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

WITNESS STATEMENT OF CAROLINE BROWN

I, Caroline BROWN of [redacted] in the State of Tasmania, do solemnly and sincerely declare that:

1. I make this statement on the basis of my own knowledge, save where otherwise stated. Where I make statements based on information provided by others, I believe such information to be true.

2. I make this statement as an individual who has worked in both the government and non-government sector, mostly concerned with children and young people in out of home care in Tasmania since 2003.

3. I ask that the contents of my statement be treated as anonymous. If the Commission wishes to use any part of this statement as evidence or in the final report, I ask that any identifying information not be included and that case examples remain strictly confidential.

BACKGROUND

4. I hold a Masters Degree in Clinical Psychology and have a broad range of experience working with children and families including in child protection and out of home care over 30 years.

5. [redacted]

6. [redacted]

7. I have provided detailed written submissions to the Inquiry in the capacity of both roles.

8. From 2003 to 2007, I was employed by the Department of Health and Human Services (**DHHS**) - (now Department of Communities), initially as the Manager of the Divisional Support Unit, Children and Families Division, working in child safety policy and practice oversight. During this time, I spent 6 months as State Manager of the then Child and Family Services (responsible for child protection and out of home care) and approximately six months as the Director of the Division. I then worked for almost two years as the Director of Disability Services (North).

9. [redacted]

10. [redacted]

11. While I do not consider myself an expert in the specialist assessment or treatment of child sexual abuse it is an issue I have worked with throughout my whole career, and I have completed the *Certificate IV in Government Investigations*. I do consider that I have expertise in safeguarding and in the identification of risk as well as the indicators of possible child sexual abuse and I know how to run an investigation.

12. [redacted]

CHILD PROTECTION AND CSS

13. Over the last 19 years in which I have worked with or interfaced with Child Safety Services (**CSS**) in Tasmania, change has been a constant theme. Senior leaders have come and gone and while all have had a significant reform agenda in reality the senior leadership tends not to stay very long, and the priorities regularly change with each new leader. Reform agendas and projects are begun but are often not fully implemented or brought to a conclusion.

14. I recall when I worked in the Department in 2003, one worker saying to me something to the effect of *I have seen off quite a few managers and I will see you off too* when I was trying to institute change. And they were right. I can think of more than 10 senior leaders in the Department over that time and I do not really think that circumstances for children themselves have much improved over this period.

15. Over this time there have also been several significant restructures within CSS. At the beginning of 2007, there was a major restructure in the then Department of Health and Human Services (**DHHS**) as well as in CSS. This restructure followed a significant change of leadership at senior levels with people coming in from the Department of Education with the agenda of 'fixing' child protection.

16. The restructure of children's services, including child protection followed and unfortunately, this resulted in a significant loss of expertise. I moved to work in disability services at this time, not through my own choice.

17. This restructure moved the Department from a State based to a regional management structure. Three new area directors were appointed with area managers underneath them.

18. This structure was put in place with an intention to progress a significant reform agenda. It substantially increased the management resources from one state manager and three service centre managers to three area directors and four area managers. This structure however in my view failed to ensure major reform and led to significant divergences in practice between the regions.

19. When I returned to the children's service sector in 2009, I noticed that in the intervening three years while I was working in Disability Services, that there appeared to be a significant loss of knowledge and expertise within CSS and child protection, including at senior levels. There had also been significant staff turnover at all levels.

20. In 2008, [redacted] KPMG's national sector lead in Human Services, in conjunction with the Department, led a process with stakeholders to reform the child protection and out of home care sector along with the other elements of Human Services. This report was cutting edge 14 years ago.

21. As part of this program of reform, the Department committed to the full outsourcing of all out of home care services. This commitment was made in the context of major policy, procedural, legislative and regulatory reform. It committed to the development of service specifications, a pricing models, performance monitoring, staff and carer standards, carer accreditation, transfer of case management to the sector along with a wide range of other initiatives.

22. Nongovernment services positioned themselves, but progress was slow following the initial outsourcing of residential care and trauma counselling with these services commencing in 2009. It took five years to outsource sibling care, a process which commenced in 2014.

23. Activity on most other priorities stalled. While some of the reforms proposed fourteen years ago were implemented, many of the reforms in relation to out of home care were abandoned.

24. The next attempt at major reform was in 2014, when Children and Youth Services, a unit with the Department of Health and Human Services, issued a paper on OOHC reform. This reform provided the framework for the reform of the OOHC system to an evidence-informed, needs-based, planned, strategic response to the needs of children who cannot live with their families.

25. The key objective of the reform was the development of a comprehensive continuum of care and an OOHC service system that addresses the needs of children in care in a structured manner.

