTON: Ms Maxwell, I'm interested to get your
35 comments on that, particularly having regard to your
36 experience, your past experience as a police officer. Do
37 you have anything you'd like to say to the Commissioners
38 about the importance of trauma-informed policing and
39 perhaps, you know, what the dangers are where a
40 trauma-informed approach isn't taken by police.
41

42 MS MAXWELL: Oh, that story warms my heart. I mean, I
43 know that, given my background, I've worked with our staff
44 to talk about how when we're present with interviews with
45 police that we can support that trauma-informed process,
46 and the majority of the time it's a similar experience.
47

1 You know, in my experience as part of SASS, not part
2 of my previous occupation, is that police are so committed
3 to justice for the victims, they just have a different role
4 to play to our service and our staff and when it's done
5 well, which is most of the time, the survivor feels
6 empowered to tell their story; whether it's the outcome
7 down the track that they may expect or not, I feel it's
8 really important that those relationships between our staff
9 and police - it could be Child Safety, it could be anyone
10 involved in the story of that survivor - works
11 collaboratively for that survivor and in my experience that
12 happens most of the time.

13
14 MS NORTON: Thank you. I'm conscious of the time. I'd
15 just like to ask a few questions about therapeutic
16 interventions for harmful sexual behaviours.

17
18 Commissioners, we will be having another session on
19 this next week with Ms Maxwell's colleague, Ms Pepper, so
20 I'll leave a lot of the content for that, but I would just
21 like to understand a bit about the delineation of service
22 provision in the state currently.

23
24 As I understand it from your statement, Ms Maxwell,
25 SASS recently, a year or so ago, received funding for a
26 two-year pilot whereby you funded to provide therapeutic
27 interventions among other supports in relation to harmful
28 sexual behaviour statewide. Is that correct?

29
30 MS MAXWELL: That's correct.

31
32 MS NORTON: How does that differ from your service
33 offering for therapeutic interventions prior to the funding
34 being provided?

35
36 MS MAXWELL: Prior to the tender for harmful sexual
37 behaviours as a stand-alone program we were funded to
38 provide a program for children up to the age of 11 that
39 were impacted by either problem sexual behaviour or harmful
40 sexual behaviours, but we increasingly saw that those from
41 12 to 17 impacted by the harmful sexual behaviours had
42 nowhere to go, or the ones committing or perpetrating those
43 behaviours, had no treatment program and we felt it was
44 really important and advocated for some time.

45
46 We probably over the last four years had our staff
47 trained under the AIM Project which Ms Pepper will talk at

1 length about no doubt, and it's the best practice model
2 from the UK, in anticipation that there would be a program
3 eventually for those up to the age of 17. And, thankfully
4 there was.

5
6 For us, we've got a whole program that delivers that
7 statewide. We can't advertise that fact at the moment
8 because it's a set amount of funding and we're at our
9 capacity with that now. And, we've only got until April
10 next year before we know whether that's continued, so it's
11 a similar funding model; it's difficult when, you know,
12 it's short funding. We set up programs like this not
13 knowing whether they continue, but fingers crossed, there's
14 certainly a need for it and we're really proud of the work
15 that we do with it.

16
17 MS NORTON: Can I ask you: having a statewide remit
18 obviously allows you to provide continuity of service
19 throughout the state, which is a positive. Do you have any
20 concerns about access issues for people in more remote
21 areas? If you have a young person in Stanley on the
22 northwest coast, do they have access to the same sorts of
23 therapeutic interventions as a peer in Hobart, for example?
24

25 MS MAXWELL: Yes. We have a worker that's based in
26 Launceston that travels across the coast, and I know she
27 does home visits and visits with other services and meets
28 young people. But, like I said, we're just relying on the
29 fact that people are aware and the referrals are coming
30 through. But, if the referral's picked up, there would be
31 issues with access, yes.

32
33 PRESIDENT NEAVE: How many young people in that 12 to
34 17-year-old age group, how many are you able to include in
35 that program?
36

37 MS MAXWELL: Ms Pepper would be able to answer those
38 questions, because she's the one that actually oversees and
39 directs that program.
40

41 PRESIDENT NEAVE: Thank you.
42

43 MS NORTON: I'd just like to give you an opportunity to
44 comment, Ms Fordyce. I understand from your statement that
45 Laurel House also provides therapeutic interventions to
46 children and young people in the north and northwest; how
47 does your service provision interact with the offering that

1 SASS provides?
2

3 MS FORDYCE: Yeah so, like Jill said, historically the
4 funding has allowed us, I guess, to a certain extent to
5 provide support for children under 12 who exhibit harmful
6 sexual behaviour or problematic sexual behaviour. I guess
7 there are circumstances where we might engage with that
8 funding, may still be providing support to slightly older
9 children or children with a disability who perhaps have
10 significant delays and where we've got a therapeutic
11 relationship, so we may continue to engage with them in
12 delivering support in relation to their harmful sexual
13 behaviour and in relation to providing support and
14 education to the people around them, the parents and
15 teachers and others.
16

17 Certainly with the introduction of the new funding
18 that SASS was successful in receiving, you know, it does
19 address a gap that was really significant, and our team's
20 experience was that the support was really ad hoc for
21 children aged 12 to 17; you know, people didn't get the
22 support - young people didn't get the support they need,
23 teachers and families didn't get the support they needed in
24 order to feel that the children's needs were being
25 addressed and the needs of their peers were being
26 addressed.
27

28 I guess, because the program is new, the SASS program
29 is new, there's still some interface challenges that we're
30 still trying to work out and work through because, you
31 know, some children who are exhibiting harmful sexual
32 behaviour at 14 may be clients of Laurel House or they may,
33 through the harmful sexual behaviour program it may be
34 identified that they've experienced sexual harm and ongoing
35 support might need to be offered by Laurel House, and so,
36 there's still some work to do which is not a surprise.
37 When any new program that comes into an existing service
38 system is, how do we do those referrals and how do we work
39 out the interface.
40

41 I mean, I certainly would be keen to see, and we're
42 working to have our team trained in the same AIM model and
43 to build some consistency across the state, that a lot more
44 funding be offered across the state and that Laurel House
45 too would be able to offer services in this space, I guess
46 in particular because we know that delivering services in
47 the regional and remote parts of the state are already

1 difficult enough, so being able to develop relationships
2 with schools, with the communities, us being able to when
3 we're already in Smithton delivering services be also able
4 to do some of the other supports, I think, would be really
5 advantageous and would benefit the community and
6 particularly teachers and families and the young people.

7
8 MS NORTON: Thank you. Commissioners, that concludes the
9 questions I had for Ms Fordyce and Ms Maxwell. If there's
10 anything you'd like to ask?

11
12 PRESIDENT NEAVE: Thank you.

13
14 COMMISSIONER BENJAMIN: Very briefly, Ms Maxwell, you told
15 us about the arrangements and the trouble you had to get -
16 not trouble, that's the wrong word - but the negotiating
17 you had to get into Risdon. If and when the State
18 Government sets up the two new Ashleys, excuse the
19 expression, is it your view that access by you and Laurel
20 House, entitled access, would offer another and better
21 level of protection for the young people in those
22 institutions?

23
24 MS MAXWELL: I'm not sure about better level of
25 protection; I think Child Safe Organisations, we all have a
26 responsibility if we're engaging with children no matter
27 what, so I don't think that would be up to SASS to say to
28 another organisation they're not fulfilling those
29 obligations. I think, having --

30
31 COMMISSIONER BENJAMIN: I think you misunderstand my
32 question, I'm just thinking that there might be another
33 level or another degree of protection; they would have
34 their own protection, but having someone independent going
35 there, would that be advantageous to those young people?

36
37 MS MAXWELL: I think our role would be to go in if there
38 was a young person that needed our support in relation to
39 experiencing either harmful sexual behaviours or sexual
40 assault, so I think that's what our role would be.

41
42 PRESIDENT NEAVE: So, it would be to offer trauma-informed
43 counselling to children who are in those places that needed
44 the help, yeah?

45
46 MS MAXWELL: Absolutely and, you know, as with any client,
47 if there's advocacy and other work to be done, we would

1 engage other stakeholders in that, but yes.

2
3 MS FORDYCE: If I may? I think that, with respect to
4 Jill, I think that it is bigger than that. I think that
5 there is a role for SASS and for Laurel House to play in
6 creating environments where children are able to disclose
7 and that the visibility of people that are trusted, either
8 being in there delivering consent education or being in
9 there, you know, consulting and advising and training, or
10 just being visible - not on the basis of a referral but
11 being present and being on site, so that almost I guess
12 it's kind of professional loitering, is kind of the term
13 that we used to use as speech pathologists; you know, you
14 would be at a child and family centre and you would just
15 professionally loiter in the hope that you would be there
16 to catch a moment.

17
18 And so, I think that that visibility helps to promote
19 children and young people to disclose, but it also then
20 allows I guess a level of, not oversight, but it's
21 sunlight, I guess: that, you know, you're there and things
22 that may happen where there's not an outsider present may
23 not happen if there's an outsider present, and so, I think
24 that there's a role that we as our services could play in
25 those kinds of services moving forward.

26
27 PRESIDENT NEAVE: What about a role in educating staff?

28
29 MS MAXWELL: Yes.