26. This Framework provided a blueprint for change based on reforms across five key areas:

    a) Shared Values and Purpose

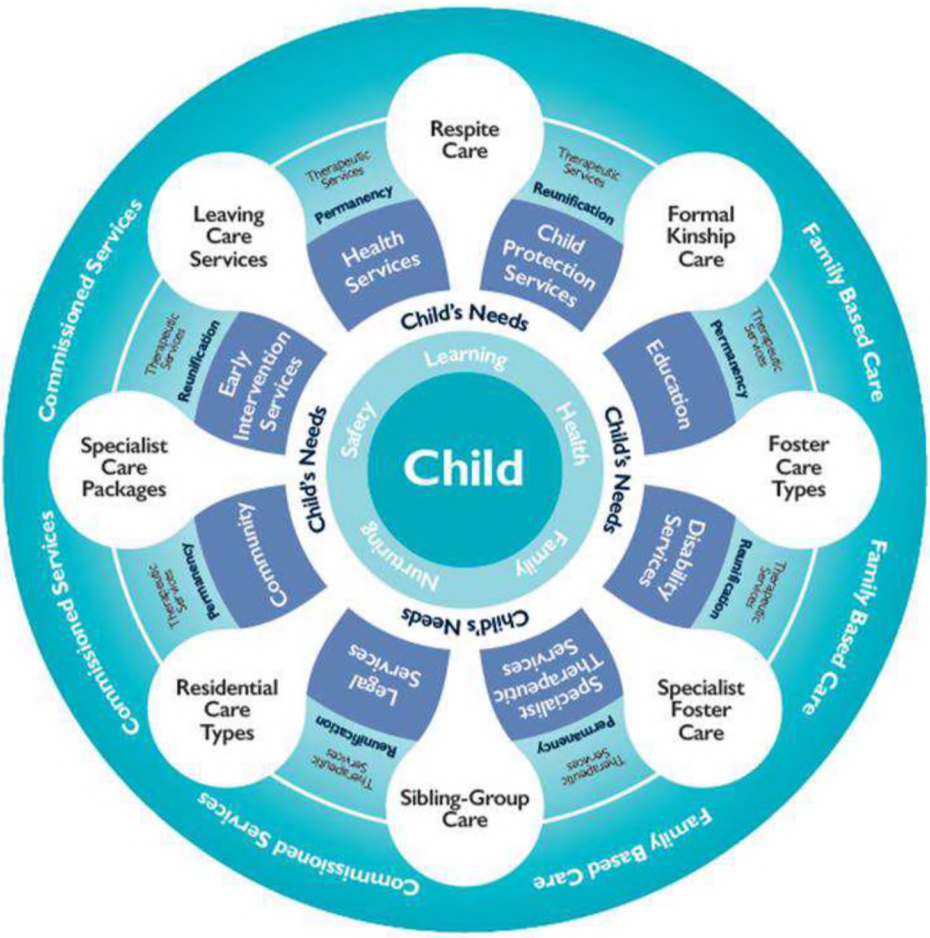
    b) A Responsive System

    c) Quality Services

    d) Strengthened Practice

    e) Structured and Accountable Funding

27. The service system model adopted was summarised in the following schema:



28. A plan was established to commission services in a phased manner, beginning in 2014 with sibling group care, residential care, therapeutic and leaving care services and intending to progress to the commissioning of family-based care, including special care packages, foster and kinship care in 2015.

29. Concurrently, Child Safety reform was intended to address:

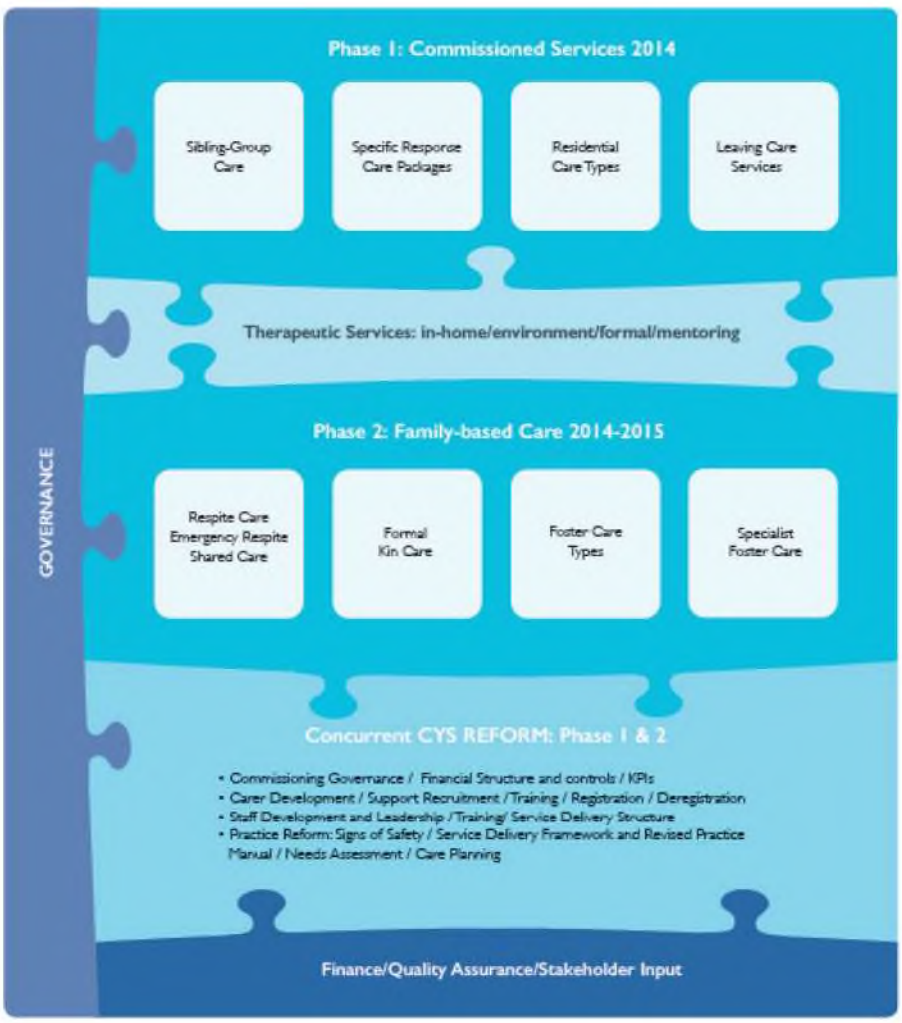
    a) Commissioning Governance / Financial Structure and controls / KPIs

    b) Carer Development / Support Recruitment / Training / Registration / Deregistration

    c) Staff Development and Leadership / Training/ Service Delivery Structure

    d) Practice Reform: Signs of Safety / Service Delivery Framework and Revised Practice Manual / Needs Assessment / Care Planning

30. Within this context, in 2014 the Department issued Request for Proposal documents for therapeutic services, residential services and sibling group care. In 2015 a Request for Proposal was issued for Special Care Packages. However, the remaining aspects of the blueprint for report and the commissioning of services have never progressed.



31. Standards for Out of Home Care or Foster Carers have been discussed since I first came to Tasmania almost 20 years ago but have not yet been introduced. Tasmania is one of the few jurisdictions with no reference to foster carers or the standards that they are expected to abide by in legislation.

32. In 2018, this issue was partly discussed in the context of the *A Future Program for Family Based Care: Out of Home Care Foundations Project*, led by [redacted]. Following the submission of comments from the sector, and several workshops, nothing more was heard about this project.

33. In July 2021 the issue of standards was revitalised, and the sector was invited to attend a workshop on the development and implementation of standards for Out of Home Care and the Development of a Carer Register. A similar workshop was also held in in the mid 2000's auspiced by the then Commissioner for Children.

34. No further communication has been received about this 2021 project and its progress remains unclear, perhaps due to the strongly expressed view at the workshop that it was not only the not-for-profit sector that should abide by any standards developed but the Department as well.

35. Regardless of the lack of Departmental or legislated standards, larger community sector agencies [redacted] are using their own published standards to guide practice as described in the [redacted] as well as the umbrella *National Standards for Out of Home Care*.

ROLE OF GOVERNMENT DEPARTMENTS

36. In my view the role of the Government Departments in Tasmania is confused and conflicted. They struggle to hold the statutory responsibility, the provision of direct services, purchasing of services from the not-for-profit sector and the management and quality assurance of all services.

37. In my view Child Safety Services should hold its statutory role only and be strong in the assessment of statutory risk and the legal processes that follow.

38. The Department more broadly should have a unit dedicated to the proper purchasing, licensing and oversight of the quality of commissioned out of home care services and case management services.

39. Across the world, governments are moving away from direct service provision and are focussing their efforts on statutory responsibilities and on the commissioning of services with a shift from input funding to outcome-based programs. There is debate in the literature about whether government can be both purchaser (or in more advanced jurisdictions, commissioner) as well as an effective and efficient provider in the human services space.

40. Across Australia most other jurisdictions have adopted this approach and there is a missed opportunity for Tasmania to continue to lead the reforms in Australia. [redacted] is now the Global Human Services Lead for KPMG International and her expertise is recognised across the world. Given the work undertaken by KPMG in the past it would be prudent for any reform to consider an update of the previous work and a review of what was undertaken in response to the previous review. In a recent paper [redacted] writes:

> *In the face of unprecedented pressures on demand, expectations and resources, governments around world are rethinking how they deliver health human services including social care, family care housing. The shift involves*

letting go their traditional roles as service providers, instead facilitating new markets collaborative environments that enable desired outcomes.[1]

SERVICE STANDARDS

41. I have often felt that there are higher standards applied to the not-for-profit sector by the Department than they apply to themselves. I support the highest possible standard when it comes to the safety and protection of children young people, and having worked in both sectors, I have concluded that the not-for-profit services are far more rigorous in the application of standards and safeguarding principles than the Department.

42. Carers are free to transfer between the Department and other agencies. All carers transferring to the Department from [redacted]s have been of concern to us in respect to quality of the care that is provided. Attempts to address the carer concerns have resulted in the carer requesting a transfer to the Department as they know the concerns will largely go unaddressed. CSS is often reluctant to even hear about those concerns which may then go on to persist for many years.

43. Tasmanian children need an independent child advocate or statutory guardian for the investigation of complaints and concerns. The current Child Advocate is not independent and, in my view, always holds a position that favours the Department's desired outcome.

44. One issue that I have observed is that the more external criticism Child Protection are subjected to, the more they 'bunker down' and develop an 'us against them' attitude. This makes the service resistant to change, particularly if suggestions for change are coming from external organisations. In my experiences child protection in Tasmania is an incredibly difficult area to influence and shift. CSS has an 'insular' culture where practices are entrenched. I also feel that good practice in the sector shines a light on poor practice in the Department.

45. I feel that it is a characteristic in general of Tasmania, and Child Safety Services in particular, that conflict avoidance is the preferred operating style and there is an uncomfortableness with open discussion and debate. This is a risky approach in the area of child abuse and neglect, and it results in the Department often not working in partnership with providers and care teams preferring a command-and-control model.