30
31 MS FORDYCE: Absolutely, without question.

32
33 COMMISSIONER BROMFIELD: Actually, on the topic of
34 education: Ms Fordyce, I believe it was you who used the
35 sheep dip analogy about consent, education and respectful
36 relationships education, and you noted the importance of
37 being able to really follow up and reinforce the learning.
38 I just wanted to ask and, Ms Maxwell, you may want to
39 comment on this as well, whether your current funding for
40 primary prevention in schools allowed you to do more than
41 the sheep dip approach?

42
43 MS FORDYCE: Absolutely our funding does not allow us to
44 do anything more than that, and in fact, it doesn't even
45 really allow us to do the sheep dip. And I guess what
46 happens for Laurel House is that, as soon as we've got any
47 kind of increase in referrals, we're kind of very quickly

1 diverted to responding to the immediate need of the
2 victim-survivors who have disclosed, which is certainly not
3 where we want to be placed but it is kind of the reality of
4 where we're placed.

5
6 So, yeah, that whole being able to work with - and
7 I've had some really great conversations in the last little
8 while with senior members in the Department of Education
9 about how do we create whole-of-school cultures that help
10 children and help parents and teachers to better understand
11 consent and respectful relationships and people's
12 responsibilities for, you know, how to respond to a
13 disclosure in a trauma-informed way, how to then, you know,
14 direct people, supporting people in relation to their
15 mandatory reporting responsibilities, but also just in
16 terms of ensuring that young people and children and young
17 people get the follow-up care that they need.

18
19 So, those conversations are really fruitful and
20 positive that we're talking about whole-school approaches
21 rather than a sheep dip approach; that, while it may be
22 useful for individual children and they get a lot of
23 benefit out of that, those every day conversations are just
24 so critical, that every interaction that adults are having
25 with children are reinforcing their rights to their bodily
26 autonomy and their right to articulate their consent, and
27 addressing importantly the drivers of sexual violence which
28 are, you know, gender inequality and addressing other
29 inequality and really challenging those things when they
30 occur as well.

31
32 MS MAXWELL: I guess a great example for us is that I
33 guess about six years ago we piloted our own primary
34 prevention consent as a conversation, unfunded with a high
35 school down here in the south, and then used their feedback
36 from the students and teachers to refine it and we got
37 funding, and so, our funding allows us to go into four
38 schools a year and that's been going for five years, five,
39 six years. It's been hugely successful and it's one where
40 we go in, and there's about six modules. We teach all the
41 students and we give the teachers and health staff located
42 at those schools a session as well so they are equipped to
43 deal with disclosures and understand the content when we
44 step out, and we also offer that to parents as well.

45
46 But with that particular high school, we've been going
47 back sort of as a thank you for road testing it at the

1 start; we've been going back every year and doing that
2 unfunded and the staff often comment that they've seen
3 quite a cultural change with us going back and topping up
4 the knowledge for those that have undergone our program,
5 but then the new students coming in, the Grade 7s, go
6 through the full program, so it's been really useful but
7 it's resource-intense if we were to do that. Like, our
8 goal would be to be in every school, but it's
9 resource-intense.

10
11 PRESIDENT NEAVE: Did you say four schools per year?

12
13 MS MAXWELL: Yes. Under the consent is a conversation;
14 under the harmful sexual behaviours one, there's extra
15 schools that we do under that funding, yes.

16
17 PRESIDENT NEAVE: Thank you very, very much indeed, that
18 was really a very helpful session, thank you, and you're
19 excused now.

20
21 MS FORDYCE: Thank you.

22
23 MS MAXWELL: Thank you.

24
25 **SHORT ADJOURNMENT**

26
27 MS ELLYARD: Thank you, Commissioners, the next session is a
28 panel involving Professor Brett McDermott and Dr Catia
29 Malvaso, I'll ask them both to come into the witness box
30 and take the oath or affirmation.

31
32 **<BRETT MICHAEL CHARLES MCDERMOTT, affirmed: [3.22pm]**

33
34 **<CATIA GAETANA MALVASO, affirmed:**

35
36 **<EXAMINATION BY MS ELLYARD:**

37
38 MS ELLYARD: May I invite you both to take off your masks
39 now that you've been sworn in for the ease of understanding
40 the evidence you're going to give. May I begin with you,
41 please, Professor McDermott, can I ask you to tell the
42 Commission again your full name?

43
44 PROF MCDERMOTT: Brett Michael Charles McDermott.

45
46 MS ELLYARD: And you are, by profession, a psychiatrist
47 and a Fellow of the College.

1
2 PROF McDERMOTT: That's correct.
3
4 MS ELLYARD: Your current roles include the role as the
5 Statewide Specialty Director for the Child and Adolescent
6 Mental Health Service in Tasmania.
7
8 PROF McDERMOTT: That's correct.
9
10 MS ELLYARD: And you're also a Professor of Psychiatry at
11 the James Cook University and the University of Tasmania.
12
13 PROF McDERMOTT: That's correct.
14
15 MS ELLYARD: You've made a statement in response to a
16 series of questions that were posed to you by the
17 Commission and that statement's dated 11 April 2022. Do
18 you have a copy of that statement with you?
19
20 PROF McDERMOTT: I do.
21
22 MS ELLYARD: Are its contents true and correct?
23
24 PROF McDERMOTT: They are.
25
26 MS ELLYARD: Thank you. May I turn to you, please,
27 Dr Malvaso, and ask for your full name?
28
29 DR MALVASO: Yes, Catia Gaetana Malvaso.
30
31 MS ELLYARD: And you're an academic and Senior Research
32 Fellow at the School of Psychology and School of Public
33 Health at the University of Adelaide?
34
35 DR MALVASO: That's correct.
36
37 MS ELLYARD: Your background is in psychology and you also
38 have a doctorate; is that right?
39
40 DR MALVASO: That's correct.
41
42 MS ELLYARD: You've made a statement to the Commission
43 dated 29 April 2022. Do you have that with you?
44
45 DR MALVASO: Yes, I do.
46
47 MS ELLYARD: Are the contents of it true and correct.

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DR MALVASO: Yes.

MS ELLYARD: And you've included amongst the annexures, as indeed has Professor McDermott, a copy of your full curriculum vitae?

DR MALVASO: Correct.

MS ELLYARD: Thank you. I want to begin - and I should finally note on that point, Dr Malvaso, you've included as annexures to your statement a number of articles in which you were an author or a co-author which are relevant to the matters that the Commission is considering?

DR MALVASO: Correct.

MS ELLYARD: May I begin with you please, Professor McDermott. Some of the questions that you were asked by the Commission to answer and have answered relate to the Child and Adolescent Mental Health Service, or CAMHS, and I'm drawing your attention to page 12 and following of your statement in which you make it plain that there's a current structure but there's also a proposed structure from CAMHS that's going to include a number of improvements following a review which you recently conducted. Can I invite you to speak in summary form to the changes that are proposed arising from your review?

PROF McDERMOTT: So, Commissioners, the review found that the local Child and Adolescent Mental Health Services were significantly underfunded, and because of that under-funding and some other reasons weren't really servicing young people with complex and severe mental health problems, and there were several areas which were outstanding in their omission. One was a youth Mental Health Service, so that's individuals generally aged from 12 to 25 years, and important because that was a major transition point from the Child and Adolescent Services to the adult services, and that was a point where some people were very much lost, you know, in that transition. That's the first one.

The second one was a Forensic Adolescent and Youth Mental Health Service, and although there was the perception of the service, if you look closely it was more like one individual who did some sessional time from

1 Melbourne. The importance of that service is that, if you
2 don't intervene early with people clearly on a trajectory
3 to prison, then many of them will go to prison when there
4 are clearly things that you can do to prevent that and put
5 them back on a somewhat more normal trajectory.
6

7 The other major admission was a service specifically
8 for Out-of-Home Care children, and we know from
9 population-based research around the world that this group
10 have very high rates of mental illness and very high rates
11 of the outcome of - one of the worst outcomes of mental
12 illness, that's completed suicide.
13

14 So, the main reform is to create a statewide service
15 to make the three regional teams have the same model of
16 care, to have a statewide leadership structure, to change
17 the culture into one that's more empirical and
18 evidence-based, and to bring on these three major services.
19 There are some other smaller things like eating disorders
20 but they're the major reforms.
21

22 MS ELLYARD: Thank you, Professor, and I'll come to ask
23 you some more questions about some of those reforms again
24 in a little while. Can I turn to you, Dr Malvaso, to begin
25 the discussion. At paragraph 9 and following of your
26 statement you refer to the concept of adverse childhood
27 experiences, something that Professor McDermott touches on
28 in his statement as well, and you draw a distinction
29 between an experience which is adverse which might
30 relevantly include child sexual abuse and trauma. Can I
31 ask you to explain the distinction that you're drawing?
32

33 DR MALVASO: Sure. I think the simplest way to understand
34 this distinction is to think of the adverse childhood
35 experience as the event and the trauma as the response to
36 that event and that response can be multi-faceted, it can
37 be physical, it can be neurobiological, it can be expressed
38 emotionally, behaviourally; that's the main distinction.
39

40 MS ELLYARD: And so, it doesn't necessarily follow then
41 that a particular adverse event will necessarily have a
42 particular consequence in the form of trauma being
43 experienced?
44