46. In my experience, CSS and child protection is a 'damned if you do damned if you don't' area. Everything is contextual and Departmental workers struggle with this. Most of the decision making is very subjective and lacks the rigour of proper analysis and critical thinking. The external perspective is that child protection never gets it right, however it's

---

[1] KPMG, *Unleashing Value: Commissioning in the Human Services Ecosystem* (2017) 3.

a very difficult role and there are workers who are doing a great job, despite the system not because of it. Tasmania needs everyone in the system to be doing a great job more of the time. The service would benefit significantly from an open approach to learning and critical thinking, analysis, reflective practice and conducting serious case reviews to continually push the boundaries of good practice.

ADVICE AND REFERRAL LINE

47. One area where there has been some recent change is the revamping of the centralised service for people needing support, known as the Advice and Referral Line or ARL.

48. The ARL is also the conduit for the reporting of allegations of abuse and neglect under the *Children, Young People and their Families Act 1997* (Tas) as a recreation of the former gateway services and the centralised system the Child Protection Advice and Referral Line, which was decommissioned as part of the area structure in 2007 having only operated for a short time.

49. One concern I have with the ARL is that it is trying to shift the responsibility for action onto the caller. This may be all very well if it is a professional that is calling but it is very difficult for a neighbour or family member and even a teacher, to take action to secure a child's safety.

50. In the months following the commencement of the ARL, I recall receiving several calls from parents and family members who were randomly calling foster care agencies in the phonebook, trying to get support to address concerns they had with their own family members harming children. I recall spending some considerable time coaching them as to what to say when they called the ARL as it is no longer the case that notifications of child abuse and neglect are caller defined and there is a risk that reports people are trying to make go unaddressed.

51. I am aware that even professionals must be very specific that the information provided is to be treated as a notification of possible abuse and neglect. For this reason, non-government workers far prefer to put their concerns in writing rather than calling the ARL via the telephone line, at least in the first instance.

52. There is concern in the sector specifically in relation to the timeframes to respond to notifications of risk for children already known to the system and instances of concerns having to wait the return of an allocated worker from annual leave. Needless to say, children at risk of abuse and neglect should not have to wait to have their concerns assessed and addressed.

53. It is of grave concern to me that the published figures reported by the Department of Communities, under the heading "Children in Active Transition", really meaning not

having an allocated worker to investigate allegations of abuse and neglect directed at them, remains high at an average of 93 children per month over the past 12 months.

OUT OF HOME CARE

Training

54. To effectively work in the areas of child protection and out of home care workers need to have skills, abilities and values appropriate to the role. This includes holding a tertiary qualification in social work, psychology or another human resources discipline together with the capacity for critical thinking, analysis, objectivity and curiosity as well as the capacity to connect well with people and, in particular, the ability to relate well to and to understand children within a trauma based developmental context.

55. At times CSS has employed staff with a wide range of backgrounds not related to social services. CSS also employs a high number of new graduates which is representative of the structural issues in the child safety workforce, a topic that was the subject of a Community and Disability Services Ministers Advisory Council subcommittee named Structural Issues in the Workforce established in 2005 and on which I represented Tasmania.

56. Highly specialised training is needed to conduct forensic investigations into child sexual abuse. Training of this type has been offered in the past to Child Safety Workers either through Tasmania police, locally by a collection of different providers or the training was sourced interstate.

57. In the early to mid-2000s there was specific training in place for Child Protection Workers focussing on the specialised assessment of sexual abuse. This was in place until at least early in the 2010s as I recall delivering a portion of that training in respect to conducting assessments and childhood trauma.

58. I am also aware that Tasmania Police have from time to time provided training to Departmental workers however am unaware if this is continuing to occur.

59. I recall an instance of alleged serious penetrative sexual abuse of [redacted] female child in foster care and the CPS worker who was investigating that allegation instructed the foster carer to take the child to the doctor for examination and the child was taken to a general practitioner. The CPS worker was completely unaware that there were specifically trained forensic medical practitioners for examinations of this type, despite working in child protection for several years. This resulted in poor evidence gathering and the child was denied her rights to a proper investigation. Injuries to the child's vagina were nevertheless detected.

60. I recall one of this most distressing and frustrating meetings of my career focussing on the feedback from this investigation.

61. A Departmental Team Leader expressed during this meeting that the then [redacted]-year-old girl may have injured herself vaginally by vigorous internal masturbation using her finger.

62. Both myself and my colleague (also a qualified counsellor) were of the view that this [redacted] year-old child had been raped by her [redacted] year-old foster brother.

63. This Senior Practice Consultant who interviewed the child did not feel her statement that [redacted] meant that penetration occurred but that it could mean "a range of behaviours". I recall this worker saying that the girl may have inserted a pencil or stick into her own vagina.

64. The focus of the response by the Department was not on the needs of the girl but on the needs of the [redacted] boy who they claimed as "not that bright" with the inference being that he could not have planned a sexual assault.

65. The Senior Practice Consultant felt that the [redacted] girl was fantasising about the sexual activity. They felt she needed help to address her "perpetrative behaviours towards older boys". The Child Protection staff agreed that the boy needed to "learn how to say no when girls jump on him".

66. A specific lack of training related to sexual abuse in general may also have contributed to a general lack of operational knowledge including in how to identify and investigate child sexual abuse.

67. This lack of training has resulted in possible sexual abuse not being identified.

68. In one more recent case, blatant indicators of possible child sexual abuse including vaginal bleeding in an [redacted] girl was not medically investigated.

69. Conversely, it is also the case that behaviours which are not actually sexual in nature can be labelled as such and become perpetuated in the child's file without being evidenced which can be further damaging to a child. I recall a child who was [redacted] being labelled as having problem sexual behaviour when in fact this behaviour was related to stress, trauma and sensory issues and was not a sexual behaviour. On other occasions when children and young people have been labelled as having "problem sexual behaviour" it has not been possible to determine what that behaviour is, seemingly only the label exists with no context about why that label was applied.

70. This lack of expertise among CSS staff impacts how child sexual abuse is recognised and acted on. CSS staff don't know what question to ask of children or how to 'read

between the lines'. Children are making disclosures but they are not being acted on. Some of this comes down to workload but it is also general values and attitudes.

71. CSS aren't well enough resourced in terms of skills and abilities to undertake proper investigations. The investigation component has been pushed entirely to the Police and if there isn't enough evidence for a criminal prosecution, the matter is just dropped. It appears to be rationalised by CSS that there must be nothing in it if criminal proceedings don't proceed. This attitude fails to recognise that CSS investigations do not require the same level of evidence. Each matter should be assessed "on the balance of probabilities" bearing in mind the Briginshaw Test. There should be an assessment of risk or the 'likelihood' that something has occurred. CSS previously did their own investigation reports where there were allegations of sexual abuse, but I have not seen an investigation report for quite some years.

72. In my opinion, child sexual abuse comes up as an issue in Tasmania far less than it should. We are not really looking for it and children are not generally encouraged to raise their concerns. I believe that some CSS workers are uncomfortable talking about sexual abuse and some cannot even name body parts correctly in discussions.

73. The general culture of conflict avoidance in Tasmania is dangerous in child protection. People don't have honest conversations as they don't want to 'burn bridges' or damage relationships in a small community. Small communities also contribute to boundary issues, as people often know each other in a variety of contexts.

74. There does appear to have been an uptick in the amount of general training offered or funded by the Department since August 2021, including workshops under the Prevention, Assessment, Support and Treatment (PAST) Program:

    a) Introductory Keeping Kids Safe

    b) Advanced Keeping Kids Safe

    c) Harmful Sexual Behaviour: An Overview for Educators

    d) Supporting Sexual Safety in the Disability Sector

75. There are also workshops offered by the charitable organisation, the Daniel Morecombe Foundation.

76. I am unaware of the extent to which Department workers access this training.

77. Training in the nongovernment sector focusses on building safe systems and on sexual abuse prevention via safeguarding and integrates safeguarding into all policies, procedures and practice guidance. These policies and procedures are regularly discussed via team meetings, case reviews and through communities of practice.

78. [redacted]

79. Children's participation is a vital component of safeguarding as having their voice heard is a protective factor. Organisations like [redacted] have a Children's Participation Strategy and are constantly working to enhance participation.

80. In my experience Departmental workers often confuse children's participation with doing what the child wants, without a thorough analysis of why the child may be expressing a decision and without understanding that views change depending on the context. As an example, I have known children to be asked if they want to live with mum or dad in front of a particular parent.

Information systems and communication with Government

81. When children are referred to organisations like [redacted] for placement or family services intervention there is often a lack of information provided by CSS. As a result, we often seek further information and sometimes contact Tasmania Police directly because significant information is either not shared or known about families.

82. In one case, the service was not notified that there had been [redacted] in a home even though we were expected to attend the house. All service providers need knowledge of these types of risks to ensure safe work practices. In another, the referral made an unqualified statement that the mother had [redacted] and no analysis in respect of this reported threat was made. In another case a mother was having a sexual relationship with [redacted] while also allowing a [redacted] but no action was taken about these matters from a Child Safety perspective nor even a sense that these circumstances might pose a risk to her [redacted] children.

Complaints and concerns

83. Raising issues with the Government has been a concern at times. I feel that you can never win an argument with CSS even about a child's safety. Often our staff, [redacted] were more qualified and experienced than the allocated child protection worker and they reverted to statutory decision-making authority and power rather than collaborative practice.

84. I feel that over the years there has been a reduction in truly collaborative practice and reduced sector consultation. The relationship between the Department and the community sector is still a traditional "master – servant" one and not necessarily a relationship based on principles of partnership, collaboration and best interests of the child. This feels quite different to other state government Departments such as Victoria

who have a well-developed partnership with the sector with clear licensing standards and audit requirements. There is also an established peak body, the Centre of Excellence in Child and Family Welfare, that works closely with both the sector and the Department to improve evidence-based practice, promote collaboration and shared problem solving with the aim of achieving the best possible outcomes for children and families.

Reporting

85. The Department historically has only investigated abuse and neglect concerns but occasionally has become involved in quality-of-care matters, particularly if there is a pattern and history of several concerns. In general, the funded community sector organisations are responsible for the carers, while CSS are responsible for the child.

86. Reporting within [redacted] depends on the level of concern. In respect to allegations of child abuse or neglect, we make notifications through the ARL and notify the case manager for that child.

87. Within the organisation we also raise an incident report for all allegations of child abuse or neglect and a wide range of other incidents. We have a procedure for reporting incidents at all levels of the organisation, with the most serious incidents reported to the Board or Chief Executive Officer.

88. For very serious incidents we generally undertake our own investigation through a Serious Incident Review Panel.

89. Serious incident reviews are important processes to be undertaken when a very serious incident occurs, and the organisation wishes to determine if there are any actions that could have been taken to prevent such an incident and if any learnings stem from it. Generally, these reviews will relate to incidents in which there has been a death or serious injury / harm to a service user but can be applied to any incident or series of incidents.