45 DR MALVASO: That's correct. There are, you know,
46 multiple definitions of adverse childhood experiences.
47 Typically they refer to ten distinct life events that occur

1 before age 18 that include all different types of child
2 maltreatment, physical, sexual, emotional abuse and
3 neglect, as well as indicators of household dysfunction, so
4 that's exposure to domestic and family violence, parental
5 separation, exposure to parents with mental illnesses,
6 substance abuse and incarceration, and we've seen
7 researcher, policymakers, practitioners and the like
8 arguing for a broadening of these experiences to include
9 other events like experiencing living or being born into
10 poverty, experiencing precarious housing conditions,
11 homelessness, bullying, racism, as well as experiencing the
12 death of a close friend or family member, and there's been
13 some practice in terms of just adding up the number of
14 adversities that a child has experienced and an assumption
15 that, well, some researched evidence to suggest that a
16 higher number of adverse childhood experiences results in
17 poorer outcomes in health, in behaviour, especially in
18 terms of contact with the justice system. However, we also
19 know from research that the vast majority of children and
20 young people who experience adversity in childhood never go
21 on to have contact with the justice system and I think
22 trauma and the response to these events has been used to
23 try and understand - has been used as an underlying
24 mechanism perhaps that is responsible for some of the
25 increased risk associated with experiencing these
26 adversities and engaging in things like offending
27 behaviour.

28
29 MS ELLYARD: And so, what you say in paragraph 11 of your
30 statement, doctor, is that one of the issues is to consider
31 the extent to which adverse childhood experiences can be
32 identified as the causes of clinical levels of symptoms,
33 which is the point at which a child might come to the
34 attention of Professor McDermott's service or a similar
35 service?

36
37 DR MALVASO: Yes, correct, and so, there's obviously
38 multiple ways to measure trauma and my knowledge is really
39 around some of the instruments and tools that have been
40 used in Youth Justice populations to measure trauma and
41 some examples of that, trauma symptoms, checklists for
42 children, but to the best of my knowledge none of these
43 tools have been validated on an Australian population of
44 children of different ages, different genders or from
45 cultural backgrounds, and there is a lot of discussion
46 around whether these tools are adequately capturing the
47 consequences of developmental or complex trauma, and this

1 is really important because when we're thinking about
2 treatment options it might be that we're overlooking some
3 symptoms or some behavioural indicators that are developing
4 as a response to trauma as being perhaps fixed or arising
5 from more fixed or non-modifiable traits. And, of course,
6 you know, then the risk of that is that we're responding
7 inappropriately to some of these symptoms and not providing
8 the appropriate treatment response for some of these
9 children.

10
11 MS ELLYARD: Thank you, doctor. Turning to you again,
12 Professor McDermott. One of the questions that you were
13 asked to answer from your perspective as a clinician and
14 experienced psychiatrist was what's understood to be the
15 short, medium and long-term effects of child sexual abuse
16 on survivors, and you were asked to identify this in terms
17 of short - biology brain development, executive function
18 and psychology. Can I ask you, you've given us a great
19 deal of detail, but perhaps to summarise at a higher level,
20 what are the key areas where one would reasonably expect to
21 see impacts on children who'd experienced child sexual
22 abuse.

23
24 PROF McDERMOTT: One of the inherent difficulties in the
25 area is, the answer is invariably is, it's complex, and I
26 don't say that in any demeaning way at all. The more you
27 study it and the more, you know, I know about it, the more
28 complex it is.

29
30 So, there are fundamental biological changes and, by
31 the way, all of this is likelihood, it's, there is an
32 increased likelihood of, it's a probability kind of matrix.

33
34 There is an increased probability that you will
35 actually have some structural brain damage. An example is
36 a famous Japanese study in girls 18 years of age who are
37 able to give consent for an MRI scan of their brain. If
38 you had sexual abuse under the age of, I think 16, you had
39 lost on average 18 per cent of the grey matter of your
40 visual cortex was not there, okay. 18 per cent is nearly a
41 fifth: wasn't there.

42
43 And there are now a series of studies that show that
44 there are fundamental brain alterations in - you know, that
45 are correlated, their increased likelihood from sexual
46 abuse and they are in various parts of the brain. There
47 are studies that show a relationship with the frontal lobe

1 which is all about executive functioning. There are
2 changes in the hippocampus, in short-term memory areas and
3 also in emotional regulation areas.
4

5 So, one area is actually brain structure. A second
6 area is, there has been a revolution in genetics in the
7 last 20 years; we thought genetics was, if you like, a
8 factory with one speed: DNA program was read by RNA which
9 led to protein synthesis, it was just a linear factory.
10 Now we know that you can speed up and slow down genes,
11 genes can work faster and slower, and we know that sexual
12 abuse and other forms of trauma are a fundamental way of
13 doing this. And there are things now called heat maps
14 where you can look at the methylation of someone's genome,
15 and the last time I checked, you know, over 12,000 genes
16 were susceptible to change based on trauma.
17

18 So, right from an early age you might have a different
19 brain, you might have a different genetic response, and
20 from there, you know, the next layer - so that's the
21 biology - the next layer is psychology related, and my
22 learned colleague is probably better to talk about that,
23 but we know that there can be changes in your attachment
24 behaviour, you can have anxious or anxious avoidance
25 attachments. We know that the very early kind of
26 relationships around temperament can change.
27

28 And then, of course, there's secondary deficits. If
29 you are, you know, biologically impulsive and your stress
30 response is less sophisticated, and you have temperamental
31 issues, you don't make friends with children who are highly
32 emotionally regulated, you make friends with children like
33 you, and you have problems sitting in your seat in school,
34 so then you develop issues in primary school. Your
35 friendships and peers influence, you know, the way you deal
36 with pro-social events and your development of schema,
37 cognitive schema and social mores, it has effects in your
38 high school. You might learn to self-medicate with drug
39 and alcohol, you might develop a mental health issue.
40

41 So, there is this for some people - not everybody -
42 this cascade of events that follows you through life,
43 certainly through the developmental parts of life, the
44 early years up to, you know, the early 20s, that are all
45 responsible, that all have their nubbin in trauma.
46

47 MS ELLYARD: Thank you, professor. Dr Malvaso, you

1 identify at paragraph 12 and following of your statement,
2 and you've said some of this already, that the question of
3 complex trauma, what has been described by Professor
4 McDermott is, as he said, this cascade of impacts that can
5 arise, none of them might be diagnosable as a clinical
6 condition, but nevertheless they all potentially combine as
7 a trauma response to the abuse; is that right?

8
9 DR MALVASO: Yes, I would agree with that.

10
11 MS ELLYARD: But you also go on to say, as you've already
12 touched on, that it's important to work out that these
13 things are abuse responses and not just innate and
14 unchangeable features of a person?

15
16 DR MALVASO: Absolutely, and I can speak to some of the
17 research finding that have been developing over the last
18 couple of years specifically in regards to
19 callous-unemotional traits or a lack of empathy; these
20 characteristics and symptoms can be quite common among
21 young people especially in the youth justice system.
22 There's of course a school of thought that suggests that
23 these traits are biologically based and they're not
24 modifiable. However, there is some research demonstrating
25 that these traits can develop in response to significant
26 adversity and as a trauma response, as a coping mechanism
27 for children and young people who perhaps are emotionally
28 detaching due to those distressing events that they've
29 experienced, and so, of course that's really important from
30 the treatment perspective because it provides us with these
31 new opportunities to provide more appropriate responses for
32 these children and young people.

33
34 I think the key is that we really need to understand,
35 you know, the drivers of these symptoms and when, how and
36 for whom adverse childhood experiences and trauma leads to
37 offending behaviour so that we can respond appropriately.

38
39 MS ELLYARD: One of the things you say thinking about
40 responses, Dr Malvaso, at paragraphs 45 and following, you
41 identify again, picking up this distinction between the
42 event and the trauma response, that ideally if you can't
43 prevent the difficult event happening, what you want to try
44 and do is intervene as quickly as possible before it can
45 have any of the cascade of consequences that Professor
46 McDermott has been discussing.

1 DR MALVASO: Yes, absolutely. I mean, in research terms
2 we think about them as mediators, so obviously we want to
3 prevent the exposure, the cause potentially of the trauma
4 or the associated outcomes, whether that's contact with the
5 criminal justice system or another negative outcome like a
6 suicide. But if we identify these risks and these
7 experiences later in the life course then there may be
8 other opportunities to prevent and intervene early to
9 reduce the chances of these negative outcomes, so focusing
10 on trauma might be one of those opportunities.

11
12 MS ELLYARD: Thank you. Professor McDermott, one of the
13 questions that you were asked to answer and you've answered
14 at page 8 of your statement is the therapeutic responses
15 that are most effective for addressing or minimising the
16 impact, so thinking about therapies that can be offered.
17 You've identified that what will be appropriate will be
18 dependent on a range of factors, including the nature of
19 the abuse. Can I ask you to speak to that?

20
21 PROF McDERMOTT: Yeah. So, abuse is, as Commissioners are
22 well aware, is an incredibly non-specific term and some
23 people have a single event of a single type of abuse.
24 Often people with complex mental health presentations have
25 many different forms of abuse over many years and, although
26 these are still, if you like, research models, it would
27 seem that sexual abuse as a form of adverse childhood
28 experience is incredibly damaging. Of course parental
29 separation is a much more normative experience of
30 Australian children, so not all abuses are the same.

31
32 There is also an issue about critical periods. For
33 instance, an example is, if you don't have binocular vision
34 at a certain time of childhood your brain will never ever
35 for the rest of its life have binocular vision and it will
36 actually choose one eye and actually the other eye will be
37 functionally blind. There are critical periods where you
38 have to develop speech and language, social development,
39 where you have to learn to regulate your sleep and your
40 eating, where you have to learn to develop friendship. So,
41 not all abuse is the same.

42
43 At its most simple, if you have complex abuse that
44 generally includes multiple forms over a long time, but it
45 also might include parents who have their own challenges
46 and help and that needs a multidisciplinary response with a
47 team who all bring different skills to the challenge who

1 might see the person over a protracted period of time.

2
3 If you have a single abuse in an otherwise normal
4 development, something like cognitive behaviour therapy
5 trauma focused cognitive behaviour therapy might be all you
6 need, so it's highly variable.

7
8 MS ELLYARD: And the question of working with the family,
9 you've identified that as one of the potential limbs; can I
10 ask you to explain a little bit more the significance of
11 working with a family where a child has experienced abuse?
12

13 PROF McDERMOTT: So, and I want to again be very broad, in
14 that some people with complex abuse don't actually have
15 what we would say is a nuclear biological family, so some
16 people actually don't have a family and you need to work
17 with their system.
18

19 But if you are with two carers in what we would
20 conceptualise a family - there is an issue, by the way,
21 that some of the family responses to abuse do need their
22 own guidance. So, for instance, if you have a single
23 episode of abuse and are never allowed to go to a party
24 again for the rest of your childhood, many of my patients
25 would look me in the eye and say, "That was highly
26 problematic", they wouldn't say "problematic", but that was
27 very difficult and got in the way of their development, so
28 often families also need guidance to, you know, help the
29 family to return to a normal way of being as well as the
30 child who's been abused.
31

32 MS ELLYARD: One of the key cohorts of children whose
33 interests the Commission is concerned with are children in
34 the Ashley Youth Detention Centre and in other cohorts
35 children in Out-of-Home Care. There's material available
36 to the Commission and I think each of you in your different
37 ways have touched on in your statement the fact that those
38 cohorts of children appear to be at increased risk of child
39 sexual abuse and at perhaps increased risk of suffering
40 some of the traumatic consequences of that abuse.
41

42 But I wanted to turn to you, Dr Malvaso, because I
43 think you've identified in your statement that, although it
44 might be the case that many people who go on to have
45 contact with Youth Justice have an experience of childhood
46 abuse, the inverse is not true, it's not the case that
47 merely having an experience of childhood abuse inevitably

1 sends you down the Youth Justice path; is that right?

2
3 DR MALVASO: That's right. So, I think one of the best
4 ways to explain this is thinking about different research
5 designs and studies. So, cross-sectional studies which
6 provide us a snapshot of a population in time. So, if we
7 take, for example, the Youth Justice population and we look
8 at how many of the children involved in the Youth Justice
9 system have experienced maltreatment or who have been
10 placed in Out-of-Home Care, we see that it is a high
11 proportion of those children have had these experiences.

12
13 This research is really important because it tells us
14 something about the characteristics of these children and
15 young people and something about their needs, and this
16 information is critical for informing planning, especially
17 of rehabilitative services and interventions.

18
19 However, in terms of planning for preventative
20 interventions across the life course it matters for
21 prevention when we know about these experiences when they
22 occur, and to understand this better we need prospective or
23 longitudinal studies. These studies are studies where
24 you're able to follow the same individuals over time; they
25 provide insight into different pathways and trajectories
26 for children, but they also, depending on whether they
27 include comparison groups, enable us to differentiate
28 children who will develop the outcome, so who will end up
29 having contact with the justice system, from those who
30 won't. So, it tells us a little bit more about perhaps the
31 when and the how and the for whom experiences of adversity
32 or placement in Out-of-Home Care might lead to Youth
33 Justice system and contact and this is really critical for
34 planning our prevention and intervention services across
35 the life course.

36
37 I think one of the most important points to make is
38 that there won't be one magical intervention that will
39 disrupt these pathways and promote a more pro-social
40 pathway, but that we need a series of these interventions
41 targeted at different opportunities across different
42 developmental periods across different contexts so that
43 there are multiple opportunities for us to intervene.

44
45 MS ELLYARD: Thank you. Thinking about the links between
46 the cohort of children who have contact with the
47 Out-of-Home Care system and the cohort of children who have

1 contact with Youth Justice, Dr Malvaso, at paragraph 21 and
2 following of your statement you've made some comments about
3 that link, and again it's, as I understand it, although it
4 might be that there's a higher content of children in Youth
5 Justice who have had an Out-of-Home Care experience, it
6 doesn't necessarily follow that most children in
7 Out-of-Home Care enter the Youth Justice system; is that
8 right?

9
10 DR MALVASO: That's right. I think we know from research
11 from around the world, from Australia, that it's
12 well-established children in Out-of-Home Care are more
13 likely to have contact with the Justice System. Our most
14 recent research in South Australia using population level
15 data suggests it's one in seven young people who have been
16 placed in Out-of-Home Care were experiencing Youth Justice
17 system contact by age 18, but that means six out of seven
18 won't, so the association is not deterministic, not all
19 children placed in Out-of-Home Care will end up in the
20 Youth Justice System, and again I keep bringing that back
21 to the importance then for understanding, you know, the
22 reasons behind or underlying that increased risk for those
23 children in terms of being able to plan and target our
24 prevention, early intervention initiatives.

25
26 I think one of the biggest challenges is the
27 difficulty in disentangling the impact of Out-of-Home Care
28 placement experiences from the reasons that a child and
29 young person ends up in Out-of-Home Care and, you know, the
30 cumulative adversity and disadvantage that we've already
31 spoken about. Out-of-Home Care itself is not one thing, so
32 children can be placed in different types of care at
33 different ages for different periods of time; some will be
34 reunified with their families, others will come back into
35 the system time and time again, so it makes it really
36 challenging to understand which cohorts of children we
37 should be focusing on and what are the suitable
38 interventions for those cohorts.

39
40 MS ELLYARD: At paragraph 26 of your statement,
41 Dr Malvaso, you talk about some research that's being done
42 that really speaks to this being a very big picture
43 whole-of-society issue but can I ask you to speak to the
44 matters in that paragraph and the potential complexity of
45 predicting what children are more likely to end up in these
46 environments.
47

1 DR MALVASO: So this is referring to some research that
2 I've conducted with my colleagues in BetterStart at the
3 University of Adelaide using whole-of-population
4 administrative-linked data, so that's where we can see
5 everyone born from 1991 to 1998 in South Australia and
6 understanding their contact with different systems,
7 specifically focusing on child protection and Youth
8 Justice.

9
10 I guess what some of this research is demonstrating is
11 that patterns of socio-economic disadvantage are evident
12 for these children before they're even born or at birth,
13 which means that we're seeing these indicators or picking
14 up - we're potentially able to pick up these indicators
15 from birth, and that's, I guess, one of the advantages of
16 using administrative-linked data. So, it's not necessarily
17 about that particular risk factor, you know, whether it's
18 mum smoking during pregnancy, but it's about what travels
19 along with those risks and those opportunities for
20 providing prevention and intervention initiatives.

21
22 We've also used the link data to see if we can
23 identify groups of children who are placed in Out-of-Home
24 Care early, so before aged 10, which ones are more likely
25 to end up having contact with Youth Justice, and so we've
26 used formal risk prediction methods which I won't go into
27 the detail of today, but essentially this requires some
28 nuanced judgments of model predictive performance.

29
30 And the conclusions from that research is that, while
31 the potential for prevention is large, there are some major
32 ethical and practical considerations that we need to think
33 about; we need to define our interventions in order for us
34 to truly understand the costs of the inevitable false
35 positive and false negative predictions that we might make,
36 so thinking about the stigma of labelling a young person in
37 Out-of-Home Care at high risk of entering the Youth Justice
38 system.

39
40 And something that I believe is really important,
41 which is, there's no point in screening for risk if we
42 don't have the effective interventions to offer those
43 children. I might leave it at that, if that answers it.

44
45 MS ELLYARD: Thank you. Can I turn then to the question
46 of where to get help and the kinds of help that's available
47 and the potential barriers to children who have experienced

1 child sexual abuse and where that's revealed while they're
2 still children.

3
4 Turning to you, Professor McDermott, in answer to a
5 question at page 13 of your statement you've given a
6 summary of the programs and services that CAMHS currently
7 delivers, including a list of the mental health
8 difficulties that services can be received for. As one
9 looks at that list and thinking about the discussion we've
10 already had, it's possible, is it not, that some of those
11 mental health difficulties might be properly understood as
12 themselves the sequelae of adverse childhood experiences
13 like child sexual abuse?