90. The management of Serious Incident Reviews will be governed by the Serious Incident Review Oversight Panel, which meets twice per year, in the absence of a specific incident, to discuss patterns and trends and the progress of recommendations relating to previous reviews.

91. [redacted]

92. The Oversight Panel will accept recommendations that a serious incident review may be required from any panel member, member of the Senior Executive Leadership team or Board.

93. The Panel will convene following a request for a serious incident review and will determine composition of the investigation team.

94. Terms of reference will be developed for each serious incident review and an investigation scope will be defined.

95. Individual case review panels will be generally chaired by the [redacted] and will include at least three members (including the Chair). The panel may undertake the review itself or other staff, such as those working in the [redacted] may be commissioned to be part of the investigation team to undertake or assist with the investigation and report preparation.

96. The resulting incident review report will be tabled at the Serious Incident Review Oversight Panel for endorsement and once approved, will be shared with [redacted] Senior and Executive Leadership Meetings, the Board and/or the relevant Board sub-committee as well as relevant organisation committees tasked with quality and practice improvement.

97. Less serious incidents are reported and tracked through our Incident Management Policy and Procedure, which includes risk assessment and safety planning appropriate to the incident under consideration.

98. In respect to foster care, lower-level incidents, such as standard of care concerns are also investigated at a local level. It is our practice to share these concerns with CSS. We conduct our own analysis of what has occurred and develop service improvement actions as a result.

Foster Carer Approvals

99. Foster carers are approved to provide foster care following a comprehensive assessment process. There is no agreed standard in Tasmania how this should be undertaken with differing practices for foster care approvals across the State. It appears that some organisations approve their own carers as the Department from time to time has not seemed to be aware of where children are placed.

100. [redacted]

This is an example of good collaborative practice occurring with the Department because of a [redacted] standard.

101. In my view this approval process is the start of a fostering journey and intensive support and coaching as well as monitoring and review are needed to ensure as far as possible that the carer is providing a safe home for vulnerable children.

102. [redacted]

COMPARING JURISDICTIONS

103. I've had experience working with Child Protection in other states, including working as the [redacted] in Victoria. In my experience, Child Protection in other states such as South Australia and Victoria are far more open to working with service providers like [redacted], and there is a sense of 'partnership' between the two. In Tasmania, the relationship between Child Protection and service providers is what I would describe as 'master to servant'. Across all the roles that I have held I have always taken a stronger approach to safeguarding than many of my child safety colleagues, even when I worked there.

Tasmania now and in the future

104. Tasmania must address the cultural and structural issues referred to in this document if we are to move forward and embrace a truly collaborative approach to child safety. I believe that the Department and Government need to redefine its role and purpose, with a focus on its statutory responsibilities and on proper and accountable commissioning of services.

105. There is little policy prescribed by the Department other than mandatory reporting. At [redacted], we are more rigorous about our own policy and procedure than the Department requires of us. In my opinion, the Department policies are minimum standards as opposed to best practice. Our own policies and procedures go further. This can, at times, be an issue with our carers as the Department will say that certain people such as babysitters don't need any screening, however in [redacted] our policy is that they do. The expectation of carers is quite reasonably that the State Government should set the standards and unfortunately this is not the case in practice.

106. As a community we need to be better educated about safeguarding and we need to prioritise the rights of children. One example of this is that all of our systems need to proactively respond to lower-level boundary issues seriously. Boundary breaches are the first step in a potential offender's journey. Offenders test the waters by testing the

system a little bit to see what happens, if there is no consequence or push back or the behaviour is accepted, they test it a little bit further.

107. I have addressed professional boundary issues throughout all of my roles. Often these processes have resulted in the person leaving or being terminated through a human resource process.

108. Working with children, the boundaries can sometimes become blurred, such as workers attending birthday parties for children afterhours. However, these circumstances can be accommodated if they are formally documented and approved by managers and staff members are clear that they are working, they are paid, and the scope of their role is clearly negotiated.

109. When workers undertake actions in an unofficial, unapproved and undocumented capacity all organisations should be concerned about safeguarding but also about potential risk these actions pose to the organisation. I am concerned that the Department is not always rigorous in the maintenance of appropriate professional boundaries within the CSS workforce.

CASE STUDIES: CHILDREN AND CARERS

110. There are a number of specific cases that I have been involved in during my career in Tasmania which in my view demonstrate some of the issues with child protection in Tasmania. I have kept very brief, deidentified notes of each of these cases which are also held in my memory as they represent some of the most significant failures to protect and support vulnerable Tasmanian children that I have come across.

'Lillian'

111. Lillian was [redacted] years old in [redacted]. The [redacted] received a referral for Lillian to receive counselling. That referral included a disclosure by Lillian to her current carer that when she was [redacted] with her previous carer named 'Lyle' she would 'help him make his penis grow'. The current carer also identified that Lillian continued to exhibit sexual behaviours. When we notified CSS the child protection worker was shocked that we treated this as a disclosure and no one from child protection spoke to Lillian. Tasmania Police were eventually notified but this occurred around 4 months later.