14
15 PROF McDERMOTT: I think the research says very clearly
16 that abuse is a non-specific risk factor to different
17 outcomes. So, for instance, abuse or trauma, and
18 especially sexually-related trauma, will increase your
19 likelihood of, for instance, post-traumatic stress disorder
20 by six times, but personality disorder by six times and
21 substance abuse disorder by six times and psychosis by two
22 times and depression by three times, so it is a
23 non-specific. There is no one particular presentation from
24 a mental health point of view that says, this is because
25 they were abused.

26
27 MS ELLYARD: But if it's a mental health presentation
28 that's found to coexist with a history of sexual abuse,
29 does that mean that understanding that is relevant to the
30 way in which the child's treated then with that condition?

31
32 PROF McDERMOTT: Stronger than that: I would say that any
33 individual who presents with a child and adolescent mental
34 health presentation should be asked about abuse, should be
35 very clearly and professionally and developmentally
36 appropriately questioned about whether abuse happens, and I
37 think the finding of that is always influential in your
38 formulation and treatment of the case.

39
40 MS ELLYARD: Can I ask you about the answer that you gave
41 to a question about CAMHS offering trauma-informed care.
42 You've answered that question on page 15 and you've made
43 the observation that there was a limited ability and
44 expertise to provide trauma-informed care to consumers with
45 severe trauma-related presentations.

46
47 May I ask you first just by matters of definition,

1 what do you mean by trauma-related presentations, what's
2 the distinction that you're drawing?

3

4 PROF McDERMOTT: So, as opposed to - I mean, if you follow
5 the logic of my last answer, everything is potentially
6 trauma-related.

7

8 MS ELLYARD: Indeed.

9

10 PROF McDERMOTT: But some are much more clear.
11 Post-traumatic stress disorder by definition links to a
12 particular event, and complex trauma, you know, links to a
13 series of particular events. So, complex PTSD, some
14 anxiety-related things like phobia can specifically be
15 related to a traumatic event. In little children some
16 attachment presentations like reactive attachment disorder
17 are specifically related to trauma. In young adulthood I
18 would say that borderline personality disorder and in fact
19 bulimia as well have very, very high rates of individuals
20 who have trauma experiences.

21

22 MS ELLYARD: I take it from the answer that you've given
23 here that, compared to the way in which CAMHS presently is
24 able to respond to children with other kinds of
25 presentations, there's a limited capacity to meet the needs
26 of that cohort where their presentation is trauma-related?

27

28 PROF McDERMOTT: Yeah, and it's more than that. I mean,
29 to, you know, force society to actually intervene
30 appropriately, there are many, many, many filters before
31 you get to CAMHS. CAMHS is, if you like, at the top of a
32 pyramid and we should be identifying the possibility of
33 trauma at multiple levels of that pyramid.

34

35 So I would have said that, in a society that was truly
36 going to take on this issue, you know, workers in child
37 cares, workers in primary school, workers - and I say
38 workers broadly - workers in high school, everybody should
39 have some ability to identify what's potentially a trauma
40 response.

41

42 MS ELLYARD: You've said in part of your answer to that
43 question that historically, and I'm conscious that you're
44 giving this in the context of a review which is proposing
45 changes for the future, historically CAMHS has apparently
46 conveyed the view that severe trauma-related mental health
47 illness is not a matter that CAMHS can help with. Taking

1 up your answer about CAMHS being at the top of the tree,
2 that seems incongruous if indeed that has been the view,
3 that the children with the most complex trauma-related
4 presentations were not suitable for the adolescent Mental
5 Health Service.

6
7 PROF McDERMOTT: I made that statement, it's in my report,
8 I stand by that statement, and I think there are various
9 reasons why that can be understood, these are reasons that
10 I don't particularly accept, but there are some views that,
11 you know, complex trauma cannot be treated by a
12 clinic-based service. These individuals are so
13 disregulated and have so much difficulty, you know, sitting
14 in a clinic-based service that they can't be helped: that's
15 one thing, that's a barrier.

16
17 Another barrier is that, if you run a service that
18 overwhelmingly has a family therapy and a family
19 orientation - I mean, a lot of these kids don't have
20 families; you know, a lot of these young folks - and
21 related to that is that, you know, for some types of
22 therapy and child and adolescent you need some placement
23 stability and unfortunately some individuals with severe
24 and complex needs have multiple placements, and some CAMHS
25 teams find this highly problematic.

26
27 The reform is all about changing the way this business
28 is being done to account for those barriers.

29
30 MS ELLYARD: Thank you, and I'll come to ask you about
31 some of those specific programs in a moment. Can I turn to
32 you Dr Malvaso. In the particular context of children in
33 the youth justice space who might have crossed over from
34 the Out-of-Home Care or child protection system, you've
35 identified in your statement the way in which sometimes the
36 Justice System becomes a de facto provider or organiser of
37 services to children who might have needed various forms of
38 support for their trauma but haven't got it. I'm drawing
39 your attention to paragraph 27 and following of your
40 statement. Can you tell us about your observations in that
41 area?

42
43 DR MALVASO: Yes. There's been a fair amount of research
44 especially from the eastern states looking at the reasons
45 why some children in Out-of-Home Care are over-represented
46 in the Youth Justice system and some of the, I guess,
47 system process or bias that leads to that

1 over-representation, and so, some of these matters are
2 around criminalisation of behaviour that wouldn't normally
3 be criminalised in a family home, so calling the police for
4 property damage or aggressive behaviour, assaults against
5 workers in Out-of-Home Care placements.
6

7 And then, once these matters progress to court
8 sometimes the courts are limited in terms of their options
9 for bail in terms of, if there's no fixed address for a
10 young person or Out-of-Home Care placement, it doesn't have
11 the capacity to accommodate that young person due to their
12 behaviour - just checking to see if there's anything else
13 I'd like to say.
14

15 MS ELLYARD: In paragraph 30 you've raised the question of
16 the courts perhaps stepping in where it perhaps ought to
17 have been a child protection response but somehow it
18 doesn't happen.
19

20 DR MALVASO: Yeah, I think it's really challenging because
21 sometimes when you think about the children who end up in
22 the Youth Justice System, I don't want to use a word as
23 strong as "has been a failure", but we can think about it
24 in that sense of other systems to pick up some of the
25 issues and some of the behaviours and some of the
26 experiences that these young people have gone through that
27 have led them up to this point of being involved in the
28 Justice System.
29

30 And so, courts, I guess, the statement is in context
31 around courts trying to link these children and young
32 people up with services that can respond to their needs;
33 whether the Justice System response is the most appropriate
34 response for that or, you know, it's happened so far down
35 the line that it's come to that response is questioned.
36 Whether it's Child Protection's remit is also questioned
37 because we know that the Child Protection system is
38 overwhelmed, we know that demand on Child Protection
39 Services is growing, it's unsustainable, and adolescents in
40 particular aren't always the focus of those, I guess, Child
41 Protection responses, and so, if we do think about it as a
42 Child Protection response there are some concerns around
43 whether these children will actually get any response at
44 all.
45

46 MS ELLYARD: Professor McDermott, picking up what you said
47 a little while ago about the systems as they existed until

1 now depending to some extent on some assumptions about
2 stability of placement and functional supportive families,
3 it sounds like then that the cohort of children that
4 Dr Malvaso is describing are precisely the cohort who, up
5 until the changes that you're proposing, might have found
6 themselves too complex to get services from CAMHS.

7
8 PROF McDERMOTT: I also think CAMHS made decisions based
9 on how best to use the money and, if you are faced with an
10 individual who has, you know, 14 placements in different
11 parts of the state, then you know, I can completely
12 understand their decision process that the money might be
13 best used somewhere else. So, there is some very
14 reasonable decision-making around, you know, model of care
15 fitting with complexity of the presenting challenge, and
16 again, hopefully we will be able to remediate that.

17
18 COMMISSIONER BROMFIELD: Sorry, excuse me, Professor
19 McDermott, in that circumstance where a child has been
20 removed by the State, do you feel that it's reasonable that
21 across Tasmanian Government services there is some
22 consideration to a duty of care to that child?

23
24 PROF McDERMOTT: Always, yes. You know, there is an
25 extension of, it takes a village to raise a child; I mean,
26 different departments should always cooperate in the best
27 interests of the child.

28
29 COMMISSIONER BROMFIELD: In the scenario you gave though,
30 we would have had a child who had experienced multiple
31 placements while in the care of the state and another state
32 service determining that, because of that, they were too
33 difficult to treat, they are wicked problems.

34
35 PROF McDERMOTT: Again, I think that these are serious
36 systematic issues and they have been, you know, the cause
37 of significant contention and they've been the cause of
38 significant consumer concerns, but also practitioner
39 concerns. Practitioners would love the degree of
40 information about a child's past to follow them very
41 seamlessly between placements and that often doesn't
42 happen. The placement would love the clinician to follow
43 the patient across placements, and that doesn't happen.
44 So, I think, you know, there's no particular one culpable
45 entity, but all entities could do much better.

46
47 COMMISSIONER BROMFIELD: Thank you. Sorry, Ms Ellyard.

1
2 MS ELLYARD: Not at all, Commissioner. Professor
3 McDermott, you've made the point fairly in your statement
4 that CAMHS is not a sexual assault service, and as I
5 understand it even under the new models that are proposed
6 you would still see there being a role for specialist
7 sexual assault services to respond to the particular needs
8 of children who have experienced child sexual abuse.
9 Assuming that they're a child who is otherwise presenting
10 in a way that makes them eligible for CAMHS services, that
11 does seem to suggest a bifurcation of the child's
12 experiences and needs that would either create duplication
13 or the potential for some dislocation in how the child can
14 be cared for.

15
16 PROF McDERMOTT: Sure. I think the way to conceptualise
17 this is a stepped care model. So, if you think of a
18 pyramid with different kind of levels, I think that CAMHS,
19 because it's funded arguably the most and it has the most
20 experienced practitioners, is at the top of the pyramid and
21 it should see complexity, and that complexity, if it is
22 sexual abuse, it is sexual abuse plus substance abuse plus
23 depression plus suicidality plus parents might be
24 struggling with drug and alcohol, but it is inherently with
25 school refusal and presentations to accident and emergency,
26 and it is incredibly complex and that's where CAMHS should
27 sit.

28
29 If you have an unfortunate person who has sexual abuse
30 but in the context of an otherwise normal educational
31 experience and family experience and they're not suicidal
32 or they don't have other things, then a sexual abuse
33 service is extremely appropriate and in fact a good model
34 of care because they can develop profound expertise in that
35 area, and best practice in that area.

36
37 So, when I say CAMHS is not a sexual abuse service,
38 CAMHS should see everything that's complex, but there
39 should be, I think, also a sexual abuse service.

40
41 MS ELLYARD: This really in part raises a question of
42 service design and system design. Dr Malvaso, at
43 paragraph 49 you've identified what you see as some issues
44 within your areas of interest relating to the way in which
45 government services are siloed with different criteria for
46 different eligibility and so forth, can I invite you to
47 speak briefly about those matters.

1
2 DR MALVASO: Yes, I think the structure and design of our
3 service systems, and this is not unique to Tasmania, this
4 is not unique to Australia all the time, but it's not
5 always conducive to the needs of families and children,
6 particularly those with complex needs that we've been
7 speaking about this afternoon and some of those barriers
8 exist at the system level in terms of agencies operating in
9 silos, and that's partly driven by really strict funding
10 models. There are barriers at the system level around
11 strict eligibility criteria, who's viewed as appropriate or
12 not appropriate for a particular service or agency, as well
13 as challenges in terms of information sharing and, when
14 there are multiple agencies involved in terms of
15 coordination and who is responsible for leading that
16 coordination, often the responsibility will fall to
17 statutory systems like Child Protection or Youth Justice.
18 Then, of course, there's individual barriers around the
19 complex needs of children and families not always being
20 aligned with the way these services are run or designed.

21
22 MS ELLYARD: You've raised the question of
23 multidisciplinary responses being appropriate for children
24 who have the complexities often associated with Out-of-Home
25 Care and Youth Justice. That's on paragraph 55.

26
27 DR MALVASO: Yes, I guess that's speaking to some of what
28 we might think of as strategies or facilitators to break
29 down some of these barriers, and of course there are other
30 barriers that arise like I've mentioned around, you know,
31 who will be the lead agency when multiple agencies are
32 involved, and sometimes it might just be the agency or a
33 practitioner who has the best relationship with that young
34 person or with that family, and it doesn't necessarily have
35 to be a professional either; in some of our research we
36 found it could just be a trusted adult or another support
37 person who won't play a role in delivering therapy, for
38 example, but they will get the child or young person or
39 parent to that service and will vouch for the service so
40 that they can engage more meaningfully and successfully
41 with those services.

42
43 MS ELLYARD: May I ask you now, Professor McDermott, about
44 a couple of the specific changes that you've touched on
45 already and which are particularly relevant to the
46 Commissioner's terms of reference. At page 18 and
47 following of your statement you answer some questions about

1 the Out-of-Home Care Intensive Support Team which, perhaps
2 picking up on the discussion that I've just been having
3 with Dr Malvaso, as I understand it it's proposed that
4 there's going to be a referral panel that's going to
5 include representatives from a number of different
6 agencies; can you speak to us briefly, and I'm conscious
7 it's early days yet, about what's proposed for that and
8 what gap it's intended to meet?

9
10 PROF McDERMOTT: Sure. And a 20 second statement to start
11 off with: "If I had the chance to change one thing, it
12 would be 'never again here' did not meet criteria." Okay,
13 it is the most exclusionary comment ever made by any
14 professional, it's unbelievable.

15
16 Okay, so I think what we are looking to do is
17 institutionalise, in the best possible way, people to
18 surround the best interests of the child, and that means a
19 referral panel has to have on it someone from Child
20 Protection, someone from Police, someone from Education,
21 someone from Health, someone from Youth Justice. In
22 Queensland we have someone from Housing, we have someone
23 from Transport, and that group of - anyone from that group
24 of people can bring a name to the panel.

25
26 Now, the panel, the caseload in this team will be low,
27 they'll only see six to eight - one clinician will only see
28 six to eight young people, so it's quite an expensive
29 resource. We have to put that resource in its best
30 possible place, and so, we have to see people with
31 extremely complex needs, and it's interesting that Housing
32 or Transport or Police might actually know the person with
33 the most complexity. Anyone from all those areas can refer
34 into that team, we think that would be incredibly helpful
35 to stop these, you know, these kind of service
36 disagreements; that group will have to make a decision on
37 who the next person is into the service.

38
39 Once you're in the service we think it needs to be
40 truly multidisciplinary because if you have complex needs
41 you might have speech and language problems, you might have
42 neuropsychological issues, you might need medication, you
43 might need psychology. A lot of these kids, occupational
44 therapists are wonderful to help them regulate their mood,
45 so it will be an interdisciplinary panel to get in and the
46 service you'll be offered will be multidisciplinary.
47

1 MS ELLYARD: One of the key barriers and challenges to
2 this great improvement that you've described, you've
3 identified as being a potential shortage of the people to
4 do the work, can you talk to us about that?

5
6 PROF McDERMOTT: So, a wonderful thing in Australia at the
7 moment is the collective and the political interest in
8 mental health: you can't go through an election without
9 some funding on mental health, which is a wonderful and
10 beautiful thing, but it does mean that at the same time as
11 huge reforms in Victoria, we are trying to recruit 60 new
12 clinicians to CAMHS in Tasmania. I know that New South
13 Wales are starting to have a reform, so it's going to be
14 problematic to get people into these positions. I think we
15 need to take a longer view and I think we need to provide
16 the best training scheme in Australia to train our own;
17 it'll take a bit longer, but I think we need to have - you
18 know, the risk to the CAMHS reform is actually our
19 workforce strategy.

20
21 MS ELLYARD: And so, what you've identified at page 22 of
22 your statement is a centre of excellence to be established
23 in association with the University of Tasmania, so as
24 you've said you're going to train up within Tasmania the
25 cohort of additional specialists that you're going to need?

26
27 PROF McDERMOTT: Yeah, so one example is occupational
28 therapists; I've already noted there the importance of this
29 cohort. We don't train OTs in Tasmania. So, the Centre
30 for Mental Health and Innovation is all about the changing
31 the culture to something more empirical, something more
32 inbuilt evaluation and, you know, creating a larger
33 workforce in this area.

34
35 MS ELLYARD: Dr Malvaso, at paragraph 67 of your statement
36 you've drawn the Commission's attention to the Exceptional
37 Needs Unit as an example of a multi-agency response to
38 children with complex needs. Can you tell us about that?

39
40 DR MALVASO: Yes, so the Exceptional Needs Unit is a
41 multidisciplinary service that sits within the Department
42 of Human Services in South Australia, and this team works
43 with systems and services, I guess, to help coordinate
44 support for individuals across the life course, so that can
45 be children and young people, it can be adults as well who
46 have multiple and complex needs, and so, obviously they're
47 children that we've been talking about today. My

1 understanding is that's quite unique to South Australia,
2 although there are some other similar types of
3 coordination-type government services in other
4 jurisdictions as well.

5
6 I'm unfortunately not aware of any formal evaluations
7 of these types of models or services within our context,
8 but in terms of reducing some of these barriers around the
9 idea of, to use more colloquial language, passing the buck
10 between agencies, that you can then take that lead role and
11 assist in that co-coordination.

12
13 MS ELLYARD: So a bit like, as Professor McDermott said,
14 not saying doesn't meet our criteria, off you go to the
15 next door?

16
17 DR MALVASO: Correct.

18
19 MS ELLYARD: Professor McDermott, can I ask you then about
20 the proposed youth forensic unit which you've dealt with at
21 pages 22 and following in your statement and ask you to
22 summarise, as you did in relation to the proposed team for
23 Out-of-Home Care care, what's this unit going to do and
24 what's the gap that it's meeting?

25
26 PROF McDERMOTT: There are two aspects to the Youth
27 Forensic Service: one aspect is a community-based and one
28 aspect is in-reach into detention-like facilities.