'Mabel'

112. Mabel was [redacted] years old in [redacted]. The [redacted] had been working with Mabel for about a year. She was living in a one-on-one residential care placement that was poorly supported. Mabel struggled to stay at the placement and eventually moved out to live with her [redacted]-year-old "boyfriend". [redacted] were aware that this man had had previous dealings with Police following a prior relationship with a [redacted]-year-old. When we notified

CSS, the Child Protection case worker said Mabel manipulates 'vulnerable men' and was 'living where she should be'. There was no intervention for Mabel or the young man. In our view Mabel was [redacted] years old and a crime was being committed. CSS wash their hands of kids like Mabel because the issues are complex and challenging and addressing them increases their workload.

113. This type of concern is still very much an issue today. Children are accepted as 'self-selecting' from as young as 10 years old and are selecting unsafe environments. In my opinion there is no intervention due to workload issue and a general sense of learned helplessness.

'Beatrice'

114. Beatrice was [redacted] years old in [redacted]. [redacted]. [redacted] met with Child Safety following a disclosure by Beatrice that a [redacted]-year-old boy, 'Hank', had penetrated her vaginally in [redacted] the foster home they lived in together. Child Safety investigated which included the Child Safety Officer at the time advising the carer to take Beatrice to a GP who identified internal injury. The conclusion reached by CSS was that while inappropriate activity had occurred there was no force from Hank to Beatrice. Hank had threatened to not play with Beatrice if she didn't participate in sexual acts, but this was not considered coercive. It was also said that it couldn't be proved penetration took place and that Beatrice's injury could have been from self-masturbation with her finger. It was considered a mutual act and therefore the boy would not be investigated as a person believed responsible for sexual abuse.

115. The risk assessment for Hank was deemed to be low because he was small, not very bright and hadn't previously displayed sexual behaviours. The [redacted] advocated for therapeutic intervention, however the view of CSS was that he only needed education in 'how to say no to girls that jump on him'. As a result, there was no therapeutic intervention, and his behaviour was minimised. He was removed from the home and placed back with [redacted] who was also [redacted] years old. Counselling of Beatrice was handed to the [redacted]. Had this case been in Victoria, Hank would likely have been placed on therapeutic treatment order. Instead, he was referred to Family Planning for education. The [redacted] also raised concerns about Hank being placed back with [redacted] however child protection did not believe a risk existed.

116. I believe that this boy Hank to be the same child who had several years earlier made a disclosure to an [redacted] worker about feeling unsafe in a placement with a carer named 'Fergus'. I recall Hank being removed from this placement. I recall an investigation taking place by CSS that took a very long time. I recall being part of a meeting at which it was decided that Fergus would be placed on the *Person Believed Responsible*

Register for harming a child via grooming behaviours. I was shocked some years later in [redacted] when Fergus approached [redacted] with a view to becoming a foster carer. It was apparent from these communications that he had continued to foster, despite being on the Person Believed Responsible Register, with [redacted]. His request to become a foster carer with [redacted] was denied on the basis of information received from [redacted] that did not relate to the incident leading to his placement on the *Person Believed Responsible Register*. [redacted] years later I received a request from his solicitor asking for an explanation about why he was not accepted to foster, which was duly provided, again based on information received from [redacted] and not my prior knowledge of this case. Fergus again contacted [redacted] with a desire to foster.

117. It is robust systems and processes that prevented Fergus progressing with a fostering enquiry. It would be of significant benefit to Tasmanian children if the Department could maintain a complete and accurate register of persons deemed not suitable to provide foster care.

'Dora'

118. Another example involves a child named Dora. She was [redacted], had [redacted] siblings and was referred to [redacted] for counselling after presenting with highly sexualised behaviours. These behaviours included offering boys to '*suck on her titties'*. Dora had previously made a disclosure about abuse perpetrated by her father but when interview by Police on that occasion, did not disclose anything to them. During subsequent counselling with SASS Dora made disclosures that her father had tried to make babies with her. She stated that she did not make disclosures to the Police because she was worried about [redacted]. Child Protection were notified of this disclosure but did not think it was significant. They did not follow up with Dora and didn't think they needed to. The primary focus of Child Protection for this family were the needs of the parents. If it wasn't for ACF and SASS intervention, the child would have gone back to live with her father.

CASE STUDIES: CSS STAFF

119. I am aware of examples of boundary breaches by CSS staff that in my view were not handled appropriately by the Department. These boundary breaches have been an issue for a long time and in my view are not adequately addressed or taken seriously. I have made numerous reports over the years in relation to CSS staff besides the reports below, including reporting a CSS worker being alleged to be using young people in care to deliver drugs and children in [redacted] care claiming CSS former staff members allegedly abused them when they were in their care and the carers were fostering with the Department.

120. The cases below are of particular concern as the staff members remain working with the Department.

'Kirk'

121. Kirk works as a child protection worker in [redacted] Tasmania. Kirk continually defies the rules in his practice, making his own rules as he sees fit. He has an 'I know best, and I'll set the rules attitude'. There has been nothing seemingly done over many years. He is a significant person of concern.

122. The first time I met Kirk in the mid to late 2000s he was endorsing an [redacted]-year-old girl being provided with cigarettes by her mother as that was a lesser evil than taking drugs like her parents.

123. I have heard people in the Department refer to Kirk as [redacted] as I understand he is also a [redacted]. There are a lot of indications that raise red flags his practice. In my opinion, it is difficult to prove sexual abuse so it is critical to respond to boundary breaches, it shows that the Department or an organisation will not tolerate boundary breaches and hence it is risky for any potential perpetrator of abuse. If you push the boundary a little bit and experience no consequence, it is easier to push it further the next time. Kirk has been pushing the boundaries for at least [redacted] years.