29
30 The community aspect is something called multisystemic
31 therapy. Multisystemic therapy is an American product that
32 has been around for at least 25 years, it has been run
33 successfully in New Zealand and Western Australia. It's an
34 incredibly intense service where you get six months of
35 therapy seven days a week with availability of your
36 therapist 24/7, which is incredibly intensive, and you're
37 expecting to see your therapist three to four times a week.
38 You're not allowed to have an office, so multisystemic
39 therapy therapists will see you in your front yard, if it's
40 safe in your living room. They will intensively work to
41 support parents and caregivers to give more sort of
42 evidence-based and responsible and impactful parenting, as
43 well as work with the young person on a multiple of - you
44 know, a range of interventions to change their trajectory
45 from prison. A lot of it's incredibly practical,
46 increasing their coping set, increasing their alternatives
47 to medication and drugs and alcohol. Actively breaking

1 relationships with other dysfunctional peers, who I've been
2 with MST teams and we've gone up to gangs and said, "You
3 promise not to meet with this gang?" And the young person
4 said, "I did", and hopped in the car and we drove away, so
5 it's an incredible service that has many, many randomised
6 controlled trials that shows that it will decrease the
7 recidivism rate to prison, and some states of America have
8 actually adopted MST because one day you're more likely to
9 pay taxes. Now, although I say that somewhat facetiously,
10 if you're more likely to pay taxes it means you're more
11 likely to get a job and you're more likely to have a
12 meaningful life. So, the community offering will be
13 multisystemic therapy. There will be a team, there will be
14 three teams in Tasmania.

15
16 The other offering will be an in-reach into the
17 replacements to Ashley Detention Centre to provide
18 assessment and treatment services, and we anticipate they
19 will be not only traditional mental health but also
20 neuropsychological. For instance, the rate of things like
21 foetal alcohol syndrome in detention populations is
22 actually very high. The rate of some types of genetic
23 presentation are actually very high. The rates of, you
24 know, speech and language issues and the need for remedial
25 education are high. So, the input to the prison will be
26 sort of neuropsychological as well as psychiatric, and
27 hopefully the two arms of this service will talk to each
28 other.

29
30 For instance, you could get some assessment and work
31 in detention and then be discharged to an MST team.

32
33 MS ELLYARD: What about if the opposite happens, a child
34 is on an MST program in the community and falls foul of the
35 law and finds themselves remanded to Ashley, is the system
36 going to be able to cope with --

37
38 PROF McDERMOTT: The one team leader and one consultant
39 will be responsible for both arms of the service; they will
40 be a truly integrated service. So, the knowledge, the
41 treatment plan, should follow seamlessly the young person
42 into detention.

43
44 MS ELLYARD: You've said that the MST program isn't going
45 to be intended for people who are themselves engaged in
46 sexual offending where sexual offending occurs in the
47 absence of other delinquent or anti-social behaviour - I'm

1 quoting from page 24. What's the reason for excluding
2 sexual offending as a basis? It's pretty anti-social
3 behaviour, one would have thought.
4

5 PROF McDERMOTT: We are very constrained by the MST model
6 of care. We actually sign a contract with MST. They
7 provide supervision and training, so that's actually a
8 contractual part of our obligations.
9

10 I think that the group who are of themselves sexual
11 offending, my firm position is that they are of increased
12 likelihood to have abuse histories themselves, and they
13 should be seen in other aspects of the service.
14

15 What we hope is these new teams will actually be
16 highly influential to our existing community CAMHS teams
17 and will more likely for those teams take serious and
18 complex as well. I would hope that those individuals would
19 be seen by community CAMHS.
20

21 MS ELLYARD: Dr Malvaso, Professor McDermott's just
22 referred to the contractual nature of the process by which
23 any organisation can use the MST model. You've made some
24 comments about your understanding of the way in which the
25 MST model has been reviewed at paragraphs 68 and following
26 of your statement. Can you tell us please about that?
27

28 DR MALVASO: Yes. So, MST's originally developed to help
29 support or rehabilitate young people with anti-social
30 behaviour, with conduct problems. As Professor McDermott
31 has talked about, it is a community-based model intended to
32 work with families, holistically and therapeutically, so
33 work with the individual young person as well as their
34 families or their Out-of-Home Care unit, their school,
35 their community and now there are various adaptations of
36 MST, including MST-CAN which is child abuse and neglect
37 which I guess is intended more as a family preservation
38 program. There are specific MST programs for children with
39 harmful sexual behaviours as well but that's not the
40 mainstream program I suppose, and MST-CAN itself excludes
41 families in which sexual abuse has occurred as well.
42

43 Much of the evidence base has been generated by
44 studies conducted in the US and there's been a recent
45 meta-analysis published last year, so meta-analysis
46 combining the results from multiple randomised control
47 trials have concluded that the evidence for MST is actually

1 quite mixed; the majority of studies used to support its
2 effectiveness were assessed as having a high risk of bias.
3 So, these authors actually, I would say, went through the
4 randomised control trials, quasi-experimental studies with
5 a fine tooth comb to assess risk of bias. So, when I'm
6 talking about risk of bias I'm talking about things like
7 issues with the randomisation process, so with trials;
8 there's random allocation of individuals to receive the
9 treatment, so to receive MST, and then random allocation to
10 a control group which might be treatment as usual or
11 another intervention. And so, they identified a high risk
12 of bias due to issues with randomised process which can
13 lead to base line differences between the groups which
14 makes it really difficult to reliably estimate the effects
15 of the program.

16
17 High risk of bias in terms of measuring outcomes,
18 missing data on those outcomes, attrition, deviations from
19 the intended intervention, so that's transportability
20 issues as well in terms of what's intended to be delivered
21 as well as selective reporting and conflicts of interest in
22 the studies that have been conducted in the US.

23
24 There are of course trials that have been conducted
25 outside of the US; recently there was a trial in the UK and
26 the conclusion from that research was that there was no
27 evidence of long-term superiority of MST over treatment as
28 usual, and so, I guess this body of more recent knowledge
29 casts some doubt over how well MST can be transported to
30 other jurisdictions and how effective it is. That's not to
31 say that it can't achieve positive outcomes, but I think we
32 need to think really carefully about the programs and the
33 interventions that we are trying to implement in an
34 Australian context, especially those from the US, and
35 acknowledging that our context does differ in some cases
36 quite significantly from the US, particularly when it comes
37 to the Youth Justice System.

38
39 So, our Youth Justice System in Australia tends to be
40 more informed by a welfare approach to responding to young
41 people who commit crimes, which is a contrast to some of
42 the more punitive-driven models in the US. We have a lot
43 more emphasis placed on diversion, which means there's
44 multiple opportunities to divert children and young people
45 from the Justice System, whether that's through police
46 formal or informal cautioning, whether that's through the
47 courts with family conferencing.

1
2 The reason I guess I'm saying this is because the
3 children and young people that we see in our Youth Justice
4 systems in Australia might not look the same, and indeed in
5 South Australia they certainly don't look the same as
6 children in the US, in the sense that we're seeing a much
7 higher prevalence of adverse childhood experiences of
8 trauma, and I think that we really need to take these
9 differences into account and ensure that we're, I guess,
10 implementing and designing interventions that are based on
11 the needs of our population, and the really important point
12 of recognising the over-representation of Aboriginal and
13 Torres Strait Islander children and young people in Child
14 Protection and Youth Justice and considering the legacies
15 of colonisation and entrenched disadvantage that leads to
16 their over-representation in these systems.

17
18 MS ELLYARD: Thank you, doctor. How are you going to --

19
20 PROF McDERMOTT: I think it's really important that I
21 respond to that.

22
23 MS ELLYARD: How are you going to be measuring this, any
24 comment that you'd like.

25
26 PROF McDERMOTT: I think it's really important that I
27 respond to that. I think a researcher could say that about
28 any intensive intervention from a methodological point of
29 view.

30
31 If you look at the methodologies of looking at complex
32 and severe, there's always biases, there's always
33 differences across jurisdictions, there's always
34 methodological issues; these are the typical things that a
35 researcher would find problematic about a system - first
36 thing.

37
38 The second thing: it's been successful in New Zealand
39 for, you know, 12 years or so, and I would suggest that,
40 similar to us, it's now successful in Western Australia for
41 many years, which I would suggest is fairly similar to us.

42
43 We've done extensive stakeholder discussions with
44 First Nations people; they find the MST approach, which is
45 non-clinic based, which is strongly family affirming and
46 strongly, you know, in the home and in the community, their
47 choice, their system of choice. And, of course, MST is not

1 our only offering.

2
3 The last thing I was involved in, the first
4 international study of MST CAN in the world, and it's
5 really important that we continue to try evidence-based
6 interventions in this area, it's crucial. And, although
7 that wasn't a very successful study, we learned a huge
8 amount about running an MST service in the Child Protection
9 environment.

10
11 I think we will be - because, you know, I have a
12 Doctorate in Science - I can assure you that we will be
13 looking assiduously at outcomes and those outcomes will
14 include wellbeing and community connectedness and a whole
15 level of functional improvements, including uptake of work,
16 uptake of education, recidivism rates, those kinds of
17 things as part of this intervention.

18
19 MS ELLYARD: Thank you, professor. Can I ask you, in the
20 context of the identified limitations that you were asked
21 about in relation to the Youth Forensic Unit you've
22 identified a couple of things and one of them is that, as I
23 understand it, part of the design of the MST program is
24 that it assumes a degree of family involvement and indeed
25 it can't work without that. Thinking about the possibility
26 of some of the children who might otherwise be good
27 candidates for it not having a stable family or indeed any
28 family at all, and you've identified that; are there going
29 to be alternative offerings for those children?