124. An example of this is that a child disclosed to their foster carer that Kirk had given them a [redacted] and told them to keep it a secret. The carer told [redacted] as the provider. I spoke directly to Kirk about this matter. He initially said that the school provided the child with the [redacted]. When I said that I would call the school and address it with him, he back tracked. I said that this type of action could be perceived as grooming. I made sure the care team and senior management knew about this matter. I told the Department's Area Director for the region. He said no one was concerned about potential sexual abuse with Kirk. He said that Kirk was difficult as he was also the [redacted] but said there wasn't any concern with regards to grooming or child sexual abuse. I also recall making a report via email to an Area Child Safety Manager for the region. I don't know what action, if any, the Department took in respect of this matter.

125. Other examples of boundary breaches by Kirk that I have either observed or been told about include:

a) Writing to foster carers and parents and advising them not to question their children about meetings between the child and the worker as these are to be kept secret. I recall reading this letter and providing it via email to the Department's Area Director for the region and discussing it with my colleagues. This would have been in late [redacted].

b) Taking children to his home to deliver an animal during a contact visit with a child;

c) Having a child stay at his own home overnight which his manager had "unofficially" approved of;

d) Making claims of openly ignoring a manager's direction and choosing to take a child on an activity for a full day to connect with them alone, then subsequently claiming to a [redacted] staff member that the child made significant sexual abuse disclosures during the outing;

e) Ignoring direction from his supervisor not to take children on another outing and doing so alone; and

f) Contacting a [redacted] foster carer and staff member directly to request an ongoing relationship with child, after no longer being the child's case manager, stating that it was for the benefit of the child.

126. Kirk talks openly about these acts. He basically says, 'my manager says I shouldn't do it but I do it anyway'. All of these things are openly discussed in meetings. Staff at [redacted] have told me that they have heard Department staff say, 'That's just Kirk'. He is the [redacted]. He seems quite powerful, and I have seen [redacted]. It concerns me that he has held a supervisory role and wonder about the modelling junior staff or new social workers experience and the potential for these kinds of behaviours to be perpetuated.

127. Child safe organisation must have clear boundaries. The Department does not have that. Child safe organisations must have environment, systems and processes to protect children as well as having safe people. In [redacted] these issues would have been addressed immediately after the report of the [redacted], which at the very least was poor and misguided practice and if a second incident occurred, it is highly likely the employee would be dismissed.

'Winston'

128. Winston is a support worker in the [redacted] on the State. He has been a support worker for a long period of time and has worked and still works for the Department for all that time.

129. When I was working in the Department he was directed to work in my office in an [redacted] because [redacted] This would have been around [redacted]. I recall that there were a number of ministerial briefings written about the matter. I believe that he was alleged to have had [redacted]. He worked closely with a

HR manger at this time. The HR manager had a [redacted] background. It seemed to me at the time that she took his side and accepted his explanation that it was [redacted]. He was still on [redacted] when I left the Department. When I commenced work with the [redacted] in [redacted], I was surprised to learn that Winston was back working as a support worker. I presume that he either was [redacted] after I'd left the Department.

130. One of the concerns that has been identified with Winston multiple times with multiple children in the different organisations in which I have worked, is that trips take longer than they should when he is transporting children.

131. On another occasion I was told that Winston came back into the child protection office and said that a girl was going to make allegations against him that he was alone in her bedroom. His job as a support worker is focussed on transporting children and he had no reason to be in her bedroom. I believe he was getting on the front foot against a possible concern by raising it in this way.

132. In [redacted] or [redacted], while I was at the [redacted], I wrote a letter to the Director of Child Safety Services at the time. The letter detailed all of the concerns that different members of my staff team had in relation to Winston. This included that he had previously been [redacted]. I wanted to bring this to notice as the senior staff in the Department were all new. We raised 4 or 5 concerns, including the [redacted] Winston taking too long in transporting children and being in a child's bedroom. I cannot now recall the details of the other examples we raised.

133. I recall that I received an email from the Department about our concerns, stating that the matter had been fully investigated and that there was no cause for concern.

134. A few years ago, a [redacted] staff member raised concerns about Winston after a foster carer and [redacted] social worker had raised concerns about transport taking too long. The concern was raised verbally with the Support Work Coordinator from the Department. Their response was to remove Winston from working with that foster carer. I'm not aware of any other action. Since these concerns were raised, [redacted] have not had contact with Winston.

135. This is an example, in my opinion of a lack of prioritisation of safeguarding and risk management. It is also an example of a worker's rights being held above children's right to safety. I would have expected that the then Department of Health and Human Services could have found a non-child related role for this worker. I would not want to take such a risk in an organisation that I led. If this type of issue occurred in my service and an alternate role could not be found, I would have dismissed the worker, if on

probation, or use existing mechanisms to end their employment within the bounds of the law.

136. I sincerely hope that this Inquiry leads to real improvements in the safety of Tasmania's most vulnerable children and young people.

I make this solemn declaration under the *Oaths Act 2001* (Tas).

Declared at [redacted]..... in the State of Tasmania

on ..9 June..... 2022

.....[redacted]..

Caroline BROWN

Before me: [redacted]