30
31 PROF McDERMOTT: Yeah, but also MST is actually aware of
32 that and the family, again, is broadly defined. If you
33 have a member of kin, you know, broadly defined, who is
34 going to be with you for six months; if you have a foster
35 parent or someone who's going to be with you for
36 six months, if you have some adult carer who's going to be
37 with you with for six months, they will accept that.

38
39 MS ELLYARD: The last topic I want to raise, conscious of
40 the time Commissioners, is what I'll call broadly the topic
41 of culture, and I'll start with you, Dr Malvaso. The final
42 comments that you've made in your statement were about your
43 observations of past enquiries which might make a lot of
44 small recommendations which are given effect, but somehow
45 the overall system doesn't seem to change and you have some
46 reflections on what is required. Can you talk to me about
47 that?

1
2 DR MALVASO: That's, there's no one answer to that and
3 it's really challenging, and I think a lot depends on major
4 social and political reform, long-term investment and
5 commitment in evidence-based programs and initiatives to
6 drive our reforms; this means that politicians and
7 decision-makers and to some extent the public need to be
8 willing to make these investments while accepting that we
9 may not see the returns or the returns may not be realised
10 for years, decades, sometimes even generations.

11
12 We need to invest in research and methods that help us
13 understand which interventions are most appropriate, which
14 ones are evidence-based, and evidence has many different
15 meanings and is not always created equally, so we need to
16 think about, for the children who are already in contact
17 with Child Protection and Youth Justice, our legal, our
18 moral and ethical obligation to them to ensure that we
19 don't do any more harm to these children.

20
21 And so, of course, I would argue we need the objective
22 and rigorous research, but we also need to listen and learn
23 and really value the evidence generated through lived
24 experience as well.

25
26 MS ELLYARD: Professor, can I turn to you. It's clear
27 from --

28
29 PRESIDENT NEAVE: Sorry, I just had one quick question on
30 that. Did the MST program evaluations to which you've
31 referred provide any opportunity for children who'd been
32 through those programs to express their views? To what
33 extent did they make use of children's voices?

34
35 DR MALVASO: Off the top of my head these are mainly based
36 on randomised control trials and quasi-experiments, so they
37 can be some self-report in terms of outcomes, but in terms
38 of any sort of in-depth qualitative investigation, I'm sure
39 there are studies, but I would have to take that on hand.

40
41 PRESIDENT NEAVE: Professor McDermott, can you...?

42
43 PROF McDERMOTT: I don't know.

44
45 MS ELLYARD: The final question to you, Professor
46 McDermott. It's clear from your evidence and your
47 statement that there are a lot of changes coming proposed

1 by you in your review of the CAMHS model and a lot of need
2 for additional investment in resources, but also perhaps
3 more fundamentally as I see potentially a change of
4 culture, if I can use that expression, attitudinal changes
5 within the service or amongst clinicians about the way in
6 which to respond to some of those issues, and I'd be
7 grateful for your reflections on how that culture shift is
8 going to happen in addition with the various specific
9 proposals that you've described.

10
11 PROF McDERMOTT: Sure. Commissioners, I graduated in
12 1984. We could have had this Commission of Inquiry in
13 1985, 1995, 2005, 2015. And I think you have an
14 interesting task to try to - and a challenging task - to
15 try to create enduring change, and my view is that system
16 recommendations won't do it, service recommendations won't
17 do it, and I'll just give you the example of Beyond Blue.

18
19 I was a board member of Beyond Blue for 10 years, so
20 I'm actually biased towards Beyond Blue. But, if you were
21 a fella, you couldn't go into a toilet in any pub in
22 Australia for 15 years without seeing a Beyond Blue
23 sticker, and you couldn't sit down and have a beer without
24 having a Beyond Blue coaster, and there was a national
25 conversation about depression, and a national conversation
26 about stigma.

27
28 We still do not have a national conversation about
29 child abuse. It is still something that people would
30 prefer not to talk about, not to acknowledge, not to think
31 about, not to realise that the prevalence is ridiculously
32 high. And I think, until we have a national - Tasmania
33 could champion it - Tasmanian ongoing entity like Beyond
34 Blue that, in a regular and profound way uses, not people
35 like me, but uses marketing experts and using national
36 leaders and national experience - you know, people that are
37 known through media or politics or whatever, that on a
38 weekly fashion encourages people to face these issues and
39 encourages things like, you know, a whole bunch of issues
40 like people to delay - you know, wouldn't it have been nice
41 if you delayed having a child until a husband and wife got
42 their ice addiction under control; that'd be kinda nice,
43 that'd be nice, and the only way to do that is not a
44 systems response from a health professional, it's actually
45 a national body or a state body reminding you in a weekly
46 fashion that you need to nurture your child's brain in
47 utero in the first five years to provide them the best

1 chance of life.

2

3 So, I don't see any change - with respect - until we
4 have those things which are way above service providers.

5

6 MS ELLYARD: Thank you, professor. Commissioners, those
7 are my questions. Are there any --

8

9 PRESIDENT NEAVE: May I just make one comment? I think
10 one purpose of this Commission is to encourage precisely
11 the conversation that you're talking about.

12

13 PROF McDERMOTT: I know, I was being rhetorical, yes.

14

15 PRESIDENT NEAVE: And that both of you I think have raised
16 as important. Any questions?

17

18 COMMISSIONER BROMFIELD: I wanted to acknowledge your
19 final comment, I think it's an excellent point and I thank
20 you for it, my question now seems quite micro in that
21 context. But, Dr Malvaso, I noticed your research, you've
22 really utilised linked data; you've used that tell us more
23 about populations, to do prospective analysis, and you
24 talked in your statement about, I guess, some of the power
25 of linked data or of data systems that tell you about
26 systems, about referral pathways and about outcomes.

27

28 Really, it's a question for both of you as to whether
29 you think that there is a role for the use of linked data
30 in Tasmania, both to inform our service system responses
31 but also potentially to evaluate and continue to monitor
32 how we're performing?

33

34 DR MALVASO: Yes, I think there definitely is a role, I
35 think linked administrative data gives us the best
36 population-wide view of different contact patterns with
37 different agencies and services; it tells us something
38 about where children have come from and where they go; it
39 tells us something about their trajectories, and
40 importantly, it's the type of data that is really valued by
41 policymakers, by decision-makers in terms of informing
42 service planning. It can be really powerful thinking about
43 how we can use the linked data to evaluate studies.

44

45 So, Professor McDermott pointed out some of the biases
46 that we're always going to see in research when it comes to
47 complex interventions with families with complex needs in

1 this area and whether we can use linked data for
2 quasi-experimental studies that don't rely on randomised
3 control trials.

4
5 I don't know the number of children who have come
6 through MST programs in Australia, but I can't imagine they
7 would be very large, and so we could be waiting years
8 and years for data to be able to evaluate the effectiveness
9 of MST in the randomised control trials. However, we can
10 use linked data to, I guess, bring in service data
11 providing we're collecting that and we're investing in
12 collecting the right type of data that we need to answer
13 questions around effectiveness. Bringing that in with
14 linked administrative data allows us to construct
15 comparison groups of children and families with similar
16 characteristics who haven't had that intervention.

17
18 I will add to that, while population level, linked
19 administrative data will give us that best population-wide
20 view, it's not always very detailed, so we do need to
21 supplement and augment that data with psychologically
22 meaningful data with service data, and importantly, that
23 point around actually talking to children and young people
24 and families and those with lived experience, and in
25 particular adhering to principles of indigenous status
26 sovereignty, ensuring that we're not just perpetuating the
27 same negative stories using this type of data but that
28 we're also using indigenous methodologies and knowledge to
29 inform what we might view as an evidence base.

30
31 COMMISSIONER BROMFIELD: Thank you.

32
33 PROF McDERMOTT: Can I just add that a lot of people don't
34 know that some of the work on sudden infant death syndrome,
35 SIDS, and the relationship of the positioning of a baby in
36 a cot and death was actually Tasmanian-linked data, and
37 it's probably saved millions of lives: this was back in the
38 90s.

39
40 Tasmania is perfect for linked data, it's an island, a
41 lot of people, you know, live here and don't go for good
42 reasons, and a lot of the linked data studies in Dunedin
43 and Christchurch and Western Australia are all from places
44 where, you know, people stay for many, many, many years, so
45 it's actually perfect for that.

46
47 COMMISSIONER BROMFIELD: And would that have utility, in

1 your view, Professor McDermott for service planning?
2

3 PROF McDERMOTT: I agree with everything my colleague
4 said, I think it's incredibly helpful, you know, you need
5 to look at multiple ways of evaluation. That is one way
6 and, you know, there's other ways of doing it. Different
7 methodologies and designs are better for answering
8 different parts of the jigsaw, so it's one powerful way.
9

10 COMMISSIONER BROMFIELD: Thank you.
11

12 PRESIDENT NEAVE: Thank you very, very much, that was
13 really a fascinating session, we learnt a lot from it.
14 Thank you.
15

16 MS ELLYARD: Thank you, Commissioners.
17

18 **AT 4.40PM THE COMMISSION WAS ADJOURNED TO**
19 **WEDNESDAY, 4 MAY 2022 AT 10.00AM**
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